



HEALTH SAMVAAD

Engage. Exchange. Empower. Enhance Health

Quarterly Newsletter

Inaugural Issue | Volume 2 | April -June 2026



Initiative by : Directorate of Family Welfare &
Delhi State Health Mission

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Foreword

It is a matter of great satisfaction that following the successful launch of the inaugural edition of Health Samvaad in January 2026, the Department of Health & Family Welfare, GNCT of Delhi, is bringing out the second edition of the quarterly newsletter, with a special focus on Child Health.

Child health remains a cornerstone of our public health efforts, as it directly reflects the effectiveness of our health systems, community outreach, and preventive care strategies. Ensuring the survival, growth, and holistic development of every child requires coordinated action across programmes, institutions, and frontline workers. The theme of this edition highlights the Department's continued commitment to strengthening child health services through innovation, collaboration, and evidence-based practices.

This edition of Health Samvaad brings together valuable contributions from the Child Health Section of the Directorate of Family Welfare, district teams, hospitals, and frontline workers, showcasing experiences, initiatives, and good practices from across the health system. Such collective documentation and sharing of field experiences help foster learning, inspire improvements, and strengthen programme implementation.

I commend the efforts of the Directorate of Family Welfare and all contributors who have worked towards making this platform a space for reflection, knowledge sharing, and recognition of the dedicated work being carried out across our health facilities and communities.

I am confident that Health Samvaad will continue to evolve as a meaningful forum for disseminating ideas, experiences, and innovations that support our shared goal of improving health outcomes for the people of Delhi—especially our children.


(RUPESH KUMAR THAKUR)



Editors Desk

The enthusiastic response to the inaugural edition of Health Samvaad released in January 2026 has been both encouraging and motivating for the entire editorial team. Building on that momentum, we are pleased to present the second edition, which focuses on the important theme of Child Health.

Child health interventions form the backbone of a responsive and equitable public health system. From preventive care and early diagnosis to timely treatment and community-based support, improving child health outcomes requires sustained efforts across multiple levels of the health system. This edition aims to highlight these efforts and bring together diverse experiences from across Delhi's public health landscape.

We are grateful for the valuable contributions received from the Child Health Section of the Directorate of Family Welfare, district teams, hospitals, and frontline workers. Their insights, field experiences, and best practices enrich this issue and reflect the collective commitment of our health workforce towards improving the health and well-being of children.

Health Samvaad was envisioned as a platform to document programme initiatives, share innovations, and foster learning across departments and districts. With every edition, we hope to strengthen this platform further and encourage greater participation from colleagues working at different levels of the health system.

We sincerely thank all contributors, reviewers, and members of the editorial and technical teams for their continued support in making this initiative possible.


(Dr.A.G. Radhika)


(Dr. Amita Raoot)



**Directorate of Family Welfare
Department of Health & Family Welfare
Government of N.C.T. of Delhi**



**Guest Editor
State Programme Officer – Child Health**



It is a privilege to be invited as the Guest Editor for this edition of Health Samvaad, which is being released in the first week of April with a thematic focus on Child Health. This issue brings together contributions from a wide range of stakeholders, including district teams, hospitals, and frontline health workers, reflecting the collective efforts and experiences from across the health system. The articles featured in this edition have been carefully curated to highlight key initiatives, best practices, and field-level insights aimed at strengthening child health services.

We extend our sincere thanks to all authors/contributors for their valuable inputs and to the editorial team for providing this opportunity to showcase the work being carried out under the Child Health programme.

Due to the overwhelming number of submissions received, we regret that we were unable to include all the articles. However, we sincerely appreciate the efforts made by contributors toward improving child health services and outcomes whose articles could not be included in this issue.

We also place on record our sincere gratitude to the Editor-in-Chief and Co-Editor-in-Chief for their constant guidance and support in the successful compilation of this edition. The compilation of this edition has been undertaken by the Child Health Section, and while every effort has been made to ensure accuracy and relevance, the responsibility for the content rests with the authors. It is hoped that this issue will serve as a useful platform for learning, reflection, and continued improvement in child health outcomes.

(Dr. Abhishek Pratap Singh)

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HEALTH SAMVAAD

Quarterly Newsletter

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"Health Samvaad is a quarterly publication that highlights health initiatives, achievements and community stories, fostering transparency, knowledge sharing, and stronger engagement through active participation and awareness for a healthier & better life across Delhi."

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FEATURE ARTICLES -PEER LEARNING & SCIENTIFIC INSIGHTS

ROAD TO SINGLE-DIGIT INFANT MORTALITY RATE IN DELHI: STRATEGIC ROADMAP FOR URBAN PUBLIC HEALTH EXCELLENCE

Dr Abhishek Pratap Singh

State Programme Officer

Child Health and RBSK, DFW



The Infant Mortality Rate (IMR) that is total number deaths in upto one year age group per thousand live births is often regarded as barometer of overall health of nation. It indirectly reflects quality healthcare service provision in the country/state. As per sample registration system (SRS) data 2023 Delhi IMR is 14 per 1000 live birth as against national average of 25 per thousand live births.

The data indicates that after consistent decline until 2020, Delhi's IMR has plateaued and shown upward movement since 2022, signifying **the need for renewed focus on neonatal and child health interventions**. Delhi's dynamic migratory population complicates the consistency of SRS (domicile-based) data; therefore, **Civil Registration System (CRS)** (registration based) data must also be monitored. According to CRS 2024, the IMR was **22.40**, a marginal improvement from **23.61 in 2023**.

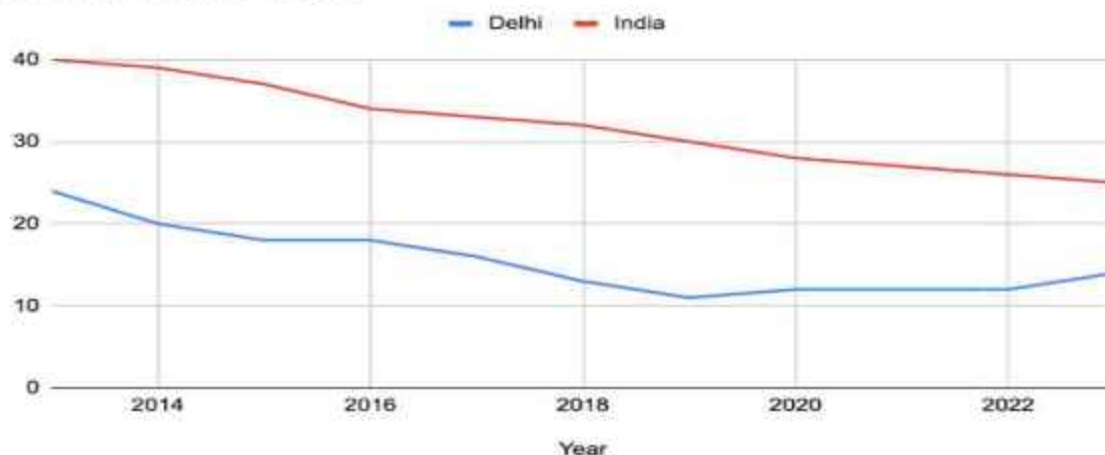
The Union Territory of Delhi is committed towards achieving single digit mortality rate and key strategies, innovation and health system strengthening are being implemented to achieve the desired outcome. Common identifiable causes monitored by Child Health Division in Delhi of Infant deaths are Prematurity, Neonatal infections, Pneumonia, Diarrhea and Heart Disease.

Table 1 Key Child Mortality Indicators of Delhi

Source(SRS 2023)	INDIA	DELHI	SDG Goal	UT Target
NMR	19	9	< 12	
IMR	25	14		Below 10
U5MR	29	16	<25	
SBR	07	4		
SRS(Sample registration system), NMR((Neonatal Mortality Rate)IMR(Infant Mortality Rate) U5MR(Under Five Mortality Rate), SBR(Still birth rate) SDG- Sustainable development goal, UT – Union Territory				

Picture 1 Line diagram of comparison trend of Infant mortality rate Delhi and National 10 year SRS data 2013-23

Infant Mortality Rate



The Key Strategies implemented in Delhi

Facility Level Intervention

- 100 % institutional delivery by trained personal will improve birth outcome, reduce morbidity and mortality.
- Strengthening of **Facility based Neonatal Care(FBNC)** set-ups like Newborn care corners(NBCCs), special newborn care units (SNCUs),Neonatal Intensive care units (NICUs),Mother Newborn care units,Kangaroo Mother care), (KMC), Lactational Management Unit (LMUs) at District hospitals. Specialised FBNC training package of health care professionals.³⁴ FBNC are including central government and MCD are functional in Delhi. The SNCU successful discharge rate is more than 80 % as per FBNC portal and Specialised FBNC training package are provided to Government health care professionals. In current financial Year Delhi achieved 100 % training target. Availability of SNCU bed and adequate human resource as per Indian public health standard (IPHS) norms for every newborn is challenge and efforts are ongoing for strengthening of human resource as per Indian public health standard norms in FBNC facilities. Furthermore FBNC are planned in next Financial year for augmentation of FBNC beds capacities in Delhi.
- **Navjat Shishu Suraksha Karyakram** – Training of health care staff doctors and Nursing personnel in basic newborn resuscitation care package
- **Janani Shishu Suraksha Karyakram (JSSK)** for provision of free drugs and diagnostic and transport to children upto one year age at Government health facilities.
- **MusQan Quality certification for paediatric care** in District/Sub district hospitals (NRCs, SNCUs, Paediatric OPD/IPD).¹⁰ such facilities are MusQan certified in Delhi.
- **Facility Based Pediatric Care** – Training of health personal in on Integrated management of common childhood illness in community (IMNCI) and Inpatient management (F-IMNCI) training package for managing children under 5 years age group. Tertiary care that is paediatric intensive care unit (PICU) is still a challenge and require Augmentation of Paediatric Intensive Care Unit vis-sa-vis adult ICU beds.

- **Rashtriya Bal SwasthyaKaryakram** - Comprehensive Newborn Screening (CNS) named Neonatal Early Evaluation Vision (NEEV) Project and District Early intervention centres (DEICs) in all district hospitals (currently 4 District Early intervention centres DEICs (Including centre of excellence at Lok Nayak Hospital are functioning in Delhi) for management of 4Ds (Defects, Deficiencies, Diseases, Developmental Delays & Disabilities).
- There is need for **Pediatric cardiac care intervention facility for newborn** born with congenital heart disease. Present infrastructure is not optimum. The Gap has been identified and steps are being taken for establishment of such unit in Delhi Government.

Community Level Intervention

- **Antenatal Counselling** :Antenatal care access, anemia reduction strategy, High risk pregnancy identification and follow up Institutional deliveries help in reduction of Low birth weight, prematurity .
- **Universal Immunisation Programme** –Vaccination is provided free of cost at Government health facility against various vaccine preventable diseases including pneumonia, Diarrhea etc and 100% vaccination of due children is required to be ensured.
- **Mother's Absolute Affection (MAA) programme**& Infant and Young Child feeding (IYCF) practices to promote breastfeeding and nutrition in children up to 2 year. Under the programme focused community outreach through MAA Meeting is done through media and interpersonal communication and training is provided to health personal for Antenatal counselling. There is also dedicated Lactational Management Units which provided support to Mother in human milk expression and storage for sick infants. At present there are 5 functional Lactational Management unit in Delhi. Efforts are ongoing to establish more such facilities. In Delhi 80 % children born are breastfed within an hour of birth. Efforts are ongoing to achieve more than 85 % .
- **Home Based Care of Newborn (HBNC)**- 7 Home visits are completed by ASHA at regular intervals till 42 days of Life. Important counselling like breastfeeding and weight gain of newborn is assessed. In case of any danger signs newborn is accompanied to the nearest

health facility. ASHAs have completed more than 80 % visits in current financial year upto February.

- **Home Based Care of Young Child** – Growth and Developmental assessment of every child on 3 monthly basis starting from 3 months of age till 15 months of age. Home visit is being done by ASHA.
- **Nutrition Inter-sectoral Coordination with women and child development(WCD),** Education department, etc. to eliminate malnutrition by having well established linkages with the community.
- Digital platforms for **real time capturing of data on FBNC portal.**
- Institutionalisation of **Child Death review** in Facility by Hospital administration and community by District Magistrate and Chief District Medical Officer
- Efforts to achieve single digit Infant mortality rates and reduction in deaths due to Diarrhoeal diseases and Pneumonia through campaigns like **Stop Diarrhea Campaign, SAANS.** Further promotion of newborn and young child care through World Breastfeeding week, National Newborn Week POSHAN etc.
- Standard Treatment Guidelines on Severe Acute Malnutrition Management in community and facility has been issued. Delhi also has **five Nutritional Rehabilitation centres** providing services to malnourished children.

Private Sector Participation – PM JAY (Pradhan Mantri Jan Arogya Yojna) ,State Schemes like EWS(Economically weaker section) , Delhi Arogya Kosh also supplement in reducing the mortality by provision of beds in Private Hospitals.

Key Takeaway

Achieving single digit target is challenging yet feasible with unwavering commitment from all stakeholders—from administrators and service providers to parents as care seeker

“TOO SMALL TO TRAVEL, TOO PRECIOUS TO LOSE: SAVING TENDER LIVES ON THE MOVE” BUILDING DELHI’S FIRST DEDICATED NEWBORN TRANSPORT SYSTEM

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Brief Narrative

Timely and safe transport of sick newborns is a critical yet often neglected link in the continuum of newborn care. In Delhi, the absence of a neonatal-specific transport system meant that critically ill neonates were frequently transferred in adult ambulances lacking thermal protection, neonatal monitoring, respiratory support, and trained personnel. This resulted in avoidable hypothermia, physiological instability during transit, and high en-route morbidity and mortality, with many babies reaching referral centres in severely compromised condition.

Recognising this critical gap, a systematic initiative was undertaken to establish **dedicated neonatal transport ambulances** for the National Capital Territory of Delhi. A needs assessment across major public hospitals highlighted the requirement for strategically located, neonatal-only ambulances. Based on this, **11 neonatal-specific ambulances**, operated through the Centralised Accident & Trauma Services (CATS), were stationed at

11 major government hospitals across Delhi, exclusively for newborn transport from April 2024 with the support of DFW, GNCT.

Each ambulance was **custom-designed for neonatal care**, addressing all domains viz Thermal care (Dedicated incubator with easy onloading off-loading) , Monitoring (Pulse oximeter),Respiratory care (T Piece, Ventilator, Suction), Nutrition (Infusion pumps ,comfort place for mothers) and enroute support with trained EMT and the emergency kit. The ambulance also had , the backup Oxygen , Charging and railing in ambulance for minimizing vibrations. Equally important was human resource strengthening. Emergency Medical Technicians (EMTs) and paramedical staff were provided **hands-on training within the newborn nurseries** of the hospitals where the ambulances were stationed (which proved to be far superior to ad hoc 2-3 day training), ensuring familiarity with neonatal physiology, resuscitation, and stabilization prior to transport.



Figure 1-3: Photographs showing the Neo-Ambulance with Baby being Transported

Standard operating procedures were developed for ambulance utilization, logistics management, real-time communication, infection prevention, and systematic disinfection after every transport. Continuous monitoring of utilization data (At the hospital level) , regular review of equipment readiness, and coordination between neonatal units and CATS ensured quality assurance.

The impact of this initiative is reflected in **substantial neonatal transport volumes**, improved physiological stability of babies on arrival, and a marked shift from unsafe adult ambulance transfers to structured neonatal transport. The programme demonstrates that **system-level innovation, when combined with training and monitoring**, can significantly strengthen newborn survival beyond the walls of the NICU. Month-wise utilization of the dedicated neonatal ambulance service at Lok Nayak Hospital in 2025. The dotted line

indicates the average monthly number of neonatal transfers, demonstrating sustained utilization above the mean for most of the year.



Special Acknowledgement: Dr Anuja Prakash, Dr Vandana Bagga, Dr Ramnesh Agarwal, Dr Arti Maria, Dr Pratima Anand, Dr Mamta Jajoo ,Secretary & Spl. Secretary Health, GNCT.

Key Takeaway

Dedicated neonatal transport systems significantly improve the safety and outcomes of sick newborns and are an essential component of urban public health systems.

EXPERIENCE FROM IYCF CENTRE OF DELHI HOSPITAL: HINDU RAO HOSPITAL

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Introduction

Infant feeding practices have major role in determining the nutritional status of the child. Optimal breast-feeding practices can prevent 13 % and complementary feeding can prevent additional almost 6% of under-five mortality. Improving these practices in children aged 0-23 months is critical to improved nutrition, health and development of children. India scores poorly on IYCF practices. This study was conducted to understand the prevailing IYCF practices in children visiting hospital for medical reasons or immunization.

Objective

- ✓ To know the prevailing IYCF practices in children attending IYCF centre of a hospital.
- ✓ To understand the reasons for sub optimal IYCF practices.

Methodology

A Structured Performa is being used for providing customized counselling to the mothers of babies 0-23 months at IYCF centre, Hindu Rao Hospital. IYCF practices and the underlying reason if not appropriate are gathered from mother/ caregiver. Accordingly, the counselling is tailored. Data of 400 children who had attended IYCF centre, Hindu Rao Hospital from 1/07/2025 to 31/12/2025 was analysed by Descriptive analysis on MS Excel.

Results-Breast feeding

Profile: There were 94 % (n=376) delivered at health facility. Out of these 73.3% (n=275) normally delivered, 49.2 % (n=184) below six months and 28.3 % (n=106) low birth weight.

Information given to mothers/Caregiver-In 72.9 % (n= 292) feeding was discussed during antenatal period and 78.7% (n=315) mother received feeding advice after delivery. About 29.8% (n=119) of the mothers faced feeding difficulties.

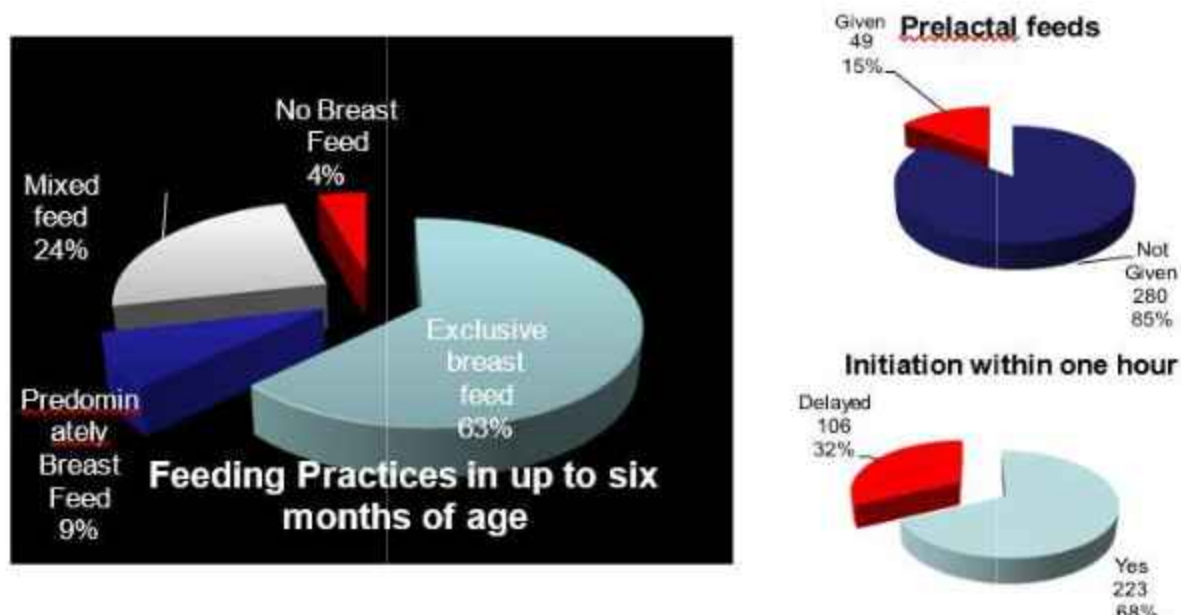


Fig 1 : Breast Feeding practices upto 6 months.

Why Late Initiation of Breast feeding

Separation (baby not with mother)	55.2%
Pain	22.9 %

Why Started Top feeding		
	Not enough milk	63.1 %
	Lack of Knowledge	12.3 %
	Family pressure	11.5 %



Bottle feed in 74.3 % (n=55/74) was due to convenience.

Fig 2 : Reasons for faulty feeding (0-6 months)

Results-Complementary feeding

- In 14.7% (n=22/150) complementary feeding was started after completing 8 months of age.
- Only 26% (n=39/150) were receiving 3 or more meals, even they were not given the recommended quantity as 76% feel that child can not take this much amount. Only 5.6% were giving quantity of complementary feed as per recommendation appropriate for age.
- 68.2% (n=75/110) had no idea about consistency and 22.7% (n=25/110) felt child will not be able to take it.
- 94.7% (n=142/150) had not been offered animal source food. 68% (n=102/150) dairy products, 25.3% (n=38/150) pulses, nuts or seeds and 82.7% (n=124/150) dark green vegetables yesterday.
- 90.7% (n=136/150) mothers/caregivers were assisting child at mealtimes and 23.5% (n=38/150) had separate bowl.

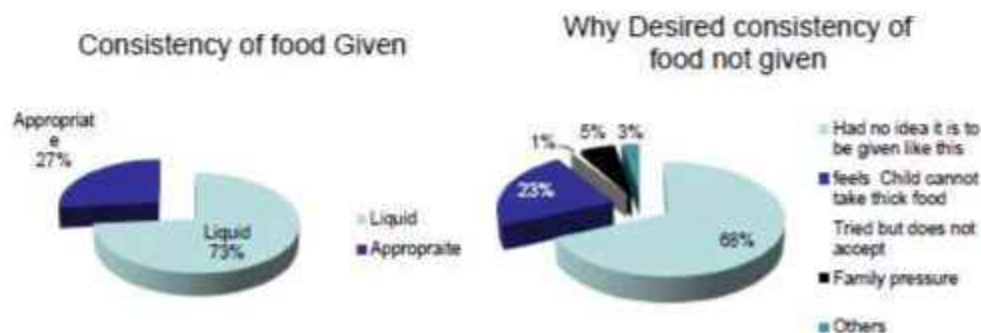


Fig 3 : Complimentary feeding practices (6-24 months)

Discussion

Early breastfeeding initiation which is a recommendation is much higher in our study in comparison to NFHS-5 data and other similar studies. As far as prelacteal feeds are

Concerned, it was received by a higher **number of infants**. **Exclusive breast feeding for 6 months is comparatively equivalent to NFHS-5 data both from Delhi & India.**

Complementary feeding (CF) was started late. There were still 14.7% who were not introduced to CF by the age of 9 months. Inadequate or delayed complimentary feeds canact as major factors for malnutrition among these children.

	Present Study (2025)	FHS 5 (INDIA)	FHS-5 (DELHI)
Early Initiation	67.8%	41.8%	51.2%
Prelacteal feeds	14.9%	NA	NA
Exclusive Breast Feeding	62.9%	63.7%	64.3%
Continued Breast feeding >1 year	77.9%	NA	NA

Table -1: Breast Feeding Practices

Minimum meal frequency was also not as per the recommendations. Very important is the quantity of food, which was as per WHO recommendations in 5.8 % only.

Conclusion

IYCF practices are not as per recommendations of WHO and IAP. Optimal Breast-feeding practices need to be promoted, protected and supported. Complementary feeding practices are even much more deviated from guidelines. Complementary feeds are introduced late and are not adequate in quantity, quality and consistency. Mothers/caregivers need support by Health workers for optimal breast-feeding practices. IYCF counselling needs to be strengthened as it can play an important role in improving nutritional status of children.

PROJECT NEEV: STRENGTHENING CHILD HEALTH THROUGH SCHOOL-BASED PREVENTIVE ORAL HEALTH INTERVENTIONS

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State Program Officer³, Mobile Dental Clinic Project (NOHP), Delhi

Context and Background

Child health is a fundamental determinant of human development, influencing educational attainment, social participation and long-term productivity. Oral health, though often overlooked in public health planning, is an integral component of overall child health. Dental caries (dental cavities), periodontal diseases (severe gum diseases), malocclusion (irregular teeth) and oral infections are among the most prevalent non-communicable conditions affecting school-aged children. Untreated oral diseases can lead to pain, difficulty in eating and speaking, poor nutrition, low self-esteem, school absenteeism, and impaired academic performance. As per the National Oral Health Survey (2002–03)¹, dental caries affected about 52% of 12-year-old school children and nearly 54% of 5-year-olds, while gingival diseases were reported in around 55–60% of children, highlighting a substantial burden of oral diseases among school-going children.

Evidence suggests that children suffering from poor oral health are significantly more likely to experience restricted activity days and miss school hours due to dental pain and

related complications. Preventive interventions during early childhood and school-going years are therefore crucial to reduce disease burden and inculcate lifelong healthy practices.

Recognizing this need, the Mobile Dental Clinic Project under the National Oral Health Programme² (NOHP-Delhi), in collaboration with the School Health Division, Department of Education, GNCTD initiated **Project NEEV** in September 2014. The term 'NEEV', meaning foundation symbolises the programme's objective of laying a strong and sustainable foundation for lifelong oral health among school children of Delhi. The WHO concept of **Health Promoting Schools**³ emphasizes creating a supportive school environment that fosters healthy behaviours through health education, services, and community involvement, and Project NEEV aligns with this approach by integrating oral health education, preventive care, and early intervention within the school setting to promote lifelong oral health among children.

Description of the Initiative

Project NEEV is a comprehensive school-based oral health programme designed to deliver preventive, promotive, and basic curative dental services directly within school premises. The programme primarily targets children from socio-economically vulnerable backgrounds, where access to routine dental care is limited or absent.

The Project has earmarked days in each week for school oral health activities, ensuring systematic outreach without disrupting routine academic schedules. The programme is being implemented through **06 Mobile Dental Clinics**⁴, each equipped to provide on-site dental services. These clinics are staffed by multidisciplinary teams comprising of Dental Consultants, Dental Surgeons, Dental Hygienists, Chairside Assistants, Helpers, Drivers and other Support Staff.

Key Components of Project NEEV

The major components of the programme include:

- **Dental Screening:** Systematic oral health screening of students and school staff in Government schools.
- **Preventive Interventions:** Application of fluoride varnish and pit and fissure sealants wherever feasible, particularly for children with high risk of dental caries.
- **Dental Health Education:** Age-appropriate oral health education through interactive lectures, innovative approaches like use of role play, comics etc to promote correct oral hygiene practices.
- **Individual Counselling and Referral to higher dental centers:** Identification of children requiring further dental treatment and referral to appropriate public health dental facilities.
- **Teacher Training and Capacity Building initiative:** Training of school teachers as “Oral Health Ambassadors” to reinforce healthy practices among students through basic screening, health education and coordination for provision of dental care for children.
- **Capacity Building Activities for school children:** Observing days of Public Health Significance like World Oral Health Day, World No Tobacco Day etc. through active learning by organizing health promoting competitions for school children like painting competitions, Street plays, debate/elocution competition etc.
- **Basic Curative Services:** Provision of basic dental treatment within school premises after obtaining informed consent from parents in coordination with school authorities.

By integrating preventive and curative clinical services with health education and capacity building, Project NEEV promotes the concept of Health Promoting Schools with a focus on Dental Health and ensures continuity of dental care.

Programme Reach and Key Outcomes (2014–2025)

Since its inception, Project NEEV has demonstrated sustained growth and impact. Between 2014 and December 2025, a total of **68,346 students and school staff** were

screened across Government schools in Delhi. The programme showed steady expansion over the years, with a temporary disruption during COVID-19 pandemic, followed by a strong resurgence in subsequent years.

Significant increases in coverage were observed during 2022–2026 reflecting renewed emphasis on preventive school dental health services. Schools across multiple districts benefitted from repeated Mobile Dental Clinic visits, allowing reinforcement of oral hygiene messages, early detection of dental problems, and timely referrals to Public Health Facilities.

The data generated through Project NEEV has also provided valuable insights into the prevalence of oral diseases among school-going children, aiding programme planning and prioritisation of funds for specific targeted approach.

Health Promotion and Capacity Building

Beyond clinical screening, Project NEEV places strong emphasis on health promotion and human resource development. Key capacity-building initiatives include organisation of three state-level workshops for School Health Officials, Principals, and Teachers, conducting eleven school-level workshops aimed at improving student engagement and awareness on Oral Health. Fifty-three teacher training sessions conducted in 44 Government schools, empowering teachers to act as “Oral Health Ambassadors.”

The programme has received recognition from the Department of Education, GNCTD, which has issued directions to Government schools to facilitate oral health education sessions and dental screening activities.

Challenges, Key Observations and Lessons Learnt

Implementation of Project NEEV over the past decade has yielded important lessons while also highlighting operational challenges. School-based screening has proven effective for early identification and prevention of dental problems, reducing the need for advanced treatment, while trained teachers have emerged as key change agents in reinforcing oral

hygiene practices among children. Integration of oral health services with the School Health Scheme ⁵ has enhanced acceptability, reach, and continuity of care, and Mobile Dental Clinics have played a crucial role in bridging geographical and socio-economic access gaps. However, implementation has faced challenges such as alignment with school timings, difficulty in accessing certain areas through Mobile Dental Clinics, occasional non-availability of school staff, and absenteeism of students. Additionally, Mobile Dental Clinics are utilized for multiple dental services throughout the week, which sometimes affects scheduling and coverage of school-based activities.

Implications for Practice and Policy

Project NEEV demonstrates that school-based oral health programmes can significantly contribute to broader child health and education goals. By reducing dental pain and infections, the programme supports improved nutrition, attendance, concentration, and overall learning outcomes.

From a policy perspective, the initiative underscores the need to integrate oral health promotion within routine school health services and curriculum. Strengthening focused School Oral Health Programs with dedicated Human Resource, along with availability of logistics and mobility support for prompt curative services with school premises. Intersectoral collaboration between health and education departments is essential for scaling up such interventions and ensuring sustainability.

Future plans include achieving universal dental coverage for all Government school children in Delhi, strengthening referral mechanisms, integrating oral health education into school calendars, and using programme data for continuous quality improvement.

Key Takeaway

1. Oral health is an essential component of child health and educational attainment.
2. School-based preventive interventions are effective in reducing life long oral disease burden among children.
3. Mobile Dental Clinics play a crucial role in reaching underserved populations.
4. Teacher training and health education are central to sustaining oral health behaviours.
5. Intersectoral collaboration is vital for scaling up child health initiatives.

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NUTRITION AND EARLY CHILD DEVELOPMENT: BUILDING THE FOUNDATIONS FOR LIFE

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BACKGROUND

Development refers to the maturation of functions and the acquisition of skills required for optimal functioning of an individual. Early child development usually refers to the physical, cognitive, emotional and social domains of development from birth to five years of age. This period is characterized by rapid and interrelated changes in brain structure and function that form the foundation for later learning, behavior and health.

The first 1000 days, from conception to two years of age, represent a critical window during which nutrition has a strong influence on development. During this time, rapid brain growth and maturation of neural circuits occur, shaping long-term cognitive, behavioral and emotional outcomes. Nutritional deficiencies during this period may result in lasting adverse developmental consequences extending into adulthood.

In India, despite improvements in child survival, undernutrition remains a major public health concern with important implications for early child development. According to NFHS-5, in the National Capital Territory of Delhi, 30.9% of children under five years are stunted, 11.2% are wasted, and 21.8% are underweight. Anaemia is highly prevalent, affecting 69.2% of children aged 6–59 months. These indicators reflect nutritional deprivation during critical periods of development and underscore the need to address

early childhood nutrition not only to improve survival, but also to support optimal developmental outcomes and long-term health, learning, and productivity.

NUTRITION AND EARLY CHILD DEVELOPMENT

Nutrition influences early child development through multiple pathways. Adequate intake of macronutrients provides the energy and building blocks required for rapid brain growth and physical development. Protein and energy deficits during fetal life and early childhood are associated with reduced brain size, altered neural architecture and long-term neurodevelopmental impairment.

Micronutrients are also essential for normal neurodevelopment. Iron supports brain myelination and neurotransmitter activity, while iodine is required for thyroid hormone production necessary for brain growth and maturation. Zinc contributes to brain cell growth, synapse formation, and immune function and vitamin A supports cellular growth and protection from infection. Long-chain polyunsaturated fatty acids, particularly docosahexaenoic acid (DHA), are important for neuronal structure and function and for visual and cognitive development.

The effects of nutritional deficiencies vary according to their timing, severity and duration. As different brain regions mature at different stages, deficiencies occurring during sensitive developmental periods may lead to long-lasting effects, highlighting the importance of prevention rather than delayed correction.

Undernutrition during early life is associated with impaired growth, delayed cognitive development, poorer school performance and reduced adult productivity. Recurrent infections further worsen outcomes by impairing nutrient absorption. In contrast, optimal nutrition supports children's ability to explore their environment, interact with caregivers, and engage in early learning experiences.

BREASTFEEDING AND COMPLEMENTARY FEEDING

Breastfeeding plays a foundational role in early child development. Early initiation and exclusive breastfeeding for the first six months significantly reduce infant morbidity and

mortality while providing optimal nutrition and immune protection. However, beyond six months, breastmilk alone is insufficient to meet the growing nutritional needs of infants.

Appropriate complementary feeding from six months onwards, with continued breastfeeding up to two years and beyond, ensures that increasing nutritional requirements are met. Infants have micronutrient needs that are five to ten times higher per kilogram of body weight than adults, highlighting the importance of nutrient-dense complementary foods.

Complementary foods should be soft, mashed or pureed, energy and micronutrient dense, and prepared from diverse home cooked foods. Infants have micronutrient requirements that are five to ten times higher per kilogram body weight than adults, making dietary quality critical. Along with cereals, diets should include pulses, milk, vegetables, fruits, and small amounts of oils or ghee. Eggs, fish, and meat may be introduced in small quantities from around eight months of age if culturally acceptable. Foods should be semisolid in consistency, without added sugar, and prepared using iodized salt. By one year of age, children can transition to the family diet, with continued emphasis on nutrient density. Additional nutritious foods including milk, fruits, small amounts of nuts, oil seeds, oil or ghee are recommended to be added to enhance nutrient density of the family diet.

KEY OBSERVATIONS AND LESSONS LEARNT

First, the effects of early nutritional deficits extend beyond physical growth and are often irreversible if not addressed early. Evaluation of nutrition interventions should extend beyond growth monitoring to include developmental outcomes.

Second, caregiver knowledge, beliefs and feeding practices strongly influence child nutrition and development. Counselling on age-appropriate feeding, dietary diversity, and responsive feeding is as important as the provision of food supplements. Cultural practices, delayed initiation of breastfeeding, and misconceptions around complementary feeding continue to limit optimal nutrition.

Third, nutrition does not act in isolation. Children benefit most when adequate nutrition is combined with responsive caregiving, early stimulation and a safe environment. Programmes that integrate nutrition with early child development services demonstrate greater impact on developmental outcomes than nutrition-only approaches.

Finally, early identification of growth faltering or feeding difficulties provides an opportunity for timely intervention. Frontline health and nutrition workers play a critical role in recognising early warning signs and helping families access timely and appropriate support.

IMPLICATIONS FOR PRACTICE AND POLICY

Improving early child development outcomes requires integrating nutrition into a broader developmental framework. Health and nutrition services should move beyond a narrow focus on anthropometric indicators to include counselling on feeding practices, caregiver–child interaction and developmental stimulation.

India has a robust policy and programme framework to support early childhood nutrition. Integrated platforms such as the Integrated Child Development Services (ICDS), Saksham Anganwadi and Mission POSHAN 2.0, and the National Health Mission provide community-based nutrition support through supplementary feeding, growth monitoring, and counselling on optimal infant and young child feeding. Legal measures, including the Infant Milk Substitutes Act and the National Food Security Act, protect breastfeeding and improve access to nutritious and fortified foods.

Programmes such as Home-Based Newborn Care and Home-Based Care for Young Children enable early identification of feeding and growth concerns. Nutrition Rehabilitation Centres provide facility-based care for children with severe wasting, while initiatives such as Mothers' Absolute Affection and Village Health and Sanitation Days increase outreach and enhance community awareness. Social protection schemes, including Pradhan Mantri Matru Vandana Yojana. (PMMVY) and Janani Suraksha Yojana (JSY), further support maternal and child nutrition by improving access to health services.

Investing in early nutrition yields substantial long-term benefits by improving health, learning and productivity. Policies should prioritise maternal nutrition, promote breastfeeding, ensure access to diverse and adequate complementary foods and strengthen the capacity of frontline workers to deliver consistent, development-focused nutrition counselling.

KEY TAKEAWAY

- Proper nutrition during early childhood influences brain development, learning capacity and long term wellbeing.
- The first 1000 days represent a critical and time-sensitive window for intervention.
- Nutrient deficiencies during sensitive developmental periods may have lasting consequences.
- Breastfeeding and appropriate complementary feeding are central to healthy early development.
- Integrated nutrition and early child development services are essential to improve outcomes at scale.

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SPOT LIGHT - EARLY INTERVENTION UNDER RBSK

No Child Left Unseen: Early Identification and Intervention through School Health programs and Rashtriya Bal SwasthyaKaryakram (RBSK)

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Developmental delays and disabilities often go unnoticed in early childhood, especially when symptoms are subtle or attributed to behavioural issues or poor academic performance. By the time concerns are formally recognised, children may already be experiencing significant educational and psychosocial difficulties. Schools therefore provide a crucial opportunity for early identification and timely intervention.

As per available estimates, 10% children are affected with development delays leading to disabilities. According to the World Bank, 5.3% of the population in India are below poverty line(BPL)[1]. Many of them live in outreach areas with limited access to tertiary healthcare facilities and the best time and place to evaluate them is when they come in contact with Institutions like Anganwadi centre, ASHA worker and Government schools.

Rashtriya Bal Swasthya Karyakram (RBSK) is an initiative under National Rural Health Mission(NRHM) aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities.

Children diagnosed with illnesses receive follow up including surgeries at tertiary level. Screening of the new-born, both at public health facilities including hospitals of Government of NCT of Delhi and at home, is an important component of the strategy done under the umbrella of Neonatal Early Evaluation Vision(NEEV). Regular health screening of pre-school children upto 6 years of age using Aganwadis as a platform is another essential component. Moreover, children from 6 to 18 years of age studying in Government and Government aided schools also receive regular health check-ups. District Early Intervention Centers (DIEC) have been setup to facilitate the diagnosis and referral without any delay.

Globally, an estimated 200 million children do not attain their full developmental potential in the first five years of life due to factors such as poverty, ill health, undernutrition, and inadequate early stimulation [2]. In addition, Technical Reports from Special Newborn Care Units (SNCUs) indicate that approximately 20% of infants discharged from health facilities later manifest developmental delays or disabilities [3].

Data from a community screening study conducted under the Rashtriya Bal Swasthya Karyakram in Bengaluru showed that out of 760 children screened, nutritional deficiencies were the most common (41.6%), childhood diseases were present in 2.6% and developmental delays and disabilities were identified in 0.3% of participants. This suggests that structured screening through various health programs can uncover previously unrecognised developmental issues in otherwise healthy-seeming children, enabling early referral and intervention^[4]. These findings highlight that the RBSK program is already making a meaningful impact by early recognition of the disease and hence aiding in prompt management, offering hope that with continued improvements and strengthening of the system, we can further improve the life of babies and their families across the country.

It is always an overwhelming experience to see grown up children with disorders like cerebral palsy in the lap of their parents or in wheelchairs, not aware of what is happening around them. Even though the parents have been explained that the disease cannot be

cured, they put all their efforts into taking care of their child and doing every little thing they can do to make the life of their kid easier.

While evaluating every single case, one question that always crosses our mind is whether there was anything, we as a healthcare professional and our healthcare system could have done to prevent this child from being in this condition right now. In most of the cases, the cause is some genetic condition, tumor, trauma or some other non preventable etiology. **In a fraction of patients, the cause is preventable and this is where the role of various healthcare screening programs becomes important.** They help in early identification and intervention to halt the progression of disease. We can think of so many examples, where the child was referred to us for some minor issues on screening like, hearing or vision defect and on detailed work up it turned out to be some metabolic or genetic disorder.

Case Reports

1. There was a case where a 6 year old boy was sent from his government school with concerns of generalised weakness and frequent fall during morning assembly and on work up it turned out to be a case of 'Medium chain acyl CoA dehydrogenase deficiency', a common metabolic disorder. Dietary modifications were done and supplements were started and after a few months when we saw the child in OPD again we could not believe how well the child was doing.

2. Under NEEV program, during routine neonatal screening, while measuring the Oxygen saturation (SpO₂) of all four limbs, we were able to pick up a case of Congenital Heart Disease (CHD). Immediately the child was sent to higher centre for a 2D ECHO where the diagnosis was confirmed. Pediatric Cardiology department of a tertiary care hospital was contacted and the child was referred there for further evaluation and management.

In our experience, we have always felt that parents are able to identify obvious problems like symptoms of pneumonia, diarrhea and other common illnesses but cases of subtle developmental delays are often missed by parents in the initial stages as they are not very much aware of what to expect in the growth and development of the child at various

ages. Behavioural disorders like Autism, ADHD, etc are also most of the times missed by parents and they tend to attribute the symptoms to the child's personality, like the child is a bit shy in cases of Autism or very playful in cases of ADHD. Many a times it's very difficult for them to accept that these behaviours can be a telltale sign of any underlying disease. In such cases, observation and screening by a health care professional through structured questionnaires becomes very crucial for further referral and management.

School-based screening under RBSK shows that developmental problems can be identified early when health and education teams work together. RBSK is a well-conceived and impactful program that has significantly strengthened early identification of health conditions among children through systematic school and community-based screening. Building on its strong foundation, the following improvements may further enhance its effectiveness:

1. Enhance quality of screening through regular refresher training of RBSK teams and wider use of standardized, age-appropriate screening tools, with emphasis on developmental and behavioral conditions.
2. Strengthen referral and follow-up mechanisms to ensure children identified during screening are successfully linked to diagnostic and treatment services.
3. Ensure inclusion of vulnerable and migrant children by adopting flexible screening approaches.
4. Increase parental and teacher awareness and counselling to reduce stigma, improve understanding of screening outcomes, and encourage timely care-seeking.
5. More research to analyze the effect and impact of this screening and early intervention strategies.
6. Utilize program data more effectively and regular audits for monitoring, identifying gaps, and planning targeted evidence based improvements.
7. Gradually include mental health and adolescent health screening to address emotional and behavioral issues early.

Seeing a child early, supporting them early, and standing by them early can change a lifetime. **Timely identification and prompt support in early childhood can significantly alter developmental trajectories and long-term life outcomes of young children.**

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SPOT LIGHT - EARLY INTERVENTION UNDER RBSK

FROM TUBE TO ORAL FEEDING: ROLE OF EARLY FEEDING & SPEECH-LANGUAGE INTERVENTION

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Brief Narrative

Working as a Speech-Language Pathologist at a hospital-based Centre of Excellence and Early Intervention Centre (COE – EIC) has provided opportunities to visit NICU (through referrals by neonatologists) for feeding-related interventions. Being embedded within a hospital setting, it has enabled early intervention services to extend into the NICU, allowing feeding and developmental support for preterm infants to begin during the neonatal phase itself.

In routine NICU practice, feeding difficulties are often the earliest developmental concerns identified in preterm infants. Many neonates begin life dependent on tube feeding as part of essential medical management. However, the transition from tube feeding to oral feeding and eventually to breastfeeding is a complex developmental process. Early intervention initiated within the NICU supports these transitions in a structured and preventive manner. A multidisciplinary, team-based approach involving Pediatricians/Neonatologists, Speech-Language Pathologists, and Occupational Therapists, working in close coordination with nursing staff, plays a crucial role. We, as Speech-Language Pathologists focus on oral readiness, feeding coordination, safe swallowing, early communication, and caregiver counselling—particularly to support the transition from tube feeding to oral feeding and breastfeeding.

Our clinical experience in NICU, highlights that through regular NICU visits and follow ups, the NICU graduate “warriors” benefit from early oro-motor stimulation and speech-language stimulation, gentle auditory exposure, caregiver voice, and early interaction promote alertness, engagement, and developmental readiness.

Following NICU discharge, continuity of care through structured referrals to Child Development Centre (CDC) & (COE – EIC) ensured ongoing developmental monitoring. Many infants who received timely NICU-based feeding intervention and consistent follow-ups (after discharge) to our Centre demonstrated improved developmental progress with respect to feeding and Speech-language development.

NICU feeding intervention experience: A NICU Warrior’s Journey

One child XYZ of NICU, preterm (28 weeks) was referred to us for feeding assessment & intervention. The child was on tube feeding and had poor oral reflexes. As SLPs team, through regular oral stimulation, cue-based feeding and care giver counselling, we managed the child to be weaned - off from tube feeding & was transitioned orally (with intermittent breastfeeding and spoon feeding) within NICU stay which lasted for 3 months. Post discharge, child is on regular follow ups for speech and language therapy and to achieve age-appropriate feeding skills. Currently, child is 3 years old with normal feeding skills and is able to express himself in sentences.

“This child has truly proved as one of our NICU warrior”

PRE



POST



Key Takeaway

Early intervention beginning in the NICU, supported through coordinated team, integrated referral pathways, administrative support, and sustained follow-up system that includes Speech-Language Pathologists (SLPs) is essential for enabling safe feeding transitions and improving long-term developmental outcomes in preterm infants.

SPOT LIGHT - EARLY INTERVENTION UNDER RBSK

THE SPACE BETWEEN IDENTIFICATION AND SUPPORT: UNDERSTANDING THE CONVERSATION GAP IN EARLY INTERVENTION

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Across public health systems, considerable effort has been invested in expanding mechanisms for developmental screening and early identification. As a result, many children are now flagged as “at risk” at one or more points during early childhood, during routine health visits, school-based screening, or community-level interactions. Yet clinical experience suggests that identification, by itself, is rarely sufficient to ensure timely engagement with early intervention services.

The period following identification often represents a fragile phase in the child’s care. Families may receive verbal advice, written referrals, or general reassurance, but these steps do not always translate into sustained follow-up and coordinated action. For caregivers, the meaning of being told that a child is “at risk” may remain unclear, particularly when concerns are described as mild, evolving, or requiring observation over time. In the absence of structured guidance, families are frequently left to navigate next steps on their own.

From a practical standpoint, referrals can be difficult to interpret and even harder to traverse. Families may be unsure about where to go, whom to approach, or how urgently to act. Appointments may be spaced far apart, services located at different facilities, or eligibility processes perceived as complex. For families facing socioeconomic constraints, caregiving burdens, or competing priorities, these challenges can result in missed opportunities for timely engagement, even when motivation to seek help exists.

How the Gap Appears in Real Life

In everyday clinical work, this gap often becomes visible in subtle ways. Families may arrive at a tertiary centre with a referral note that is several months old, uncertain about why it was given or what was expected of them in the interim. Some caregivers recall being told to “wait and watch,” while others were reassured that the child might “grow out of it.” In such situations, the absence of a clearly communicated follow-up plan can delay engagement even when services are available.

Developmental concerns also compete with immediate day-to-day demands. Travel distance, loss of wages, caregiving for other children or elderly family members, and limited familiarity with specialised services can make follow-up feel overwhelming. When guidance is not structured and proactive, early identification risks becoming a one-time event rather than the beginning of a supported journey.

When Worry Meets Uncertainty

Awareness of developmental milestones varies widely. Early differences in speech, social interaction, or behaviour may initially be interpreted as normal variation. Statements such as “he will talk later,” “she is just shy,” or “boys are naturally more active” often reflect attempts to reassure rather than dismiss concerns, but they can delay the decision to seek further evaluation.

Being told that a child may have a developmental delay can be emotionally complex. Some families experience anxiety but remain unsure about urgency. Others interpret reassurance as an indication that action can be postponed. Without clear and repeated communication about why early intervention matters and how to access it, motivation can fluctuate and follow-through may weaken over time.¹

Social stigma around developmental disorders can further shape responses. Fear of labelling, uncertainty about long-term implications, and concerns about social perceptions may lead families to hesitate even when services are accessible. In some families, denial or fear of diagnosis becomes an emotional barrier to early engagement.

Cultural beliefs also influence how developmental differences are understood. Variations in temperament or behaviour may be attributed to personality, fate, or gender norms—for example, higher activity levels being considered typical in boys, or quietness in girls being seen as a personality trait rather than a communication concern. These interpretations often arise from differing frameworks of child development rather than lack of care.

Barriers That Are Often Invisible

Health-system interactions during this phase also influence continuity. Advice to “wait and watch,” particularly when not accompanied by structured follow-up, may be interpreted as a signal that immediate action is unnecessary. Access to trained developmental specialists remains uneven, and services may be concentrated in selected centres, requiring families to travel or navigate unfamiliar systems.

Financial considerations can also affect care seeking. Some families exhaust resources seeking private consultations before reaching public-sector services, leading to pauses in care due to cost or fatigue. For families in rural and urban slum areas, travel and time constraints further complicate sustained engagement.

Connecting the Dots after Identification

Primary care providers are often the first point of contact for developmental concerns. While awareness of developmental screening is growing, integration into routine visits varies, and referrals may sometimes be delayed simply because developmental issues compete with more immediate medical priorities.

The challenge, therefore, lies less in detection and more in conversion ensuring that early identification leads smoothly into sustained engagement with appropriate services. Even where screening and referral mechanisms are in place, families may experience each interaction as a separate episode rather than part of a connected continuum of care.²

Strengthening this continuum does not always require entirely new services. Often, it involves improving linkages: clearer referrals, defined points of contact, scheduled follow-

up after screening, and consistent messaging across providers. Small improvements in continuity can reduce uncertainty and prevent incremental delays.

Moving Forward

Bridging the space between identification and intervention calls for attention to the processes that connect screening with care. Early intervention systems are most effective when families feel supported not only in recognizing developmental concerns but also in navigating the path forward.³ Ensuring that identification is paired with guidance and follow-up can help transform early detection from a single event into the starting point of meaningful and life-altering intervention.

SPOT LIGHT - CHILD HEALTH PROGRAMME

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With the objective, vision and target to reduce Child Mortality & Morbidity by monitoring of Mortality Indicators as per Sample Registration System Report of Registrar General of India (SRS), viz. Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR), Under Five Mortality Rate (U-5 MR) to single digit levels. Child Health Section at Directorate of Family Welfare, GNCT- Delhi is working and striving to approach towards the set targets through following programs mandated under National Health Mission's Child Health program.

Under Rashtriya Bal Swasthya Karyakram (RBSK)

Facility level RBSK being implemented in Delhi is as follows:

a) Comprehensive Newborn Screening (CNS) under Mission NEEV (Neonatal Early Evaluation Vision) carried out screening, identification and management of metabolic and visible birth defects (VBDs) under RBSK, in 56 designated public health delivery points for newborns. Point of Care Screening and or Testing for VBDs specifically for Cleft Lip and Palate, Clubfoot, Neural tube defects, Developmental Dysplasia of Hip (previously known as Congenital Dislocation of Hip), Critical Congenital Heart Disease (through Pulse Oximetry), hearing screening for early detection of Congenital Hearing Loss/ Deafness (through Oto Acoustic Emission-OAE), Retinopathy of Prematurity (ROP) screening and Metabolic screening of Congenital Hypothyroidism, Congenital Adrenal Hyperplasia, Thalassemia, Sickle cell anemia, Another Hemoglobinopathies detected by the Dried Blood Spot test sent out to the lab. Total 127289 newborns have been screened out of 140879 live births during April 2025 to January 2026 in F.Y. 2025-26 under Mission NEEV.



(Picture 1 Courtesy: Mission NEEV, MAMC & LNH; Dried Blood Spot (DBS) sample collection, DBS card, OAE, Pulse Oximetry)

b) District Early Intervention Centers (DEICs):

currently 4 Early intervention centers (EICs) are functional for management of children detected with 4Ds (i.e. Defects, Deficiencies, Diseases, Developmental Delays & Disabilities). Centre of Excellence Early Intervention Center at Lok Nayak Hospital (COE-EIC-LNH) is operational since



October 2021 and managed 14078 children till February 2026 in F.Y. 2025-26, DEIC at Swami Dayanand Hospital managed 24423 children, and DEIC at Guru Gobind Singh Govt. Hospital managed 6772 children till February 2026 in F.Y. 2025-26.

DEIC at Chacha Nehru Bal Chikitsalya functional since 23rd September 2025, managed 1249 children till February 2026 in F.Y. 2025-26. (Picture 2 Courtesy: COE-EIC at Lok Nayak Hospital)

Interventions for Newborns: Under Hospital level Activities

- For strengthening of **Newborn care corners (NBCCs)** to ensure Essential newborn care at every 'delivery' point at time of birth by provision of infrastructure and skilled human resource; Navjaat Shishu Suraksha Karyakarm (**NSSK**) trainings for Medical Officers and Nursing personnel, 2 batches each were conducted at hospital facilitated by Health and

Family Welfare Training Center, DFW at Chacha Nehru Bal Chikitsalay (CNBC) and Lal Bahadur Shastri Hospital in F.Y. 2025-26.

- **Facility based Neonatal Care (FBNC):** There are 34 FBNCs approved under NHM in F.Y. 2025-26 with varying capacities of set-ups like Special newborn care units (SNCUs), Neonatal Intensive care units (NICUs), Kangaroo Mother care (KMC), Lactation Management Unit (LMUs) at District hospitals and Medical Colleges level are functional. 2 batches of **FBNC Training** (4 days classroom + 12 days observership) were conducted by the State in F.Y. 2025-26 at CNBC, Lok Nayak Hospital and Swami Dayanand Hospital. Training for sensitization of FBNC online portal for doctors, nursing personnel and CDEOs were also conducted wherein facilitator from Child Health Division, MoHFW, GoI were also invited to take the sessions.



Picture 3 SNCU Portal training in UTCS, GNCTD, Karkardooma

- Hospitals with high delivery load are encouraged to establish **Lactation Management Unit (LMUs)** for provision of expressed mother's own breast milk suitable for feeding sick, preterm and low birth weight babies, currently there are 5 functional LMUs at BSAH, CNBC, SDNH, LNH and BMH. More LMUs are expected to be established soon at BJRMH and SGMH. 40642 mothers received Lactation Counseling; 4725 mothers used LMU facility for Expression of breastmilk; 881.585 liters of expressed breastmilk (EBM) was collected and 3919 newborns / infants received expressed breastmilk from own mothers using LMU facility at 5 LMUs in Delhi at BSAH, CNBC, SDNH, LNH and BMH till Q-3 F.Y. 2025-26.
- **National Newborn Week** was celebrated from 15th to 21st November 2025 with the Theme of "Newborn Safety: Every Touch, Every Time, Every Baby". 5 days State Level

Webinar Series was conducted on the occasion of National Newborn Week- 2025. Awareness sessions were held in hospitals on National Newborn Week-2025 for parents and care givers. 1391 number of Doctors, Staff Nurses and Health workers participated in the orientation at District level during National Newborn Week. 36 FBNC (SNCU/NICU/MNCU/NBSU) facilities conducted MusQan baseline or facility level assessments and 39 FBNC conducted prescription audit for antibiotic usage during period (15 to 21 November 2025) of National Newborn Week 2025.



Picture 4 – State Level Webinar on National Newborn Week (Above) ,Hand hygiene activities conducted for caregivers in hospitals (Below)



- **Mother's Absolute Affection (MAA) programme:** To improve and promote the breastfeeding and child feeding practices. Early initiation of breastfeeding (within an hour of birth) rate is 79.19% till Q-3 F.Y. 2025-26. (Source: HMIS Portal).
- 4 batches of 24 participants each for Infant & Young Child Feeding (IYCF) trainings (4 days duration) were conducted by the State, for capacity building of health personnel to increase awareness and emphasis on exclusive breastfeeding till 6 months of age

and age optimal complementary feeding practices, through community engagement by ASHA worker and health care providers at health facilities and IYCF centers in hospitals. At community level, mothers' meetings are conducted by ASHA & ANM under MAA program. 13946 mothers' meetings were conducted by ASHAs till December 2025 (till Q-3 F.Y. 2025-26) and 143840 mothers (including 71278 pregnant women and 72672 lactating mothers) participated in these meetings.



Picture 5 : Mother meeting being held by ASHA at Anganwadi Centre

- **World Breastfeeding Week (WBW) 2025** was celebrated from 1st to 7th August 2025 in Delhi wherein activities to augment and intensify awareness about supporting Breastfeeding were undertaken at health facility and community level. Pledge was taken by health care providers, mothers and care givers in different types of health facilities and community set-up like Anganwadis to support breastfeeding. Various IEC and IPC activities were carried out like Pledge taking, Poster Making, Board stamping activity by parents, Healthy baby shows etc. to ensure acceptance of a healthy life choices just after birth the of the baby and beyond.



Picture 6 Activities undertaken to support breastfeeding during World Breastfeeding Week- 2025)

Child Health interventions

- **Nutrition Rehabilitation Center (NRC):** For facility-based management of children with Severe Acute Malnutrition (SAM), currently there are 5 functional NRCs in Delhi at Hindu Rao Hospital, Kalawati Saran Children Hospital, Bhagwan Mahavir Hospital,

Lok Nayak Hospital and Chacha Nehru Bal Chikitsalya in Delhi. Total sick SAM child admissions in 5 NRCs till Q-3 F.Y. 2025-26 were 1601. Recently, children with Moderate Acute Malnutrition may also be admitted in NRCs

- **STOP Diarrhoea Campaign 2025** implemented by state for promoting use of ORS and Zinc by creating awareness among community to identify the danger signs and initiate timely remedy, thus reducing morbidity and mortality due to childhood diarrhoea.

During two-month long campaign in June till 31st July 2025, 1250346 under five children were pre-positioned with ORS packets by the ASHAs and various IEC and IPC activities were carried out. Sensitization and refresher trainings were carried out at State, district, and Hospital level. Anganwadi, School level activities were carried out to raise awareness on hand hygiene and nutrition component.



(Picture 7 ORS -ZINC Corners established in facilities, ORS Prepositioning in the Community – 1250346 under 5 children were prepositioned with ORS in Delhi, IEC in Community, Health talk & Hand-Washing Demonstration in AWC)

- **Social Awareness and Actions to Neutralize Pneumonia Successfully (SAANS)** initiative for reduction of childhood morbidity and mortality due to Childhood Pneumonia. The three and half months long SAANS campaign from 12th November 2025 has just concluded on 28th February 2026. Activities were carried out in the community to bring about awareness among the parents and caregivers through ASHA workers to identify the age-appropriate danger signs and symptoms of Pneumonia in children, to follow protection and prevention strategies through optimal IYCF practices, vaccination and avoiding indoor pollution etc. SAANS corners are established at health facilities with easy and prompt access to pulse oximeters, Nebulizers and requisite medicines Mass Media IEC activities were carried out in Delhi. 2 batches of SAANS training were conducted at State level at Burari Hospital.



Picture 8 – Mass Media activities SAANS State Level Training in Burari Hospital , GNCTD

- **Conduct of F-IMNCI and IMNCI training are facilitated by the State and districts.** State in collaboration with HFWTC and hospitals, conducted one batch of Training of Trainers (TOT) on Facility based Integrated Management of Neonatal and Childhood Illnesses (F-IMNCI) and one batch of State F-IMNCI training at Swami Dayanand hospital. State also conducted one batch of TOT on Integrated Management of Neonatal and Childhood Illnesses (IMNCI) at Dr. Baba Saheb Ambedkar Hospital. Several

batches of District level IMNCI trainings for Medical Officers, Nursing Officers and ANMs were conducted by districts. These trainings help in capacity building and empowerment of health personnel posted in facilities to frontline workers to screen, identify, manage and or refer for timely intervention in case of sick children encountered in community/ primary health facility.



Picture 9 – F IMNCI training in SDN Hospital , MCD

- **Child Death Review (CDR) Mechanism** is functional in Delhi. Conduct of District CDR committee meetings (DCDR) and State level task force for CDR (STF-CDR) meetings, to assess and implement various strategies to reduce child mortality.

One such fruitful intervention was borne out of STF-CDR meeting in year 2023 whereby, services of safe Neonatal Transport Ambulance was initiated in Delhi w.e.f. October 2024, in collaboration with CATS ambulance by the efforts undertaken by the then Director and SPO-CH, DFW.

DCDR meetings undertaken by the districts under the chairpersonship of CDMO or District Magistrate help in identification and resolution of local issues leading to under five child deaths. MPCDSR portal update by districts and hospitals is being done.



(Picture 10 - Last State level task force for CDR (STF-CDR) meeting was held on 4th July 2025 under the chairmanship of the worthy Secretary (H&FW), GNCT Delhi

DISTRICT BUZZ

Dr. Aradhana kumari¹

Dr. Rajni saini²

District Child Health Officer¹

CDMO North West²

Background

The district faced significant child health challenges, including high home and in-transit child deaths, widespread anaemia, and a substantial burden of acute malnutrition, compounded by limited access to quality healthcare in underserved areas. To address these issues, the North West District adopted a comprehensive and integrated approach under child health programs, focusing on early risk identification, strengthened preventive and promotive services, timely treatment, and community-based interventions. These targeted efforts have improved healthcare access and contributed to better child health outcomes and a reduction in preventable child deaths.

Key Interventions

1. Cascade Training of Health Personnel

Cascade training programs were conducted for Medical Officers, PHNOs, ANMs, and CDEOs focusing on Child Death Review (CDR), Mother's Absolute Affection (MAA) for breastfeeding and adequate complementary feeding promotion, and screening and management of malnutrition to ensure standardized and effective child health practices across all levels.



2. Capacity Building of Frontline Workers

ASHAs and Anganwadi Workers (AWWs) were trained in the early identification of children with Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM), timely referral and treatment of sick children in case of diarrhoea, pneumonia and other paediatric diseases along with regular follow-up to improve child survival outcomes.



3. Strengthening Child Death Review Mechanism

Monthly Child Death Review (CDR) meetings were conducted at the district level and chaired at the District Magistrate (DM) level, with focused discussions on key child health indicators such as early initiation of breastfeeding within one hour, verbal autopsy, and accurate reporting to identify systemic gaps and corrective actions.



4. Anaemia Control through T4 Strategy (test, treat, talk, track)

A total of 9 T4 camps were conducted covering a total of approximately 4000 children in which cases of mild and moderate anaemia were given treatment and around a total of 43 cases of severe anaemia referred to higher centre.



5. IEC and BCC Activities

Regular Information, Education, and Communication (IEC) and Behaviour Change Communication (BCC) activities were organized, including Healthy Baby Shows, Nukkad Nataks, quiz competitions, and Focus Group Discussions (FGDs) to promote healthy child care practices and improve community awareness.



6. Implementation of State and National Programs

Effective implementation of state and national child health initiatives, including SAANS (Social Awareness and Actions to Neutralize Pneumonia Successfully), was ensured to strengthen preventive and promotive child health services at the community and facility levels.



7. IMNCI Training was conducted in 04 batches

IMNCI training was conducted during the year 2025–26. A total of 04 training batches were organized, in which 25 Medical Officers and 08 LHVs, 02 PHNO & 60 ANMs were trained. The training aimed at strengthening skills for effective management of neonatal and childhood illnesses as per IMNCI guidelines.

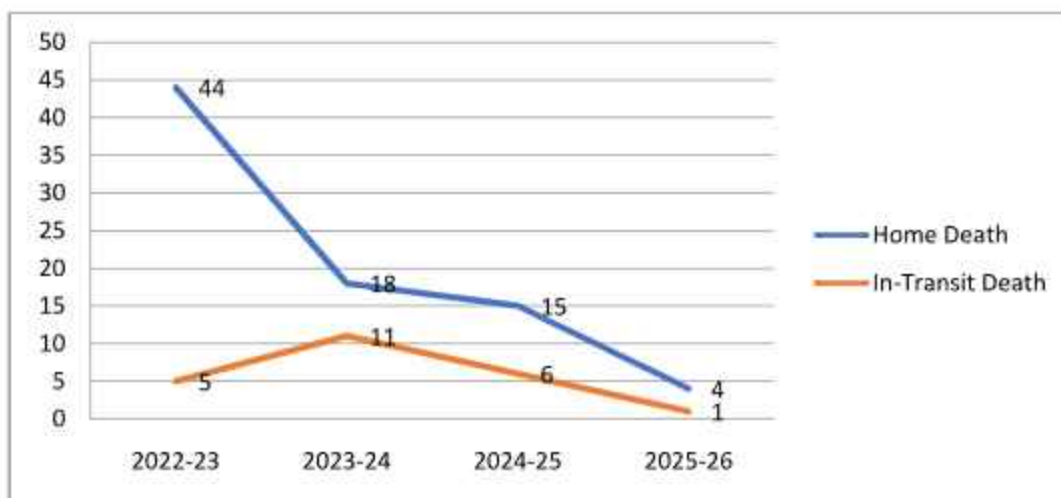
The training has enhanced the capacity of health staff for improved child health service delivery.



Achievements

1. Reduction in Home and In-Transit Deaths

A notable decrease in the number of home and in-transit child deaths was observed due to improved early identification, timely referral, and strengthened emergency response mechanisms.



2. Improved Reporting of Verbal Autopsies

There was a significant increase in the number of verbal autopsies reported by both health facilities and community-level functionaries, leading to better analysis of causes of child deaths and informed corrective actions.

3. Enhanced Management of SAM and MAM Children

An increase was recorded in the number of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) children being identified, followed up, and treated, resulting in improved nutritional outcomes.

4. Expansion of T4 Camps for Anaemia Control

The number of T4 (Test, Treat, Talk, Track) camps conducted increased substantially, strengthening anaemia screening, treatment, counseling, and follow-up among children and adolescents.

Conclusion

Through focused planning, capacity building, and strong community engagement, the north -west district has made measurable progress in improving child health outcomes. The reduction in preventable deaths, improved nutritional management, strengthened anaemia control, and enhanced reporting mechanisms reflect the effectiveness of integrated interventions and the district's continued commitment to ensuring better health and survival for every child.

AWARDS & ACHIEVEMENTS

1. Establishment of District Early Intervention Centre (DEIC) at Chacha Nehru Bal Chikitsalaya (An Autonomus Institute under Government of Delhi)

Dr. Mamta Jajoo

Miss. Vasundhara Rana

Dr. Mohd. Afsar

Dr. Manoj Malhotra

Miss. Kiran Kriti

TEAM DEIC, CNBC, Delhi

Introduction:

Developmental disorders affect approximately 10% of the paediatric population, with a higher burden among high-risk newborns. In India with more than 1000 Sick Neonatal Care Units (SNCU), survival of preterm have been increased to more than 70 percent but almost 5-10% of had severe impairment. Delayed recognition and fragmented care often result in long-term disability and increased socio-economic burden on families and society.

Early intervention is crucial to minimise disability and enhance child development, as plasticity, the ability of the brain to affect structural and functional changes caused by external and internal influences is at its peak in the birth to 2-year period. Additionally, the malleability of the developing brain at this stage makes it possible to bring about these changes. If the child misses this opportunity, further learning will be slow or inadequate. The idea behind early intervention is to intervene early and minimize disability. The adverse effect of failing in early identification and early intervention can lead to irreversible developmental damage.

The DEIC addresses this critical gap by providing timely, integrated, and multidisciplinary intervention during the most crucial years of brain development, when neuroplasticity is at its peak.



The District Early Intervention Centre (DEIC) at Chacha Nehru Bal Chikitsalaya was inaugurated on 25 September 2025 at the Delhi Secretariat. It represents a significant advancement in the delivery of comprehensive early childhood healthcare services in Delhi. Established under the Rashtriya Bal Swasthya Karyakram, the



centre is dedicated to the early identification and management of developmental delays and disabilities among children from birth to six years of age and has been fully operational since then.

The DEIC Model: Key Features

The DEIC at CNBC provides **comprehensive, multidisciplinary care under one roof**, including:

- **Medical assessment:** Diagnosis using the “4 Ds” framework
- **Psychological services:** Developmental, behavioural, and cognitive assessment
- **Therapy services:** Occupational therapy, speech and language therapy
- **Special education:** Early learning and developmental stimulation
- **Screening services:** Audiology (OAE/ABR), vision assessment
- **Support services:** Dental care, social work, caregiver counselling

The centre represents a significant step toward addressing developmental disorders in early childhood through a structured, multidisciplinary, and family-centred approach.

At DEIC, children are referred from hospital outpatient departments, peripheral health facilities, and community-based programmes.

The care pathway begins with a detailed clinical assessment by a paediatrician, including neurological examination, growth monitoring, and nutritional evaluation. Children are assessed within the framework of the “4 Ds”—defects at birth, deficiencies, diseases, and developmental delays including disabilities—ensuring a holistic understanding of their health needs and formulation of individualized care plans.

Subsequent multidisciplinary interventions include psychological assessment for cognitive, behavioural, and adaptive functioning; occupational therapy for motor development, sensory integration, posture, balance, and activities of daily living and functional independence through evidence-based approaches such as neurodevelopmental therapy and biomechanical interventions. Caregivers are actively trained in home-based rehabilitation strategies, positioning techniques, and the use of assistive devices.



Special educators provide individualized early learning interventions focusing on communication, play, social interaction, and pre-academic skills. Evidence-based practices, including behaviour modification strategies and elements of Applied Behaviour Analysis for children with autism spectrum disorders, are incorporated as appropriate, while also guiding families on inclusive education pathways and disability certification processes.



Audiology and speech-language services include hearing screening (OAE, ABR, audiometry), speech and language assessment, and therapy for communication and feeding disorders, including the use of augmentative and alternative communication where indicated. Vision screening and management are conducted by optometry services, ensuring early detection of refractive errors, amblyopia, squint, and cerebral visual impairment, with appropriate referrals to ophthalmology when required.



Dental care and preventive oral health services further contribute to comprehensive child health.

A key strength of the DEIC is its family-centred approach. Caregivers are actively engaged through counselling, training in home-based interventions, and guidance on stimulation, positioning, and daily care practices. Social workers play a crucial role in linking families to government welfare schemes, facilitating disability certification, and addressing socio-economic barriers that may hinder continuity of care.



The seamless functioning of the centre is ensured by trained nursing staff, who coordinate patient flow, assist in clinical processes, maintain records, and ensure effective follow-up. This integrated model eliminates the need for multiple referrals and long waiting times across departments, thereby improving service accessibility and adherence.

Since its inception, the DEIC at CNBC has provided services to more than 800 children, underscoring both the demand for and the impact of such integrated early intervention services. By reducing delays in diagnosis and initiating timely interventions, the centre contributes significantly to improved developmental outcomes and reduction in long-term disability.

In a setting where awareness and access to early intervention services remain limited, the DEIC serves as a model of efficient, equitable, and patient-centred care. It exemplifies how strengthening early childhood services within the public health system can yield long-term benefits for individuals, families, and society.

By delivering comprehensive services under a single roof, the DEIC significantly reduces the need for multiple hospital visits, minimizes delays in diagnosis and intervention, and enhances adherence to long-term therapy plans. This integrated model ensures that children receive timely, coordinated, and continuous care, leading to improved developmental outcomes.

The DEIC at Chacha Nehru Bal Chikitsalaya stands as a testament to the Government of Delhi's commitment to child health and development—ensuring that every child receives the opportunity to achieve their full potential through timely and appropriate care.

Programmatic Performance Indicators (September 2025 – February 2026)

Table 1. Service Coverage and Utilisation

Indicator	Value
Total children registered	742
New registrations per month (median)	120
Age group 0–3 years (%)	48%
Age group 3–6 years (%)	52%
Male : Female ratio	1.4 : 1
Referrals from CNBC OPD	55%
Referrals from other public facilities	30%
Community/other referrals	15%

Table 2. Multidisciplinary Service Uptake

Service Component	Children
	Receiving Service (%)
Paediatric evaluation	100%
Psychological assessment	78%
Occupational therapy	80%
Special education	80%
Speech and language therapy	30%
Audiology screening	40%
Vision assessment	80%
Dental services	25%
Social work counselling	90%

Impact and Health System Significance

The above indicators highlight the **high service uptake, though its very less time to comment on indicators like follow-up adherence, and early measurable improvements** among enrolled children.

The DEIC model demonstrates several critical health system advantages:

- **Improved access:** Single-window delivery reduces fragmentation of care
- **Early diagnosis:** Structured screening ensures timely identification of developmental disorders
- **Continuity of care:** High follow-up rates support sustained intervention
- **Family empowerment:** Caregiver training improves adherence and home-based outcomes
- **Equity in care:** Public sector provision ensures affordability and inclusiveness

Conclusion

Since its inception, the DEIC at Chacha Nehru Bal Chikitsalaya has emerged as a comprehensive, child-centred hub for early identification and intervention. By bridging critical gaps in developmental care and aligning with national child health priorities under Rashtriya Bal SwasthyaKaryakram, the centre is contributing significantly to improved developmental trajectories and reduced long-term disability.

The DEIC stands as a model of integrated, equitable, and evidence-based care—demonstrating that **timely intervention in early childhood can transform lives and strengthen the foundation of a healthier society.**

“Nurturing every child’s potential—one step earlier, one step closer to a brighter tomorrow.”

2. Lactation Management Unit in Bhagwan Mahavir Hospital, Pitampura , GNCTD

Dr Aman Pratap Singh (Hod-Paeds)

Dr Pradeep Kumar Kanaujiya (Specialist)

Dr Menaxi Rohilla (SMO)



Department of Pediatrics, Bhagwan Mahavir Hospital, Pitampura , GNCTD.

The National Health Mission has taken the initiative to establish Lactation Management Centers of secondary and tertiary level public health facilities to provide lactation support for mothers who can or can eventually breastfeed and for provision of mother's own milk for sick and preterm newborns.

Mother own milk Reduces mortality and morbidity, decreases infections ,reduced length of hospital stays , Improves neurodevelopment in vulnerable infants, nutritional benefits-provides essential nutrients and antibodies against illness and reduces cost on the health system.

Bhagwan Mahavir Hospital has 12 beded Special newborn care unit with more than 3000 live births reported in financial year 2024-25. 924 newborns were low birth weight and 259 preterm born in Financial year 2024-25. In view of the above the initiative of establishment of Lactational Management unit was taken up at Bhagwan Mahavir Hospital.The Lactational management unit became operational from 16th June 2025.

120 mothers have availed the facility of Lactational Management unit since operationalization by December 2025.



Counselling session in LMU by staff nurse.

Experience sharing

Kalpana, a new mother who struggled to breastfeed her baby, she was anxious and frustrated after multiple attempts to latch him onto her breast. The LMU team at the hospital noticed her struggles and offered support.

The staff nurse, Mrs. Anupama, spent quality time with Kalpana, addressing her concerns and demonstrating proper latching techniques. With gentle guidance, Kalpana successfully breastfed her baby, and both felt a sense of confidence & satisfaction.

3. STATE EVIN AND U-WIN REFRESHER TRAINING BY IMMUNIZATION SECTION, DFW (10 & 11 FEB 2026)



ASHA Felicitation during state eVIN and U-WIN refresher training



Special address by Director, DFW during state eVIN and U-WIN refresher training



Felicitation of vaccinators during state eVIN and U-WIN refresher training



Felicitation of ASHAs during state eVIN and U-WIN refresher training



Group Photo during state eVIN and U-WIN refresher training



Felicitation of Delivery points during state eVIN and U-WIN refresher training



Felicitation of District Vaccine Store Managers during state eVIN and U-WIN refresher training



Felicitation of District Immunization Officers during state eVIN and U-WIN refresher training



Felicitation of Cold Chain Handlers during state eVIN and U-WIN



Felicitation of VCCMs during state eVIN and U-WIN refresher training

4. Successful Launch of HPV Vaccination

The Immunization Section successfully launched the HPV vaccination campaign with the Hon'ble Chief Minister at GTB Hospital on 28th February, alongside the national rollout by the Hon'ble Prime Minister. The campaign offers a single-dose Gardasil-4 vaccine to 14-year-old girls, protecting against cervical cancer—one of the leading cancers among women in India. Eligible beneficiaries can register through the U-WIN portal. Exclusions include pregnancy, prior vaccination, severe allergy, moderate/severe illness, and those outside the target age group. After the 3-month campaign, it will be integrated into the routine immunization programme.



5. Successfully Released the inaugural edition of Health Samvaad

The Directorate of Family Welfare (DFW), Department of Health & Family Welfare, GNCT of Delhi, successfully released the inaugural edition of Health Samvaad—the first-ever quarterly health newsletter of the Department—at a formal launch event held at the Main Auditorium, Delhi Secretariat. The Directorate of Family Welfare (DFW), Department of Health & Family Welfare, GNCT of Delhi, successfully released the inaugural edition of Health Samvaad—the first-ever quarterly health newsletter of the Department—at a formal launch event held at the Main Auditorium, Delhi Secretariat on 9th January 2026. The launch marked an important milestone in strengthening institutional documentation and knowledge sharing within the public health system. The event was graced by the presence of former Directors DFW, Dr. Monica Rana and Dr. D.K. Dewan, along with current senior functionaries including the Director, DHS Dr. Vatsala Aggarwal and Director, AYUSH Dr Yogita Munjal, reflecting the collaborative and inclusive spirit of this initiative.



FIELD VOICES

ASHA KI JUBANI

This report highlights the successful community-based management of a *low-birth-weight (LBW) newborn with jaundice* through the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) approach. Using systematic assessment, family counselling, and regular home follow-up by frontline health workers, the infant's condition was effectively managed without institutional care.

CASE NO. 1- B/O R , Birth wt. 2.2kg, date of birth 19/12/2025, B/O Ruby born on 19/12/2025 with 2.2kg and Breathing problem baby was in Pvt. Hospital after parents brought baby home against medical advice

PNC/HBNC visit done by ANM (REKHA) and ASHA (Sonijha) with help of form of IMNCI the team assessed the New born baby and with this classified the baby as Low birth weight and jaundice and referred to SPUHC Gopal Nagar But parent refused to go to any facility then was explained all the danger sign poor feeding excessive cry, vomiting, Fast Breathing, Temperature (Fever) and movement only when stimulated as no. movement and convulsion.

Advice given to Mother

1. Continued breastfeeding
2. Visit to medical facility if you see any danger sign as explained
3. Maintain baby's body temperature (Kangaroo Care Explained)
4. Maintain good hygiene (Hand Wash)
5. No Home Medicine or traditional remedies

Result

Baby's General condition is good Baby has No sign of Danger and Jaundice Baby weight is on 17/01/2026 is 3.5kg.

Key Takeaway

IMNCI is not just for referral—it is a comprehensive framework enabling community-level, life-saving care led by frontline health workers.

PRO TIP POINTS

GOLDEN BEGINNINGS: PREGNANCY TO THE FIRST 1,000 DAYS

Dr. Puja Jain

Specialist Grade II obs & gynae
Dr Hedgewar Arogya Sansthan,
Government of NCT, Delhi



A child's developmental trajectory originates prenatally. The first 1,000 days—from conception to age two—represent a critical window for neuro development, immune maturation, and physical growth, during which approximately 90% of neural connections form. Optimal maternal care, evidence-based birth practices, and early infant interventions establish lifelong health foundations, substantially mitigating undernutrition risks.

The Golden Hour: Initial 60 Minutes Post-Birth

The immediate postpartum hour, termed the Golden Hour, optimizes neonatal adaptation and reduces mortality risks. Facility protocols incorporate:

- Skin-to-skin contact to stabilize vital signs
- Breastfeeding initiation within one hour for colostrums delivery
- Delayed umbilical cord clamping (1–3 minutes) to enhance iron reserves
- Thermal protection and monitoring to avert hypothermia

Targeted staff training and checklists yield improved thermo regulation, feeding efficacy, and maternal-infant bonding, thereby elevating survival and lactation outcomes.



The First 1,000 Days: Conception to Age 2

This continuum encompasses:

- Prenatal care: Routine antenatal visits, micronutrient supplementation, and comorbidity management avert low birth weight and prematurity; eight or more visits are recommended.
- Infancy (0–12 months): Exclusive breastfeeding, immunization schedules, and Responsive care giving foster cognitive and immunological development.
- Toddlers (12–24 months): Nutrient-dense complementary feeding, anthropometric surveillance, and stimulation promote motor and language milestones.
- Integrated interventions in maternal nutrition, lactation support, vaccination, and growth Monitoring effectively address stunting and cognitive deficits.

Key Implications for Facility Staff

- Antenatal vigilance directly influences fetal outcomes.
- Adherence to the Golden Hour enhances bonding and lactogenesis.
- Sustained care from conception to age two yields optimal trajectories.
- Inter disciplinary coordination ensures protocol fidelity.



Imperative for Healthcare Professionals

“Systematic interventions from antenatal care through the Golden Hour and early childhood forge resilient futures. Adhere to guidelines and provide empathetic support for every neonate’s optimal trajectory.”

Key Takeaway

Early, continuous, and quality care during pregnancy and the first 1000 days lays the foundation for lifelong health and wellbeing of both mother and child.

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UPCOMING EVENTS

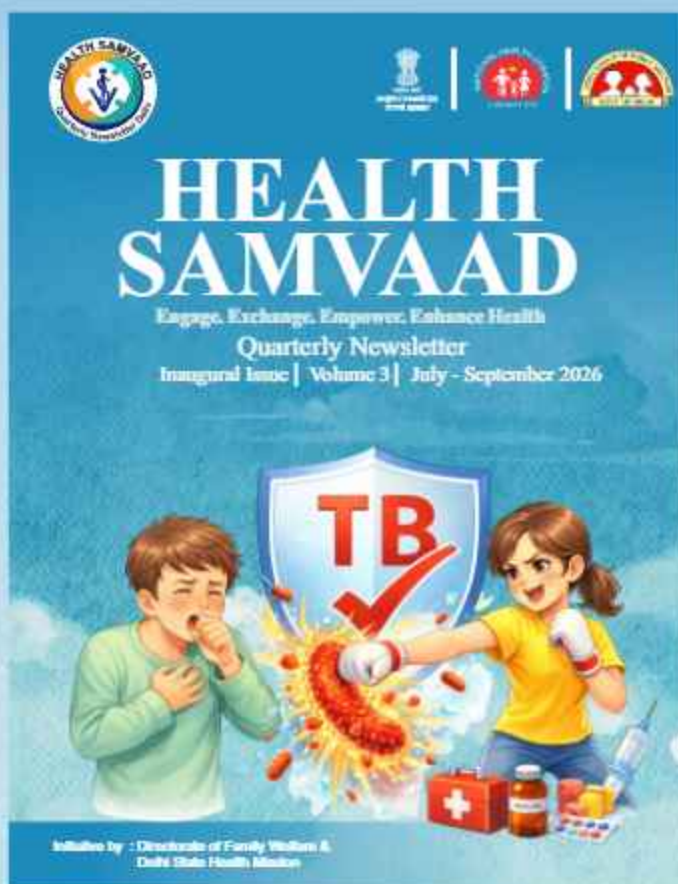
APRIL- MAY

2ND APRIL	<i>"World Autism Awareness Day"</i>
APRIL AND MAY	<i>"T4 camp (Test-Treat-Talk -Track) Anemia camps in schools "</i>
6TH APRIL TO 11TH APRIL	<i>"Vitamin A Supplimentation Drive"</i>
APRIL AND MAY	<i>"HPV campaign through schools based mobilization "</i>
21ST TO 30TH APR	<i>"Special Immunization Campaign on occasion of World immunization week "</i>
APRIL AND MAY	<i>"Safe Motherhood campaign "</i>

JUNE - JULY

1ST WEEK OF JUNE TO 31ST JULY	<i>"Stop Diarrhea Campaign "</i>
JUNE	<i>"World population campaign "</i>

Forthcoming Issue



**Directorate of Family Welfare
Government of N.C.T. of Delhi**