



Ministry of Health & Family Welfare
Government of India



Anemia Mukta Bharat Abhiyaan

Operational Guidelines



Anemia Mukh Bharat Abhiyaan

Operational Guidelines

Nutrition Division
Ministry of Health and Family Welfare
Government of India

JUNE 2026

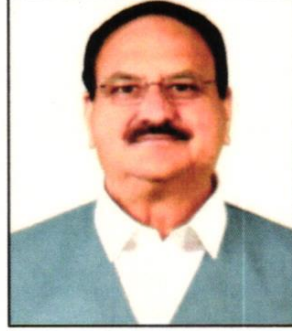


जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA



मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India



MESSAGE

Over the past decade, India has made remarkable progress in strengthening its healthcare system and advancing public health outcomes. We have witnessed significant improvements in maternal & child health, nutrition and disease prevention. These achievements are a reflection of our collective resolve and dedicated efforts.

Anemia remains central to health, nutrition and overall well-being of women and children. Recognizing its far-reaching consequences, the Government of India has placed anemia reduction at the forefront of its public health programmes. Reaffirming our commitment to this cause, we are launching this initiative to accelerate and strengthen our collective efforts towards its elimination.

Anemia Mukta Bharat Abhiyaan is envisaged as a transformative step forward to achieve sustained anemia reduction with greater intensity, saturation, precision and accountability. It will mark a paradigm shift from universal prophylaxis to a screening-led, outcome-focussed approach. The strengthened Anemia Mukta Bharat Abhiyaan emphasis on intensive integrated testing, therapeutic management, digital tracking and Eat Right Strategy.

I urge all States/UTs to accord high priority to implement this Programme. I am confident that intensive implementation of the initiative will lead to improvements in Infant Mortality Rate and Maternal Mortality Ratio and will accelerate our progress towards a healthier and more productive nation.

(Jagat Prakash Nadra)



अनुप्रिया पटेल
ANUPRIYA PATEL



राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

MINISTER OF STATE
HEALTH & FAMILY WELFARE
AND CHEMICALS & FERTILISERS
GOVERNMENT OF INDIA

Message



Anaemia, a public health challenge facing our country today, disproportionately affects adolescent girls, women of reproductive age and young children—the very groups whose health and nutrition shape the future of our nation. Addressing anaemia is therefore not merely a programme objective; it is a commitment to equity, human development and the well-being of this and future generations.

Through the revised guidelines as Anaemia Mukht Bharat Abhiyan, we expand our efforts through intensified screening, management, digital tracking, campaign for eating right and diet diversification along with community engagement. These guidelines will build upon those efforts laid under Anaemia Mukht Bharat and reflect on the lessons learned from implementation, emerging scientific evidence, and our determination to accelerate progress.

The shift of strategy to the "Test, Treat, Talk, and Track " approach marks an important step forward with clear protocols for integrated testing, treatment, follow-up, and resolution, ensuring that every individual identified with anaemia receives the care and support needed to address it. This approach places our collective responsibility at the centre of programme implementation to achieve measurable outcomes. With a shift of implementation, transitioning from only prophylactic to both prophylactic and therapeutic with compliance focused management, we also intend to transition from fragmented, manual record-keeping to inter-operable digital ecosystems that enable data sharing across platforms allowing seamless tracking of hemoglobin levels.

These revised guidelines provide a stronger operational framework to guide our efforts in the years ahead. I call upon State Governments, district administrations, development partners, civil society organizations, and communities to work together with renewed commitment and shared purpose. With coordinated action, effective implementation, and sustained resolve, we can ensure that every woman, adolescent, and child has the opportunity to lead a healthier, more productive life.

(Anupriya Patel)

June 24, 2026
New Delhi



पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव

PUNYA SALILA SRIVASTAVA, IAS
Secretary



भारत सरकार
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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare



MESSAGE

Anaemia, a major public health concern in India, requires sustained investment and commitment to help reduce its burden to achieve the targets envisaged under the Sustainable Development Goals (SDGs), while alongside contribute to the creation of a healthier, more resilient, and a prosperous nation.

2. The guidelines on Anaemia Mukht Bharat Abhiyaan build on learnings from experts from the field of academia, programme implementation, State experiences and reflect a careful assessment of the factors that need strengthening for further progress. The revised strategy shifts from a supplementation-focused approach to a comprehensive screening-led, outcome-oriented model. These guidelines seek to provide clarity by outlining comprehensive protocols for screening, treatment, follow-up, referral, and digital reporting. In doing so, they aim to promote greater consistency, enhanced outreach and effectiveness in programme implementation across all States and Union Territories.

3. These revised guidelines emphasize on healthy diets for anaemia prevention and a stronger communication strategy 'Jan Chetna' which is action oriented to bring about a change in not only perception of anaemia, but also promote active participation in management and resolution of the same. The strengthened convergence architecture embedded within the Anaemia Mukht Bharat Abhiyaan provides a framework for actions to be undertaken so that efforts across sectors contribute towards a common objective of Anaemia Mukht Bharat.

4. I am confident that these revised guidelines will further strengthen and streamline the implementation of the Anaemia Mukht Bharat Abhiyaan and accelerate progress towards our shared goal of addressing anaemia as a public health concern. Through committed leadership, effective convergence, and sustained community engagement, we can ensure that women, children, and adolescents across the country are empowered to lead healthier, more productive, and more fulfilling lives.


(Punya Salila Srivastava)

#StopObesity

टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega



आराधना पटनायक, भा.प्र.से.

अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)

Aradhana Patnaik, IAS

Additional Secretary & Mission Director (NHM)



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स्वास्थ्य एवं परिवार कल्याण मंत्रालय

Government of India

Department of Health and Family Welfare

Ministry of Health and Family Welfare

MESSAGE

Anemia Mukta Bharat Abhiyaan guidelines represent an important evolution in the Anemia Mukta Bharat strategy, marking a deliberate shift from a focus on service coverage to a focus on health outcomes. The original framework played a critical role in expanding the reach of prophylactic iron and folic acid supplementation and establishing a strong foundation for anemia management efforts across the country.

The revised guidelines have been designed to bridge the implementation challenges and strengthen the continuum of care from identification to recovery. A comprehensive strategy under Anemia Mukta Bharat Abhiyan has combined both targeted and complementary approaches to ensure effective and sustained reduction in anemia.

The strategic shift under Anemia Mukta Bharat Abhiyan reorients the programme from a supplementation-focused approach to a screening-led, diet-integrated, and digitally enabled continuum of care aimed at achieving sustainable anemia reduction. The introduction of the 'Test, Treat, Talk, and Track until Resolution' framework reflected through systematic screening, severity-based case management, structured follow-up, and integrated counselling with Focus on Eat Right and community mobilization, moves the needle from delivery of interventions to a result-oriented strategy that places individuals and their recovery at the centre of programme implementation.

Particular significance must be accorded to the strengthened digital tracking and data driven monitoring framework to systematically track progress from diagnosis through treatment and resolution, enabling valuable insights into performance and facilitate timely corrective action and accountability across all levels of the health system.

I would also like to acknowledge the dedication of our frontline workforce – ASHAs, ANMs and Community Health Officers and our Medical Officers as well. These revised guidelines are intended to support and empower their efforts. By providing greater clarity on roles, protocols, follow-up mechanisms, and documentation, they aim to make implementation more effective and ensure that your invaluable contributions are visible and measurable.

Through collective action and sustained commitment, we can achieve an Anemia-Mukta Bharat, ensuring that every woman, child, and adolescent has the opportunity to lead a healthy, productive, and fulfilling life.

Dated: 22nd June, 2026


(Aradhana Patnaik)

#StopObesity

टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega



मीरा श्रीवास्तव, आई.आर.एस.
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MESSAGE

भारत सरकार
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Department of Health and Family Welfare
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Anemia affects individuals across the life cycle, impairing physical growth, cognitive development, work productivity, and maternal and birth outcomes, thereby perpetuating an intergenerational cycle of poor health and nutrition. To reduce burden of anemia a comprehensive approach encompassing adequate nutrition, dietary diversity, screening and management of underlying causes, and sustained behaviour change interventions to remain Anemia free remains critical.

Anemia Management spreads over a lifetime and it requires mindfulness at every stage. During the formative years habits related to healthy lifestyle can play an important role in preventive & promotive care. Similarly, anemia in pregnancy is not just a number on a lab report. It is a risk that a woman carries through every stage of her pregnancy, one that shapes her delivery, her recovery, and the earliest days of her child's life. The consequences of missed or incomplete treatment in pregnancy can be irreversible.

The reformulated strategies under the Anemia Mukta Abhiyaan are designed to shift that curve through the integration of promotion of dietary diversification, digital interventions for improved monitoring and compliance, and deep dive into root cause analysis for identifying causative factors. The updated protocols provide clear guidance, emphasizing convergence of anemia testing and structured counselling to enhance program efficiency and impact. This strategic shift reorients the programme & weans away from a supplementation model to a screening-led, diet-integrated, and digitally monitored continuum of care framework aimed at sustainable anemia reduction.

I am hopeful that the convergent efforts of the programme teams and frontline workers across States and UTs will ensure effective field level implementation to bridge the gap between policy intent and positive outcomes. The dedication and commitment of all the stakeholders will definitely pave the way towards the goal of stronger and anemia free India.

मीरा श्रीवास्तव

(Ms. Meera Srivastava)

#Measles Rubella Elimination
#Anemia Mukta Bharat



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The revised Anemia Mukta Bharat Abhiyan guidelines have been prepared following extensive technical deliberations and collaborative consultations with technical experts, institutions, development partners, and programme implementers across the country.

I would like to express my sincere gratitude to Smt. Aradhana Patnaik, Additional Secretary & Mission Director, NHM, who's vision and support helped us deliver and drive the agenda of revising the guidelines. I also sincerely thank Smt. Meera Srivastava, Joint Secretary (RCH), Ministry of Health & Family Welfare, whose guidance and helping hand were instrumental in shaping this revision.

I am deeply appreciative of the valuable contributions of National Technical Expert Committee including Dr Bharati Kulkarni (Director, NIN), Dr Priyanka Bansal (ICMR), Dr Pankaj Malhotra (PGIMER), Dr S. Anuradha (MAMC), Dr Praveen Kumar and Dr Ratna Biswas (LHMC), Dr Neena Malhotra, Dr. Ratna Sharma, Dr Kapil Yadav and Dr. Kalpana Luthra (AIIMS), Dr Bindu Bajaj (SJH) and Dr Ashok Kumar (Dr RML Hospital), Dr. H.P.S. Sachdev (Paediatrician, SRBISR), Dr Anura Kurpad (SJRI), Dr Sutapa Neogi (Director, IIHMR), Dr Molly Jacob (CMC, Vellore), Dr Ranadip Chowdhury (SAS), Dr Prema Ramachandran (NFI) and Dr Siddharth Ramji whose technical expertise and constructive feedback has enriched the content of these guidelines. Special mention for the contribution of the IT team of the NHSRC under Air Cmde (Dr) Ranjan Choudhury, Advisor, HCT-IT.

My heartfelt thanks go to the Nutrition Division Team, Dr Sneha Mutreja, Dr Rajesh Kukade, Dr Shruti Sachdeva and Dr Ria Ahuja who worked hard to finalise the documents. Their dedication and meticulous efforts ensured the successful development of this document. I am also appreciative of my colleagues in the Ministry who contributed through technical reviews and consultations.

I am thankful to all stakeholders including the State Teams involved in the consultation process and I hope that the State and District Teams, Programme managers, and frontline functionaries who will continue to strengthen anemia prevention and management efforts across the country. Their commitment is central to realizing the vision of an Anemia Mukta Bharat Abhiyaan.


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- ▶ We also acknowledge support from UNICEF, WHO and Nutrition International

Abbreviations

AAM	Ayushman Arogya Mandir	ICMR	Indian Council of Medical Research
AMB	Anemia Mukht Bharat	IDA	Iron Deficiency Anemia
ANC	Antenatal Care	IFA	Iron Folic Acid
AWC	Anganwadi Centre	IMR	Infant Mortality Rate
AWW	Anganwadi Workers	IPC	Indian Pharmacopoeia Commission
CDSCO	Central Drug Standard Control Organization	IV IS	Intravenous Iron Sucrose
CKD	Chronic Kidney Disease	JANANI	Journey of Antenatal, Natal and Neonatal Integrated Care
CSO	Civil Society Organizations	LBW	Low Birth Weight
CTD	Central TB Division	M&E	Monitoring and Evaluation
DDCs	Drug Distribution Centres	MAA	Mothers Absolute Affection
DH	District Hospital	MAM	Moderate Acute Malnutrition
DIH	Digital Invasive Hemoglobinometer	MCP	Mother Child Protection Card
DMC	Designated Microscopy Centers	MHT	Mobile Health Team
ECR	Eligible Couple Register	MMR	Maternal Mortality Ratio
FCM	Ferric Carboxy Maltose	MIB	Ministry of Information and Broadcasting
FP	Family Planning	MR	Measles Rubella
FRU	First Referral Unit	NAAT	Nucleic Acid Amplification Tests
FSSAI	Food Safety and Standards Authority of India	NACO	National AIDS Control Organization
FTDs	Fever Treatment Depots	NCD	Non Communicable Diseases
Hb	Hemoglobin	NDD	National Deworming Day
HBNCC	Home-based Newborn and Child Care	NHM	National Health Mission
HMIS	Health Management Information System	NHP	National Health Policy

NHSRC National Health Systems Resource Centre

NICU Neonatal Intensive Care Unit

NIN National Institute of Nutrition

NIPI National Iron Plus Initiative

NNACP National Nutritional Anemia Control Programme

NNAPP National Nutritional Anemia Prophylaxis Programme

NRLM National Rural Livelihood Mission

NSS National Service Scheme

NTEP National Tuberculosis Elimination Programme

NVBDCP National Vector Borne Disease Control Programme

NVHCP National Viral Hepatitis Control Programme

NYKS Nehru Yuva Kendra Sangathan

PICU Pediatric Intensive Care Unit

PMSMA Pradhan Mantri Surakshit Matritva Abhiyan

E-PMSMA Extended Pradhan Mantri Surakshit Matritva Abhiyan

PNC Postnatal Care

PRI Panchayati Raj Institutions

PTM Parent Teacher Meeting

RBSK Rashtriya Bal Swasthya Karyakram

SAM Severe Acute Malnutrition

SDG Sustainable Development Goals

SHG Self-Help Groups

SNCU Special Newborn Care Units

STH Soil Transmitted Helminths

Td Tetanus Diphtheria Vaccine

T3 Test, Treat, Talk

T4 Test, Treat, Talk and Track

TI Thalassemia Intermedia

TM Thalassemia Major

U-WIN Universal Immunization WIN

VHSND Village Health Sanitation And Nutrition Days

WASH Water, Sanitation and Hygiene

WCD Women and Child Development

WHO World Health Organization

WIFS Weekly IFA Supplementation

WRA Women of Reproductive Age

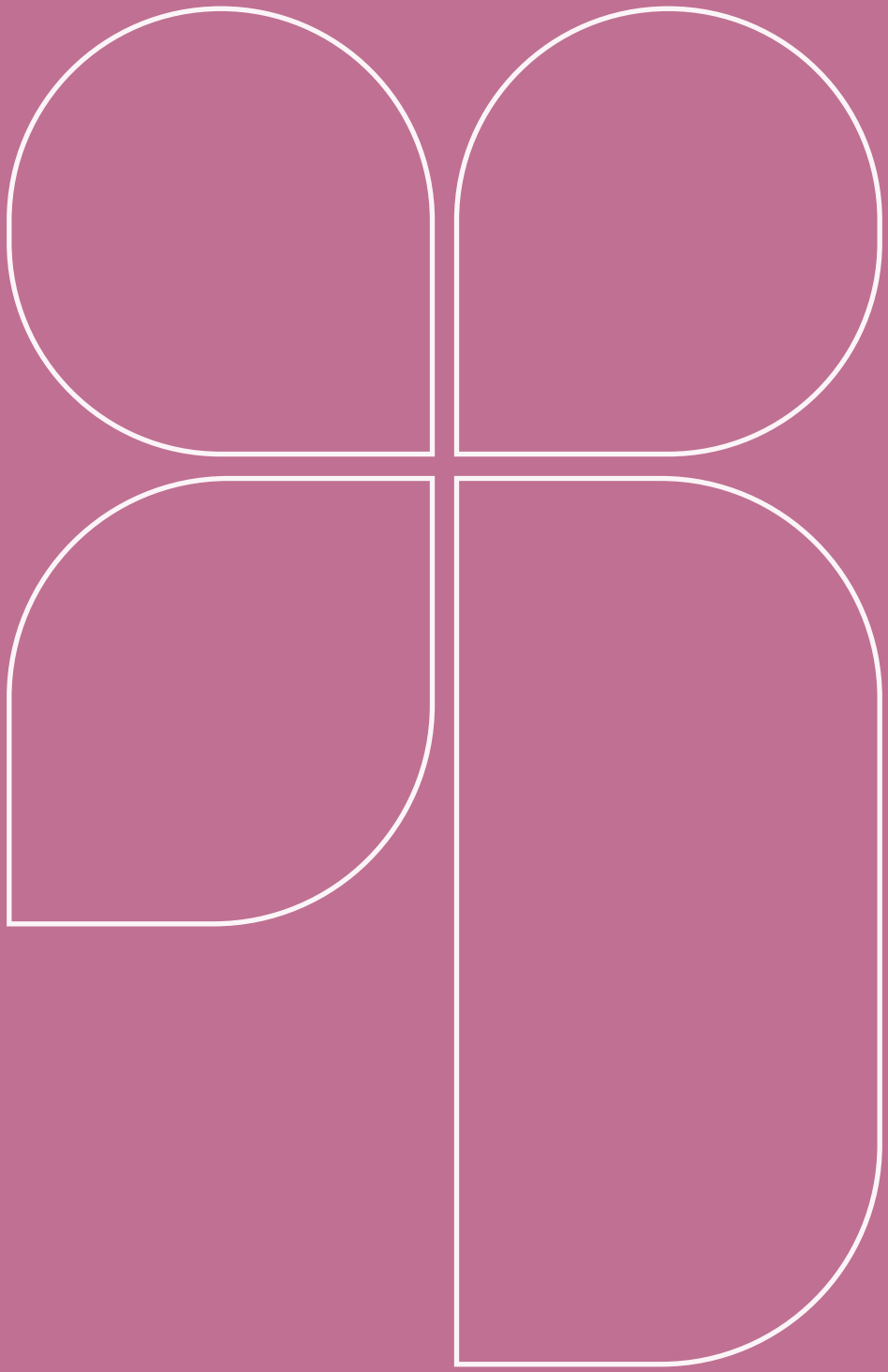
Table of Contents

Messages	i
List of Contributors	vii
Abbreviations	ix
CHAPTER 1	
Introduction	1
CHAPTER 2	
Comprehensive Framework under AMB Abhiyaan	13
CHAPTER 3	
Prophylactic Iron and Folic Acid (IFA) Supplementation	23
CHAPTER 4	
Testing and Therapeutic Management	31
CHAPTER 5	
Deworming and Delayed Cord Clamping	53
CHAPTER 6	
Addressing Non-Nutritional Anemia	59
CHAPTER 7	
Eating Right and Diverse to Prevent Anemia	67
CHAPTER 8	
Jan Bhagidari: Communication Strategy	79
CHAPTER 9	
Strengthening Intra-Ministerial and Inter-Ministerial Coordination	89
CHAPTER 10	
Roles and Responsibilities	97
CHAPTER 11	
Digital Framework	101
ANNEXURES	xxx

CHAPTER 1

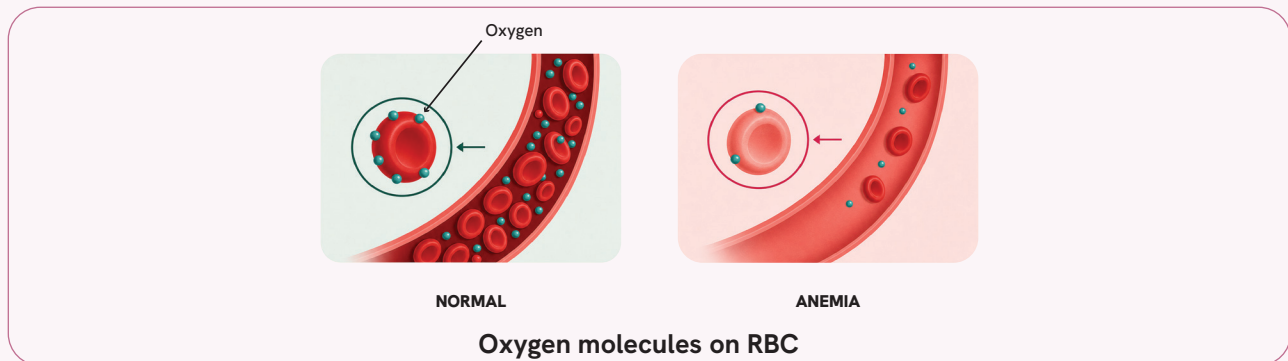
Introduction





1.1 Background

Anemia is a condition in which the number and size of red blood cells, or the hemoglobin (Hb) concentration falls below an established cut-off value, consequently impairing the capacity of the blood to transport oxygen around the body. It is categorized as mild, moderate and severe anemia based on the hemoglobin levels specified for different ages and sex. The manifestations of anemia are varied in severity, ranging from fatigue, weakness, dizziness and drowsiness to increased morbidity.



As a global public health problem that affects all sections of society, particularly the vulnerable categories such as young children, menstruating adolescent girls and women, pregnant women and lactating mothers, it is an issue that requires due care in life. The latter two remain susceptible to the adverse outcomes of anemia while anemia among adolescent girls can fuel a vicious intergenerational cycle of poor maternal and child health. Childhood anemia contributes to poor health outcomes, suboptimal overall well-being, impaired cognitive development, and a repeated cycle of malnutrition.

Common Symptoms of Anemia



Fatigue



Weakness



Dizziness



Drowsiness

As per the WHO report on Global Prevalence of Anemia 2011, approximately 50% of the cases of anemia are considered to be due to iron deficiency, with variation among population groups and in different geographical areas, according to the local conditions. Causes of anemia also include other micronutrient deficiencies (e.g. folate, riboflavin, Vitamin A and Vitamin B12), acute and chronic infections (e.g. malaria, cancer, tuberculosis and HIV), and inherited or acquired disorders that affect hemoglobin synthesis, red blood cell production or red blood cell survival (e.g. hemoglobinopathies).

Impact of anemia across population groups:

Children (0-5 years and School-age)



- ▶ Impairs growth and development
- ▶ Increases susceptibility to infections
- ▶ Affects overall well-being

Adolescents (10-19 years)



- ▶ Impacts growth and development
- ▶ Affects school attendance and performance
- ▶ Increases risk of anemia during future pregnancy

Women of Reproductive Age & Lactating Mothers



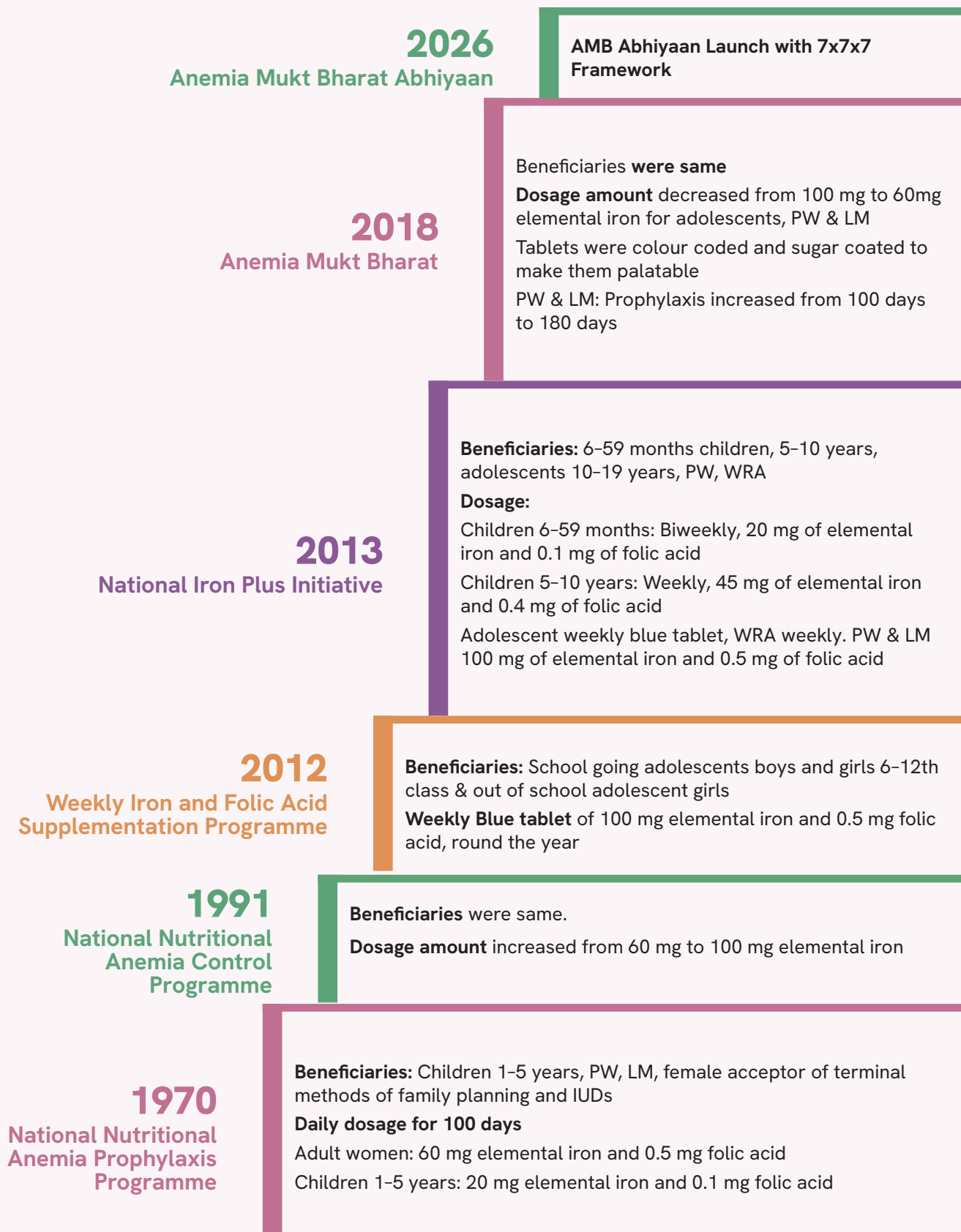
- ▶ Causes fatigue and reduced work capacity
- ▶ Increases vulnerability to infections

Pregnant Women



- ▶ Increases risk of morbidity and pregnancy complications
- ▶ Associated with preterm birth and low birth weight babies
- ▶ Contributes to intergenerational malnutrition

1.2 Evolution of Anemia control programmes in India



Anemia Mukht Bharat (2018)

Launched in 2018, Anemia Mukht Bharat is implemented to reduce prevalence of anemia in life cycle approach through the 6X6X6 strategy, as given below.

<p>6 Beneficiaries</p> <ol style="list-style-type: none"> 1. Children 6-59 months 2. Children 5-9 years 3. Adolescents 10-19 years 4. Pregnant women 5. Lactating mothers 6. Women in reproductive age (20-49 years) 	<p>6 Interventions</p> <ol style="list-style-type: none"> 1. Prophylactic IFA supplementation 2. Deworming 3. Intensified year-round BCC campaign 4. Testing of anemia using point of care treatment 5. Mandatory provision of fortified food in public health programmes 6. Addressing non-nutritional causes of anemia 	<p>6 Institutional Mechanisms</p> <ol style="list-style-type: none"> 1. Intra-ministerial coordination 2. National Centre of Excellence and Advanced Research on Anemia 3. Strengthening supply chain and logistics 4. National Anemia Mukht Bharat Unit 5. Convergence with other Ministries 6. Anemia Mukht Bharat dashboard
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Anemia Mukht Bharat Abhiyaan (2026)

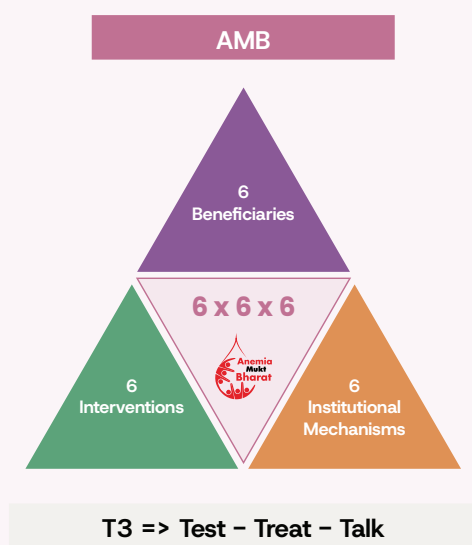
Anemia Mukht Bharat Abhiyaan will be implemented to reduce prevalence of anemia in life cycle approach through the 7X7X7 strategy, as given below.

<p>7 Beneficiaries</p> <ol style="list-style-type: none"> 1. Children 6-59 months 2. Children 5-9 years 3. Adolescents 10-19 years 4. Pregnant women 5. Lactating mothers 6. Women in reproductive age (20-49 years) <p>7th beneficiary:</p> <ol style="list-style-type: none"> 7. 0-6 months LBW babies 	<p>7 Interventions</p> <ol style="list-style-type: none"> 1. Prophylactic IFA supplementation 2. Testing of anemia 3. Therapeutic management of anemia 4. Deworming and delayed cord clamping 5. Jan Bhagidari - communication strategy 6. Addressing non-nutritional causes of anemia <p>7th intervention:</p> <ol style="list-style-type: none"> 7. Eating Right - promotion of locally available iron rich food and diet diversification 	<p>7 Institutional Mechanisms</p> <ol style="list-style-type: none"> 1. Intra-ministerial coordination 2. National Centre of Excellence and Advanced Research on Anemia 3. National AMB Abhiyaan Unit 4. Strengthening supply chain and logistics 5. Convergence with other Ministries 6. Anemia Mukht Bharat Abhiyaan Portal <p>7th institutional mechanism:</p> <ol style="list-style-type: none"> 7. Digital Framework for monitoring through T4 approach
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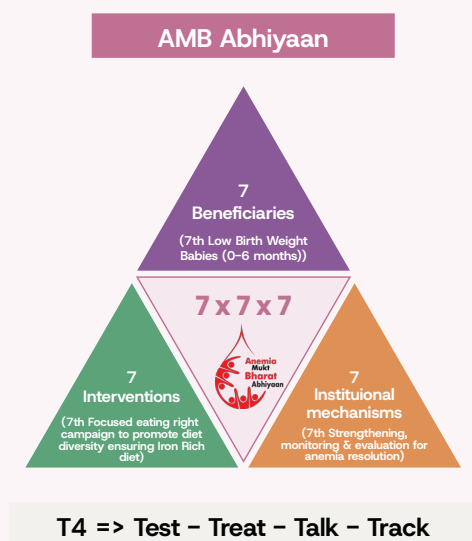
Over the past 50 years, the country has taken continuous progressive approaches to address the issue of high prevalence of anemia among women and children. The journey began in 1970 with the **National Nutritional Anemia Prophylaxis Programme (NNAPP)**, which mainly focused on provision of iron-folic acid (IFA) tablets to pregnant and lactating mother.

In 1991, it became the **National Nutritional Anemia Control Programme (NNACP)**, expanding its focus from prevention to treatment of anemia. The **Weekly Iron Folic Acid Supplementation (WIFS) programme** was launched in 2012 targeting adolescent population in schools and out of school adolescent girls. The **National Iron Plus Initiative (NIPI) was launched in 2013** as a complete lifecycle approach to tackle the burden by expanding its reach to six beneficiary groups: children (6-59 months), children (5-10 years), adolescents (10-19 years), pregnant women, lactating mothers and women of reproductive age with age-specific IFA supplementation, bi-annual deworming and standardized dosage protocols.

Shift from T3 (2018) to T4 (2026) framework



- ANEMIA MUKT BHARAT ABHIYAAN**
- COMPONENTS**
- 1 Prophylaxis to therapeutic management
 - 2 Hb testing of target beneficiaries
 - 3 Robust digital tracking
 - 4 Segregate nutritional & non-nutritional anemia
 - 5 Eating Right- Promote locally available iron rich foods
 - 6 Whole of Government Approach
 - 7 Jan Bhagidari for community participation



All components of AMB Abhiyaan will contribute to a sustained reduction in anemia prevalence, as well as improvements in the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)

Building on NIPI, **Anemia Mukt Bharat was launched in 2018** with a stronger focus on reducing anemia rates through the **6x6x6** strategy: six target groups, six interventions (including

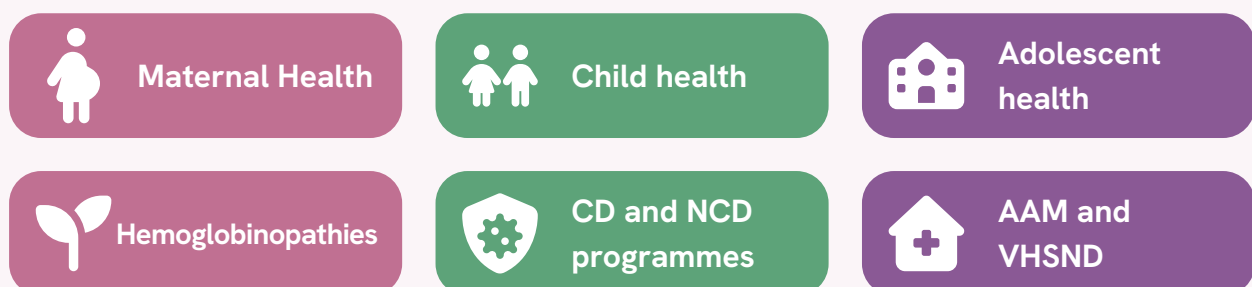
testing, treatment, behaviour change communication, and delayed cord clamping), and six institutional mechanisms. New elements such as new dosage and change in elemental iron, point-of-care hemoglobin testing, improved supply chain systems, scorecards and attention to non-nutritional anemia were added as programme components.

Based on expert consultations, learnings from programme implementation and State experiences, a revised framework of 7x7x7 has been developed as **Anemia Mukh Bharat Abhiyaan**. It moves away from the prophylactic supplementation approach to targeted therapeutic management as per category of anemia diagnosed, saturation of hemoglobin testing using DIH and emphasizing on healthy diet as a preventive measure for anemia and moving away from a supplementation-focused approach to comprehensive screening-led and a consequent outcome-focused management.

It includes in its ambit a diaspora of intervention such as integration of testing, counselling and therapeutic case-based management, dietary diversification, digitalization of data for supporting compliance till resolution and a communication strategy to counteract normalization of anemia. It reflects the organic development of India's anemia control strategies, which have been continuously influenced by extent of data, national surveys, evidence from studies and lessons learned from fieldwork, extending into a convergent approach. **Anemia Mukh Bharat Abhiyaan** has incorporated various components (existing and new) into a plenary framework for continuum of care.

1.3 Cross-Cutting Linkages with National Health Mission Programmes

Anemia is a cross-cutting public health issue that is closely linked with multiple programme components under the National Health Mission (NHM). Its causes and consequences span across the lifecycle, making anemia control an integral part of maternal, child, adolescent, nutrition, communicable disease, and primary health care programmes rather than a stand-alone intervention.



Addressing anemia remains pivotal for achieving and attaining healthy life, social and economic outcomes and has consequential positive impact on India's Sustainable Development Goal (SDG) and National Health Policy indicators.

Under RMNCAH+N, anemia prevention and management during pregnancy are embedded through Hb screening at every ANC contact points, identification of high-risk pregnancies, Iron-Folic Acid (IFA) supplementation, and treatment during antenatal and postnatal care. In child health programmes, anemia control is supported through IFA and Vitamin A supplementation, deworming, facility-based management of malnutrition and regular screening by the RBSK mobile health teams. The adolescent health platform addresses anemia through weekly IFA supplementation (WIFS), school and community outreach, deworming and nutrition counselling, helping break the intergenerational cycle of anemia.

Anemia control is also strongly linked with outcomes of Mothers Absolute Affection (MAA) Programme through components of dietary diversification and IYCF counselling.

Non-communicable and Communicable disease control programmes contribute to reduce anemia through addressing infection, worm infestation and chronic systemic diseases such as soil transmitted helminths infestation, malaria control, chronic kidney disease (CKD), diabetes, Tuberculosis, HIV, cancer etc. Under Ayushman Arogya Mandir (AAM), decentralized screening, early diagnosis, treatment, and follow-up at the primary care level helps address anemia early. Community platforms such as Village Health Sanitation and Nutrition days (VHSNDs) and frontline worker outreach strengthen last-mile delivery and adherence support.

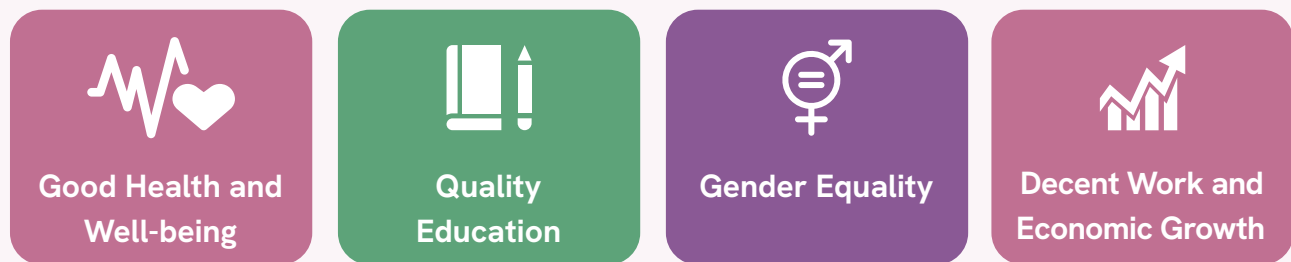
Thus, addressing anemia, a priority across NHM programmes includes focus on coordinated planning, shared delivery platforms, and integrated monitoring for effective outcomes.

1.4 Anemia Mukht Bharat Abhiyaan as a Vital Component of Sustainable Development Goals (SDGs)

Anemia control is closely aligned with the Sustainable Development Goals (SDGs) as it directly influences nutrition, health, education, gender equity and economic productivity. Reducing anemia addresses micronutrient deficiencies and improving overall nutritional status across vulnerable populations supporting SDG 3 Goal (Good Health and Well-being) by reducing maternal and child morbidity and mortality, improving pregnancy outcomes, and strengthening universal health coverage.

Anemia reduction also advances SDG 4 Goal (Quality Education), as improved iron status enhances cognitive development, school attendance and learning capacity among children and adolescents. Its focus on adolescent girls and women, supports SDG 5 Goal (Gender

Equality) by improving women's health, work capacity, and reproductive outcomes. Further, by enhancing physical productivity and reducing fatigue-related work loss, anemia control contributes to SDG 8 Goal (Decent Work and Economic Growth).



As anemia affects multiple sectors and life stages, its control serves as a high-impact, cross-sectoral strategy for accelerating progress toward SDG targets simultaneously.

1.5 Alignment with National Health Policy (NHP) 2017

Anemia Mukht Bharat Abhiyaan also furthers the goals of the National Health Policy (NHP) by strengthening preventive and promotive healthcare across the lifecycle. Effective screening, supplementation, and treatment of anemia contribute to reduction in **maternal mortality, under-five mortality, and low birth weight babies**, which are key NHP outcome targets. Addressing anemia among women, children, and adolescents improves overall nutritional status and reduces disease vulnerability.

Through delivery via primary care platforms such as AAM and community outreach, anemia interventions advance the NHP vision of **comprehensive primary health care and universal access to essential services** for anemia prevention and contributes to improving productivity and long-term health outcomes.

1.6 Rationale for Anemia Mukht Bharat Abhiyaan

The field level learning, scientific evidence and data analysis have been a continuous exercise in evaluating programme outcomes. Data from successive national surveys across age groups have shown a near plateau in anemia prevalence, underscoring the need for a critical evaluation into current implementation framework and recalibrating the extant strategies for an enhanced strategic framework.

Some of the areas which require increased focus to drive measurable reductions in anemia prevalence across all beneficiary groups are as below:

Low Birth Weight babies



Address age groups at risk of anemia such as Low Birth Weight (LBW) babies (0-6 months) for breaking the intergenerational cycle of anemia: Low birth weight babies born with low iron stores are at high risk of developing anemia within the first few months of life. To prevent the long-term burden of childhood anemia, it is essential to include LBW babies as seventh beneficiary group under AMB. **All and any anemia linked intervention for this category will be exclusively managed based on Paediatrician / specialist advice which remains essential and mandatory.**

Integrated beneficiary records



Different testing platforms across the beneficiaries: Hemoglobin (Hb) testing for pregnant women is routinely carried out during Antenatal Care (ANC) visits on VHSND, PMSMA visits and recorded in JANANI and PMSMA portal respectively giving us robust data for this group. Children upto 18 years are tested for anemia in schools and anganwadi centres by RBSK team, with screening/ testing data reported on RBSK portal. Women of Reproductive Age (WRA) and other beneficiaries are also tested for anemia during T3 anemia screening camps. Given that the use of different platforms and digital systems leads to fragmentation of data collection, maintaining integrated beneficiary-wise records is essential for accurate mapping and complete coverage.

Nutritional and Non-Nutritional anemia



Segregation of Nutritional anemia and Non-Nutritional anemia- Segregation into Nutritional and Non-nutritional anemia among non-responder cases will be undertaken at referred facilities through comprehensive root-cause analysis along with testing and assessment of underlying etiologies and linking of causative factors.

Case-based therapeutic management



Case-based Management approach with emphasis on therapeutic treatment: IFA prophylaxis with high compliance needs to be complemented with stronger emphasis on case-based therapeutic approach to treat anemia; addressing pertinent issues of non-compliance/ drop outs and therefore requires integration between testing, treatment, counselling on iron rich diet, tracking and follow up till resolution.

Priority cluster identification



Pre-requisite for Root Cause Analysis and Priority Cluster Identification: Recognizing multifactorial causes of anemia, a mechanism is required for identification of high priority clusters and deep dive into root cause analysis for anemia to enable linking with causative factors for facilitating case-based approach.

Digital tracking and alerts



Robust digital system for tracking anemia services is required with personalised alerts to beneficiaries for promoting compliance to IFA supplementation. A shift in policy from T3 (Test, Treat, Talk) approach to T4 approach (Test, Treat, Talk and Track) will be required

Targeted communication



Targeted communication strategies: This will be planned to reach all beneficiary age groups to transform mindset from passive acceptance of anemia to active ownership of managing anemia.

Whole-of-Government Approach

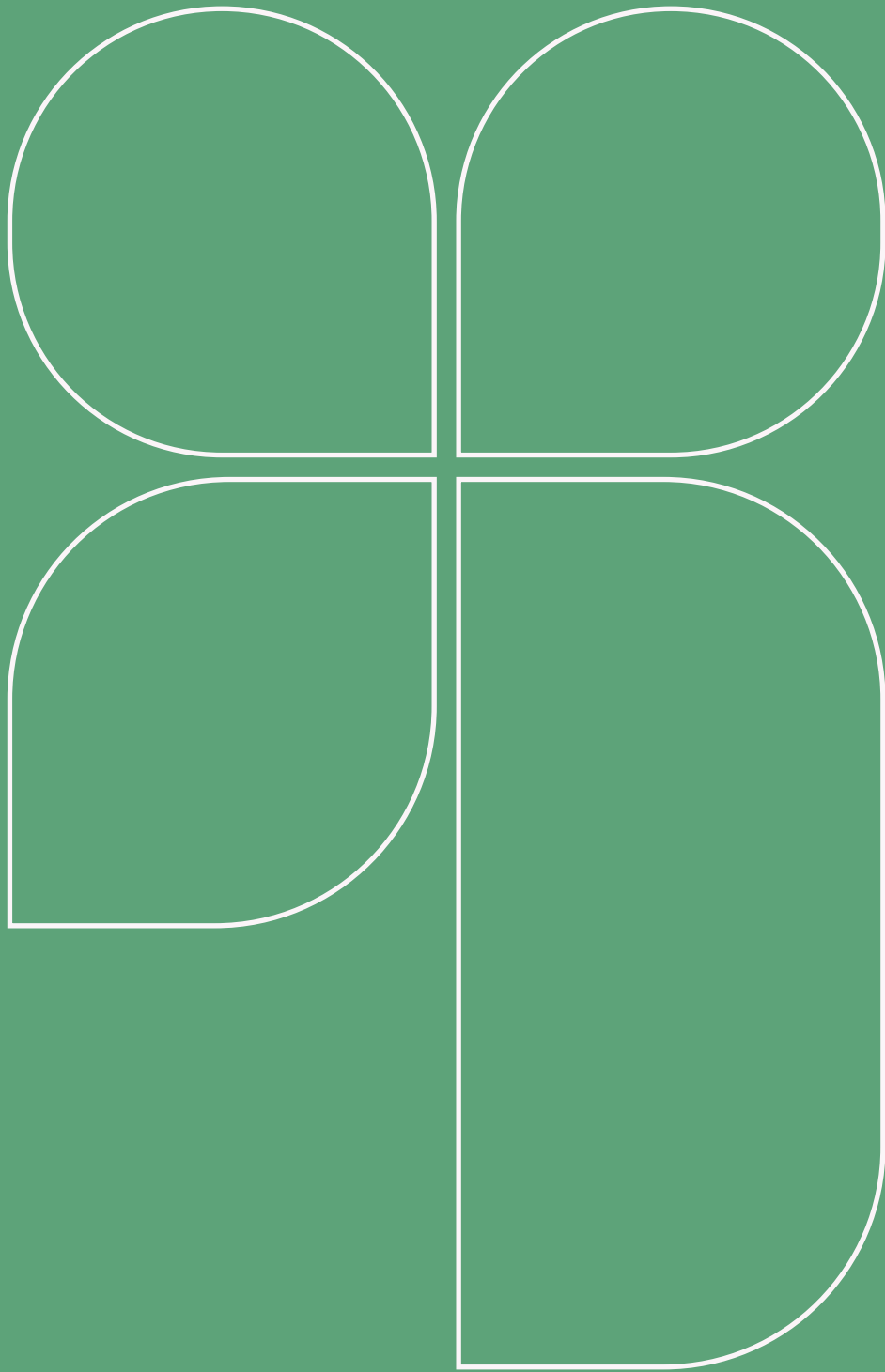


Convergent approach: Implementation of "Whole of Government approach" for implementation of complementary interventions with both intra-ministerial and inter-ministerial convergence at various levels of programme.

CHAPTER 2

Comprehensive Framework under AMB Abhiyaan





The new comprehensive framework of AMB Abhiyaan has combined both essential existing, newer targeted as well as complementary approaches for effective and sustained reduction in anemia across all beneficiary groups. This will address both nutritional and non-nutritional anemia comprehensively through case-based and gradual saturation approach.

The restructured AMB Abhiyaan consists of the following interventions:

2.1 Shift from existing 6X6X6 strategy to 7X7X7 strategy

The existing 6x6x6 strategy is expanded to a 7x7x7 framework under Anemia Mukht Bharat Abhiyaan to strengthen preventive, promotive, and outcome-oriented approaches across lifecycle for anemia reduction. The addition are the following:

7th Beneficiary Group



Inclusion of **0–6 months Low Birth Weight (LBW) babies** for timely anemia detection, risk mitigation and continuum of care from birth. Addressing anemia pre-emptively among LBW babies supports increase iron store and thereby contributes indirectly in reduction in **Infant Mortality Rate (IMR)** and improved early childhood outcomes.

7th Intervention



Introduction of the **“Eating Right” approach**, promoting conscious consumption of iron-rich and diversified diets in everyday habits to complement supplementation and enhance and sustain long-term dietary behaviour change.

7th Institutional Mechanism



Strengthened **Monitoring & Evaluation (M&E)** framework with a revised set of indicators to capture AMB Abhiyaan priorities, enabling end-to-end tracking of beneficiaries till anemia resolution and emphasizing preventive and promotive health outcomes.

This strategic shift reorients the programme from a supportive prophylactic supplementation model to a screening-led, targeted therapeutically managed, diet-integrated and digitally monitored continuum of care framework aimed at sustained anemia reduction.

2.2 Focus on Intensified Testing Coverage of Target Beneficiaries with Ease of Testing

Scaled up testing for anemia enables identification of beneficiaries as non-anemic or anemic and further classification of anemic cases into mild, moderate, or severe categories. This will be accompanied by case-based counselling and timely therapeutic management as per AMB Abhiyaan management protocols, thereby preventing complications, and improving health and quality of life.

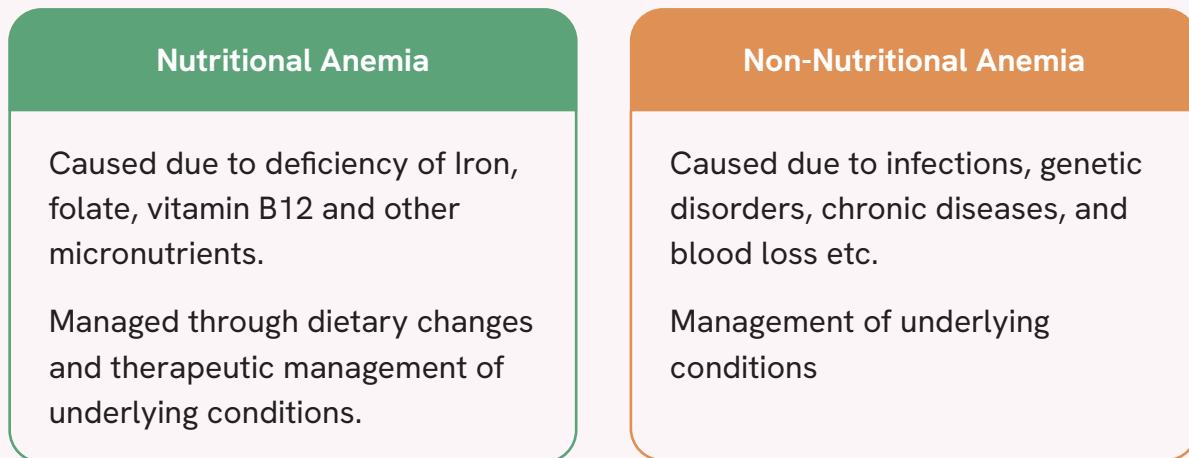
With streamlining the access and reach for testing under Anemia Mukh Bharat Abhiyaan and digitalization of AMB services, once tested, repeated visits for anemia testing at facility or camps will be reduced, as testing records will be readily accessible on the AMB Abhiyaan portal. Such systems will help identify missed beneficiaries, reduce drop-outs, and improve continuum of care across all target beneficiary groups.



2.3 Source Correction Approach for Management of Anemia

Recognizing that anemia has far-reaching consequences across the life cycle—from infancy and adolescence to pregnancy and adulthood, it is critical to undertake a systematic root cause analysis to identify the underlying determinants in different population groups and geographies across high priority clusters. This should be followed by a structured source-correction approach under AMB Abhiyaan to address these specific causes directly, whether they relate to nutritional deficiencies, infections, dietary practices, social determinants, or compliance challenges.

The segregation of **nutritional anemia** (anemia due to deficiency of iron, folate, vitamin B12 and other micronutrient deficiencies) and **non-nutritional anemia** (anemia due to infections, genetic disorders, chronic diseases, and blood loss etc) is critical for effective management of anemia. Nutritional anemia is managed through dietary changes, counselling for consuming iron rich foods and therapeutic management of anemia, while non-nutritional anemia cases require treatment of the underlying conditions. A comprehensive strategy under Anemia Mukh Bharat Abhiyaan will combine both targeted and complementary approaches to address both nutritional causes and timely referral for non-nutritional causes.



2.4 Defined Strategies for Redressal/ Correction of Anemia in Vulnerable Groups

Based on the experiential learning, literature review and State initiatives, use of Inj FCM among the vulnerable groups (pregnant women, lactating mother) and improved quality IFA tablets among all 7 beneficiaries must be accompanied by measures for strengthening compliance. The provision of IFA salt and IV iron will be considered within budgetary stipulations and within the norms of Programme Implementation Plan (PIP) processes.

2.5 Implementation of Convergent Approach with other Complementary Interventions

AMB Abhiyaan advocates a 'Whole of Government Approach' for implementation of complementary interventions synergistically for resolution of anemia. This includes inter-ministerial convergence with Ministry of Women and Child Development, Ministry of Education and other line Ministries; intra-ministerial convergence within NHM programmes such as national sickle cell anemia elimination mission, Pre-pregnancy care, Maternal health,

Child health etc. The convergence will integrate efforts to reduce the Maternal Mortality Ratio and Infant Mortality Rate in a lifecycle approach. Further, inclusion of pre-pregnancy care among women of reproductive age (WRA) group under Anemia Mukh Bharat Abhiyaan framework is a critical intervention to address anemia in lifecycle approach, which indirectly addresses high burden of Infant and Maternal Mortality.

2.6 Case-based management with focus on compliance till resolution as a key intervention

Given the heterogeneous and multifactorial etiological factors for anemia in India, a standardized prophylactic IFA supplementation approach alone was insufficient to address non-nutritional cases of anemia and socio-cultural dimensions attached to it. Additionally, individual factors such as gastrointestinal side effects, palatability of IFA supplementation and perceived normalization of anemia may reduce compliance to IFA supplementation. This necessitated improved quality of oral IFA supplementation for better compliance to prophylaxis and positive outcomes of case-based management to effectively address the high burden of anemia. Moreover, in cases requiring rapid correction of anemia among severe/ moderately anemic pregnant and lactating mothers or non-compliant/non-responsive cases, intravenous iron (Iron Sucrose and Ferrous Carboxy-Maltose)¹ builds up iron stores and is found to be an effective intervention.

Integrated case-based management approach is critical to accelerating progress toward anemia reduction targets. The gradual shift from prophylactic IFA supplementation to targeted case-based management will help pave the way for a stronger and anemia free India.

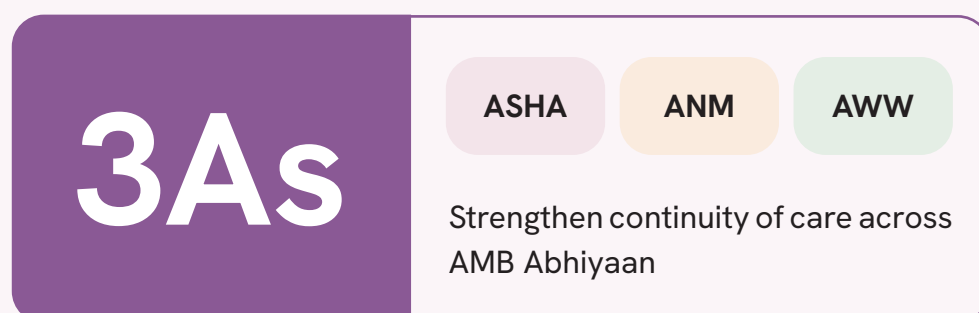
2.7 Integration of testing and counselling activities for efficient management

The revised AMB Abhiyaan emphasizes convergence of anemia testing and structured counselling to enhance programme efficiency, feasibility, and impact. By integrating point-of-care hemoglobin testing with immediate counselling on diet, IFA compliance, deworming, and follow-up care, the strategy translates screening into actionable health-seeking behaviour and therapeutic adherence.

This approach is further strengthened through coordinated action of the “3As” - ASHA, Anganwadi Worker (AWW), and ANM - who will work synergistically for early symptom

¹ Operational guidelines for use of intravenous iron in pregnant women and lactating mothers

recognition, timely screening, therapeutic management, referral of severe/non responding cases, and sustained nutrition counselling support. Such integrated service delivery minimizes missed opportunities, improves case tracking, enhances compliance, and strengthens continuity of care across the life cycle under AMB Abhiyaan.



2.8 Dietary Diversification with Eating Right Approach and Promotion of Locally Available Iron Rich Foods on Everyday Basis

The iron-rich food diet consumption is emphasized under AMB Abhiyaan, addresses not only iron deficiency but also other essential nutrients required for hemoglobin synthesis, such as folate, vitamin B12 and vitamin C, which are naturally present in diverse diets. Everyday dietary diversification along with adoption of conscious consumption of iron rich diet with enhancers can significantly improve iron absorption and help prevent recurrent anemia once supplementation is discontinued. Treating and preventing anemia through food and healthy lifestyle instead of sole reliance on supplements, is a sustainable and life-course approach to improving anemia status.

2.9 Communication Strategy for Transformation of Mindset from Passive Acceptance and Normalization of Anemia to Active Ownership

This will build on promoting active participation from every section of Indian population to realize the importance of normal level of hemoglobin level by individuals, family and communities to bring about the change. The campaign under varied thematic framework e.g. 'I am Anemia free', " Sahi Hb ki matra, Achhi sehat ki hai paribhasha" will change attitude as a call to action from normalization of anemia state to cognizance and self-awareness of maintaining appropriate hemoglobin level.

2.10 Robust Digital System for Tracking Anemia Services with Personalized Alerts to Beneficiaries for Promoting Compliance till Resolution

The entire process of AMB Management will be digitized from testing till resolution. The AMB Abhiyaan collates programmatic data for testing, management and follow up of targeted beneficiaries. The various platforms will provide beneficiary-wise data such as pregnant women anemia records will be mapped from JANANI portal, children's anemia testing records will be mapped from RBSK portal (school and anganwadi going children) and screening anemia alongside Immunization will be recorded in U-WIN portal and linked to AMB Abhiyaan portal where the treatment and follow-up at individual level will be maintained. Information regarding beneficiaries beyond the above mentioned groups will be recorded through the AMB Abhiyaan mobile application linked to the AMB Abhiyaan portal.

Breaking the siloed approach in anemia management requires transitioning from fragmented, manual record-keeping to **inter operable digital ecosystems** that enable data sharing across platforms allowing seamless tracking of hemoglobin levels, iron-folic acid (IFA) distribution, and patient follow-ups, reducing manual errors and improving treatment compliance, making the process of anemia management more efficient and feasible. Digitalization will lead to management and follow up of anemia cases at the click of a button.

Further, the digital interventions for testing and tracking will help in mapping and identification of missed cases/non responders/non compliant which, if left undiagnosed and untreated in timely manner can lead to criticalities of Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR).

2.11 Ease of Access of Service through Convergence with Various Programmes under NHM

This incorporates strategies wherein anemia testing and data entry is integral to the existing programmatic interventions which mandate regular visits to public health facilities e.g. antenatal care visits for screening during pregnancy, immunization services, RBSK-4Ds check-ups in schools/ AWCs. Further opportunistic testing approach will enable scaling up of testing and counselling activities in addition to facilitating achievement of anemia related goals as envisaged in guidelines so framed.

2.12 Shift of policy from T3 approach (Test Treat Talk) towards T4 approach (Test Treat Talk Track)

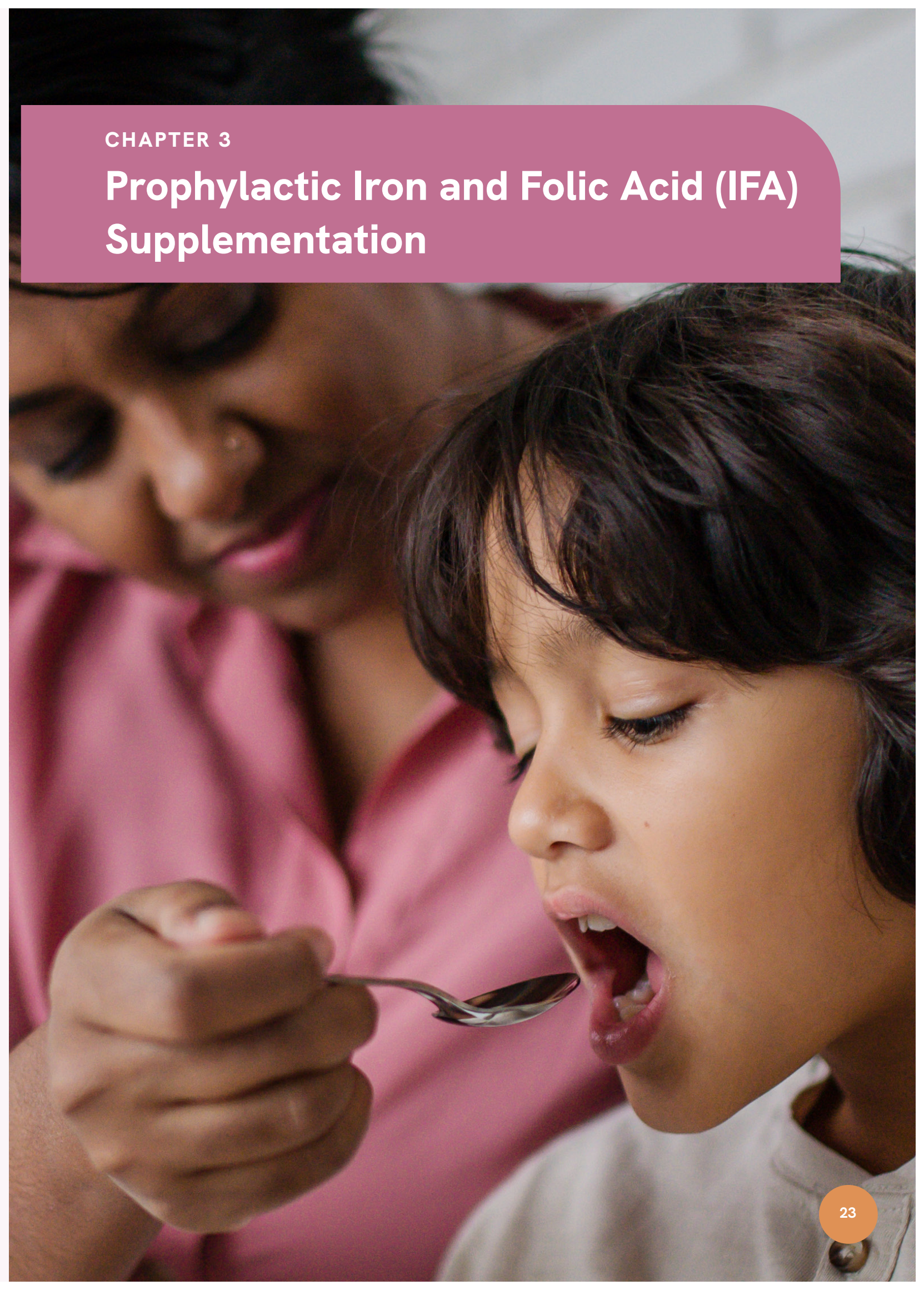
Transitioning from prophylactic to therapeutic and compliance focused approach: Anemia Mukht Bharat Abhiyaan endeavours to strengthen the population cohort with sustained and sufficient Hb levels. T4 strategies will therefore contour the scope and shape of AMB Abhiyaan for expansion across the board for anemia management.

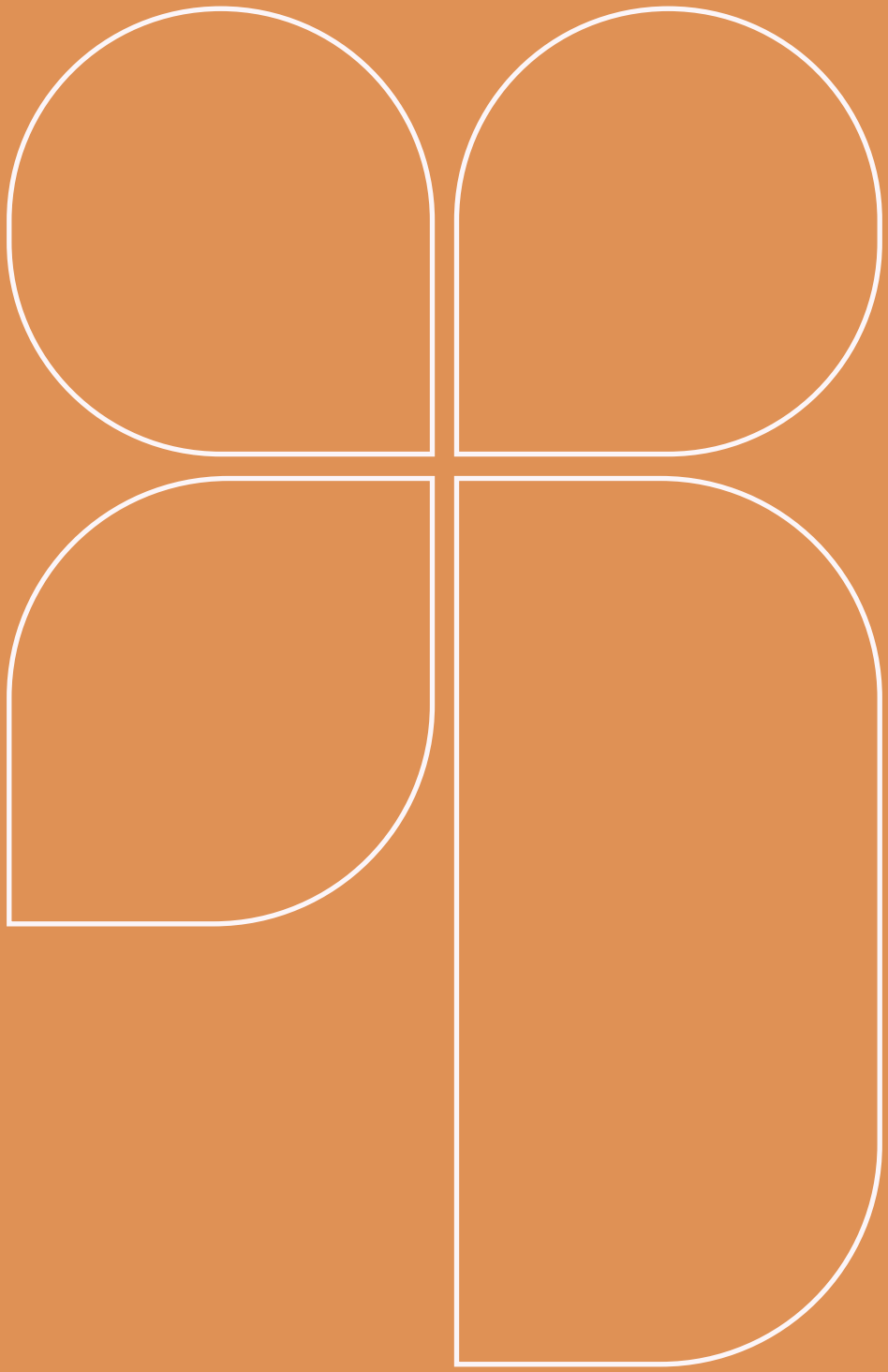


Therefore, the **Anemia Mukht Bharat Abhiyaan** provides a comprehensive framework that shifts from a blanket prophylactic approach to a screening-led, outcome-focussed management approach emphasizing early detection, therapeutic management, and systematic follow-up. This will be strengthened through the integration of the Eating Right approach, promotion of dietary diversification and digital interventions for improved monitoring and compliance. Promoting compliance till resolution will remain critical. Together, these measures aim to enhance programmatic uptake across all components of AMB Abhiyaan and contribute to a sustained reduction in anemia prevalence, as well as improvements in the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). With such strategy it is also endeavoured that there is a gradual shift to therapeutic treatment of anemia leading to a sustained anemia free status through dietary modification enabling healthy body and healthy mind.

CHAPTER 3


Prophylactic Iron and Folic Acid (IFA) Supplementation





Prophylactic iron supplementation is crucial to build iron stores and maintain optimal health. Iron is essential for producing hemoglobin, which transports oxygen throughout the body. A proactive approach helps to prevent iron deficiency in the body before it can progress to anemia. It is a key public health intervention under Anemia Mukht Bharat Abhiyaan. It supports provision of IFA supplements to all groups of beneficiaries irrespective of anemia status as detailed out below along with counselling on eating right habits and inclusion of iron rich foods in their daily diet, which has been further discussed in Chapter 7 in detail.

1. Children 6-59 months

	
Platforms Fortnightly home visits by ASHA for a month to demonstrate skill to mother/caregiver Then mother/care giver to continue giving prophylactic bi-weekly doses	Dose and regime Biweekly, 1 ml Iron and Folic Acid syrup (Each ml contains 20 mg elemental Iron + 100 mcg) IFA bottle (50 ml) with dropper

Additionally, ASHA will counsel mothers on the benefits of IFA syrup for their child, improving iron and folate content of the diets and the importance of sanitation and hygienic practices in order to prevent anemia and worm infestation in the child. This would help in confidence building of the mothers in providing IFA syrup to their child. ASHA will record doses given in the IFA compliance card attached with the Mother Child Protection card (MCP) card and teach mothers to mark the compliance after administering every dose. The data is compiled at facility level for entry into HMIS; with a shift to digital reporting under the Anemia Mukht Bharat Abhiyaan Portal.

In case of children with moderate or severe acute malnutrition (SAM/MAM), IFA supplementation may be continued after clinical evaluation as per SAM/MAM protocol.

2. Children 5–9 years



Platforms

PM-POSHAN platform through teachers in Government and Government-aided schools
After lunch break through teachers in private schools.

Out-of-school children 5–9 years will be provided IFA tablets through ASHA during home visits/ at AWC

Dose and regime

Weekly, one Pink WIFS-IFA tablet
(Each sugar coated tablet contains 45mg elemental Iron + 400 mcg Folic Acid)

Reporting of the prophylactic doses provided to children in school and out of school will be collated by the Nodal WIFS teacher in schools and by the Anganwadi Worker (AWW) at the Anganwadi Center (AWC) level respectively. This has to be accompanied by counselling for compliance to IFA consumption along with inclusion of iron rich locally available foods and vitamin C to improve absorption and thereby prevent anemia. The data is compiled at Block level for entry into HMIS; with a shift to digital reporting under the Anemia Mukht Bharat Abhiyaan Portal.

3. Adolescents 10–19 years



Platforms

Mid-day meal platform through teachers in Government and Government-aided schools
After lunch break through teachers in private schools.

Out-of-school children 10–19 years will be provided IFA tablets through ASHA during home visits/ at AWC


Dose and regime

Weekly, one Blue WIFS-IFA tablet
(Each sugar coated tablet contains 60 mg elemental Iron + 500 mcg Folic Acid)

Reporting of the prophylactic doses provided to children in school and out of school will be collated by the Nodal WIFS teacher in schools and by the Anganwadi Worker (AWW) at the Anganwadi Center (AWC) level respectively. This has to be accompanied by counselling

for compliance to IFA consumption along with inclusion of iron rich locally available foods and vitamin C to improve absorption and thereby prevent anemia. The data is compiled at Block level for entry into HMIS; with a shift to digital reporting under the Anemia Mukta Bharat Abhiyaan Portal.

4. Women of reproductive age (WRA)




Platforms	Dose and regime
VHSNDs ANM/HWF will reach out using the Eligible Couple Register (ECR). Using Mission Parivar Vikas platform in eight states, to provide Nayi Pehal Kit for target group for women of reproductive age 20-24 years State specific platforms as Colleges/ work places/campaigns	Weekly, one Red-IFA tablet (Each sugar coated tablet contains 60 mg elemental Iron + 500 mcg Folic Acid)

During VHSNDs the WRA will be counseled by ANM on the importance of compliance to IFA prophylactic supplementation to prevent anemia along with inclusion of iron rich locally available foods and vitamin C to improve absorption. Beneficiaries will be encouraged to undergo hemoglobin testing at the nearest health facility also. The data is entered by ANM at facility level into HMIS ; with a shift to digital reporting under the AMB Abhiyaan Portal.


If the woman is planning for pregnancy, she should be counselled to stop IFA supplementation and initiate Folic Acid supplementation. All women in the reproductive age group (20-49 years) are advised to have 400 mcg of Folic Acid tablets, daily during the period of pre-pregnancy up to the first trimester of the pregnancy, to reduce the incidence of neural tube defects in the foetus.

5. Pregnant women

	
Platforms Ante Natal Clinic (ANC) contact points VHSNDs PMSMA and e-PMSMA	Dose and regime Daily one Red-IFA tablet for 180 days starting from the second trimester of pregnancy. (Each sugar coated tablet contains 60 mg elemental Iron + 500 mcg Folic Acid)

The pregnant women should be provided the Red-IFA tablets for one month at one time during their ANC visits. This has to be accompanied by counselling for compliance to IFA consumption by ASHA along with inclusion of iron rich locally available foods and vitamin C to improve absorption and thereby prevent anemia . ANM will enter the data of prophylactic doses on JANANI portal .

6. Lactating mother

		
Platforms		Dose and regime
Delivery ward	HBNCC visits by ASHA	Daily one Red-IFA tablet for 180 days starting from delivery upto 6 months post partum (Each sugar coated tablet contains 60 mg elemental Iron + 500 mcg Folic Acid)
PNC Clinic	VHSNDs	
FP Clinic	Immunization sessions	

Lactating mother can be provided prophylactic IFA supplements on multiple platforms as mentioned above. This has to be accompanied by counselling for compliance to IFA consumption by ASHA along with counselling on inclusion of iron rich locally available foods and vitamin C to improve absorption and thereby prevent anemia. ANM will enter the data of prophylactic doses on JANANI portal.

7. LBW babies 0-6 months

	
Platforms SNCU NICU Paediatric Ward/PICU	Dose and regime As prescribed by the attending Pediatrician/ Specialist at the Health facility

3.1 Management of Side Effects during Oral Iron Prophylaxis

Oral iron supplementation (e.g., IFA tablets/syrup) is generally safe, but some individuals may experience mild side effects initially. Most gastrointestinal side effects as nausea, stomach cramps/discomfort and constipation are temporary and tend to fade over the first few weeks of consistent therapy. It is advisable not to discontinue iron supplementation in case of such mild discomfort. In many cases, these side effects diminish as the body gradually adapts to iron supplementation. If supplementation is interrupted and restarted later, the same discomforts may recur. Therefore, continued intake, along with appropriate counselling and supportive measures, is recommended to help the symptoms subside over time and the intended health benefits of iron supplementation are achieved.

Side Effects	Management
Nausea	Take the tablet after meals or at bedtime. Encourage adequate hydration.
Vomiting	Take iron after food; if persistent, assess for other causes and consider medical review and visit a doctor.
Abdominal discomfort/ cramps	Continue supplementation with food; reassure that symptoms often improve over time.
Constipation	Increase fluid intake, dietary fiber (fruits, vegetables, whole grains), and physical activity.
Diarrhea	Adequate hydration; continue supplementation unless severe.
Metallic taste	Reassure beneficiary that this is a known temporary discomfort, the person will get used to its taste if continues taking the pill and reassure that the minimal discomfort may be acceptable for better health outcomes

Side Effects	Management
Dark/black stools	Reassure that black discoloration of stools is a normal effect of iron and not harmful. It doesn't signify any harmful effects of the tablet in the body. It is completely normal. It is advisable to counsel mentioning
Teeth staining (with iron syrup)	Use a dropper/spoon where feasible; rinse mouth or brush teeth after administration.

3.2 Role of Counselling in effective management of side effects

- ▶ Inform beneficiaries in advance about possible side effects to improve adherence.
- ▶ Encourage continuation of supplementation despite mild side effects. In case of severe side effects such as severe vomiting, persistent abdominal pain, allergic reactions (rash, swelling, breathing difficulty), seek medical attention.
- ▶ Encourage experience-sharing with other beneficiaries, if possible. This can help reassure beneficiaries, build trust, normalize temporary discomforts, and improve adherence to iron supplementation. Health workers should emphasize that mild side effects are common, usually temporary, and tend to subside with continued use. Beneficiaries should be reached through home visits, VHSNDs and at health facilities for counselling to continue with the IFA uptake with compliance.

3.3 Digital Tracking of Prophylactic Iron and Folic Acid Supplementation

To strengthen monitoring, improve adherence, and enable beneficiary-level follow-up under Anemia Mukht Bharat Abhiyaan, prophylactic Iron and Folic Acid (IFA) supplementation shall be tracked through the HMIS and displayed on the AMB Abhiyaan portal

The digital platform aims to facilitate real-time recording and monitoring of IFA distribution, consumption, counselling, follow-up visits, management of side effects, and referrals across all beneficiary groups covered under the programme.

Detailed information can be found in Chapter no.11

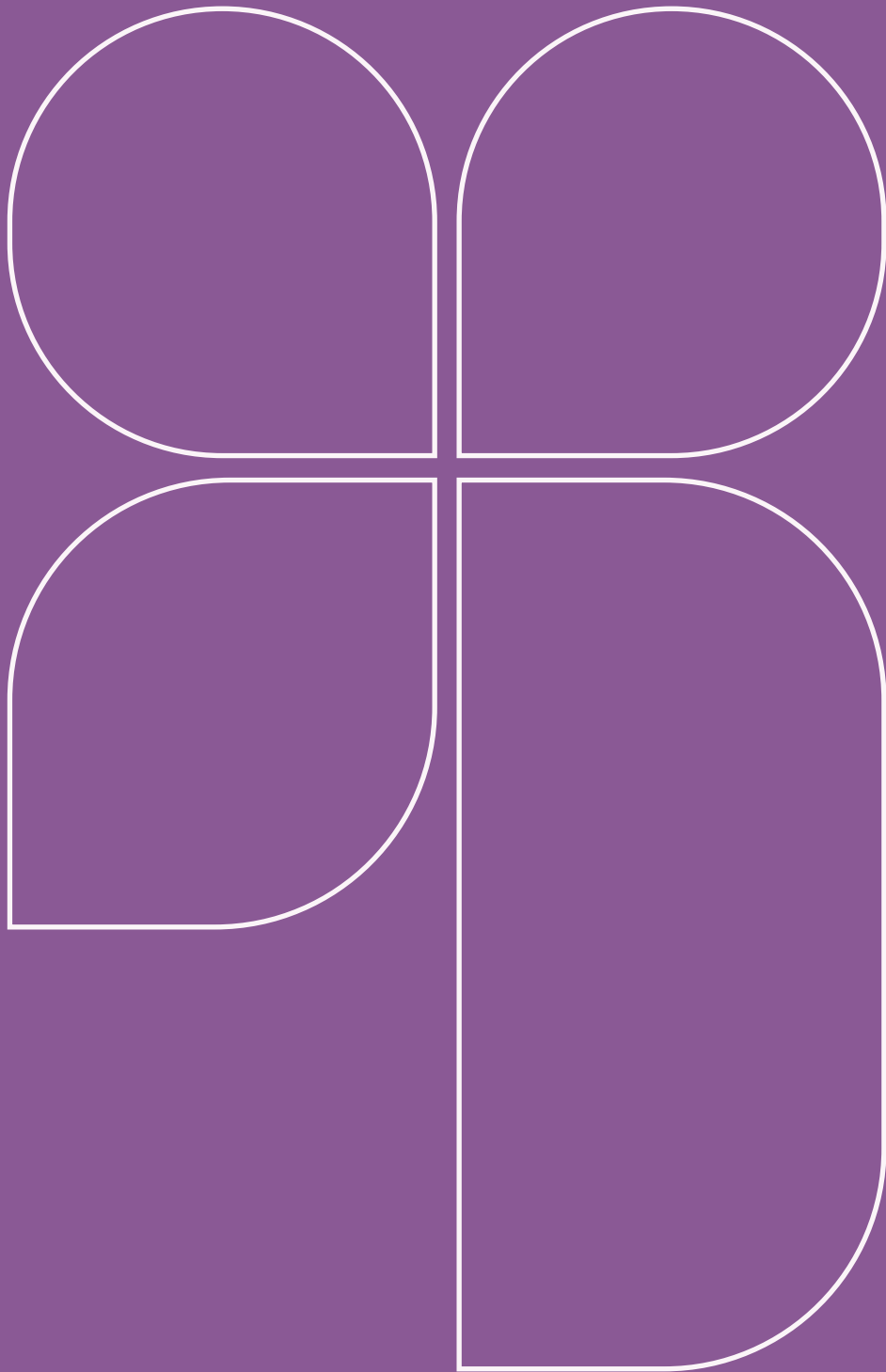
Note 1: Prophylaxis with iron should be withheld in case of acute illness (fever, diarrhoea, pneumonia, etc.), and in a known case of thalassemia major/history of repeated blood transfusion.

Note 2: Prophylaxis with IFA tablets/syrup will be gradually tapered with more emphasis being placed on testing followed by treatment till resolution along with inclusion of iron rich foods in the daily diet.

CHAPTER 4

Testing and Therapeutic Management





4.1 WHO Hemoglobin Cut Offs (2024)

As per the WHO Hemoglobin cut offs (2024), there is a modification in the hemoglobin cutoffs for defining anemia for two population groups, children 6–23 months of age and pregnant women in the second trimester, both being reduced by 0.5 g/dl from 11g/dl to 10.5g/dl, rest of the values remain the same as those of 2011.

Children aged 6 months to 5 years

Hb cut off	WHO 2011	WHO 2024	
Children Age	6 to 59 months	6 to 23 months	24 to 59 months
Non anemic	11.0g/dL or higher	10.5g/dL or higher	11.0 g/dL or higher
Mild	10.0-10.9g/dl	9.5-10.4 g/dl	10.0-10.9 g/dl
Moderate	7.0-9.9g/dl	7.0-9.4 g/dl	7.0-9.9 g/dl
Severe	< 7.0g/dl	< 7.0 g/dl	< 7.0 g/dl

Children aged 5-14 years

Hb cut off	WHO 2011 and WHO 2024	
Children Age	5-11 years	12-14 years
Non anemic	11.5 g/dL or higher	12.0 g/dL or higher
Mild	11.0-11.4 g/dl	11.0-11.9 g/dl
Moderate	8.0-10.9 g/dl	8.0-10.9 g/dl
Severe	< 8.0 g/dl	< 8.0 g/dl

Adult males

Hb cut off	WHO 2011	WHO 2024
Age	15 years & above	15-65 years
Non anemic	13.0 g/dL or higher	
Mild	11.0-12.9 g/dl	
Moderate	8.0-10.9 g/dl	
Severe	< 8.0 g/dl	

Adult females, non pregnant

Hb cut off	WHO 2011 and WHO 2024
Age	15-65 years
Non anemic	12.0 g/dL or higher
Mild	11.0-11.9 g/dl
Moderate	8.0-10.9 g/dl
Severe	< 8.0 g/dl

Adult females, pregnant

Hb cut off	WHO 2011	WHO 2024	
Age		First trimester & Third trimester	Second trimester
Non anemic	11.0 g/dL or higher	11.0 g/dL or higher	10.5 g/dL or higher
Mild	10.0-10.9g/dl	10.0-10.9g/dl	9.5-10.4 g/dl
Moderate	7.0-9.9g/dl	7.0-9.9g/dl	7.0-9.4 g/dl
Severe	< 7.0g/dl	< 7.0 g/dl	< 7.0 g/dl

4.2 Testing Of Hemoglobin for Detection of Anemia

Identifying anemia is the first crucial step in its management. Testing allows anemia to be categorized as mild, moderate, or severe, which helps guide timely and appropriate treatment.

Anemia develops when iron stores are depleted; hence treating anemia involves not just correction of anemia, but also supporting restoration of iron stores to prevent relapse once supplements discontinue. Hence, annual testing for anemia becomes very important. Many beneficiaries remain unaware that they are anemic, as common signs such as tiredness, fatigue, generalised weakness, and difficulty in concentration are often mild and easily ignored or attributed to daily stress or workload. As a result, anemia frequently goes undiagnosed until severe symptoms appear, as pale skin, shortness of breath, dizziness, or even chest pain, which then demand immediate medical attention.

Regular hemoglobin testing supports early detection, enabling prompt care and ultimately improving overall health and quality of life.

4.2.1 Methods of Testing for anemia

Anemia can be assessed using capillary, venous, or arterial blood sampling methods. Under Anemia Mukta Bharat Abhiyaan, capillary and venous blood samples are used for testing anemia in field settings and in health facilities (PHC and above) respectively.



NORMAL



ANEMIA

Venous blood testing is the gold standard for accurate measurement and confirmation of hemoglobin levels. Capillary testing involves a single prick to the finger (heel)² and is useful for rapid screening in community or field settings. Digital Invasive Hemoglobinometers have been used regularly under AMB.

4.2.2 Why Digital Invasive Hemoglobinometer (DIH) is used?

The Digital Invasive Hemoglobinometers (DIH) are point of care testing devices that can be used for estimation of hemoglobin near the beneficiary, outside the health facility, thereby making it more accessible and easy to use. Being light and easy to carry, DIH can be easily used for the purpose of screening for anemia in hard to reach areas amongst the vulnerable age groups for initiation of appropriate treatment as per the severity of anemia. Its portability and quick results enable early detection of anemia and support prompt clinical decision-making and timely initiation of appropriate treatment. The technical specifications for the DIH are available on NHM website³.

Additionally, diagnostic services for confirmation of anemia are available at the facility level (PHC and above).



²: Heel testing is advised for infants on advise of treating physician/paediatrician

³: <https://nhm.gov.in/index1.php?lang=1&level=4&sublinkid=1455&lid=804>

Calibration and Quality Assurance of Digital Hemoglobinometers

Accurate Hb estimation is critical for appropriate screening, diagnosis, classification and management of anemia. Hence, all Digital Hemoglobinometers (DIH) should be regularly calibrated, maintained and checked for performance in accordance with the manufacturer's specifications and standard operating procedures.

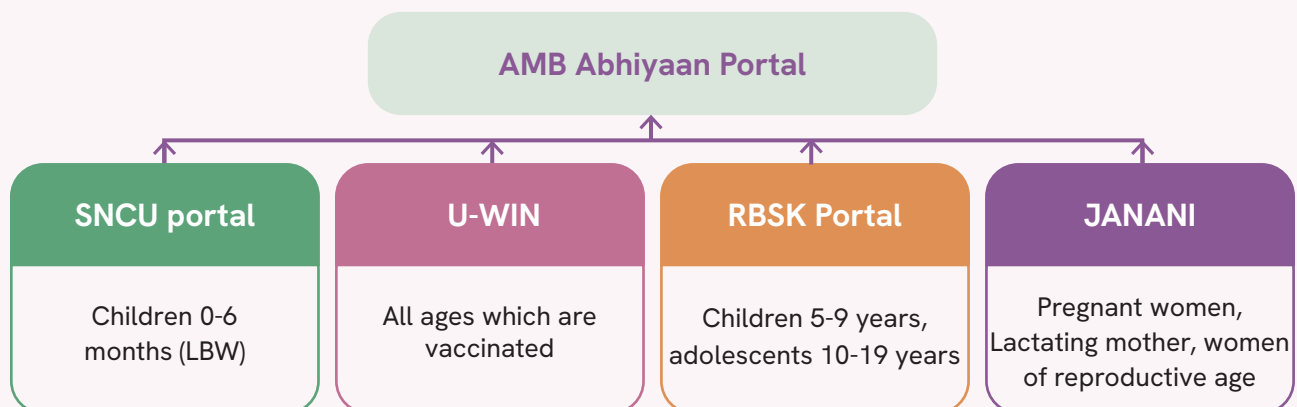
Routine quality assurance measures, including calibration checks, validation using control materials (where applicable), battery and device performance checks, and periodic preventive maintenance, should be undertaken at prescribed intervals. Health facilities should maintain records of calibration, servicing, repairs, and quality control activities.

Any device found to be producing inconsistent, inaccurate, or erratic readings should be immediately withdrawn from use and subjected to troubleshooting, recalibration, or replacement as per established protocols. Regular calibration and quality assurance help reliability of Hb measurements, minimize diagnostic errors and strengthen the quality of anemia screening and management services.

4.2.3 Hb Testing record keeping and analysis

Testing is of utmost importance as it will make beneficiaries aware of their hemoglobin status and need to address the anemia on time. All beneficiaries will be registered on a digital platform at the time of Hb testing as seen in table below.

Beneficiary-wise source of data sets:



All these portals will feed into the AMB Abhiyaan Portal and will enable the detailed data analysis in the AMB dashboard.

The saturation of testing of targeted beneficiaries gradually over a period of time will help in estimating the burden of severity of anemia of into mild, moderate and severe categories and support programme managers in monitoring and taking timely corrective action.

4.3 Treatment of Anemia

Once the beneficiaries are screened/ diagnosed anemic, they are placed on therapeutic management of anemia as per Anemia Mukht Bharat Abhiyaan guidelines, beneficiary wise therapeutic management protocols are placed in tables 1 to 7 at the end of the chapter.

4.3.1 Source correction approach for management of anemia

It is critical to undertake a systematic root cause analysis to identify the underlying determinants of anemia in cases of relapse/ non responders/ refractory⁴ cases etc among the beneficiary groups.

The causes can be further assessed in depth in areas of high prevalence of anemia or across vulnerable populations. This should be followed by a structured source-correction approach under AMB Abhiyaan to address these specific causes directly, whether nutritional deficiencies, infections, dietary practices, social determinants, or compliance challenges.

The segregation of **nutritional anemia** (anemia due to deficiency of iron, folate, vitamin B12 and other micronutrient deficiencies) and **non-nutritional anemia** (anemia due to infections, genetic disorders, chronic diseases, and blood loss) is critical for effective management of anemia. The nutritional anemia is managed through therapeutic doses along with dietary changes and counselling for consuming iron rich foods, while non-nutritional causes require treatment of the underlying conditions through timely referral to higher centres.

4.3.2 Case-based management approach

An individualized, case-based management approach has been integrated with existing framework under Anemia Mukht Bharat Abhiyaan using digital interventions.

Case-based management of anemia comprises of individual assessment to investigate for the underlying causes of anemia; provide tailored treatment as per protocols, assess issues with compliance, follow-up based on individual clinical advice and address socio-cultural determinants of the anemia by counselling and debunking misconceptions.

This will strengthen correction of the underlying causes, treatment of infections, referral for specialized care, and/ or management of chronic conditions. Additionally, it will

4: relapse: Return of anemic state after a period of non-anemic state

Non-responder: Rise of Hb <1 g/dl after 1 month of treatment

Refractory: Anemia which is resistant /unresponsive to standard treatment

support regular reassessment of hemoglobin levels, and treatment adherence with timely modification of therapeutic strategies to enable resolution of anemia.

This will allow service providers to identify the non-responders, non-compliant cases, and help focus approaches to initiate the treatment and improve compliance till resolution. Case-based management with compliance until resolution is the key to reduction in anemia prevalence. Therapeutic management with IFA should be continued for 2 to 3 months after Hb level normalizes to rebuild iron stores.

4.3.3 Identification of vulnerable population for effective anemia management

Anemia is one of major contributing factors for maternal morbidity and mortality which makes pregnant women, lactating mother more vulnerable to the adverse outcomes of anemia during pregnancy and postnatal period. Similarly, anemia among adolescent girls perpetuates the intergenerational cycle of poor maternal and child health increasing the vulnerability to the adverse maternal outcomes. There is a strong need to focus on a pre-emptive approach through early identification and management of anemia among adolescent girls at the onset stage itself which will correct anemia before she enters the preconception period; thereby averting subsequent complications that arise due to anemia during pregnancy, especially severe anemia.

Correction of anemia during the preconception period among all women of reproductive age is an effective way to reduce the burden of anemia and its adverse effects, rather than correcting anemia during pregnancy, which offers a limited scope for intervention, especially in cases of severe anemia. The testing records maintained on digital platforms will help line list vulnerable population and help plan for targeted testing and timely follow up.

4.4 Retesting Anemic Cases

The causes of anemia range from nutritional deficiencies and infections to inflammation, gynaecological and obstetric conditions, and genetic disorders. Accurate measurement of hemoglobin levels, adequate treatment and timely retesting are essential to monitor improvement following treatment. If no improvement or inadequate improvement is observed (< 1 g/dL per month of treatment inspite of good compliance) after completion of therapeutic IFA intake for desired period (varies across beneficiaries), the beneficiary should be referred to a higher facility, such as a First Referral Unit (FRU) or District Hospital (DH), for further investigations to differentiate between iron deficiency anemia, other nutritional deficiencies, and non-nutritional causes of anemia, for further investigations and appropriate treatment. The referral, treatment provided and follow-up will be managed in the AMB Abhiyaan Portal.

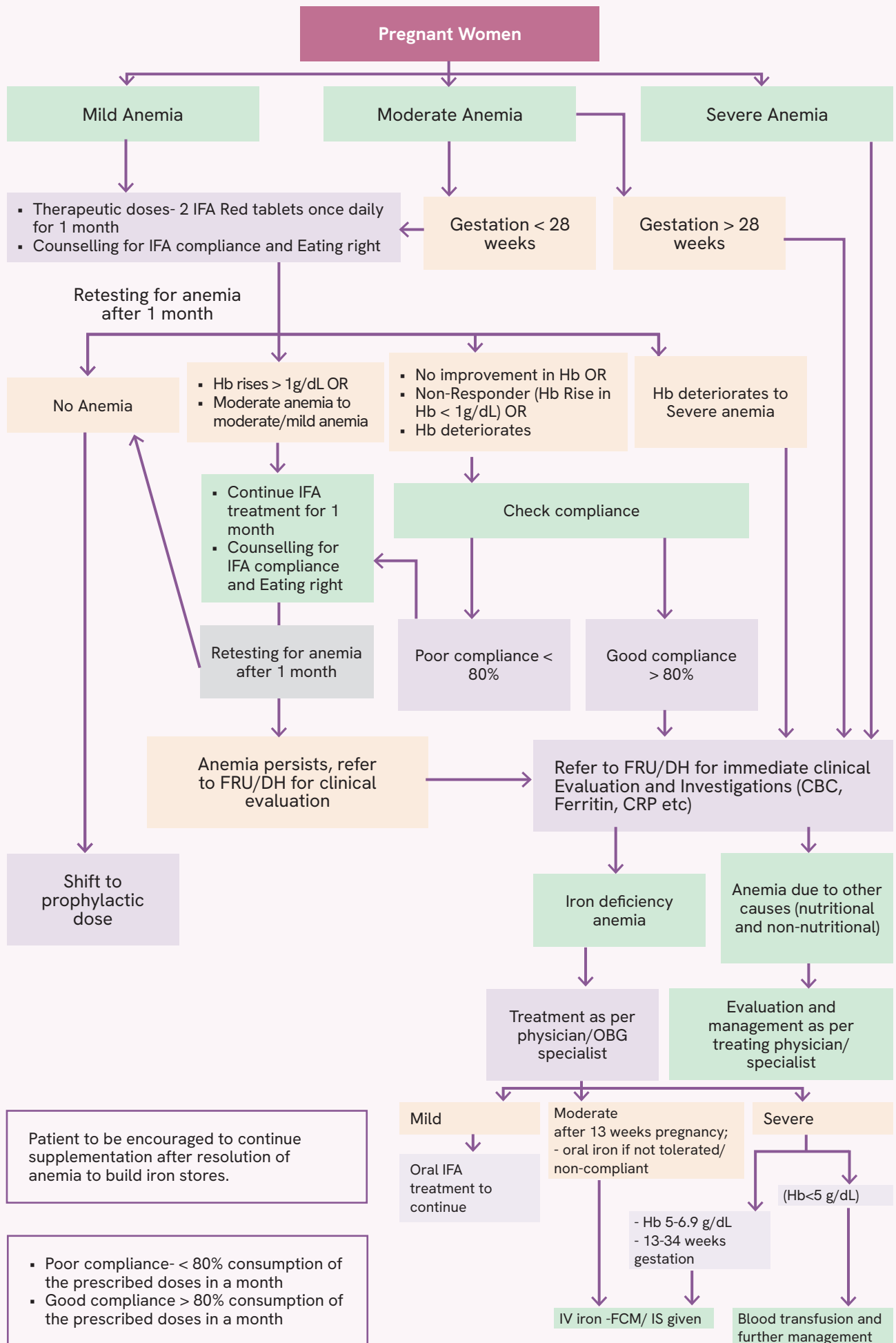
The cases not showing improvement in hemoglobin status during retesting, despite compliance to therapeutic IFA will be referred to higher facility for further investigations and appropriate treatment.

Therapeutic management of anemia with iron should be prescribed as per treating physician/ specialist in case of acute illness (fever, diarrhoea, pneumonia, etc.), and in known cases of Sickle cell disease/ thalassemia major/history of repeated blood transfusion

The frequency, platform for testing for anemia, and therapeutic management beneficiary-wise is detailed in the following tables 1-7.

Table 1

Pregnant Women	
Test protocol	
Periodicity	<p>At every ANC contact (at least 4 times):</p> <ul style="list-style-type: none"> ▶ 1st- within 12 weeks ▶ 2nd- 14-26 weeks ▶ 3rd- 28-34 weeks ▶ 4th- 36-40 weeks ▶ 8 times for all HRPs
Who will screen and platform for screening	<p>ANM: VHSND/UHSND/ANC clinic SN/MO: PMSMA/e-PMSMA</p>
Record keeping	<ul style="list-style-type: none"> ▶ MCP Card ▶ JANANI portal ▶ AMB Abhiyaan Portal ▶ e-PMSMA portal ▶ U-WIN
Line listing of anemic pregnant women	ANM, ASHA
Therapeutic/ Treatment Protocol: Mild-Moderate anemia	
Iron formulation	<p>IFA Red tablet (60 mg elemental iron and 500 mcg folic acid) Intravenous Iron -IV Iron Sucrose or IV Ferric Carboxy Maltose (FCM)</p>
Treatment duration	<p>IFA tablet - 2 tablets daily for 1 month after Hb testing</p> <ul style="list-style-type: none"> ▶ If there is improvement, but target Hb not reached; continue the treatment with 2 tablets daily for 1 months ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (once daily) ▶ If no improvement, refer the Pregnant women to higher facility - FRU/DH for further investigation and management of anemia <p>Intravenous Iron treatment For moderate anemia as advised by treating physician based on gestation period and clinical evaluation: IV Iron Sucrose - 5 doses IV FCM - 2 doses (Please refer to Operational guidelines - Intravenous Iron treatment for Pregnant women and lactating mothers)</p>
Follow-up and monitoring for treatment compliance	<ul style="list-style-type: none"> ▶ Monthly home visits by ASHA for treatment compliance ▶ VHSND
Record keeping	<ul style="list-style-type: none"> ▶ JANANI Portal ▶ AMB Abhiyaan Portal ▶ e-PMSMA portal
Therapeutic/ Treatment Protocol : Severe anemia (Hb <7 gm/dl)	
<p>Refer the Pregnant women to higher facility - FRU/DH for further investigation and management of anemia (IV iron /Blood transfusion). Follow up as per advice of treating specialist/gynaecologist.</p>	



Patient to be encouraged to continue supplementation after resolution of anemia to build iron stores.

- Poor compliance- < 80% consumption of the prescribed doses in a month
- Good compliance > 80% consumption of the prescribed doses in a month

Table 2:

Lactating Mother	
Test protocol	
Periodicity	Within six months of delivery
Who will screen and platform for screening	ANM: VHSND, at times of child's Immunization visits
Record keeping	JANANI portal within 6 weeks post partum AMB Abhiyaan Portal-6 weeks to 6 months post partum
Line listing of anemic women	ANM, ASHA
Treatment Protocol -Mild-Moderate anemia	
Iron formulations	IFA Red tablet (60 mg elemental iron and 500 mcg folic acid) Intravenous Iron –IV Iron Sucrose or IV Ferric Carboxy Maltose (FCM)
Treatment duration	<p>IFA tablet – 2 tablets daily for 3 month</p> <ul style="list-style-type: none"> ▶ If there is improvement, but target Hb not reached; continue treatment with 2 tablets daily for 3 months ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (once daily) ▶ If no improvement, refer the Lactating Mother to higher facility - FRU/DH for further investigation and management of anemia <p>Intravenous Iron treatment</p> <p>For moderate anemia as advised by treating physician based investigation and clinical evaluation: IV Iron Sucrose – 5 doses IV FCM – 2 doses (Pl refer to Operational guidelines - Intravenous Iron treatment for Pregnant women and lactating mothers)</p>
Retesting	<ul style="list-style-type: none"> ▶ For severe anemia-After 1 month of treatment ▶ For moderate anemia- After 2 months of treatment ▶ For mild anemia- After 3 months of treatment
Follow-up and monitoring for treatment compliance	<ul style="list-style-type: none"> ▶ Monthly home visits by ASHA to follow-up for treatment compliance ▶ HBNCC visits ▶ VHSND
Record keeping	<ul style="list-style-type: none"> ▶ JANANI Portal ▶ AMB Abhiyaan Portal
Therapeutic/ Treatment Protocol : Severe anemia	
<p>Refer the Lactating Mother to higher facility - FRU/DH for further investigation and management of anemia (IV iron /Blood transfusion)</p> <p>Follow up as per advise of treating specialist/gynaecologist</p>	

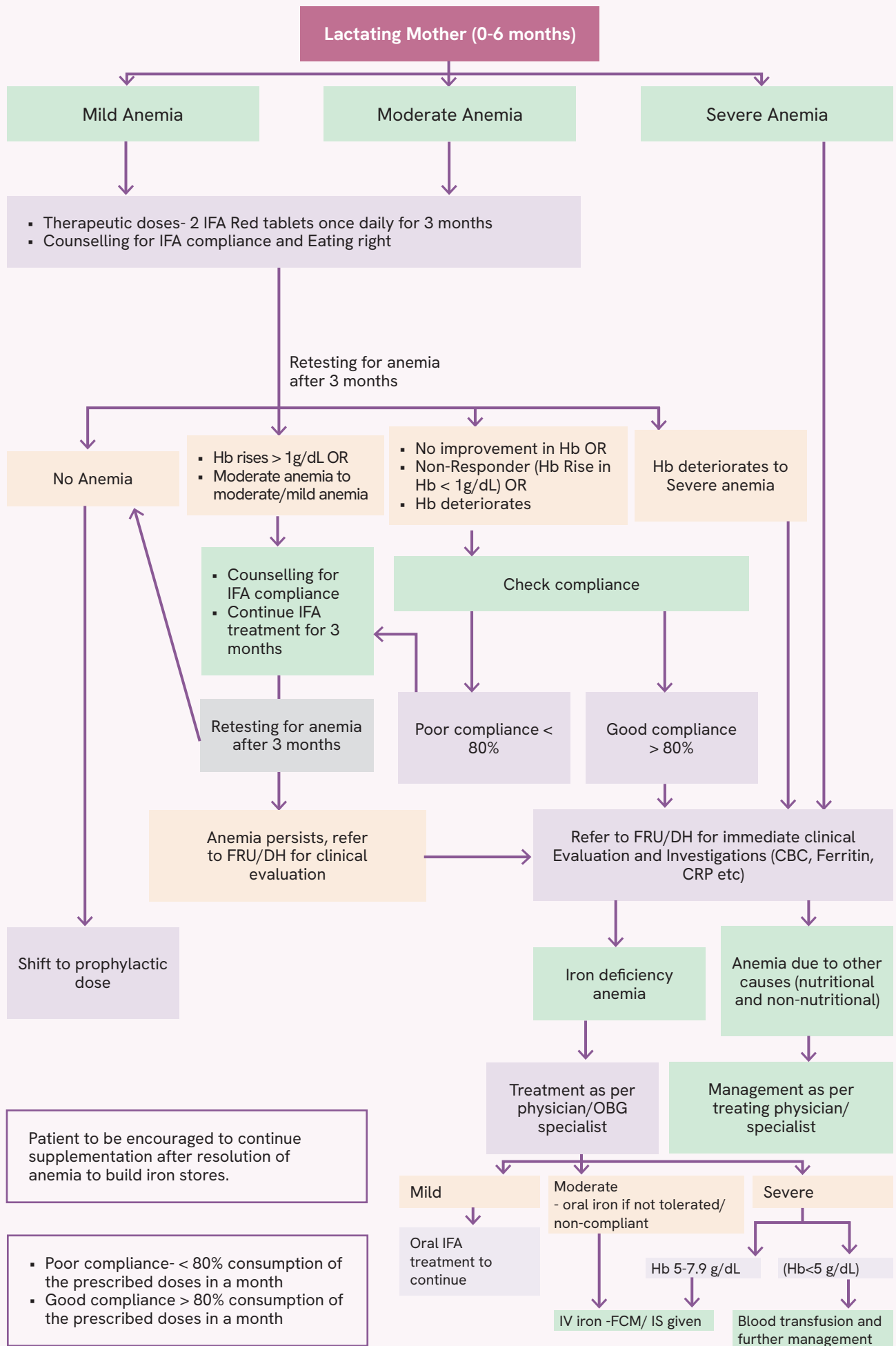
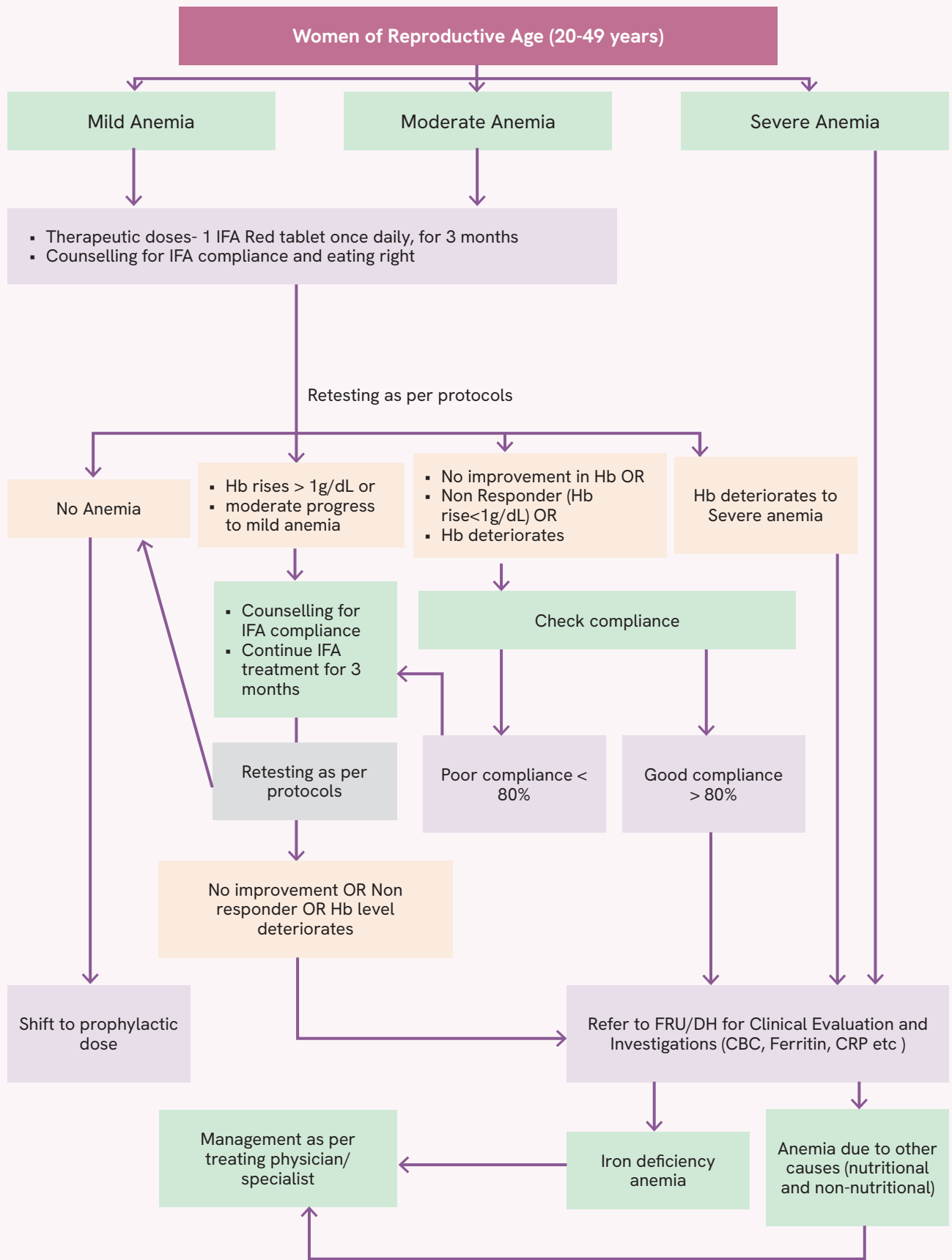


Table 3:

Women of Reproductive Age (20-49 years)	
Test protocol	
Periodicity	Annual
Who will screen and platform for screening	<ul style="list-style-type: none"> ▶ CHO: at AAM- opportunistic screening and referrals ▶ MO: opportunistic screening and referrals ▶ T4 Camps/Health camps
Record keeping	AMB Abhiyaan Portal/ JANANI Portal
Line listing of severely anemic WRA	ANM, ASHA
Treatment Protocol	
Iron formulation	IFA Red (60 mg elemental iron and 500 mcg folic acid)
Treatment duration	<p>1 IFA Red tablet daily for 3 months</p> <ul style="list-style-type: none"> ▶ If there is improvement, but target Hb not reached; continue the same treatment for another 3 months ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (once a week) ▶ If no improvement, refer the WRA to higher facility - FRU/DH for further investigation and management of anemia
Retesting	<ul style="list-style-type: none"> ▶ For severe anemia-After 1 month of treatment ▶ For moderate anemia- After 2 months of treatment ▶ For mild anemia- After 3 months of treatment
Follow-up and monitoring for treatment compliance	<ul style="list-style-type: none"> ▶ ASHA will monitor every month for compliance ▶ Further, ASHA is given incentive for mobilizing WRA for testing, compliance and follow up under Anemia Mukht Bharat Abhiyaan.
Record keeping	AMB Abhiyaan Portal/ JANANI Portal
Therapeutic/ Treatment Protocol: Severe anemia	
<p>Refer the WRA to higher facility - FRU/DH for further investigation and management of anemia</p> <p>Follow up as per advice of treating specialist/gynaecologist</p>	

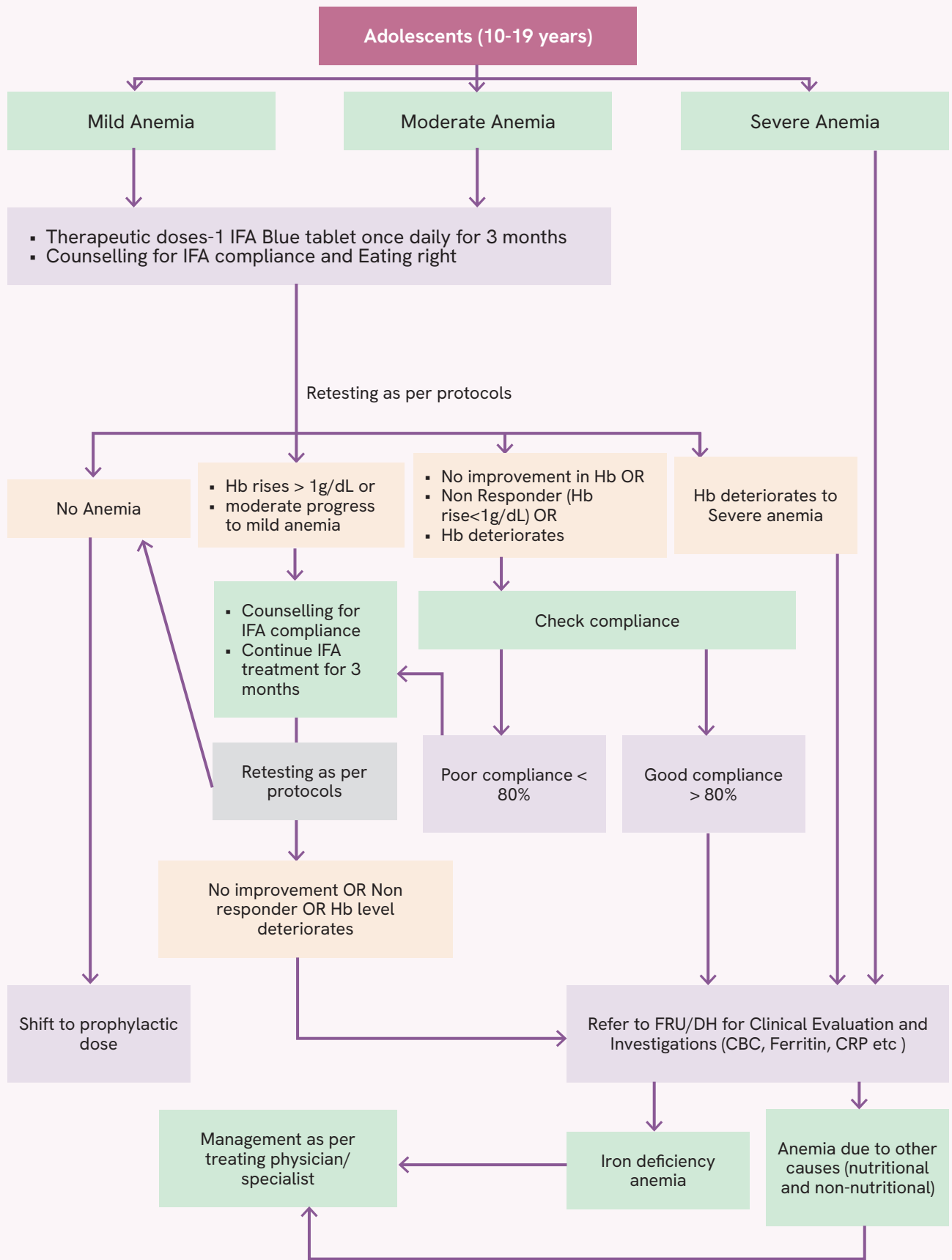


Patient to be encouraged to continue supplementation after resolution of anemia to build iron stores.

- Poor compliance- < 80% consumption of the prescribed doses in a month
- Good compliance > 80% consumption of the prescribed doses in a month

Table 4:

Adolescents (10-19 years)	
Test Protocol	
Periodicity	Annual
Who will screen and platform for screening	RBSK MHT: In school and Out of school in AWC CHO /ANM: Opportunistic screening and referrals from schools/ community/AWC
Record keeping	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ AMB Abhiyaan Portal
Line listing of anemic children	RBSK MHT to share line list of anemic adolescents with HWAs, ANM and School Teachers Separate list of severe anemic Adolescents
Treatment Protocol for Anemic Children	
Iron formulation	IFA Blue (60 mg elemental iron and 500 mcg folic acid)
Treatment duration	1 IFA Blue tablet daily for 3 months <ul style="list-style-type: none"> ▶ If there is improvement, but target Hb not reached; continue the same treatment for another 3 months ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (once a week) ▶ If no improvement, refer the adolescent to higher facility - FRU/DH for further investigation and management of anemia
Retesting	<ul style="list-style-type: none"> ▶ For severe anemia-After 1 month of treatment ▶ For moderate anemia- After 2 months of treatment ▶ For mild anemia- After 3 months of treatment
Follow-up and tracking for Treatment Compliance	<ul style="list-style-type: none"> ▶ Class teacher/ Nodal teacher at school to orient parents during Parent Teacher Meeting (PTM) for compliance of treatment ▶ Parents to follow-up for retest after 90 days of therapeutic treatment at nearest AAM/health facility ▶ RBSK MHT to follow up child in coordination with nodal teachers/HWAs during next visit
Record Keeping	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ RBSK School Health Reports ▶ AMB Abhiyaan Portal
Therapeutic/ Treatment Protocol: Severe anemia	
Refer the adolescent to higher facility - FRU/DH for further investigation and management of anemia Follow up as per advise of treating specialist/physician	

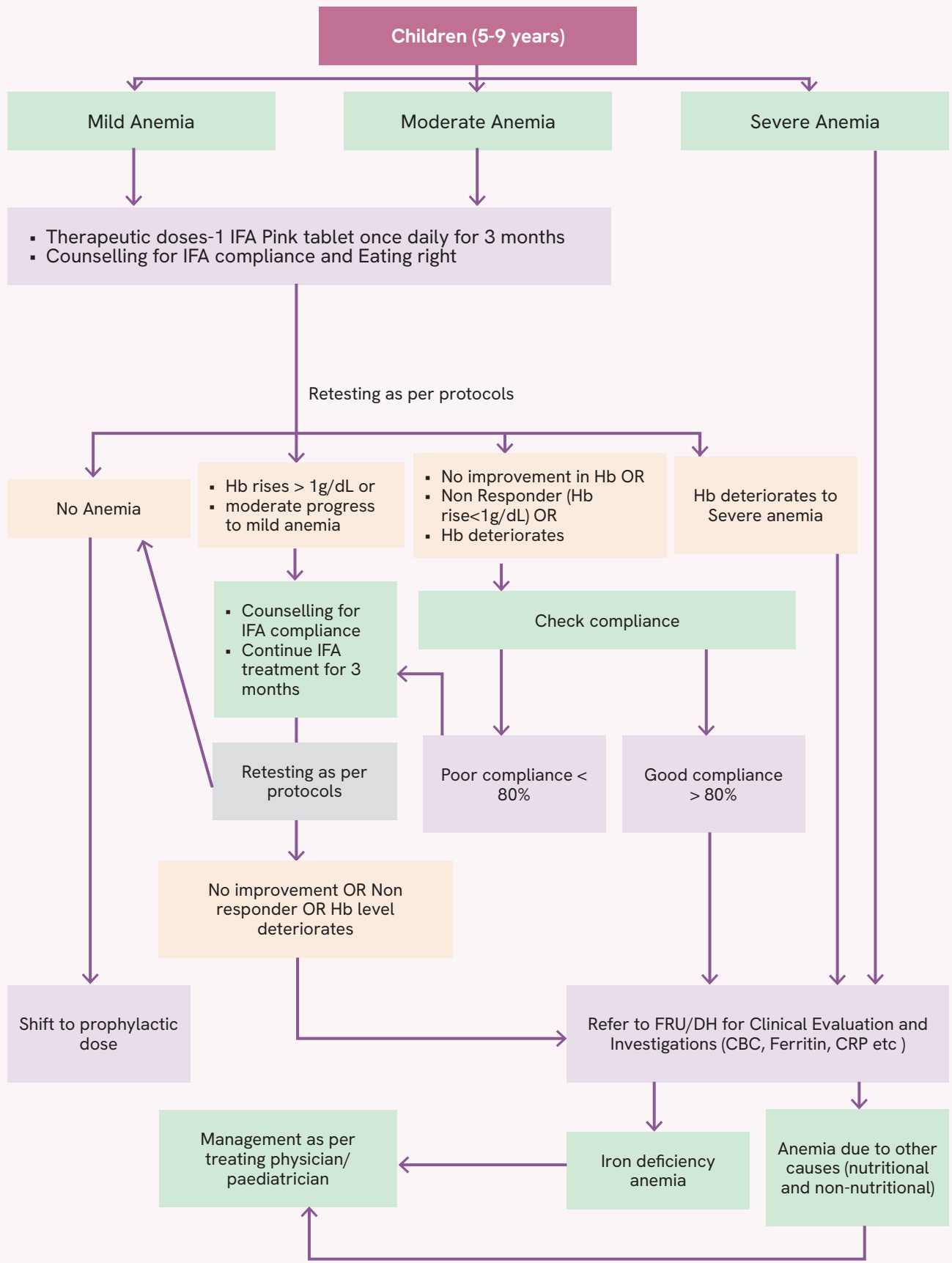


Patient to be encouraged to continue supplementation after resolution of anemia to build iron stores.

- Poor compliance- < 80% consumption of the prescribed doses in a month
- Good compliance > 80% consumption of the prescribed doses in a month

Table 5:

Children (5-9 years)	
Test Protocol	
Periodicity	Annual
Who will screen and platform for screening	RBSK MHT : In school and Out of school in AWC CHO /ANM: Opportunistic screening and referrals from schools/ community/AWC
Record keeping	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ AMB Abhiyaan Portal ▶ U-WIN
Line listing of anemic children	RBSK MHT to share list with HWAs ⁵ , ANM and School Teachers Separate list of severe anemic children
Treatment Protocol	
Iron formulation	1 IFA -Pink tablet (45mg of elemental iron and 400mcg of Folic acid)
Treatment duration	<p>1 IFA Pink tablet daily for 3 months</p> <ul style="list-style-type: none"> ▶ If there is improvement, but target Hb not reached; continue the same treatment for another 3 months ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (once a week) ▶ If no improvement, refer the child to higher facility - FRU/DH for further investigation and management of anemia
Retesting	<ul style="list-style-type: none"> ▶ For severe anemia-After 1 month of treatment ▶ For moderate anemia- After 2 months of treatment ▶ For mild anemia- After 3 months of treatment
Follow-up and monitoring for Treatment Compliance	<ul style="list-style-type: none"> ▶ Class teacher/ Nodal teacher at school to orient parents during Parent Teacher Meeting (PTM) for compliance of treatment ▶ Parents to follow-up of child after 90 days at nearest AAM/health facility ▶ RBSK MHT to follow up child with coordination with nodal teachers/ HWAs
Record Keeping	
Records	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ AMB Abhiyaan Portal ▶ School Health Reports
Therapeutic/ Treatment Protocol: Severe anemia	
Refer the child to higher facility - FRU/DH for further investigation and management of anemia . Follow up as per advise of treating specialist/Paediatrician.	

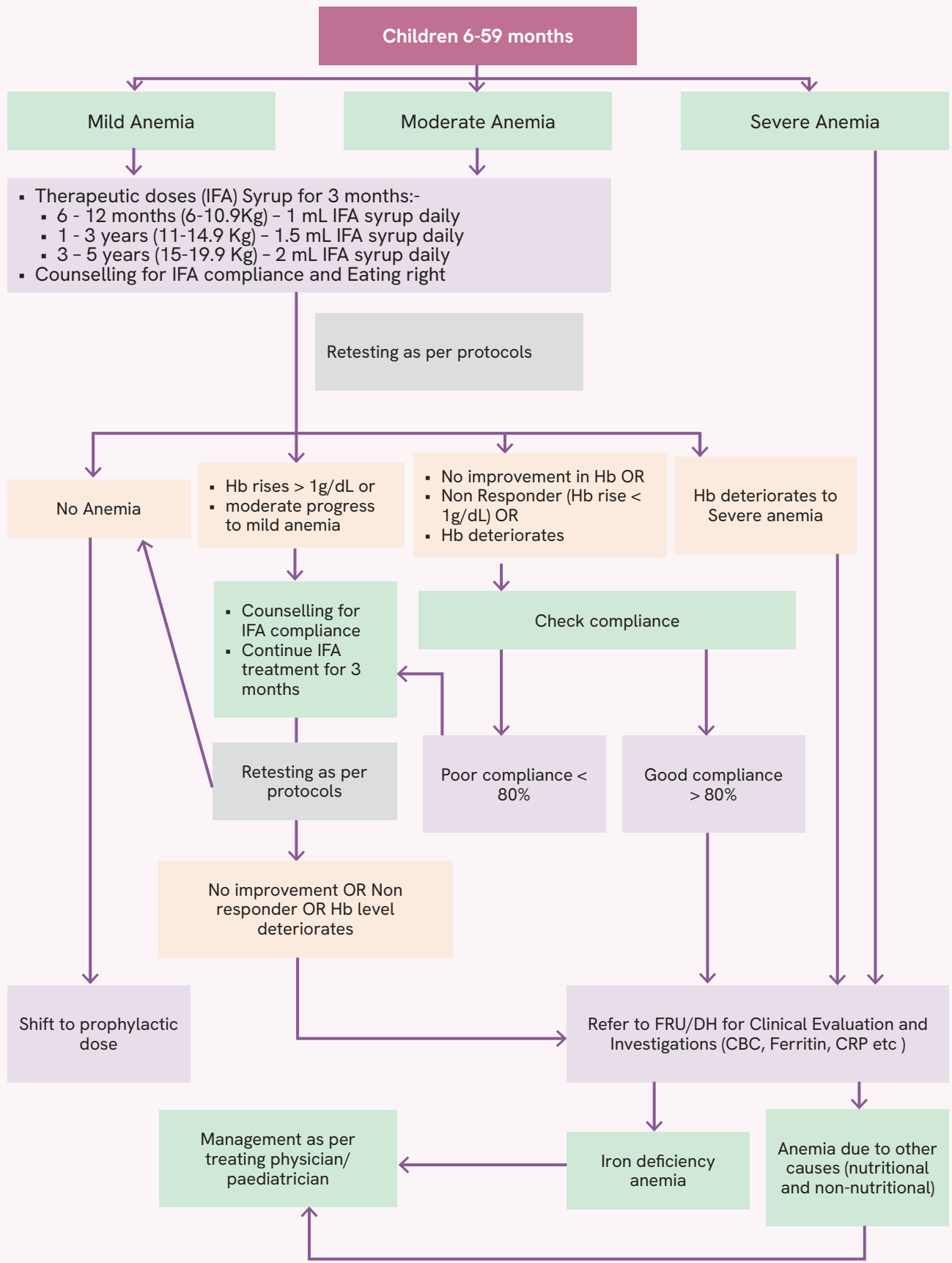


Patient to be encouraged to continue supplementation after resolution of anemia to build iron stores.

- Poor compliance- < 80% consumption of the prescribed doses in a month
- Good compliance > 80% consumption of the prescribed doses in a month

Table 6:

Children 6-59 months	
Test Protocol	
Periodicity	Annual
Who will screen and platform for screening	<ul style="list-style-type: none"> ▶ ANM: At VHSND/ T4 camps/AAM/ Immunization session sites (during MR-1, MR-2 vaccination; Vitamin A supplementation) ▶ RBSK MHT: at Anganwadi Centre ▶ SN/ MO/ CHO: Opportunistic screening of children visiting the OPD at health facility
Record keeping	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ AMB Abhiyaan Portal ▶ U-WIN
Line listing of anemic children	<ul style="list-style-type: none"> ▶ RBSK MHT to share list with ANM, ASHA ▶ Compiled updated list of anemic children to be available with ANM/ASHA from all portals
Treatment Protocol	
Iron formulation	IFA syrup bottle (50ml) containing 20 mg of elemental iron and 100 mcg of folic acid per ml
Dosage	<p>3 mg of elemental iron/kg/day for 3 months / as advised by treating paediatrician</p> <ul style="list-style-type: none"> ▶ For 6-12 months (6-10.9 kg): 1 ml IFA syrup Once a day for 3 months ▶ For 1-3 years (11-14.9 kg): 1.5 ml IFA syrup Once a day for 3 months ▶ For children 3-5 years (15-19.9 kg): 2 ml IFA syrup Once a day for 3 months
Treatment duration	<p>Daily for 3 months</p> <ul style="list-style-type: none"> ▶ If there is improvement i.e >1g/dL increase in Hb level, after 1 month of therapeutic dose, but target Hb not reached; continue the same treatment for another 3 months ▶ If there is no improvement in Hb level (<1 gm/dl increase in Hb level) in following months and target Hb is not achieved after 3 months of treatment- Check for compliance and refer patient to higher facility for further clinical evaluation and management. ▶ If there is improvement, and target Hb reached; switch to prophylaxis dose (bi-weekly)
Retesting	<ul style="list-style-type: none"> ▶ For severe anemia-After 1 month of treatment ▶ For moderate anemia- After 2 months of treatment ▶ For mild anemia- After 3 months of treatment
Follow-up and monitoring for Treatment Compliance	<ul style="list-style-type: none"> ▶ ASHA will follow up through home visits ▶ HBNCC visits ▶ ASHA will mobilise all anemic cases for follow up testing after 3 months of treatment ▶ Counselling of mothers/caretakers by ASHA and ANM on reassurance of common side effects of the Iron supplementation ▶ ANM to report compliance on AMB Abhiyaan portal
Record Keeping	
Records	<ul style="list-style-type: none"> ▶ RBSK Portal ▶ U-WIN ▶ AMB Abhiyaan Portal
Therapeutic/ Treatment Protocol: Severe anemia	
Refer the child to higher facility - FRU/DH for further investigation and management of anemia .	
Follow up as per advise of treating Paediatrician.	



Patient to be encouraged to continue supplementation after resolution of anemia to build iron stores.

- Poor compliance- < 80% consumption of the prescribed doses in a month
- Good compliance > 80% consumption of the prescribed doses in a month

Table 7:

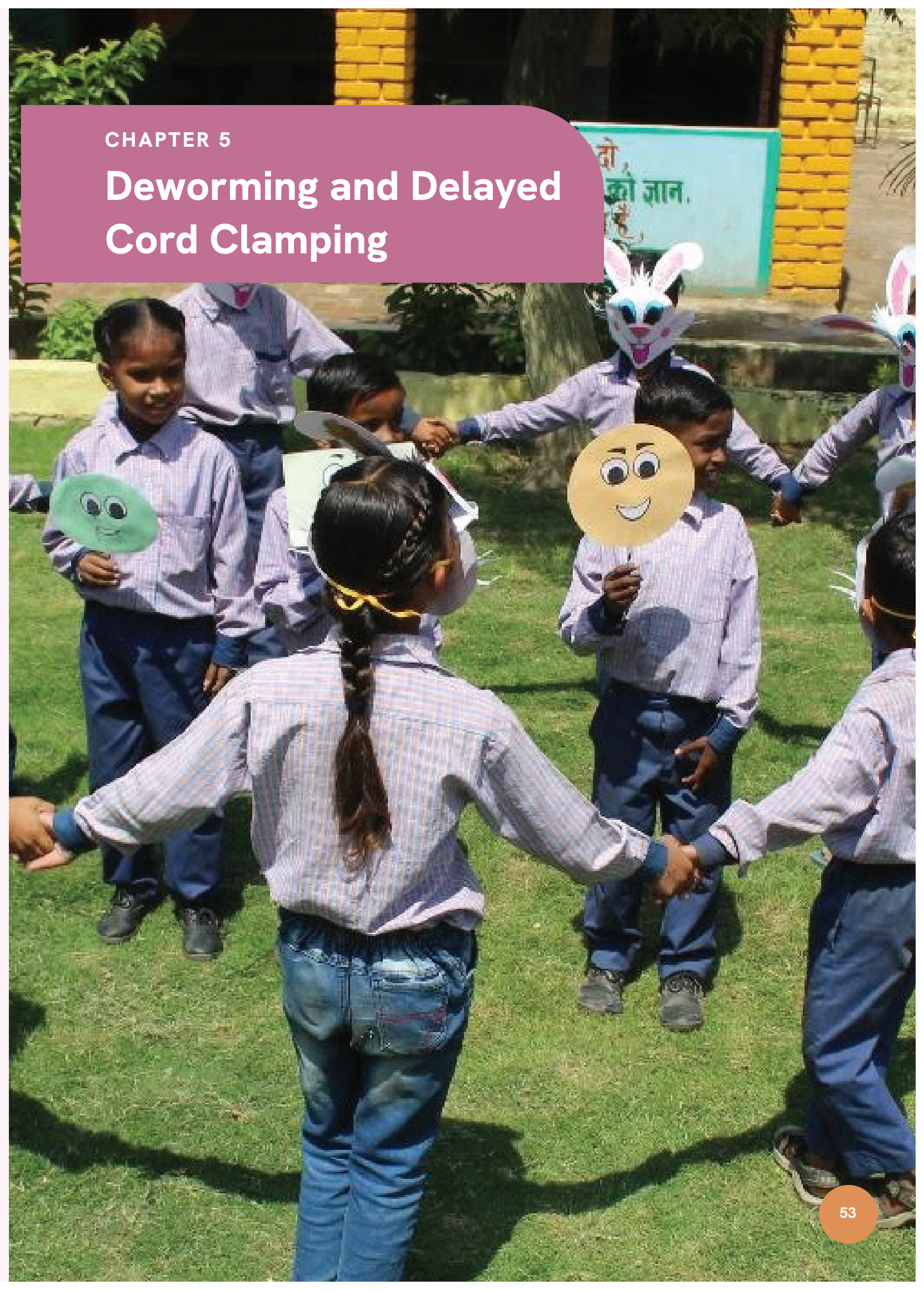
Children (0-6 months)-LBW	
Test protocol	
Periodicity	As directed by SNCU-in-charge/Paediatrician
Who will screen and platform for screening	Screening at SNCU/NICU/Paediatric ward as per advice of Physician/ Paediatrician
Record keeping	<ul style="list-style-type: none"> ▶ SNCU records ▶ AMB Abhiyaan Portal ▶ U-WIN
Treatment Protocol	
Iron formulation	IFA drops
Dosage	As per advise of Paediatrician/ FBNC guidelines
Treatment duration and follow up	As directed by Paediatrician

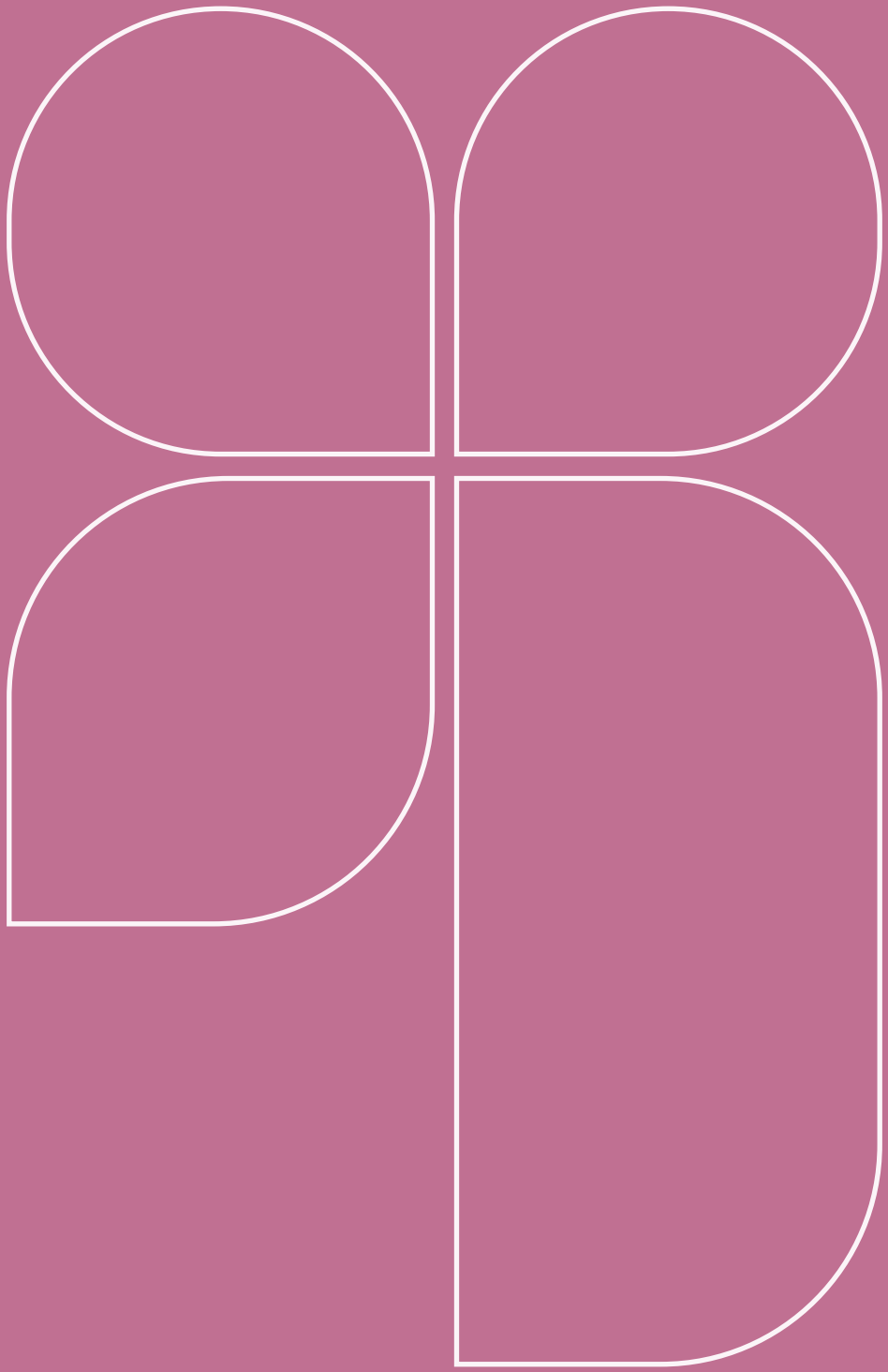
Compliance:

1. If compliance is poor, < 80% consumption of the prescribed doses in a month Counsel beneficiary or mother/ caretaker of child and continue the treatment for next month.
2. If compliance is good, > 80% consumption of the prescribed doses in a month.

CHAPTER 5

Deworming and Delayed Cord Clamping





Anemia is a multifactorial public health issue that cannot be addressed through iron supplementation alone. Along with Iron-folic acid supplementation, a comprehensive strategy must include other allied interventions that complement supplementation. Deworming and Delayed cord clamping are proven effective interventions complementing IFA supplementation; details as below.

5.1 Deworming

Deworming is an essential component of Anemia Mukht Bharat Abhiyaan and should be implemented as a routine, convergent public health intervention among populations at risk. Intestinal helminth infections contribute directly to anemia by causing chronic intestinal blood loss, reducing iron and micronutrient absorption, suppressing appetite, and damaging gut lining, thereby worsening nutritional deficiencies. Regular deworming of preschool and school-age children, adolescents, pregnant women and women of reproductive age reduces parasite load, improves nutrient absorption, and enhances the effectiveness of iron-folic acid supplementation. For sustained impact, deworming must be combined with water, sanitation, and hygiene measures to prevent re-infection. Strengthened behaviour change communication will support long-term reduction in anemia prevalence.

Dose and regimen for all ages:

Children 1-2 year of age	
Dose and regime Biannual dose of 200 mg albendazole (1/2 tablet of 400 mg)	Platform Anganwadi Centre
Children 2-19 years of age including out of school adolescent girls	
Dose and regime Biannual dose of 400 mg albendazole (1 tablet)	Platform 2-5 years and out of school children and adolescents: Anganwadi Centre 6-19 years school going children: School
Pregnant women	
Dose and regime One dose of 400 mg albendazole (1 tablet), after the first trimester, preferably during the second trimester	Platform VHSND/ANC Clinic/ PMSMA/ ePMSMA
Women of reproductive age (non-pregnant, non-lactating) 20-49 years	
Dose and regime Biannual dose of 400 mg albendazole (1 tablet)	Platform Anganwadi Centre

National Deworming Day:

To intensify efforts towards Soil transmitted Helminths (STH) control in India, the Ministry of Health and Family Welfare has been implementing the National Deworming Day. Under NDD, biannual mass deworming (albendazole tablet) for children and adolescents in the age groups between 1 and 19 years is carried out during the months of February and August every year. This is followed a week later by mop-up rounds to cover the left-out and missed children.

The objective of National Deworming Day is to deworm all preschool and school-age children (enrolled and non-enrolled) between the ages of 1-19 years through the platform of Anganwadi Centers and schools in order to improve their overall health, nutritional status, access to education and quality of life.

Key stakeholders for conducting National Deworming Day:

The Ministry of Health & Family Welfare, Government of India will be the nodal agency for providing all States/UTs with guidelines related to National Deworming Day⁶ (NDD) implementation along with training material, IEC material for community mobilization and awareness generation, reporting formats, monitoring checklists and Adverse Event management protocols. The Departments of School Education & Literacy and Women and Child Development (MWCD) are key stakeholders for the National Deworming Day.

5.2 Delayed Cord Clamping

Delayed cord clamping, a recommended early-life intervention for anemia prevention is included as a standard delivery-room practice in all health facilities, and is promoted as a part of Anemia Mukta Bharat Abhiyaan. Delayed cord clamping, defined as clamping the umbilical cord at least 1-3 minutes after birth or after cessation of cord pulsations, which allows additional placental blood transfer to the newborn, resulting in higher neonatal hemoglobin levels and improved iron stores during the first months of life. This low-cost, high-impact practice reduces the risk of early childhood iron deficiency and anemia without requiring additional supplies or complex procedures.

Early cord clamping, which is generally carried out before 60 seconds after birth, is not preferred unless the newborn shows signs of asphyxia and needs immediate resuscitation.

All skilled birth attendants should be trained to practice delayed cord clamping during normal deliveries and caesarean sections as a part of essential newborn care. Compliance with delayed cord clamping protocols should be integrated into labor room quality assurance, staff training, and supportive supervision. It is beneficial in preventing iron deficiency for this crucial period till the initiation of prophylactic IFA supplementation doses.

Delayed Cord Clamping



When?

1-3 minutes after birth
After cessation of cord pulses



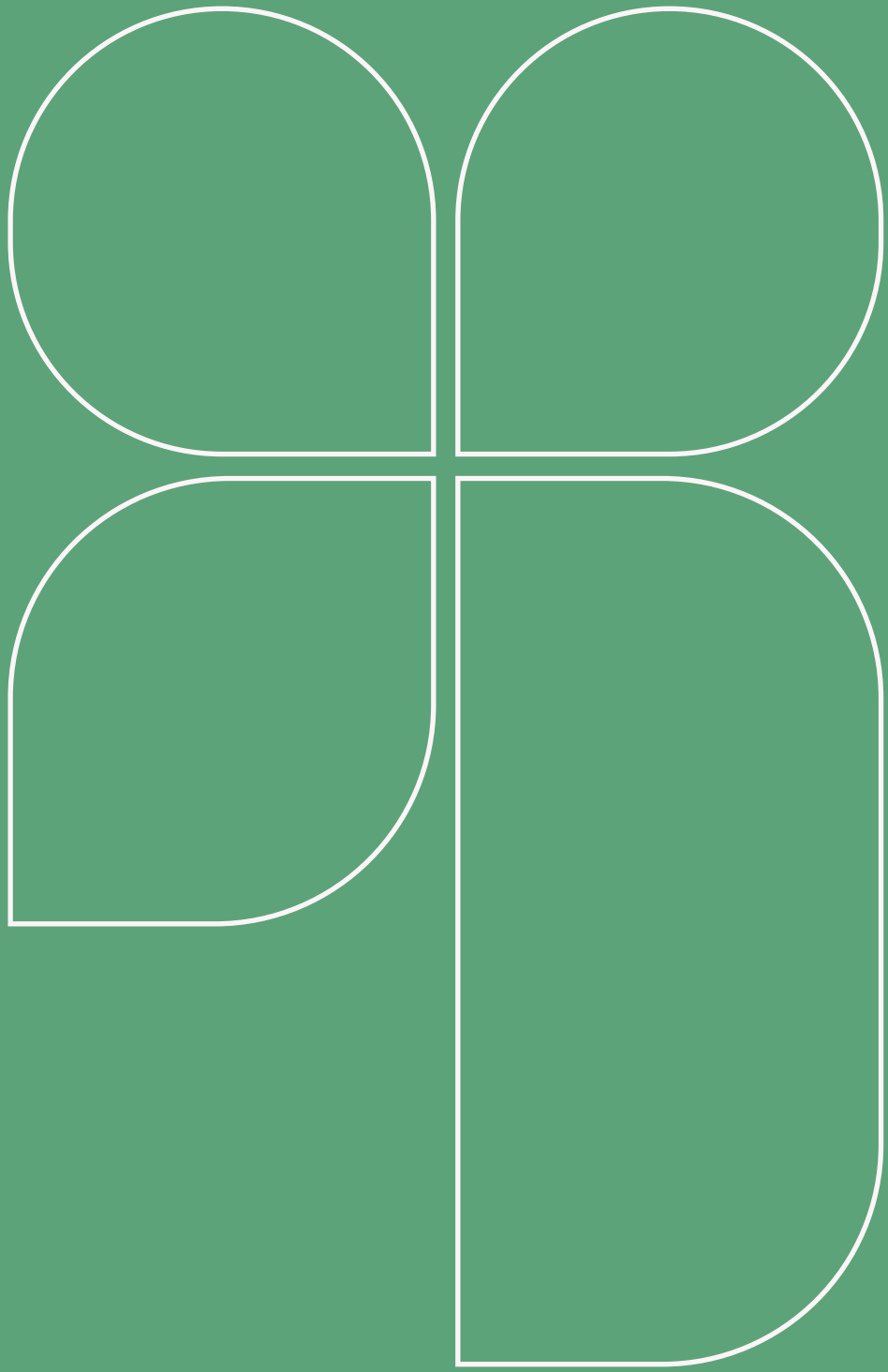
Why?

Allows Placental blood transfer,
resulting in higher neonatal hemoglobin

CHAPTER 6

Addressing Non-Nutritional Anemia





Non-nutritional anemia results from conditions such as malaria, worm infestation, tuberculosis, chronic inflammation, hemoglobinopathies, and other medical disorders.

To achieve the goal of reducing the anemia prevalence, it is important to address the underlying conditions causing non-nutritional anemia. Screening and managing these underlying causes, will improve the programme outcomes, especially among the vulnerable sections through combined and reinforcing effects. Non responders to IFA treatment may be referred to be screened for hemoglobin disorders, acute/ chronic infections such as pneumonia, TB, HIV, and other chronic conditions at PHC/ CHC/DH, followed by timely referral, treatment and follow-up to resolve these underlying causes.

6.1 Hemoglobinopathies

Hemoglobinopathies are genetic disorders of hemoglobin broadly categorised as structural hemoglobin disorders or malformed hemoglobin. These disorders are among the major etiological factors contributing to the high prevalence of anemia worldwide. Being one of the most common inherited diseases with high prevalence in tribal parts, these disorders have substantial public health impact due to their intergenerational transmission and contribution to high morbidity.

In structural hemoglobin disorder, structural defects in hemoglobin may alter its stability and functions leading to clinical disorders like Sickle Cell Anemia, HbE and HbC, while thalassemia is genetically malformed hemoglobin. Sickle cell disease and thalassemia, the commonest hemoglobinopathies are discussed as below.

6.1.1 Sickle Cell Anemia

Sickle cell anemia is caused by the inheritance of the abnormal sickle hemoglobin (HbS) genes that create defective hemoglobin leading to elongated, crescent or sickle shaped red blood cells which is highly fragile leading to severe anemia. These sickled cells are rigid and sticky blocking the blood flow to internal organs causing severe health implications like pain, infections and organ damage. Its prevalence is disproportionately higher in the tribal population in which about 1 in 86 births have Sickle Cell Disease⁷.

6.1.2 Thalassemia

Thalassemia is an inherited blood disorder that affects the production of hemoglobin leading to pale, small (microcytic hypochromic) red blood cells with shortened life span. Based on the part of hemoglobin affected, thalassemia is categorised into β and β -thalassaemia. Thalassemia Major (TM) and Thalassemia Intermedia (TI) types of β thalassemia result in severe anemia and constitute the major burden of disease. β -Thalassemia minor and β -thalassaemia are mostly asymptomatic and lead to mild microcytic hypochromic anemia.

7: <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2026348®=48&lang=2>

6.1.3 Need of diagnosing hemoglobinopathies

Hemoglobinopathies associated with hemolytic or microcytic anemia are susceptible to misdiagnosed as iron deficiency anemia (IDA) and inappropriately treated with iron supplementation which may have significant adverse effects such as iron overload.

Iron overload is one of the most important complications of hemoglobinopathies. Treating hemoglobinopathies with iron supplements under AMB may potentially result in iron overload which may affect cardiac, liver, endocrine system and in skeletal issues. This necessitates safeguards to be put in place to rule out the presence of hemoglobinopathies in each case of anemia with proper medical and personal history, investigation and clinical assessment for accurate diagnosis, rational iron use, prevention of iron overload, and the long-term reduction of anemia prevalence.

Do not give empirical iron to a non-responder without first ruling out a hemoglobinopathy.

Anemia Mukht Bharat Abhiyaan emphasizes the recognition of hemoglobinopathies in susceptible patients. Health workers must be aware of these genetic conditions to distinguish nutritional anemia from hemoglobinopathies for referral to the higher centres for further management.

Government of India implements National Sickle Cell Anemia Elimination Mission to improve care of all Sickle Cell Disease patients for their better future and to lower the prevalence of the disease through multi-faced coordinated approach towards screening and awareness strategies. Under National Sickle Cell Anemia Elimination Mission, Government of India provides free screening and diagnostic services for Sickle Cell Disease at all level of health facilities. Government has published guidelines⁸ for prevention and control of hemoglobinopathies- thalassemia, sickle cell disease and other variant hemoglobin to address this significant public health challenge.

National Sickle Cell Anemia Elimination Mission

Improving care for Sickle Cell Disease care

- ▶ Multi-faceted coordinated approach
- ▶ Free screening and diagnostic services
- ▶ Published guidelines for prevention and control

2: <https://sickle.nhm.gov.in/home/guidelines>

https://www.nhm.gov.in/images/pdf/programmes/RBSK/Resource_Documents/Guidelines_on_Hemoglobinopathies_in%20India.pdf

6.2 Detection and Management of Acute and Chronic Diseases and Infections

Infectious diseases such as malaria, hepatitis, tuberculosis, HIV can alter the production and destruction of Red Blood Cells through diverse mechanism which leads to development or exacerbation of anemia. Further, certain chronic conditions such as chronic kidney diseases (CKD) may cause inflammation which lead to anemia through disruption of production and metabolism of the RBCs. Side effects of drugs given to manage these infections and chronic diseases may also contribute to the anemia incidence. If these factors remain undiagnosed and left untreated, they can lead to persistent anemia, reducing the effectiveness of anemia treatment, affecting overall health outcomes.

Correction of non-nutritional associated factors through early identification, prompt diagnosis, and effective management should be focused to effectively address the challenges in reducing the anemia prevalence. Strengthening referral linkages, supporting free drugs and diagnostics, and providing nutritional support during treatment further improve hemoglobin recovery and overall health outcomes. Several public health programmes implemented under the National Health Mission (NHM) address these associated factors through facility and community based interventions which include specific screening, diagnostic procedures and treatment as outlined below.

Malaria

It can be screened at community level and health facilities by rapid diagnostic tests (RDT) of all fever cases while confirmation is done at higher centres through blood microscopy. Treatment follows the administration of anti-malarial drugs under national drug policy. Drug Distribution Centres (DDCs) and Fever Treatment Depots (FTDs) are established at health facilities to provide easy accessibility to the community for full-course treatment, with emphasis on adherence and cure. Under National Health Mission, the Ministry of Health and Family Welfare implements **National Vector Borne Disease Control Programme (NVBDCP)**⁹ which integrates surveillance, prevention, and case management strategies enabling timely management of malaria.

⁹: <https://nhm.gov.in/index4.php?lang=1&level=0&linkid=279&lid=346>

Tuberculosis

It is one of the most common infection diseases in which the host immune response and chronic inflammation along with nutritional deficiency predispose patients to iron deficiency anemia. **TB Mukd Bharat Abhiyaan (TBMBA)** provides free screening, diagnosis, and treatment, along with nutritional support to tuberculosis patient. Under **TBMBA**, Government of India provides free diagnostic services such as nucleic acid amplification tests (NAAT), sputum smear microscopy at Designated Microscopy Centers (DMCs) and for its early diagnosis along with prompt treatment under anti-tubercular drugs regimen¹⁰.

Under the TBMBA, Ayushman Arogya Shivirs are being organized to provide a package of integrated health services, including hemoglobin (Hb) screening for early identification of anemia. The initiative facilitates timely detection, counselling, referral, and management of anemia, particularly among vulnerable populations.

Hepatitis

Viral Hepatitis is categorized as Hepatitis A, B, C, D and E based on causative viruses. The Ministry of Health and Family Welfare implements **National Viral Hepatitis Control Programme (NVHCP)** which creates awareness, prevention, early diagnosis, and free treatment services across all levels of care, reducing morbidity and complications that can contribute to anemia.

Under this programme, free screening and diagnosis services for Hepatitis are available at all public health facilities e.g. Hepatitis B surface antigen (HBsAg), serum bilirubin levels. Further, severity of liver disease is assessed at tertiary level through investigation like HBV DNA levels, liver enzymes, alanine aminotransferase (ALT), aspartate aminotransferase (AST), transient elastography (FibroScan) and Liver biopsy, if available.

Treatment for Hepatitis B and C is available at all levels of health care under the drug regimens outlined in National Guidelines for Diagnosis & Management of Viral Hepatitis¹¹. Additionally, **Routine immunization** prevents vaccine-preventable diseases including hepatitis B, thereby reducing infection-related anemia risk among children.

10: <https://tbcindia.mohfw.gov.in/guidelines/>

11: https://nvhcp.mohfw.gov.in/common_libs/diagnosis-management-viral-hepatitis.pdf

HIV-AIDS

HIV infection precipitates anemia through chronic inflammatory response and as drug induced side-effects. **National AIDS Control Programme (NACP)**¹² works on prevention, testing, and treatment services to reduce HIV-related complications that may contribute to anemia. Government of India provides free HIV screening at all public health facilities and treatment through designated Anti-Retroviral Treatment (ART) centres. HIV screening is also an integral part of Ante-natal services for all pregnant women.

Chronic Kidney Diseases (CKD)

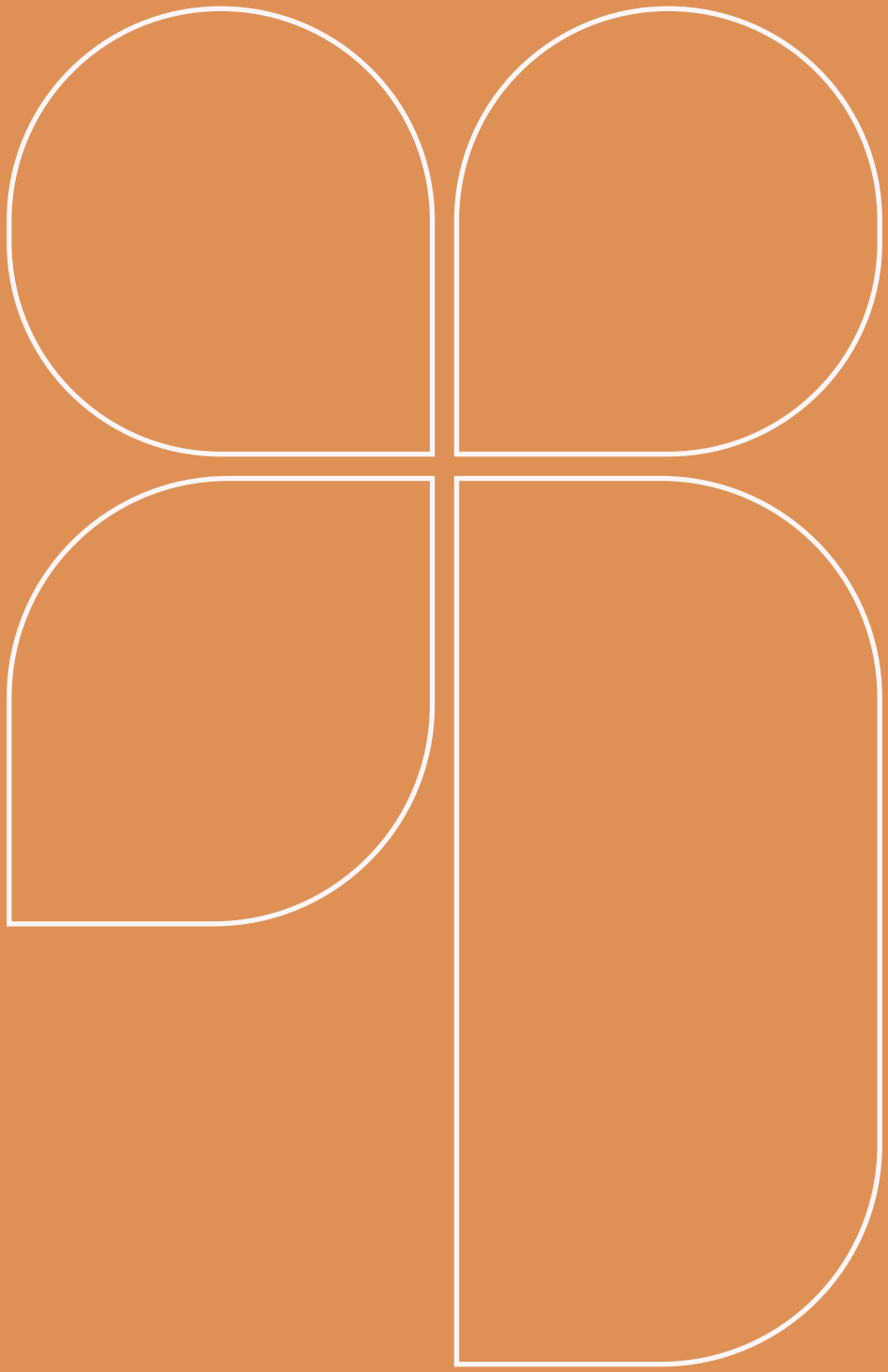
Anemia is the most common complication of CKD caused due to erythropoietin deficiency, chronic inflammatory response, bone marrow dysfunction and nutrition deficiency. Screening for anemia is crucial for each of the patient suffering from CKD along with further laboratory tests like complete blood count (CBC), serum ferritin, transferrin etc. to confirm the severity and to plan management accordingly. **Pradhan Mantri National Dialysis Programme** provides case-based management of chronic kidney diseases contributing to anemia.

Strengthened referral linkages with the above-mentioned interventions will facilitate correction of the associated factors of anemia. The Anemia Mukht Bharat Abhiyaan emphasizes integration with these programmes by intensifying awareness, screening, and treatment of non-nutritional causes of anemia attaining the goal of Anemia Mukht Bharat.

6.3 Water, Sanitation and Hygiene Practices (WASH)

Water, sanitation and hygiene (WASH) practices are one of the key determinants for the health and nutrition outcomes. Poor WASH practices such as lack of availability of safe drinking water, open defecation and poor hand hygiene are responsible for most of the infectious diseases and STH infestations. Promoting the WASH practices at community and individual level is crucial to address high burden of iron deficiency, especially among the vulnerable sections of the society.

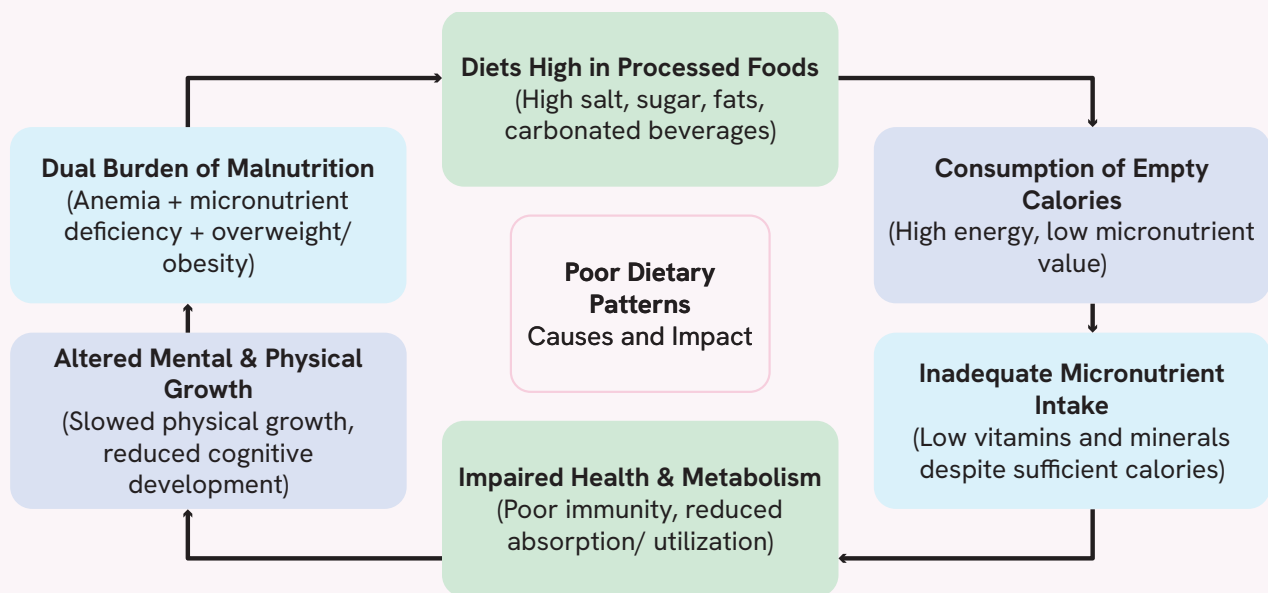
¹²: <https://naco.gov.in/operationalguidelines>



Healthy food forms the foundation of preventive healthcare and is an integral component of overall well-being. Both macronutrients (carbohydrates, proteins and fats) and micronutrients (vitamins and minerals) together form a healthy diet, in adequate quantities to meet the body’s physiological requirements to support growth and development, tissue repair, maintenance of muscles and bones, immune function, and overall health throughout the course of life.

Nutrition plays a critical role in enabling individuals to achieve their full physical, cognitive and productive potential. The foundations of good health are laid even before birth. Adequate nutrition during adolescence, the preconception period and pregnancy is essential for healthy fetal growth and development. After birth, optimal breastfeeding practices provide infants with essential nutrients and protective factors that support growth, immunity and long-term health outcomes. As children grow, establishing healthy eating habits and consuming nutrient-rich foods become critical for physical growth, cognitive development and prevention of micronutrient deficiencies.

Inadequate dietary intake of iron-rich food and poor nutrient bioavailability in foods is a major contributor to the persistently high burden of anemia in India. **Eating Right** through conscious practices as dietary diversity, improved cooking practices to enhance iron bioavailability is therefore a critical pillar of Anemia Mukta Bharat Abhiyaan.



Continued Poor Dietary Pattern Reinforce the Cycle

Diets high in processed foods, calories, excessive salt sugar, and carbonated beverages provide empty calories i.e. high calories with minimal or no nutritional value. Such dietary patterns, when continued for a very long time, contribute and give rise to being overweight and obese and causes deficiencies in nutrients.

While iron deficiency is the most common cause of anemia, it can also result from deficiencies of folate, vitamin B12, vitamin A, vitamin C and other nutrients involved in red blood cell production and hemoglobin synthesis. Inadequate dietary intake, poor dietary diversity and low bioavailability of nutrients contribute significantly to the burden of anemia. As emphasized in the ICMR-NIN Dietary Guidelines for Indians (2024)¹³, no single food contains all nutrients required by the body. Therefore, consumption of a diverse diet comprising multiple food groups is essential for nutrient adequacy. Promoting dietary diversity, healthy food choices, improved cooking practices and enhanced nutrient bioavailability forms an important pillar of the Anemia Mukht Bharat Abhiyaan.

Maintaining good health requires the regular consumption of a diverse diet in appropriate quantities, aligned with the body's needs. It is important to have macronutrients and micronutrients from a minimum of 5-6 food groups, with vegetables, fruits, green leafy vegetables, roots and tubers. As described in NIN, Dietary guidelines for Indians, there are 10 food groups and to achieve dietary diversity, it is essential to consume at least 5-6 food groups in the daily diet. Equally important are proper cooking practices, including cooking at appropriate temperatures, adherence to food and personal hygiene, and healthy lifestyle practices which comprise physical activity, sleep timings, water intake etc. Together, these factors help the individual in building a healthy lifestyle.

7.1 Healthy Food - Foundation for Anemia Prevention

Factors causing anemia may be nutritional or non-nutritional. The nutritional factors include deficiency of nutrients in diet, bioavailability of nutrients, while the non-nutritional includes infection, thalassemia, malaria, sickle cells etc. Lack of other nutrients beside iron that can cause anemia by affecting the formation of hemoglobin in the body are vitamin A, C and B12, Folic acid, thiamine and pyridoxine.

To overcome these deficiencies, the first line is to adopt corrective actions and healthy lifestyle practices. While Iron and Folic Acid supplementation is provided under the Anemia Mukht Bharat Abhiyaan, it is equally important to prioritize the consumption of nutritious, locally available foods within the household. Preparing balanced, home-cooked meals and regular intake of freshly cooked food can significantly improve dietary quality.

While supplementation can correct existing deficiencies, sustained inclusion of nutrient-dense diverse foods in daily diets is essential to rebuild and maintain physiological nutrient reserves, thereby reducing the risk of recurrent deficiencies once the supplementation is dropped.

India has a wide variety of iron-rich foods available across all states and regions, yet many of these are underutilized in daily diets. By making conscious changes in food choices, adopting

13: https://nin.res.in/dietaryguidelines/pdfs/locale/DGI_2024.pdf

appropriate food combinations, and following proper cooking practices in measurable ways, individuals can meet their daily iron and other micronutrient requirements through diet alone. Such habits should be encouraged and sustained throughout the life course, from childhood to adulthood. Traditional food combinations such as pairing plant-based iron sources with vitamin C rich foods or combining cereals and pulses-can significantly improve nutrient absorption.

Are costly and trending 'Healthy Foods' better for iron than regular home foods?

Costly and trending "healthy foods" are not necessarily better sources of iron than regular home-based diets. The body is well adapted to traditional eating patterns, and shifting to fad diets without adequate scientific evidence is not advisable. Locally available and seasonal foods are often equally nutritious and more affordable.

A nutritionally adequate diet does not need to be expensive. Locally available foods such as jackfruit in Assam, ragi and millets in Karnataka, bajra in Rajasthan, often provide substantial nutritional value, including iron, when consumed appropriately.

Emphasis should be placed on sustainability, affordability, accessibility, and cultural suitability of foods by following proper cooking practices and combining foods wisely to enhance absorption and effectively meet daily iron requirements.

Whole foods provide adequate nutrients in combination and in forms that support better absorption and utilization by the body, especially when meals are planned with bioavailability in mind, such as pairing iron-rich foods with vitamin C-rich fruits and vegetables and using traditional practices like soaking, germination and fermentation.

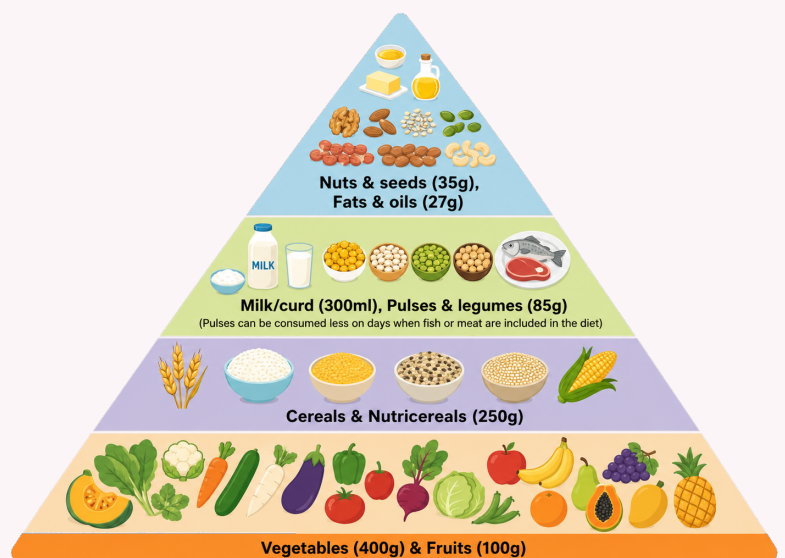
Evidence suggests that dietary diversification and improved food practices can significantly enhance iron absorption and help prevent recurrent anemia once supplementation is discontinued. Long-term anemia management across age groups depends on establishing healthy eating habits, improving diet quality, and regular consumption of locally available, nutrient-dense foods as part of everyday meals once the adequate hemoglobin level is reached and iron stores in the body replenished.

Dietary Diversity and Anemia

Anemia is often the result of multiple nutrient deficiencies rather than iron deficiency alone. A diverse diet provides adequate intake of iron, folate, vitamin B12, vitamin A, vitamin C, riboflavin and protein, all of which contribute to hemoglobin synthesis and red blood cell formation. Therefore, improving dietary diversity is one of the most sustainable food-based approaches for prevention and control of anemia.

7.2 Food Pyramid - The Principles of a Balanced Diet

The concept of Food pyramid clearly defines what to be eaten and how much to be eaten using an illustration. The pyramid is divided into four levels, representing different food items, cereals and legumes/beans at the base which means these are the food groups that should be eaten in sufficient quantity, vegetables and fruits on the second level meaning these should be eaten liberally, animal source foods and oils on the third level that are to be eaten moderately, and at the apex, highly processed foods high in sugar and fat to be eaten sparingly.



reference: ICMR-National Institute of Nutrition. Indian Council of Medical Research, Dietary guidelines for Indians, 2024

Following this while preparing meals and deciding what to eat will help the individuals in creating healthy dietary choices.

To simplify dietary recommendations for households, ICMR-NIN advocates the Healthy Plate approach. The plate should consist of approximately $\frac{1}{2}$ portion of vegetables and fruits, $\frac{1}{4}$ of cereals and millets, and $\frac{1}{4}$ should include pulses, legumes, eggs, fish, meat or other protein-rich foods. Inclusion of milk or milk products, nuts and seeds as part of daily meals further improve nutrient adequacy and dietary quality. It is advisable to include seasonal and locally available food sources in daily meal preparation.

The inclusion of 'Various Food groups' approach offers a practical framework for regular intake of a broad spectrum of micronutrients through everyday foods, since no single

food provides all the micronutrients/antioxidants. For example, green foods, particularly green leafy vegetables, are rich sources of iron, folate, magnesium, and vitamin K, which are essential for hemoglobin synthesis, cellular growth, and bone health. Red-colored foods such as tomatoes, beetroots, and pomegranate contribute non-heme iron, vitamin C, and antioxidant compounds like lycopene, which enhance iron absorption and support immune function. Orange and yellow foods supply provitamin A carotenoids, vitamin C, and potassium, playing a critical role in linear growth, vision, and immune competence.



reference: ICMR-National Institute of Nutrition. Indian Council of Medical Research, Dietary guidelines for Indians, 2024

7.3 Role of Micronutrients in Anemia - Iron, Folate, Vitamin B12 and Vitamin C

Iron



Iron is an essential element for the synthesis of hemoglobin, the protein responsible for oxygen transport in blood. Insufficient iron intake or poor absorption reduces hemoglobin production, leading to iron deficiency anemia. Iron is crucial for the development of brain, in case of children, the brain is like fast-growing cities, making new connections daily and establishing thoroughfares. Appropriate levels of iron facilitate such development; conversely, iron deficiency negatively impacts the growth and maturation process of the brain leading to serious cognitive consequences. These are not peculiar to children; adults also suffer from cognitive impairment on account of inadequate supply of iron affecting memory and attention which are highly dependent on efficient transmission in the brain.



Folate

Folic acid is a vitamin essential for production of red cells. Its deficiency leads to megaloblastic anemia. Folic acid intake during pregnancy protects the fetus from developing certain congenital defects like neural tube defects and promotes gain in birth weight of infants. Folate deficiency results from poor dietary habits, malabsorption disorders, alcohol abuse and certain medications.



Vitamin B12

Vitamin B12 is critical for DNA synthesis and red blood cell formation. Deficiency of B12 leads to anemia even in the presence of adequate iron intake, with fatigue, weakness, and potentially irreversible neurological damage if left untreated. It can result from pernicious anemia, malabsorption disorder, GI surgery, certain diets and medications.



Vitamin C

Vitamin C plays a critical role in absorption of iron from food as it reduces ferric to ferrous iron due to its antioxidant properties and thereby supports absorption. Deficiency of Vitamin C results from poor dietary choices, malabsorption disorders and poor lifestyle choices as excessive alcohol/smoking.

Do these nutrients wash off when cooked?

The answer is yes; vitamins are often lost during washing of cut vegetables. Thus, one should always wash vegetables first in the running tap water and then cut it into desired pieces. It is not advisable to discard the excess water when using vegetables for soups.

Do not overcook or reheat the food multiple times, as it leads to loss of vitamins and nutrients.

7.4 Nutritional Sources of Nutrients that Play a Role in Anemia

Iron in the diet comes from **heme** sources (animal foods) which are more readily absorbed, and **non-heme** sources (plant foods) which are less bioavailable. A diversified diet combining both increases total iron intake and net absorption. The heme and non-heme foods cut across cereals, millets, pulses, green leafy vegetables, seeds and animal foods. Traditional millets such as **bajra and finger millet (ragi)** offer significant iron content and can be included in routine diets.

Folic Acid: Fruits and vegetables are our best sources of vitamins and minerals in the diet. The terminology 'Folic' means leaves in Latin, since its available in leafy vegetables abundantly. The rich sources are chicken, liver, beef, eggs, spinach, beetroot, fresh orange juice are also some of the good sources of folic acid.

Vitamin C is an essential nutrient found in fruits and vegetables. Citrus fruits like oranges, guava, amla and lemon are the richest sources of vitamin C as compared to other fruits.

Vitamin B12: is derived from foods from animal origin, including fish, meat, poultry, eggs, and dairy products. Plant foods do not naturally contain vitamin B12.

7.5 Enhancers and Inhibitors to Iron Absorption

Iron bioavailability refers to the **fraction of dietary iron that is absorbed and utilized**. Indian diets are predominantly cereal pulses based with high phytate and polyphenol content, which bind iron and reduce its absorption. Typical iron bioavailability from vegetarian diets ranges from **1-6%**; in contrast, animal-sourced heme iron has an absorption rate of **15-35%**.

The most potent enhancers include:

- ▶ **Vitamin C (ascorbic acid)** increases non-heme iron absorption several-fold when consumed in the same meal (e.g., citrus fruits, guava, amla). These foods should be eaten along with meals for better absorption of iron.
- ▶ **Animal protein and heme iron** - improve overall iron absorption.
- ▶ **Food processing methods** - fermentation (e.g., dosa, idli batter), germination, and soaking reduce phytates and enhance bioavailable iron in millets and legumes. Studies show fermentation and germination in millets can increase bioavailable iron by **3.4 times**¹⁴ and 2.2 times respectively.

14: Anitha, S., Govindaraj, M., Kane-Potaka, J., et al. (2021). Millets Can Have a Major Impact on Improving Iron Status, Hemoglobin Level, and in Reducing Iron Deficiency Anemia-A Systematic Review and Meta-Analysis. *Frontiers in Nutrition*, 8, 725529. <https://doi.org/10.3389/fnut.2021.72552>

Dietary Inhibitors of Iron Absorption

Common inhibitors include:

- ▶ **Phytic acid** (found in whole grains, millets, legumes)
- ▶ **Polyphenols** (tea, coffee)

Phytates and polyphenols can reduce absorption markedly; consuming iron-rich meals with vitamin C foods counteracts these effects.

<p>Cereals and Millets</p> 	<p>Iron Rich Foods</p> <ul style="list-style-type: none"> Amaranth seed, black Amaranth seed, pale brown Quinoa Bajra Ragi 	<p>Folic Acid Rich Foods</p> <ul style="list-style-type: none"> Quinoa Maize, tender, local Maize, tender, sweet Varagu Jowar
<p>Grain Legumes</p> 	<p>Iron Rich Foods</p> <ul style="list-style-type: none"> Bengal gram, dal Black gram dal Cowpea Horse gram Moth bean 	<p>Folic Acid Rich Foods</p> <ul style="list-style-type: none"> Moth bean Rajma- black, brown, red Soya Bean- brown, white Field Bean- brown, black and white Cowpea- white, brown Bengal gram, whole
<p>Green Leafy Vegetables</p> 	<p>Iron Rich Foods</p> <ul style="list-style-type: none"> Gogu leaves, red, green; Amaranth Beet Greens Fenugreek Leaves Pumpkin leaves Garden cress 	<p>Folic Acid Rich Foods</p> <ul style="list-style-type: none"> Parsley Colocasia leaves, green Agathi leaves Spinach Mustard leaves
<p>Other Vegetables</p> 	<p>Iron Rich Foods</p> <ul style="list-style-type: none"> Cluster beans Onion, stalk Field beans, broad 	<p>Folic Acid Rich Foods</p> <ul style="list-style-type: none"> Field beans, tender, lean Drumstick French beans, hybrid Bitter melon Capsicum, yellow, red Ladies finger

Fruits



Iron Rich Foods

Tamarind, pulp
Raisins, dried
Dates

Folic Acid Rich Foods

Mango, ripe, Variants
Papaya, ripe
Guava
Jackfruit, ripe
Dates

Roots and tubers



Iron Rich Foods

Lotus root
Yam, elephant and wild
Tapioca

Folic Acid Rich Foods

Beetroot
Lotus root
Radish
Tapioca
Carrot, orange

Nuts and oil seeds



Iron Rich Foods

Niger seeds, grey, black
Garden cress, seed
Gingelly seeds, white, brown
Jaggery

Folic Acid Rich Foods

Niger seeds, black
Gingelly seeds, white, black, brown
Mustard seeds
Linseeds
Safflower seeds

Poultry/ Animal Meat/ Marine



Iron Rich Foods

Chicken Liver
Goat, spleen
Goat, Lung
Sheep, spleen
Beef, spleen
Pork Spleen
Fish (variants)

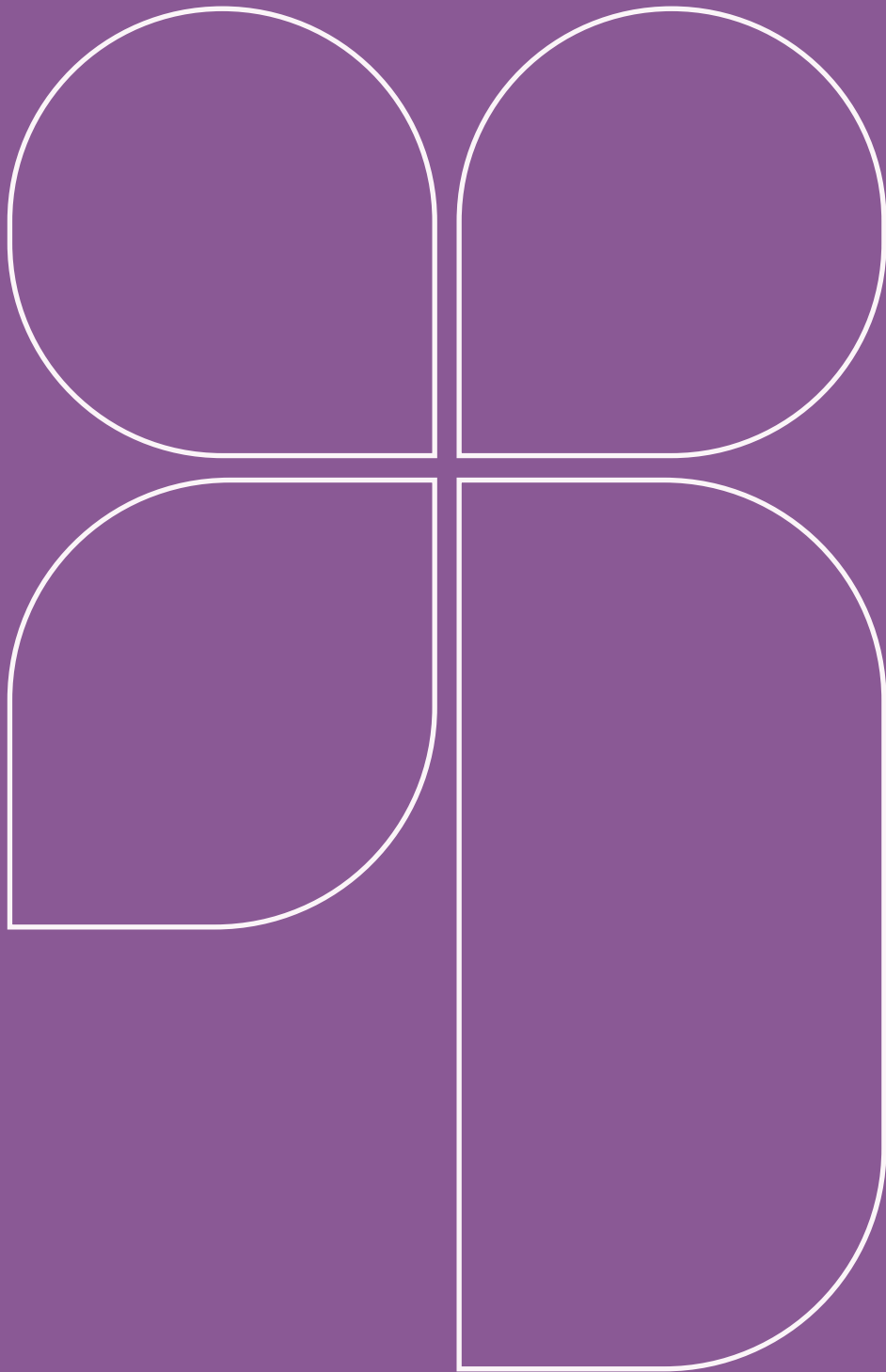
Folic Acid Rich Foods

Egg (variants)
Chicken
Goat Liver
Beef liver
Pork Liver

CHAPTER 8

Jan Bhagidari: Communication Strategy





8.1 Supporting Community Participation and Behaviour Change Communication

Effective communication planning and systematic implementation are critical pre-requisites for expanding outreach, strengthening service uptake, and accelerating sustained behaviour change in public health programmes. The component was an integral pillar of the initial Anemia Mukht Bharat Programme and continues to be strengthened under Anemia Mukht Bharat Abhiyaan, reinforcing the programme's emphasis on self-awareness, active ownership and collective action.

Under **Anemia Mukht Bharat Abhiyaan**, a strategic, multi-layered communication approach is particularly essential to address the deeply normalized perception of anemia across communities which reduces the perceived urgency for hemoglobin testing, iron-folic acid (IFA) consumption, dietary improvement, and timely treatment. Therefore, Anemia mukht Bharat Abhiyaan's communication strategy must go beyond information dissemination and focus on transforming mindsets—from passive acceptance of anemia as “normal” to active recognition that it is preventable, detectable, and treatable.

8.2 Understanding the Anemia Challenge: Transforming from Normalization to Self-Awareness and Action

In India, anemia is widely normalized due to its non-specific symptoms such as fatigue and weakness and is not perceived as a serious health threat. This leads to:

- ▶ Low risk perception
- ▶ Limited proactive health-seeking behaviour
- ▶ Acceptance of anemia as a part of life
- ▶ Negligence towards hemoglobin (Hb) testing
- ▶ Inadequate intake of iron-rich foods
- ▶ Suboptimal adherence to Iron and Folic Acid (IFA) supplementation

Such normalization perpetuates intergenerational cycles of poor health, reduced productivity, and unrealized potential, thereby creating barriers for achieving desired outcomes.

The **Communication strategy under Anemia Mukh Bharat Abhiyaan** aims to transform this mindset-from passive acceptance to active ownership-by creating a buzz around importance of anemia and need for generating self-awareness, building individual responsibility and fostering community-wide participation.

8.3 Communication Strategy Under Anemia Mukh Bharat Abhiyaan

A comprehensive multidimensional strategy is envisaged that underpins and emphasizes that the actual correction must begin and be sustained at the individual and family level to highlight the core theme of sustained behaviour change across communities. In order to address and sustain the behaviour change, use of core themes for promotive IEC and content related to addressing myths and misconceptions related to anemia is advocated under AMB Abhiyaan.

One of the tag lines for behaviour change embodied under this **Jan Bhagidari** is named **“Khood ki paryapt matra, swasth jeevan ki hain paribhasha”** which represents achieving optimal hemoglobin levels for self and every family member and unlocking full physical and cognitive potential.

It represents:

- ▶ Plan for health
- ▶ A marker of pride and performance
- ▶ A symbol of responsible healthy families and communities

A step toward a healthier and more productive self-aware communities

Other thematic frameworks include **‘I am Anemia free’**, **‘varied colours on my plate’** which will change attitude as a Call to Action from normalization of anemic state to cognizance and mindful state of promoting screening of Hb value and self-awareness of maintaining appropriate hemoglobin level. These campaign position **anemia-free status as aspirational and socially desirable**.

8.4 Key Behavioural Nudges Under this Communication Strategy for Anemia

- ▶ Shift from ignorance to mindful consumption of iron-rich foods and proactive service utilization

- ▶ Creating a buzz around anemia through various activities highlighting the importance of knowing why anemia testing is important and promoting conscious eating of iron rich foods.
- ▶ Promoting oneself to regular Hb testing for the family and being aware of individual hemoglobin status.
- ▶ Encourage actionable mindful practices such as IFA compliance along with daily inclusion of 2-3 iron-rich foods with vitamin C for better absorption.
- ▶ Stop normalizing anemia and emphasizing to achieve 'I am Anemia Free' status and seeking timely testing and treatment .
- ▶ Appropriate IYCF practices.

8.5 Behaviour Change Pathway

The campaign facilitates a progressive shift from awareness to sustained behavioural change through following stages:

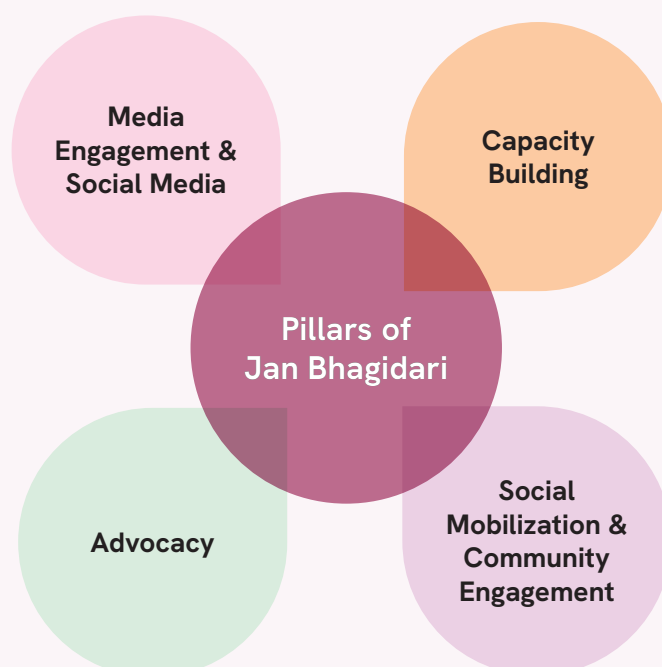
- ▶ **Awareness** - Understanding anemia, Hb levels, and its impact
- ▶ **Initial Action** - Improved diet and uptake of IFA supplementation
- ▶ **Habit Formation** - Regular practice supported by family/community through repeated nudges
- ▶ **Sustained Behaviour** - Long-term adherence through continued engagement

8.6 Pillars of Jan Bhagidari

The Jan Bhagidari communication strategy for community mobilization aims to shift mindset from passive acceptance of anemia to active community ownership. The communication strategy for Anemia Mukh Bharat Abhiyaan will comprises of 4 key elements-

8.6.1 Advocacy

Advocacy campaigns through various stakeholders at National, State and



District level are required to promote awareness for effective implementation of AMB Abhiyaan. Stakeholders who may lead the advocacy campaign for creating communication strategies for Anemia Mukht Bharat Abhiyaan will include Panchayat Raj Institutions (PRIs), Civil Society Organisations (CSOs), Experts working in the anemia research, Front Line Workers and Members of society. Existing platforms such as Jan Arogya Samiti, VHSNC committee, Self-Help Groups (SHGs) and women's collectives, School Management Committees, Youth clubs and Nehru Yuva Kendra platforms, Poshan Pakhwada and other Religious and local community gatherings may be used to create momentum for Anemia Mukht Bharat Abhiyaan campaign.

Key Actions:

- ▶ Engage Political leaders and elected representatives at National, State, and Local levels to champion key messages of **Anemia Mukht Bharat Abhiyaan** and position anemia reduction as a priority.
- ▶ Development of advocacy package- FAQs, leaflets, factsheet, multimedia material, along with their language versions.
- ▶ Sharing communication materials and messages for efficient use by stakeholders.
- ▶ Leveraging national and state-owned media agencies for organizing advocacy activities.
- ▶ Organizing interviews and discussions with PRIs, doctors, experts and other credible voices.
- ▶ Garnering momentum for anemia by including anemia as a part of discussion during Talks/conferences/Panel discussion/Health Podcasts/Committee and review meeting involving various stakeholders such as Health Experts, local celebrities, public figures, influencers.
- ▶ Involving religious leaders/traditional healers to generate for creating awareness and influencing the community behaviour.
- ▶ State governments to strengthen interdepartmental coordination to support awareness generation.

8.6.2 Capacity Building of Key Stakeholders

Capacity building of all the stakeholders for effective communication aligned to AMB Abhiyaan should be done at various levels. States will be required to identify platforms and convergence mechanisms to reach the extensive network of PRIs, frontline workers, health care providers, community-based volunteers, influencers and stakeholders from other line departments. Resource materials for effective communication to target the resistant, hard to reach areas, tribal and vulnerable population should be developed in local languages.

8.6.3 Strengthening Mass Media, Social Media, Engaging International Media, Social Mobilization and Community Engagement

Mass media and social media play a critical role in creating awareness, generating an

enabling environment and influencing behaviour regarding prevention and treatment of anemia. It is particularly utilised to target the perceptions about normalizing anemia. Mass media and social media engagement will involve activities at the national, state, district levels and community levels considering local culture, customs and beliefs. It will target the lack of knowledge among the individual and family member empowering them to make conscious food choices especially iron rich and vitamin C foods.

Key Actions:

A. Consistent National Branding

Launch and sustain the Jan Bhagidari campaign with unified branding of Anemia Mukta Bharat Abhiyaan, standardized IEC materials, and mass slogans developed at the national level to enhance awareness and strengthen community participation.

B. Promoting concept of Anemia-Free Identity through “I Am Anemia Mukta”

Roll out the “I am Anemia Mukta” campaign to build individual ownership and pride in being anemia-free. Encourage regular hemoglobin screening, increased consumption of iron-rich foods, and improved adherence to Iron and Folic Acid (IFA) supplementation.

C. Mass Media Engagement

Develop and disseminate TV and radio spots under the communication strategy framework to:

- ▶ Promote iron-rich dietary practices
- ▶ Improve compliance with IFA supplementation
- ▶ Raise awareness about the intergenerational consequences of anemia
- ▶ Inform communities about services available under the AMB Abhiyaan programme

D. Digital and Social Media Strategy

Create engaging, shareable content-including short videos, infographics, reels, and testimonials-for dissemination through social media platforms and other digital channels to all beneficiaries especially adolescents and urban populations.

E. Community and Peer Mobilization

Encourage peer-led discussions and community participation, particularly among adolescents, to leverage positive peer influence and normalize preventive behaviors.

F. Influencer and Celebrity Engagement

Engage local celebrities, public figures, influencers, and mascots to amplify messaging, enhance credibility, and promote iron-rich food consumption and IFA compliance; however

it is essential that these influencers/celebrities do not violate any government norms and that their messages must be scientifically sound in sync with the programme guidelines.

G. Myth-Busting Campaigns

Design mass media messages across print, television, and digital platforms to debunk common myths and misconceptions regarding anemia, IFA supplementation, and dietary practices.

H. Positive Storytelling and Testimonials

Document and disseminate positive stories of individuals successfully treated for anemia to counter the invisibility of the condition and reinforce the message that anemia is preventable and treatable.

I. Regional Media Leveraging

Utilize regional and local media outlets to support contextualized messaging tailored to local language and cultural needs.

J. Social Listening and Feedback Mechanisms

Use social listening tools and community feedback mechanisms to continuously adapt messaging based on emerging concerns, misconceptions, and local needs.

8.6.4 Social Mobilization and Community Engagement

Social mobilization will comprise actions on community engagement especially for testing and treatment drives and IFA consumption. It will respond to perceptions of communities and health service providers on the necessity of anemia testing and consumption of IFA as prophylaxis and for treatment of anemia.

The social mobilization plan will be contextualized to state and community requirements, and address state-specific variations and vulnerabilities such as urban-rural, tribal – nontribal, and hard to reach pockets. While social mobilization actions will reach public across all beneficiary groups, it will specifically focus on motivating the groups with high anemia prevalence and their family members through community consultations and inter-personal communication during house visits.

Key Stakeholders:

- ▶ Ministry of Health and Family Welfare
- ▶ Ministry of Information and Broadcasting
- ▶ Ministry of Women and Child Development

- ▶ Other Line-Ministries for amplifying content
- ▶ Social media managers of Development Partners

Key Actions:

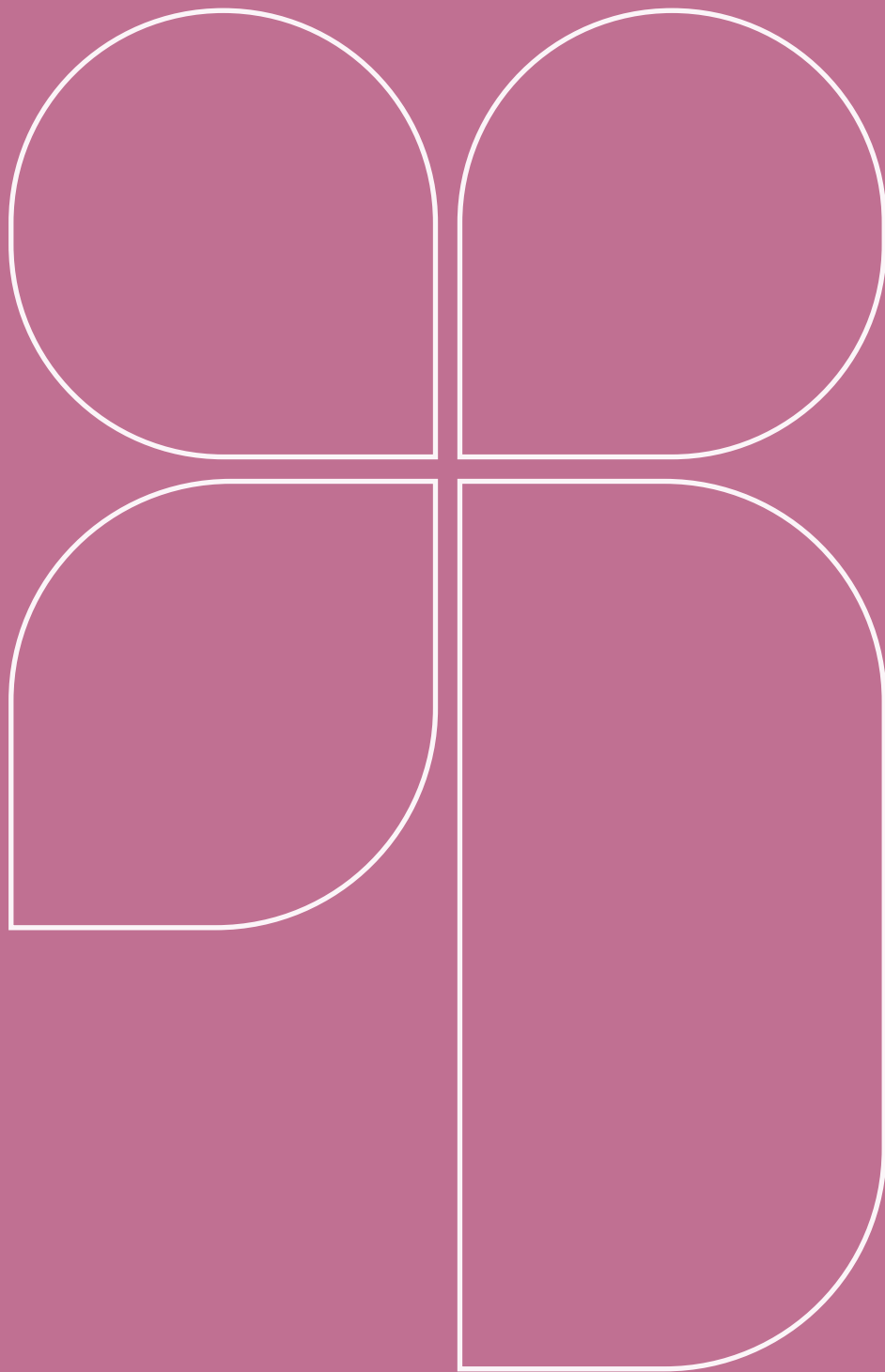
Anemia Mukht Bharat Abhiyaan guidelines translated to local languages to support cohesive and correct information for all stakeholders

- ▶ Identifying existing official social media handles for the campaign and designing and relaying messages contextualized to local audience.
- ▶ Coordination between social media cell of social media managers from central and state governments and development partners.
- ▶ Establishment of a virtual content production cell/hub with filmmakers, designers, editors, writers etc. who will design and package content in multiple languages for use on various social media platforms (including PIB, My Gov etc.).
- ▶ Development of an audience targeting plan to push specific messages to specific predefined sets of audiences, for greater impact.
- ▶ Sharing stories, photos, videos, testimonials with the virtual content cell/hub for packaging and amplification.

CHAPTER 9

Strengthening Intra-Ministerial and Inter-Ministerial Coordination





9.1 Background and Rationale

Given the multifaceted and complex nature of Anemia which encompasses nutrition, sanitation, infection control, dietary practices, socio-economic conditions, comprehensive and coordinated efforts will be required to prevent, manage, and reduce its burden. This underscores that no single Ministry, Department, or sector can address anemia in isolation; rather, it necessitates sustained convergence and collaborative actions across health, nutrition, education, water and sanitation, rural development and tribal welfare departments to address its multifactorial etiology and determinants.

Anemia Mukta Bharat Abhiyaan addresses these challenges through institutionalized convergence mechanisms that establish shared responsibility, integrated planning, unified monitoring, and coordinated service delivery from national to community level. This chapter details out the convergence framework essential to achieving the goal of Anemia-Free India.

The framework operates on two critical components:

- 1. Intra-ministerial coordination** strengthens seamless implementation of the “Test, Treat, Talk and Track” continuum across maternal health, child health, adolescent health, immunization, nutrition, disease control programmes, including Tuberculosis, vector borne diseases, NCD, NACO, hemoglobinopathies, NHSRC and Statistics Divisions.
- 2. Inter-ministerial coordination** of Health with the sectors like Women and Child Development (WCD), Education, Jal Shakti, Rural Development, Tribal Affairs, Information and Broadcasting, Youth Affairs to address the multiple determinants of anemia through synchronized action.

9.2 Objectives of Strengthening Inter-Ministerial and Intra-Ministerial Coordination

Strengthening the Inter-Ministerial and Intra-Ministerial Coordination aim to achieve following strategic objectives:

- ▶ Role Delineation across Ministries and Departments defining their respective mandate and eliminating ambiguity.
- ▶ Integrated Planning at national, state, and district levels to allocate the resources cohesively and implement the interventions through convergent service delivery

platforms such as Anganwadi Centers, Schools, health facilities and community events.

- ▶ Integrated Monitoring and Review Mechanisms through joint field visits and review meetings, sharing data across dashboards for monitoring and coordinated course correction.
- ▶ Responsibility at National, State, District, and Block Levels for implementing the interventions and their outcomes, with tracking and review of shared indicators through multi-stakeholder platforms.
- ▶ Intensive Communication through multi-sectoral mobilization, implementing AMB Abhiyaan campaign through synchronized messaging, coordinated events, and multi-platform outreach.

9.3 Supportive framework for Inter-Ministerial Coordination

Many determinants of anemia fall within the mandate of a specific Ministry or Department. For delineation of the roles and support, it is necessary to establish broad institutional/supportive framework as given below:

Key Roles	Supporting Ministry
<ul style="list-style-type: none"> ▶ Screening of women, adolescents and children ▶ Case -based treatment with oral/IV iron; prophylactic IFA distribution ▶ Deworming (NDD); management of non-nutritional anemia at distt hospital and above level ▶ Counseling on compliance and nutrition (iron rich food) ▶ Digital tracking until anemia resolution 	Ministry of Health & Family Welfare
<ul style="list-style-type: none"> ▶ Supplementary nutrition through Anganwadi Centers ▶ Establishment and maintenance of Poshan Vatikas (kitchen gardens) ▶ Bi-annual deworming for out of school children ▶ Counseling on iron-rich foods and feeding practices ▶ Home visits for pregnant and lactating mother 	Ministry of Women & Child Development (WCD)
<ul style="list-style-type: none"> ▶ Weekly IFA distribution through schools (WIFS) ▶ Establishment of school kitchen gardens ▶ Promotion of Eating Right monthly calendar and nutrition education ▶ Quiz competitions on nutrition and anemia; ▶ WASH facilities in schools ▶ School-based deworming ▶ Training of School Health Wellness Ambassadors on anemia awareness 	Ministry of Education (School Education & Literacy)

Key Roles	Supporting Ministry
<ul style="list-style-type: none"> ▶ Implementation of WASH (Water, Sanitation, Hygiene) in rural and urban areas ▶ Provision of safe drinking water; construction and maintenance of toilets ▶ Provision of WASH facilities in schools, Anganwadi Centers, and health facilities 	Ministry of Jal Shakti (Water & Sanitation)
<ul style="list-style-type: none"> ▶ Nutrition-sensitive livelihoods through Self-Help Groups and rural development schemes ▶ Promotion of community kitchen gardens ▶ Training of PRI members on nutrition and anemia prevention ▶ Capacity building of SHG members for community mobilization ▶ Linking nutrition interventions with livelihood programmes 	Ministry of Rural Development (NRLM/SRLM)
<ul style="list-style-type: none"> ▶ Targeted interventions to improve access and equity in tribal areas ▶ Screening for non-nutritional anemia including sickle cell disease ▶ Culturally appropriate IEC materials and community engagement ▶ Training of frontline workers in tribal contexts strengthening service delivery in hard-to-reach areas 	Ministry of Tribal Affairs
<ul style="list-style-type: none"> ▶ Nationwide media campaigns promoting thematic tag lines like I am anemia free etc ▶ Creation and dissemination of TV spots, radio programmes, and digital content on iron-rich foods, IFA compliance, and anemia screening ▶ Leveraging Doordarshan, All India Radio, and regional media for sustained messaging ▶ Coordination with state-level media agencies for the communication sharing 	Ministry of Information & Broadcasting
<ul style="list-style-type: none"> ▶ Mobilization of youth organizations (NSS, NYKS, Nehru Yuva Kendras) for anemia awareness campaigns; ▶ Training youth volunteers as anemia ambassadors ▶ Organizing youth-led communication activities ▶ Leveraging sports platforms for nutrition messaging; ▶ Peer-to-peer education on healthy eating and supplementation ▶ Engagement of youth influencers and college students in community outreach 	Ministry of Youth Affairs & Sports

9.4 Intra-Ministerial/Intra-Departmental Coordination

Within the Ministry of Health & Family Welfare, anemia-related interventions are delivered through multiple technical divisions and programmes. Effective coordination among these divisions is essential to address anemia comprehensively, given its life-cycle dimensions and the wide range of contributing factors, including both nutritional and non-nutritional causes. Nutrition Division is nodal department for implementing AMB Abhiyaan which is supported by national programmes under Maternal health, Child health and Adolescent health divisions. In addition, the National Vector Borne Disease Control Programme (NVBDCP) Central TB division, NACO and the Hemoglobinopathies address key non-nutritional causes of anemia.

It is imperative to establish a structured and systematic internal coordination across these divisions to tackle the anemia burden in an integrated manner reducing the fragmented implementation, inconsistent messaging, duplication of interventions, monitoring and gaps in service delivery.

Key roles	Supporting Department
<ul style="list-style-type: none"> ▶ Nodal Division for implementation, monitoring and course correction of the AMB Abhiyaan ▶ Prepare and share the technical and operational guidelines, protocols and communication material ▶ Bi-annual convergence meetings with line ministries and departments ▶ Regular supportive supervision visits to States/UTs 	Nutrition Division, MoHFW
<ul style="list-style-type: none"> ▶ Screen and Counsel of pregnant women and lactating mothers for anemia through ANC and PNC visits ▶ Management and follow up of anemic pregnant women, lactating mothers and women of reproductive age for pre-conception care ▶ Record data on JANANI portal 	Maternal Health
<ul style="list-style-type: none"> ▶ Screen all children coming for immunization ▶ Screen for anemia of all PW coming for Td vaccination ▶ Record data on U-WIN 	Immunization
<ul style="list-style-type: none"> ▶ Screen children for anemia through HBNCC visits ▶ Management of anemia and follow up of LBW babies ▶ Screen and record Hb testing data of school going and AWC children ▶ Referral of all anemic children for treatment and follow up ▶ Record on the RBSK Portal 	Child Health
<ul style="list-style-type: none"> ▶ WIFS supplementation to adolescents in and out of school ▶ Coordinate with RBSK for regular school-based screening for anemia ▶ Promote eat right strategy in schools through SHWP 	Adolescent Health
<ul style="list-style-type: none"> ▶ Screen, prevent and manage of Malaria and Filariasis ▶ IEC/BCC strategies for prevention of Malaria 	NVBDCP
<ul style="list-style-type: none"> ▶ Address anemia in TB cases across age groups ▶ Appropriate referral and management 	CTD
<ul style="list-style-type: none"> ▶ Address anemia in chronic diseases incl CKD ▶ Appropriate referral and management 	NCD
<ul style="list-style-type: none"> ▶ Address anemia in PLHIV ▶ Appropriate referral and management 	NACO
<ul style="list-style-type: none"> ▶ Share the technical specification on Iron supplements ▶ Update newer salts/formulations 	CDSCO/ IPC
<ul style="list-style-type: none"> ▶ Maintain the HMIS, JANANI portal ▶ Integrate JANANI data with AMB Abhiyaan portal for digital tracking 	Statistics Division

Key roles	Supporting Department
<ul style="list-style-type: none"> ▶ Maintain the AMB Abhiyaan portal and the application ▶ Analytics and scorecards based on the real time data ▶ Plan for predictive AI use in the portal 	NHSRC
<ul style="list-style-type: none"> ▶ Awareness generation on Eating Right for including iron rich and Vitamin C rich food 	FSSAI

9.4.1 Coordination Framework for AMB Abhiyaan

Cross-Sectoral convergence is crucial to address multifactorial nature of anemia and to reduce its burden achieving sustained impact. To operationalize coordination for AMB Abhiyaan, Committees at National, State and district level will be formed, bringing together all stakeholders and technical divisions to strengthen inter-sectoral coordination, integrated planning, implementation, regular review and provide strategic guidance to address challenges and gaps in implementation. These committees will be chaired by Mission Directors at National and State level and by District Collector at district level, having representation from line ministries and departments respectively.

The Convergence framework for AMB Abhiyaan is placed below. States and UTs will follow the similar structure to strengthen the coordination for effective implementation of AMB Abhiyaan.

Level of coordination	Composition of Committee	Supporting Roles
National level	<ul style="list-style-type: none"> ▶ Additional Secretary & Mission Director (NHM) –Chairperson ▶ Joint Secretary RCH- Co-chair ▶ Deputy Commissioner -Nutrition Member Secretary ▶ Members- Programme representatives from Maternal Health, Child Health, Adolescent Health, CTD, NVBDCP, Statistics Division, NCD, NACO, CDSCO, NHSRC, FSSAI ▶ Line Ministries: Ministry of Women & Child Development, Ministry of Education, Ministry of Jal Shakti (Water & Sanitation), Ministry of Consumer Affairs, Food & Public Distribution, Ministry of Rural Development, Ministry of Tribal Affairs, Ministry of Information & Broadcasting, Ministry of Youth Affairs & Sports 	<ul style="list-style-type: none"> ▶ Annual/Bi-annual Review of programme implementation to States/UTs in implementation of AMB ▶ State-specific challenges and best practices ▶ Review of non-nutritional anemia-programmes and challenges ▶ Review of allocated budget and logistics

State level	<ul style="list-style-type: none"> ▶ Chairperson- Additional Chief Secretary/ Principal Secretary/Secretary (H&FW) - ▶ Co-chair- Mission Director -NHM ▶ Convener- State Nodal Officer -AMB ▶ Members- Director Health Services and Public Health, State Nodal Officers for Maternal Health, Child Health, Adolescent Health, NTEP, NVBDCP, NHM, Statistic Division ▶ Members from line departments- Women & Child Development (ICDS), School Education and literacy, Jal Shakti (Water & Sanitation), Food & Public Distribution, State Rural Livelihood Mission, Tribal Development and Affairs, Youth Affairs & Sports 	<ul style="list-style-type: none"> ▶ Review of programme implementation, Capacity building, logistic and supply chain and Joint Supportive supervision ▶ Convergence with stakeholder departments ▶ Review and implementation IEC/ BCC strategies ▶ District-specific challenges and best practices ▶ Review of allocated budget and logistics as per plan ▶ State specific communication creatives ▶ Review of non-nutritional anemia-programme performance and challenges
District level	<ul style="list-style-type: none"> ▶ Chairperson- District Collector/Magistrate ▶ Co-chair- Chief Executive Officer (Zila Parishad) ▶ Secretary- Chief Medical Officer/Civil Surgeon (H&FW) ▶ Convener- District Officer -AMB ▶ Members- Nodal Officer for Maternal Health, Child Health, Adolescent Health, NTEP, NVBDCP, NHM, Statistic Division ▶ Members from line departments- Women & Child Development (ICDS), School Education and literacy, Jal Shakti (Water & Sanitation), Food & Public Distribution, State Rural Livelihood Mission, Tribal Development and Affairs, Youth Affairs & Sports 	<ul style="list-style-type: none"> ▶ Review of allocated budget and logistics as per plan ▶ Universal screening status as against targets ▶ Biannual/ Annual/ ANC deworming planning and review ▶ Status of training of health providers and frontline workers ▶ Status of Training of stakeholders (JAS, School HWAs, PRI, Urban Bodies, SHGs etc) ▶ Review of performance -HMIS and U-WIN ▶ Review on IV-iron implementation and challenges and adverse events ▶ Communication creatives

9.5 Intra-Ministerial/ Inter-Ministerial Coordination

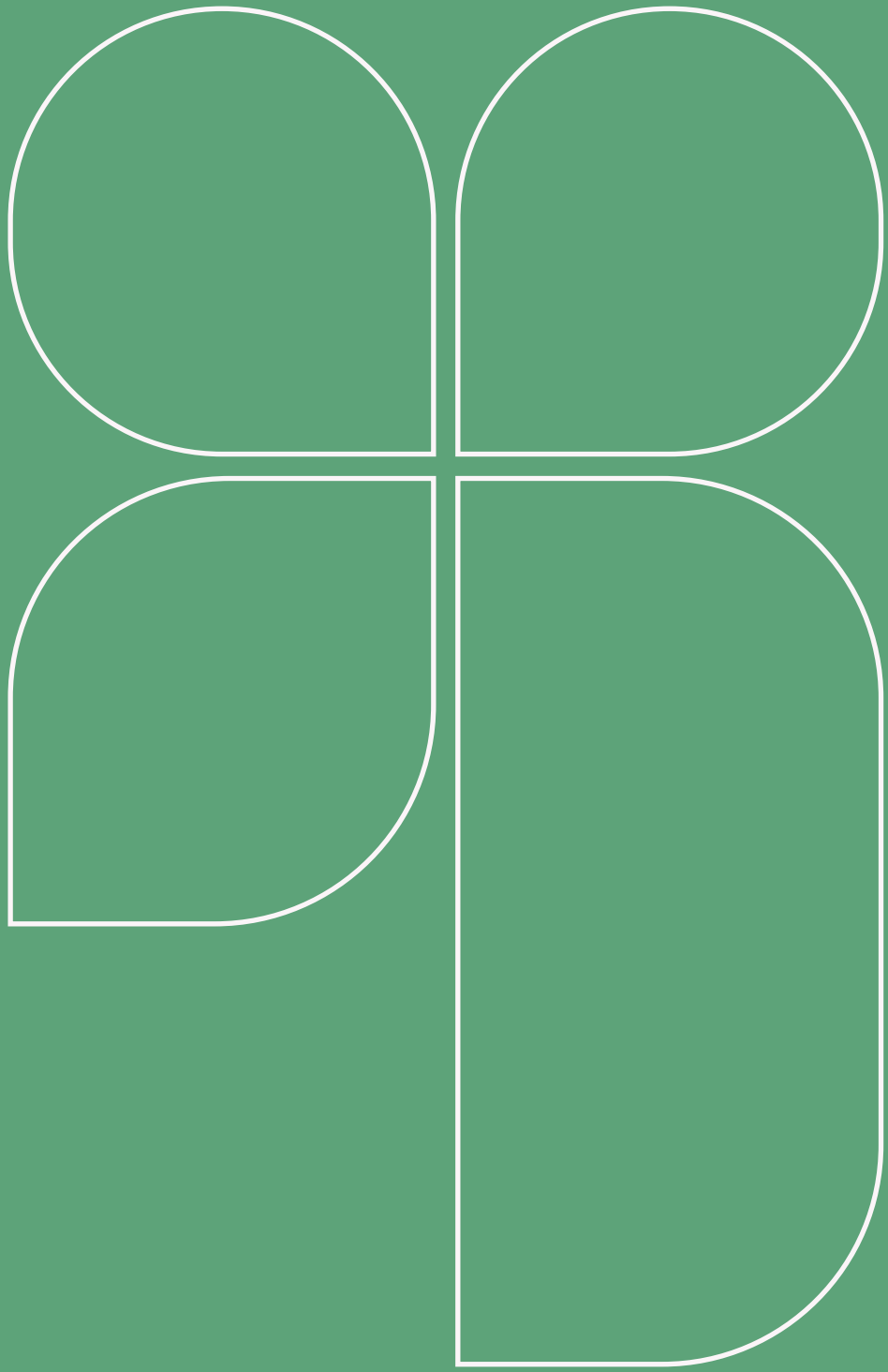
National and State/UT level committees will meet at least bi-annually to review the progress of AMB Abhiyaan identifying the intra and inter-sectoral challenges and bottlenecks to suggest corrective actions to strengthen the intervention. District level Committees would meet quarterly to review the implementation and to address the field level challenges encountered during the implementation. State/UTs should designate AMB nodal officers at State and District level who will be responsible for the implementation, capacity building, review of the intervention and intra-sectoral coordination at their respective level.

The coordination mechanisms outlined in this chapter translate the vision of an Anemia-Mukt Bharat Abhiyaan into actionable processes, clear and shared responsibilities, and coordinated service delivery.

CHAPTER 10

Roles and Responsibilities





Roles and responsibilities of different frontline workers as per the interventions are presented in the table below.

10.1 Role of Different Frontline Functionaries

Functionary	Role
ASHA	<p>For Test, Treat, Talk, Track:</p> <ul style="list-style-type: none"> ▶ Create line listing of beneficiaries of children 6-59 months, children 5 to 9 years, adolescents 10 to 19 years, WRA 20 to 49 years, Pregnant and Lactating Mother. (The family enumeration registry maintained by the ASHA may be leveraged for line listing) ▶ Mobilise beneficiaries using VHSND/UHSND/AAM Shivir to get annual testing- WRA 20 to 49 years, lactating mother, children (6-59 months), children 5 to 9 years and adolescents 10 to 19 years. ▶ Demonstrate to mothers and Supervise IFA syp doses in children (6-59 months) for the first week and then fortnightly. ▶ Educate mothers to fill IFA syp doses consumed in the MCP card. ▶ Perform home visits to check prophylactic and treatment compliance in children 6-59 months, children 5 to 9 years and adolescents 10 to 19 years, WRA 20 to 49 years, pregnant women and lactating mother. Additionally, arrange collaborative home visits with the CHO and ANM for severely anaemic pregnant women. ▶ Refer to AAM for testing and treatment for anemic beneficiaries. ▶ Counselling during home visits and using platforms like; VHSNC, MAS, JAS, VHSND/ UHSND and AAM Shivir of all beneficiaries for compliance and iron rich diet. Reassure in cases of mild side effects. ▶ Distribution of prophylactic IFA syp/tablets for children 6 to 59 months and WRA 20 to 49 years. ▶ Entry for counselling and compliance into AMB Abhiyaan App for beneficiary/ maintain records in ASHA diary and forward it for subsequent app updates.
ANM and CHO	<p>For Test, Treat, Talk, Track:</p> <ul style="list-style-type: none"> ▶ Perform annual testing and create line listing (taken out of CBAC) of anemic individuals for follow up: children, WRA 20 to 49 years, pregnant women, lactating mother. ▶ Testing of left-out beneficiaries of RBSK teams (5-19 years in and out of school); list shared by RBSK team. ▶ Conduct re-testing of anemic individuals as per protocols- children 6 to 59 months, children-adolescents 5-19 years, WRA 20 to 49 years, pregnant women, lactating mother and data entry for the same. ▶ Provide treatment doses to children 6 months to 59 months, children-adolescents 5-19 years, WRA 20 to 49 years, pregnant and lactating mother and data entry for the same. ▶ Check treatment compliance in all beneficiaries and data entry on AMB Abhiyaan App ▶ Counsel beneficiaries as per the category of anemia. ▶ Record referrals in AMB Abhiyaan App and record treatment received at referral institution. ▶ Follows up of refractory and missed cases through App generated due list

CHO	<p>Along with above duties, the CHO will also:</p> <ul style="list-style-type: none"> ▶ Manage stock position of the drugs and diagnostics under AMB ▶ Support outreach activities as T4 camps ▶ Refer and manage severe anemia cases and report on AMB Abhiyaan App
RBSK Team	<p>For Test, Treat, Talk, Track:</p> <ul style="list-style-type: none"> ▶ Perform bi-annual Hb testing in children 6-59 months in AWC, annual testing in schools for children 5 to 9 years, adolescents 10 to 18 years ▶ Line list of anemic individuals- children 6-59 months, children 5 to 9 years, adolescents 10 to 19 years will be available on AMB Abhiyaan portal.(linkages with RBSK 2.0 portal) ▶ Refer all anemic children to ANM/CHO for treatment, follow up and compliance ▶ Share Anemic children report with school teachers* and ANM for follow up and compliance (*The Health & Wellness Ambassadors at school would be provided the line list of the anemic children who then can follow up with the relevant health personnel). ▶ Entry of Hb data for all children in RBSK portal, which will be further linked with AMB Abhiyaan portal. ▶ Share list of left-out beneficiaries of RBSK visit at school for testing by ANM/CHO

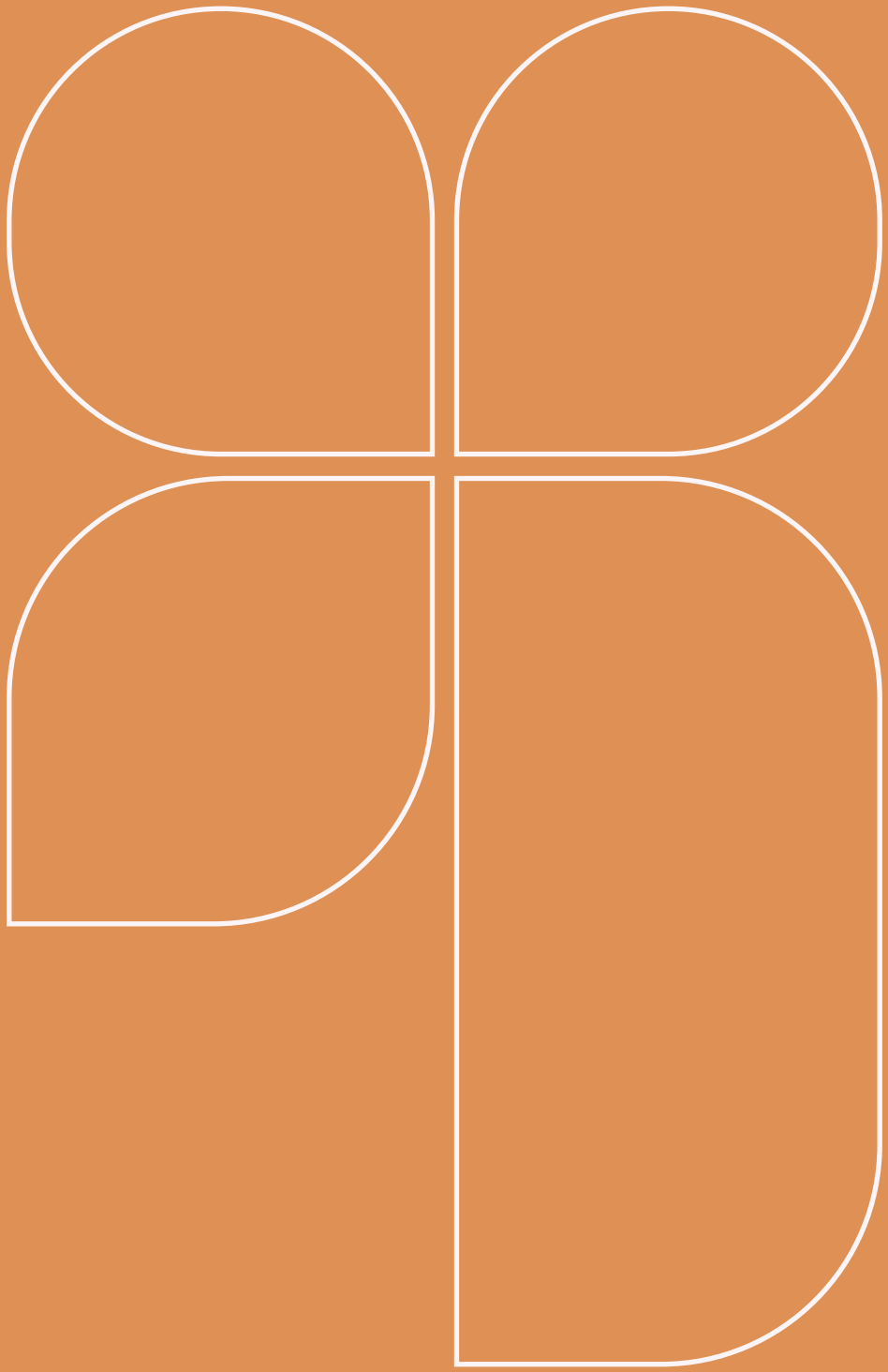


CHAPTER 11

Digital Framework



8	9	10	11
Opening Balance	400		
Received Quantity			
Issued Quantity			
Total Stock In Hand (col. no. 7+8-9)	400		
Remains			



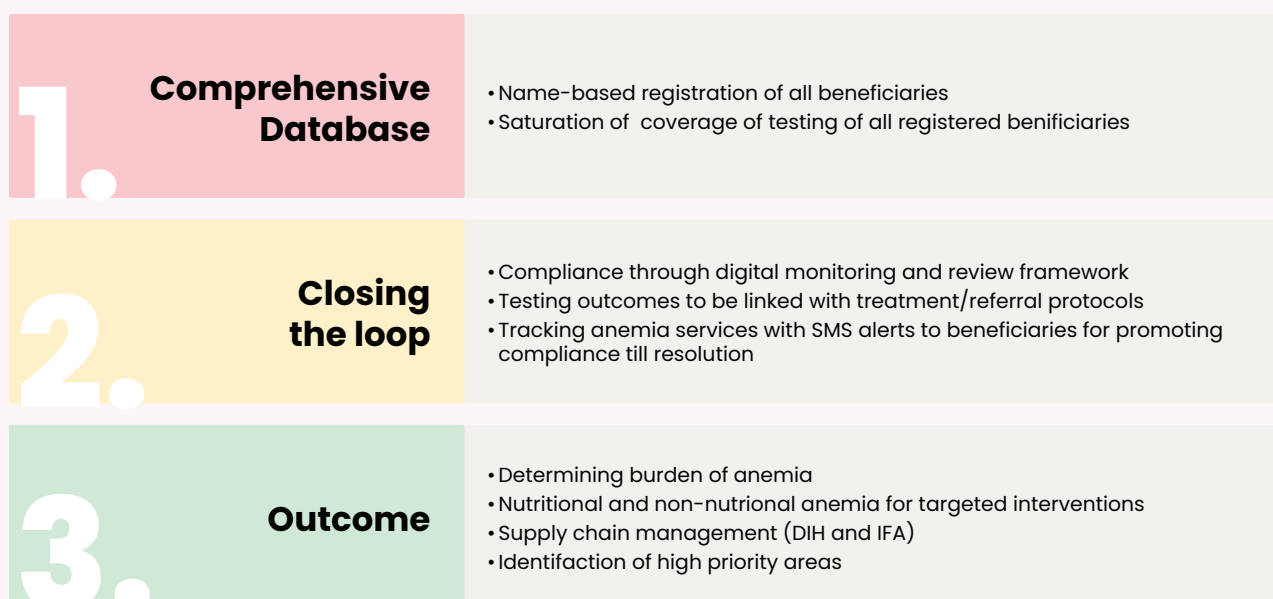
11.1 Introduction: Closing the Loop on Anemia Management

The Anemia Mukht Bharat Abhiyaan adopts **digitally enabled, lifecycle-based approach** to anemia management, anchored in the principle of “closing the loop” which begins right from identification and testing to treatment and follow-up. Based on State learnings and experiences, the AMB Abhiyaan Portal uniquely integrates data flow of key digital platforms like U-WIN, JANANI, and RBSK, enabling a consolidated platform for data review and analysis. By enabling real-time monitoring, trend analysis, the dashboard supports data-driven decision-making, such as targeted interventions in underperforming districts etc. These efforts translate into efficient delivery of the 7x7x7 strategy across the TEST-TREAT-TALK-TRACK (T4).

11.2 Rationale

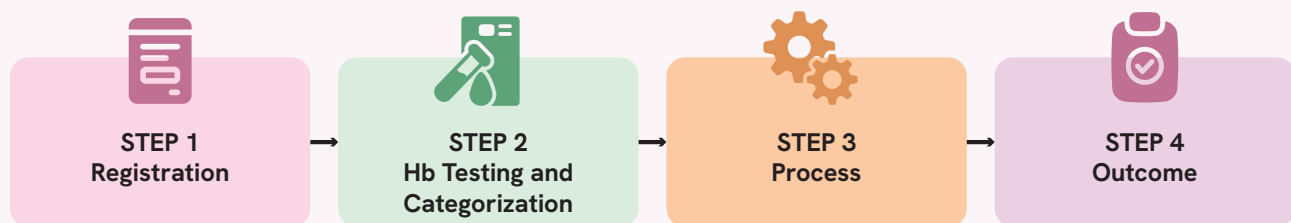
The core rationale of the Anemia Mukht Bharat Abhiyaan digital framework is to transform fragmented anemia interventions into a continuous, outcome-driven care pathway through name-based registration, protocol-linked workflows and proposed real-time monitoring.

Beginning with name-based registration of all beneficiaries, it strengthens coverage and unique identification, enabling personalized tracking across platforms like JANANI Portal, RBSK and U-WIN inclusive of all target population groups. It is endeavoured that the testing outcomes will be digitally monitored and linked to treatment/referral protocols, with automated SMS alerts for compliance, facilitating the T4 continuum (Test-Treat-Talk-Track).



11.3 Core components of the Digital Ecosystem

The digital framework mirrors the operational flow of AMB Abhiyaan so that no beneficiary exits the system without an outcome. To achieve this the framework links services for user convenience. For instance, a mother bringing her infant for MR vaccination at 9 months can be tested for hemoglobin levels along with the testing of the infant in the same visit, their test data will be reported on AMB Abhiyaan Portal and U-WIN respectively. This integration benefits beneficiaries, frontline workers, and programme managers by creating coherence across programmes.



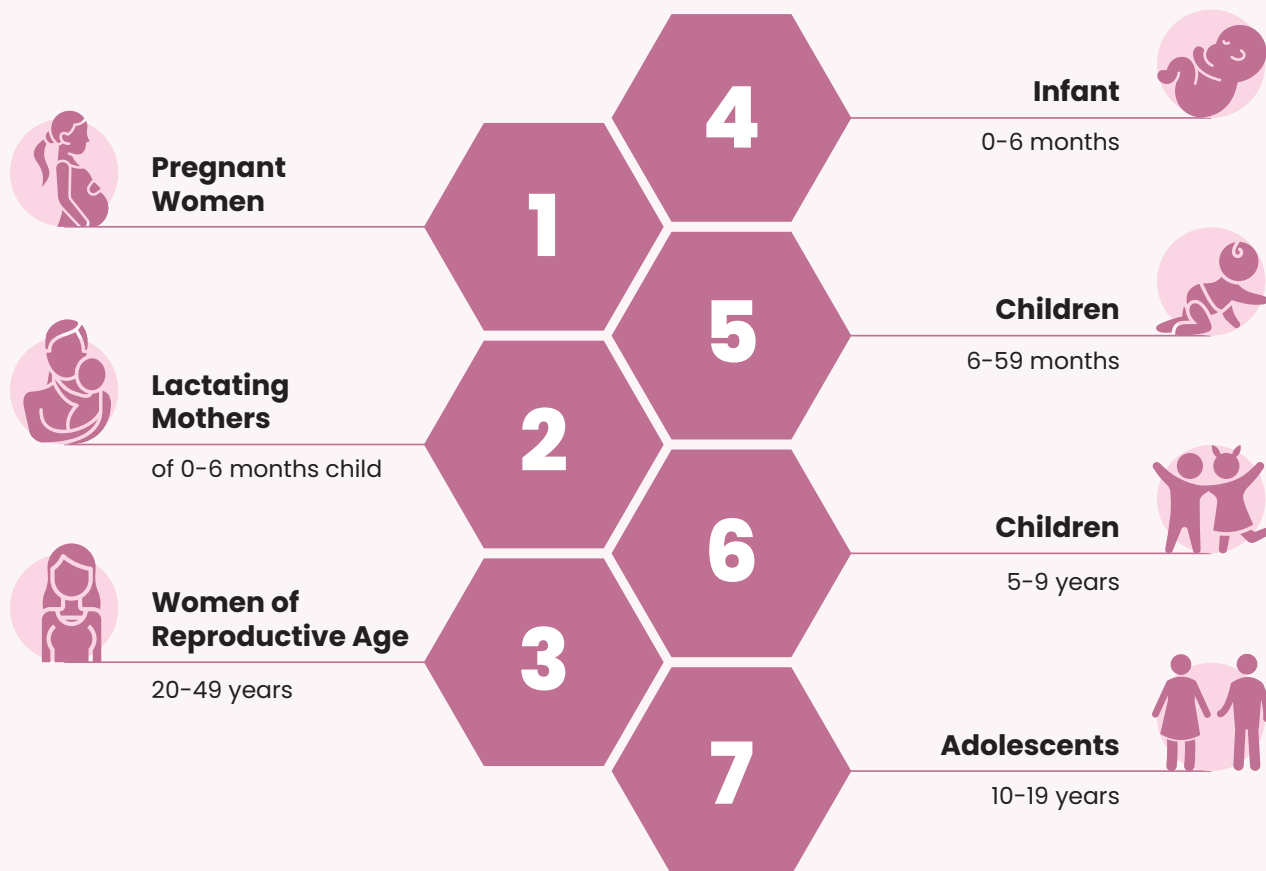
STEP I: Registration

- ▶ **Unique Beneficiary Identification enabling interoperability:** ABHA/Aadhaar ID provides for unique, name-based tracking of beneficiaries across age groups, from infants to women of reproductive age, preventing duplication across platforms (U-WIN, JANANI, RBSK portal). The system captures individuals across the entire life-cycle spectrum, from women of reproductive age, pregnant women, lactating mothers, infants, children, and adolescents, supporting comprehensive population coverage.
- ▶ **Registration**
All beneficiaries are digitally registered across service delivery points:
 - ▶ Immunization sessions
 - ▶ VHSND
 - ▶ ANC/PNC visits
 - ▶ RBSK Mobile Health Teams
 - ▶ T4/ Outreach camps

STEP 2: Hemoglobin Testing & categorization

Details of platforms used for testing are placed in Chapter 4 “Testing and therapeutic management”.

Clinically tested Hb values are captured digitally for the following 7 beneficiaries:



Beneficiary Categorization:

Anemia will be categorized as no anemia, mild, moderate and severe anemia based on the WHO Hb cut-offs (2024). This will be fed into the AMB Abhiyaan Portal for real-time monitoring for further capturing of treatment and management of the respective case.

STEP 3: Treatment, Referral, and Follow-up

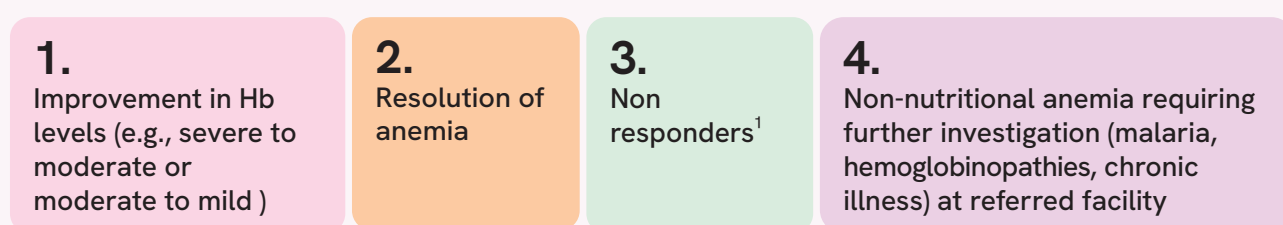
- ▶ **Protocol-Linked Investigations and Treatment:** Treatment is undertaken based on anemia category as per algorithms detailed out in the Chapter no 4 earlier.
 - ▶ Prophylactic IFA supplementation for no anemia
 - ▶ Therapeutic IFA tablets for mild/moderate cases
 - ▶ IV iron (Iron Sucrose/FCM) for moderate and severely anemic pregnant women and lactating mothers
 - ▶ Referral of ALL severe anemic beneficiaries

- ▶ **Referral Mapping:** Non responders/non compliant/ all severe anemia cases are digitally mapped to appropriate health facilities for referral and further management purposes.
- ▶ **Follow-up: Re-testing and Continued Care:** The system prompts re-testing (1–3 months) based on severity, with auto reminders to frontline workers and beneficiaries both.

STEP 4 : Outcome

Based on the beneficiary type and Hb test results, individuals are classified into non-anemic, mild, moderate, or severe anemia categories, and this information feeds into the AMB Abhiyaan Portal for monitoring.

Outcomes are recorded as



Under the AMB Abhiyaan, the focus expands to clinical management and outcome tracking for each beneficiary. Based on the anemia severity, beneficiaries undergo appropriate treatment guided by targeted interventions. A referral mechanism is mapped for moderate and severe cases requiring higher-level care. The system also mandates re-testing within 1-3 months of previous Hb test to track progress (based on severity of anemia). Outcomes are then recorded as either resolution of anemia (target Hb achieved) or need for further investigation and continued treatment. All data loops back into analytical dashboards and reports, enabling continuous programme monitoring, evidence-based decision-making, and policy refinement.

Overall, the flow represents a closed-loop, digital-first continuum of care, from identification and classification to referral, treatment, follow-up, and outcome measurement, so that no beneficiary is missed and enabling precise, data-driven anemia control.

11.4 AMB Abhiyaan Portal with Enhanced Robustness

This serves as the real-time dashboard, enabling routine monitoring and review at the national, state, and district levels. The Management Information System (MIS) emerging from the integration of JANANI, and RBSK with U-WIN, serves as a critical bridge to address data silos and implementation gaps in anemia management. Data analytics tools enable gap analysis such as low referral completion rates or drop-outs between testing and re-testing thereby, facilitating targeted interventions at sub-national levels.

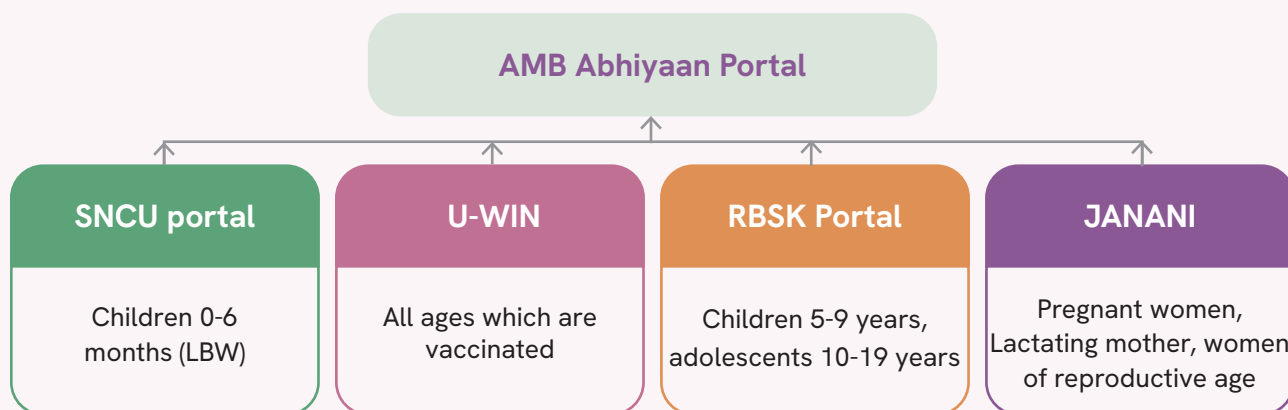
The beneficiary-wise source of data sets are as below:

Key Features

- ▶ Anemia data compilation from U-WIN, JANANI and RBSK and display
- ▶ State and district-wise visualization of pre-defined KPIs
- ▶ Age and category-specific anemia burden based on testing
- ▶ Treatment and follow-up status

Purpose

- ▶ Track saturation of registration and testing
- ▶ Monitor adherence to treatment and re-testing protocols
- ▶ Enable rapid identification of high anemia clusters/zones or population groups
- ▶ Support routine review meetings
- ▶ Service delivery gaps



11.5 Advanced Analytics and Decision Support

Predictive and Forecasting Capabilities: It is proposed that machine learning models on historical and current hemoglobin trends, treatment responses, and auxiliary indicators (e.g., regional hotspots from cluster analysis) will be leveraged to strengthen the programme implementation. These AI-driven projections will support proactive supply chain planning, early warning alerts for non-responding cases, and scenario modelling to optimize the 7x7x7 AMB Abhiyaan framework outcomes.

Key Features envisaged

- ▶ Pre-loaded, query-based analytics tools
- ▶ Correlation of input, process, output, and outcome indicators
- ▶ Cluster analysis to identify geographical hotspots of anemia
- ▶ Linkage of programme performance with service delivery gaps
- ▶ Planned AI-enabled tools for predictive insights and scenario analysis

Desirable deliverables

- ▶ Identify causative patterns (nutritional vs non-nutritional anemia)
- ▶ Assess protocol and treatment adherence
- ▶ Link service delivery with anemia outcomes for all beneficiaries

11.6 Analytical Indicators¹⁶ for Review and Monitoring

Under AMB Abhiyaan following indicators are envisaged to be recorded for strengthening monitoring and review of programmatic interventions:

1. Testing Indicators

- ▶ Percentage of registered beneficiaries tested for Hb values, beneficiary-wise
- ▶ Testing coverage by the service delivery point, beneficiary-wise

2. Anemia Burden and Categorization

- ▶ Burden of anemia (overall, age and geography-wise)
- ▶ Distribution of mild/moderate/severe anemia by age and geography
- ▶ Identification of anemia hotspots (clusters) for targeted interventions by State/UT

3. Treatment and Referral Indicators

- ▶ Percentage of anemic beneficiaries initiated on treatment
- ▶ Percentage of severe anemia cases referred to Health Facilities
- ▶ Percentage of non responders cases referred to Health Facilities
- ▶ Percentage of all referred cases managed at the facility

¹⁶: Indicators mentioned are applicable to iron deficiency anemia

4. Follow-up and Re-testing

- ▶ Percentage of under treatment beneficiaries re-tested
- ▶ Drop-out rate from treatment

5. Outcome and Resolution Indicators

- ▶ Percentage of beneficiaries achieving anemia free status
- ▶ Conversion rates (severe → moderate, moderate → mild)
- ▶ Proportion of non-nutritional anemia cases detected

11.7 Supply Chain Optimization

AMB Abhiyaan emphasizes on uninterrupted availability of commodities for quality programme implementation. The following commodities IFA tablets/Syp, IV Iron (Iron Sucrose/FCM), DIH and consumables (lancet, cuvette/strips) stocks will be managed and analysed as per following:

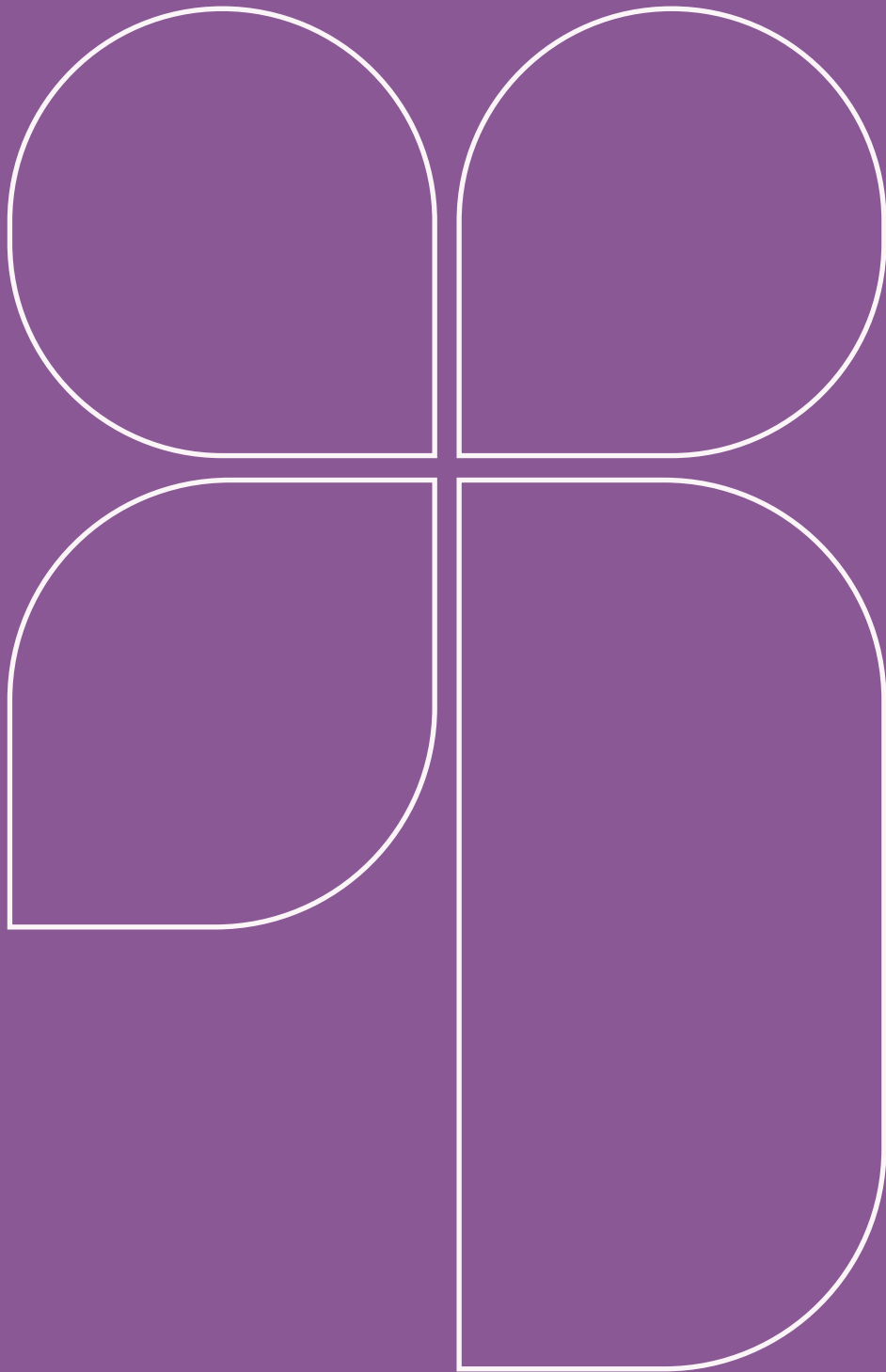
- ▶ Real-time stock visibility
- ▶ Batch and expiry monitoring
- ▶ Automated indent generation
- ▶ Reduction in stock-outs and wastage

Each commodity will be tagged for Batch number, Expiry date, Stock level and Lead time.

The AMB Abhiyaan framework supports frontline workers, program managers, and policymakers to drive acceleration in anemia reduction, contributing to improved IMR, MMR, and long-term positive health outcomes.

Framework of Compliance





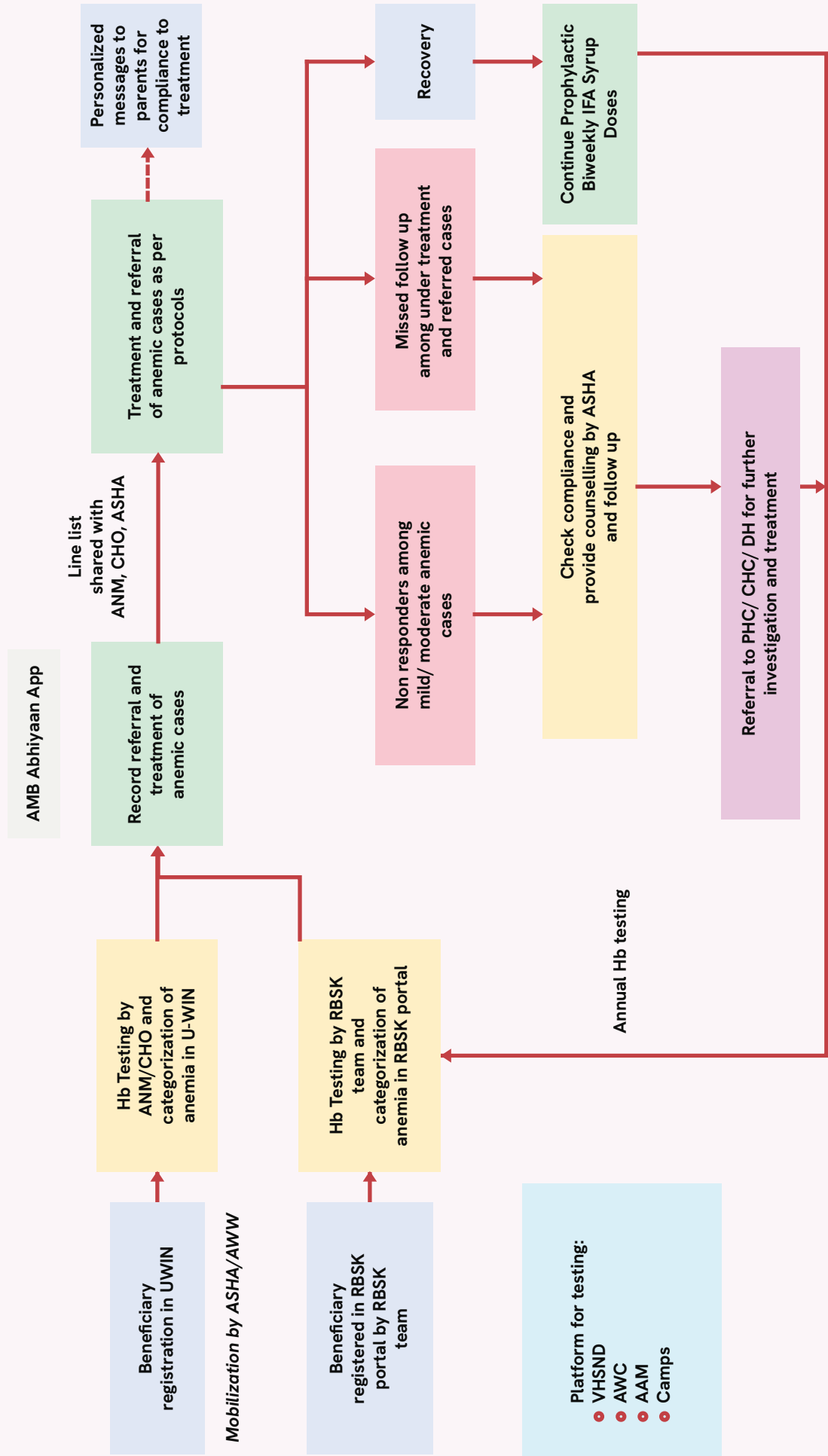
Compliance Framework

Compliance to IFA supplementation is the cornerstone of both prophylactic and therapeutic interventions for anemia prevention and management. Poor IFA compliance is one of the major contributing factors to persistent anemia. Hence, it is crucial to monitor compliance among the beneficiaries, especially among vulnerable groups, to achieve the desired outcomes of IFA supplementation.

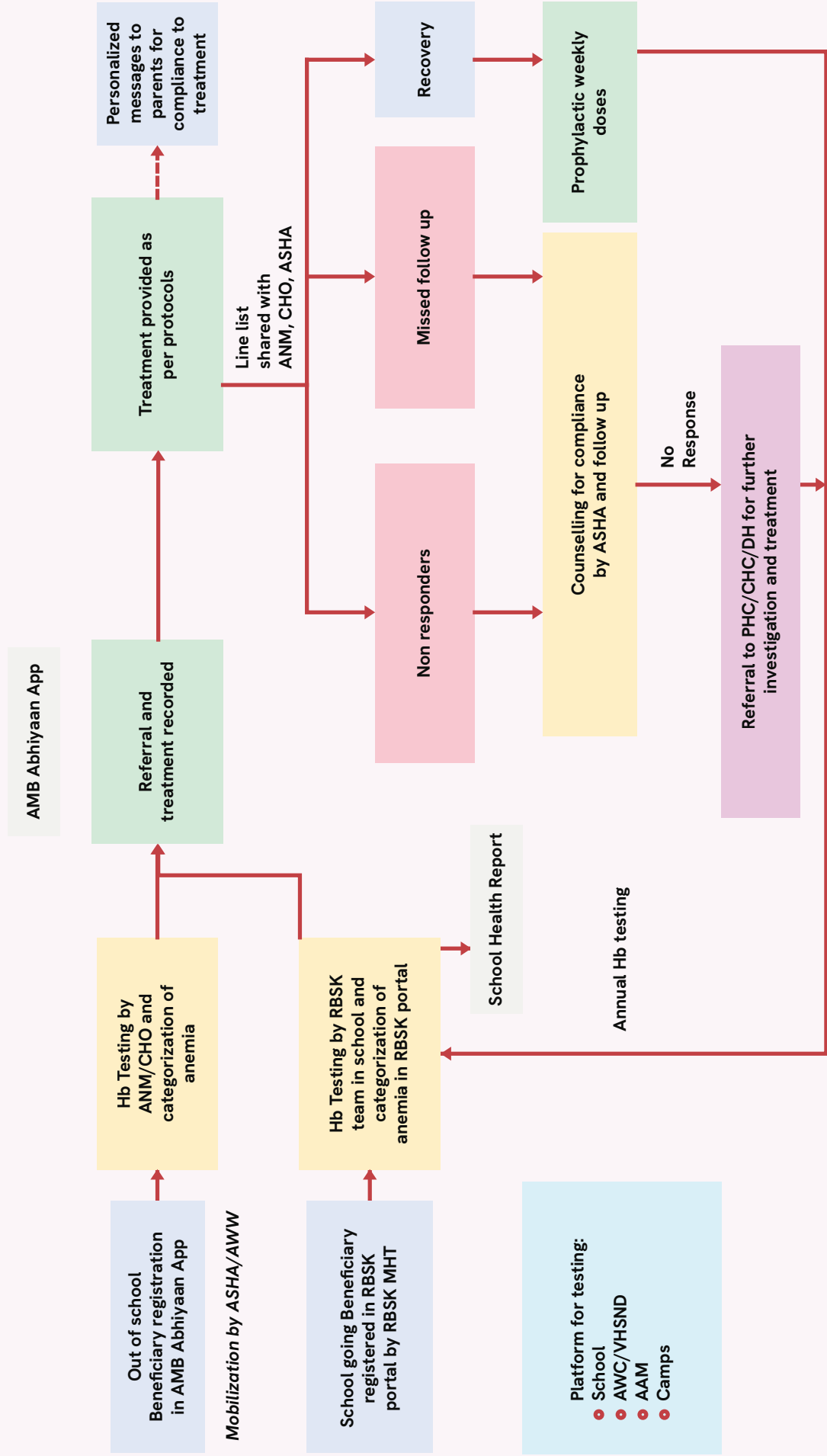
Under AMB Abhiyaan, a comprehensive approach for strengthening compliance is to be implemented which includes individual as well as community level interventions. At individual level, personalised counselling of beneficiaries by health workers on the immediate as well as long term benefits of IFA supplementation will be the key strategy to address the compliance for IFA supplementation. Additionally, case-based management approach along with reassurance about the common and transient side effects such as dark stools, nausea, or mild gastrointestinal discomfort will play crucial role for adherence to the prescribed IFA doses. The digitalization of AMB Abhiyaan services will reinforce strategies to enhance compliance through personalized alerts to anemic individual regarding IFA doses, Hb status and follow up so that prescribed course of therapy can be completed.

To improve compliance at community level, Jan Bhagidari, an intensified communication strategy, will be implemented to create mass awareness through convergence with supporting departments and ministries aims to enhance self-awareness, improve health-seeking behaviour, and encourage adherence to IFA supplementation. The strategy targets the prevalent perception of normalising anemia, considering it as trivial health condition, by educating communities about the wide array of benefits of being anemia free. The robust framework for facilitating the IFA compliance across the beneficiaries is given as below.

Compliance Framework for 6-59 Months

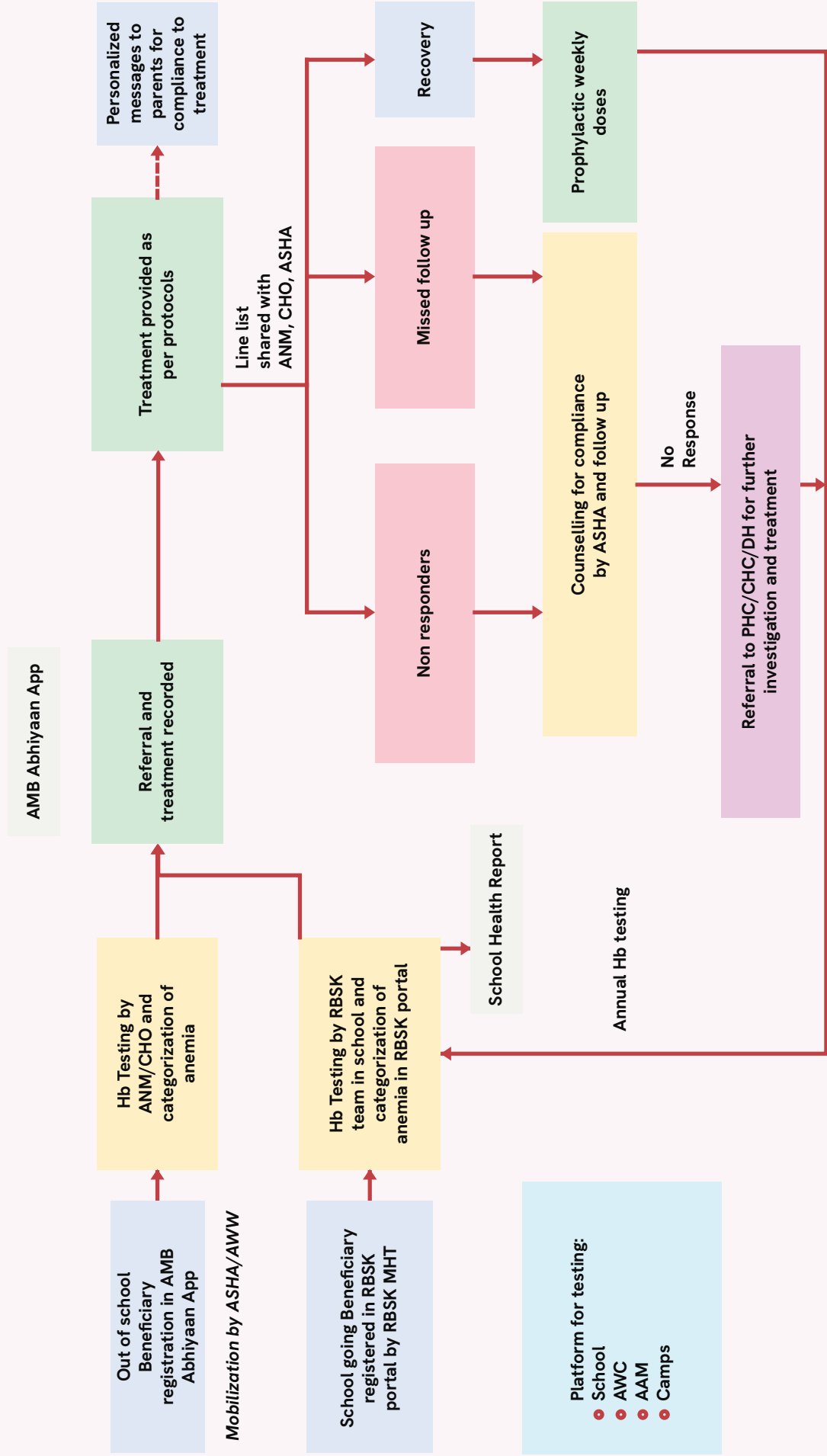


Compliance Framework for 5-9 Years

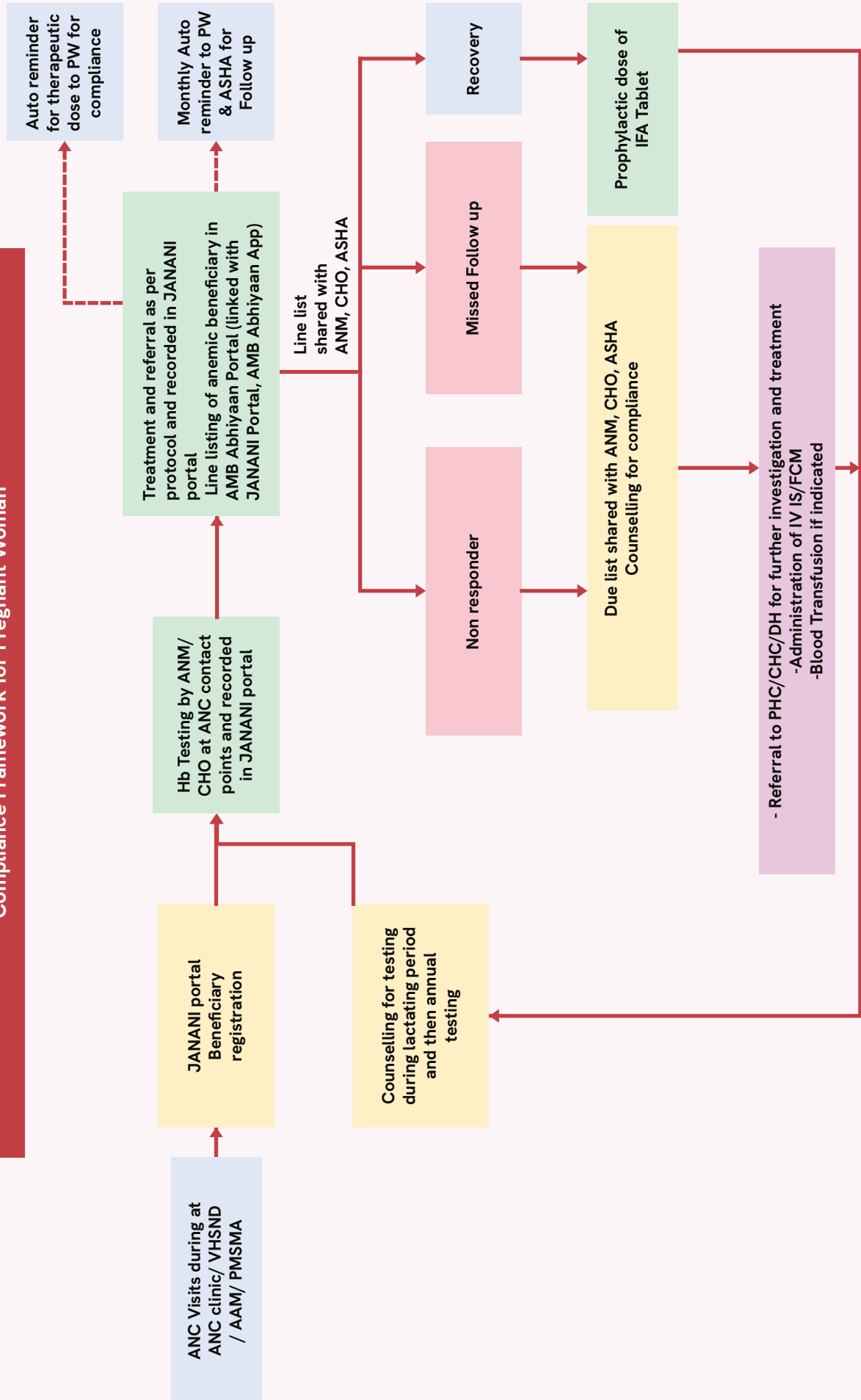


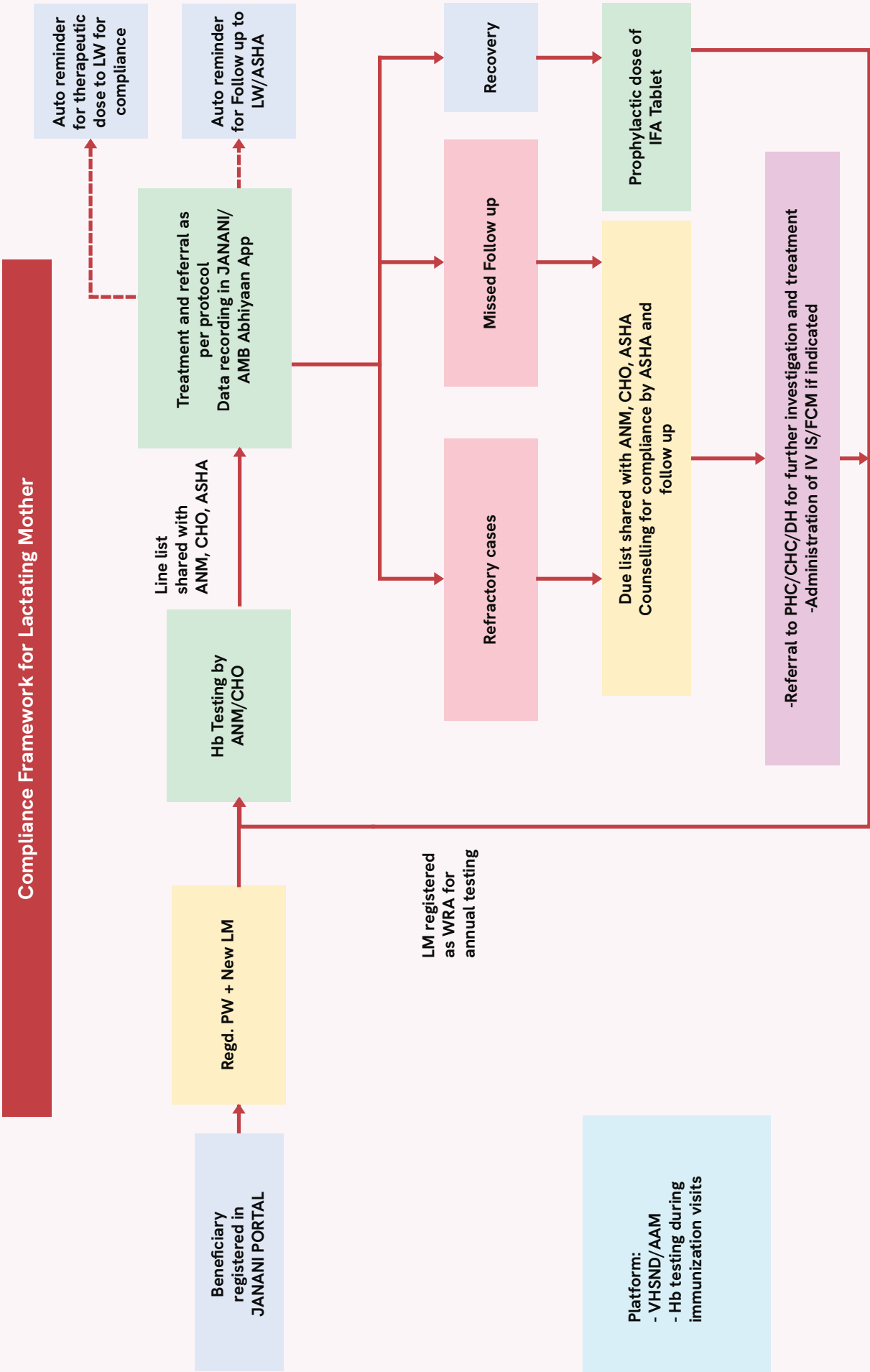
- Platform for testing:
- School
 - AWC/VHSND
 - AAM
 - Camps

Compliance Framework for Adolescent 10-19 Years

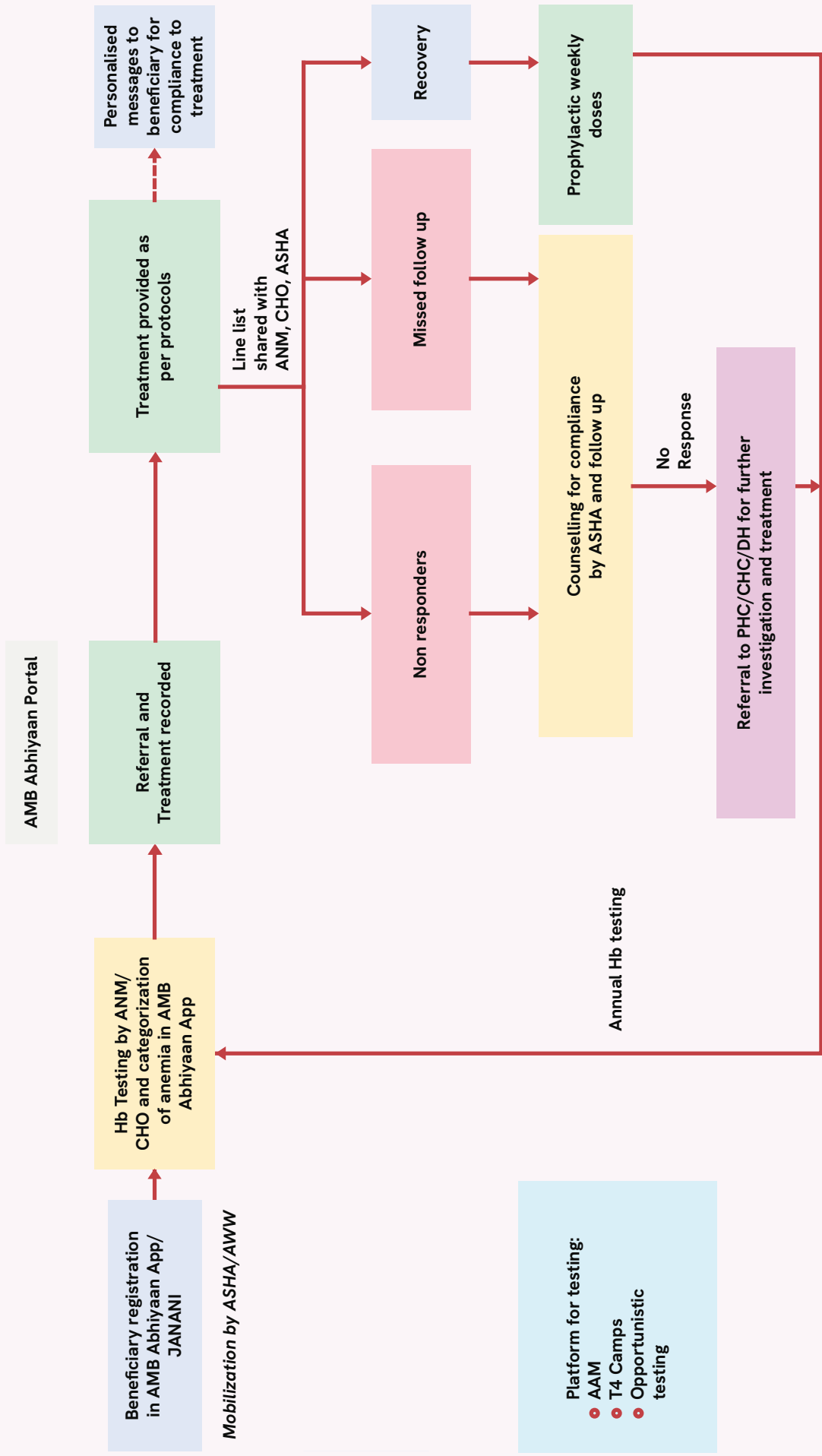


Compliance Framework for Pregnant Woman



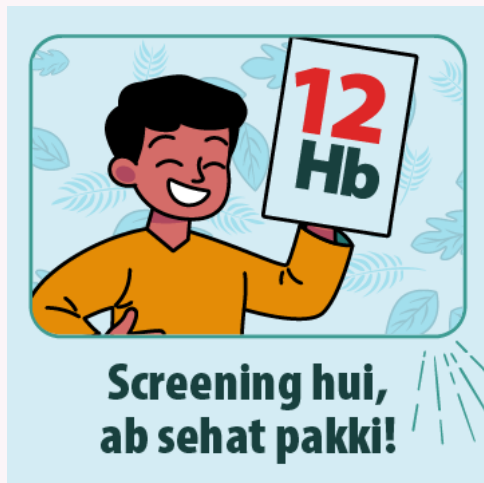


Compliance Framework for WRA (20-49 Years)



- Platform for testing:
- AAM
 - T4 Camps
 - Opportunistic testing

Nudging behaviour change through IECs





Nutrition Division
Ministry of Health and Family Welfare
Government of India