

Operational Guidelines for the integration of

Non-alcoholic Fatty Liver Disease [NAFLD]

into

NPCDCS



Directorate General of Health Services
MoHFW, GOI





डॉ हर्ष वर्धन Dr Harsh Vardhan

स्वास्थ्य एवं परिवार कल्याण, विज्ञान और प्रौद्योगिकी
व पृथ्वी विज्ञान मंत्री, भारत सरकार

Union Minister for Health & Family Welfare,
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Government of India

सबका साथ, सबका विकास, सबका विश्वास
Sabka Saath, Sabka Vikas, Sabka Vishwas

Message

It gives me immense pleasure to note that Operational Guidelines have been developed and are being released to assist in detection and management of Non-Alcoholic Fatty Liver Disease (NAFLD).

Non-Alcoholic Fatty Liver Disease (NAFLD) is a leading cause of Chronic Liver Disease all over the world including India. As per estimates, the prevalence of NAFLD in our country is as high as 9% to 32%. This obviously is alarming because on one hand it causes morbidity and mortality which has social and economic costs in terms of loss of man days and on the other hand increases our expenditure on healthcare impeding socio-economic growth of our country.

In order to ease the implementation of the NAFLD programme, it has been included under the flagship programme of the Government of India for Non-Communicable Diseases namely, "National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)" because of the prevalence of similar risk factors and it is fact that identification of diabetes and obesity by NPCDCS will help in detection of NAFLD in a big way.

The Operational Guidelines have been developed after great deliberations by the experts and will be beneficial to move forward in a systematic manner to tackle the menace of NAFLD.

I wish all the best for rolling out of this program and hope that all concerned stakeholders will follow the guidelines in letter and spirit to create a significant impact on morbidity and mortality due to NAFLD.


(Dr Harsh Vardhan)

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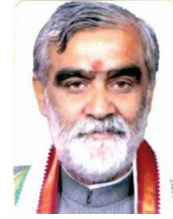
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MESSAGE

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MINISTER OF STATE FOR
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The liver is an important organ in the body which performs many vital functions. Unhealthy lifestyle, obesity, and uncontrolled diabetes are the major contributor to the development of Non-alcoholic fatty liver disease (NAFLD). This is emerging as an important cause of liver disease in India with various epidemiological studies suggesting the prevalence of around 9% - 32% of the general population in India. An even higher prevalence is expected in those with overweight or obesity and those with hypertension, dyslipidemia, diabetes, or pre-diabetes. Once the disease develops, there is no specific cure available, and health promotion and prevention aspects targeting weight reduction, healthy lifestyle, and control of aforementioned risk factors are the mainstays to disease progression and prevent the mortality and morbidity due to NAFLD.

The government of India has realized that existing NPCDCS programme Strategies can be aligned to prevent the NAFLD through lifestyle changes, early diagnosis, and management of associated non-communicable diseases as well as NAFLD. Accordingly, doable actions have been identified with main focus on health promotion and prevention of common NCDs which would also specifically cater to the identified needs of NAFLD. These actions have been consolidated in this guideline document to guide the States/UTs and stakeholders to support the NAFLD initiatives.

Let us have a healthy lifestyle individually and in the family as well as in the community. Healthy living should become a way of life for all the citizens of the country.

जीवेम शरदः शतम्।

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Message

Non-alcoholic fatty liver disease (NAFLD) is emerging as an important cause of liver disease in India with various epidemiological studies suggesting the prevalence of around 9%-32% of the general population in India. An even higher prevalence is expected in those with overweight or obesity and those with diabetes or prediabetes.

Lifestyle-related problems clubbed with a high prevalence of diabetes and obesity is a critical issue both in urban and rural settings in our country. The brunt of attack due to this lifestyle is borne by the liver, which performs many vital functions. These issues lead to the development of NAFLD. Once the disease develops, there is no cure available and health promotion and prevention aspects are the mainstays to prevent the mortality and morbidity of NAFLD.

Existing NPCDCS programme strategies can be aligned to prevent the NAFLD through lifestyle changes, early diagnosis, and management of associated non-communicable diseases as well as NAFLD. Accordingly, doable actions have been identified with main focus on health promotion and prevention of common Non Communicable Diseases i.e. NCDs which would also specifically cater to the identified needs of NAFLD. These actions have been consolidated in this guideline document to guide the States/UTs and stakeholders to support the NAFLD initiatives.

Given the magnitude of NAFLD and its incurability, I urge that prevention, control, and management of NCDs including NAFLD should be implemented in mission mode and have visibility as a people's movement so that healthy living becomes a way of life for all the citizens of the country.

(Rajesh Bhushan)



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Preface

It gives me immense pleasure to present the Operational Guidelines for Non-Alcoholic Fatty Liver Diseases (NAFLD) to be implemented under the existing National Program for Prevention and Control of Cancer Diabetes Cardiovascular Diseases and Stroke (NPCDCS) in India.

Changes in lifestyle particularly dietary habits and sedentary living, rising incidence of obesity and diabetes have all contributed, leading to a smoldering epidemic of lifestyle liver disease known as Non-Alcoholic Fatty Liver Diseases (NAFLD). It is pertinent to note that to date, no effective medical interventions exist that completely reverse this disease and therefore lifestyle changes, dietary alterations remain the mainstay to avert the mortality and morbidity from NAFLD.

It is interesting to note that many of the strategies being implemented under the NPCDCS programme can be utilized to tackle the problem of NAFLD. The present guidelines particularly point out the areas of integration between the NAFLD and NPCDCS program at each level of the health care delivery system and highlights the steps and strategies for the proposed integration.

I request all the stakeholders to implement the operational guidelines. I am sure that working as a team together we can save many precious lives due to this dreaded disease.


14/1/21
(SUNIL KUMAR)





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FOREWORD

Non-alcoholic fatty liver disease (NAFLD) is a common cause of chronic liver disease. NAFLD is characterized by elevated liver enzymes in the absence of alcohol consumption and secondary causes of liver disease. It is an independent predictor of future risk of cardiovascular diseases, type 2 diabetes and metabolic syndrome (hypertension, abdominal obesity, dyslipidemia, glucose intolerance).

This book will be reference guide for health professionals about NAFLD. Each chapter presents information in a simple, structured manner making this text an ideal handbook for supplementing National Program for Cancer, Diabetes, CVD and Stroke (NPCDCS) guidelines. It is apt to make NAFLD part of NPCDCS program for optimising and synergising the activities under National health Mission in the Health care delivery System in India.

I congratulate Prof. Shiv K. Sarin, Director, Institute of Liver and Biliary Sciences, New Delhi, Niti Ayog and the Ministry team for initiating and spearheading this movement about Liver Diseases including NAFLD. At this juncture this is very timely intervention about NAFLD that would save many lives and reduce the premature mortality from NCDs.

(Vandana Gurnani)

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Acknowledgment

At the very outset, I wish to thank Dr. S.K. Sarin, Senior Professor and Director, Institute of Liver and Biliary Sciences (ILBS) for bringing Liver and Non-Alcoholic Fatty Liver Disease (NAFLD) in the centre of Non-Communicable diseases (NCDs) and the suggestion for its inclusion in the National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS). It is under the guidance of Dr. Harsh Vardhan, Honourable Health and Family Welfare Minister and the directions given by Sh. Rajesh Bhushan, Secretary, Health & Family Welfare, that this integration is possible.

Dr. Sunil Kumar, the Director General of Health Services (DGHS) chaired the Committee to draft the Operational Guidelines for integration of NAFLD into NPCDCS and had directed the team to complete the tasks in the minimum time possible without any compromise in the quality. The entire members of the technical committee deserve mention for their hard work and bringing out this document in a record time.

Ms. Vandana Gurnani AS & MD and the entire NHSRC team [in particular, Dr.(Flt Lt). M.A. Balasubramanya, Advisor-Community Process, NHSRC] has been instrumental and supportive in drafting operational guidelines.

National NCD Teams both in the Directorate and the Ministry [Sh. Vishal Chauhan, Joint Secretary (NCD) Dr. Sudhir Gupta, Sr. CMO & Team Lead; Dr. L.Swasticharan, Additional DDG, Dr. Pradip Khasnobis, CMO, Dr. Sunny Swarnkar, Public Health Specialist and Consultants [Dr. Harsavardhan, Dr. Abhishek Khanna, Sh Arvind, Mr.Varadharajan.S] Ms Bindu Tewari, Director, NCD-II. Mr. R.B.Kushwaha, Under Secretary and Mr. Kiran Bala Section Officer. My other team members Poonam and Jitender in my office also deserve special thanks for taking care of the team while they were drafting the Operational Guidelines in our office room.

ILBS Team under the leadership of Dr. Umesh Kapil Professor, LBS along with Dr. Archana Ramalingam and Dr. Neeraj Raizada, Asst. Professor, ILBS deserves special mention for all the technical inputs. Senior Resident Dr. Perna Srivastava's tireless efforts are also duly acknowledged.

We wish to thank each and everyone who had contributed in any way in conceptualization, actual writing, proof reading and printing this Operational Guidelines

Thank you.



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Expert Committee

The following members of the Expert Committee for the inclusion of Non-Alcoholic Fatty Liver Disease within the National Programme for Prevention and Control of Cancer Diabetes Cardiovascular Diseases and Stroke were involved in the finalization and drafting of the operational guideline.

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Acronyms

ANM	Auxiliary Nurse-Midwives
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BMI	Body Mass Index
CBAC	Community Based Assessment Checklist
CHC	Community Health Center
CHO	Community Health Officer
CT scan	Computerized Tomography Scan
CPHC NCD Application	Comprehensive Primary Health Care Non-Communicable Diseases Application
DH	District Hospital
Dte.GHS	Directorate General Health Services
ELF test	Enhanced Liver Fibrosis test
FIB 4 score	Fibrosis-4 score
HCC	Hepatocellular Carcinoma
IEC	Information Education Communication
ILBS	Institute of Liver Biliary Sciences
JAS	Jan Arogya Samiti
LFT	Liver Function Test
MAS	Mahila Arogya Samiti
MPW (F/M)	Multipurpose worker (Female/Male)
NAFLD	Non-Alcoholic Fatty Liver Disease
NASH	Non-Alcoholic Steatohepatitis
NCD	Non-Communicable Diseases
NCoE	National level Center of Excellence
NFS score	NAFLD Fibrosis Score
NHM	National Health Mission
NHSRC	National Health System Resource Center
NIHFW	National Institute of Health & Family Welfare
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke
NPCBVI	National Programme for Control of Blindness and Visual Impairment

NPCHE	National Programme for Health Care of the Elderly
NMHP	National Mental Health Programme
NTCP	National Tobacco Control Programme
MoHFW	Ministry of Health and Family Welfare
PIP	Program Implementation Plan
PHC	Primary Health Center
PBS	Population-based screening
RKS	Rogi Kalyan Samiti
SBCC	Social and Behavioral Change Communication
SCoE	State-level Center of Excellence
SC	Sub-center
USG	Ultra Sonography
VHSNC	Village, Health, Sanitation and Nutrition Committee

Chapter 1: INTRODUCTION

1.1 Definition

Nonalcoholic fatty liver disease (NAFLD) is the buildup of extra fat in liver cells that is not caused by alcohol. In some individuals, NAFLD may further lead to liver inflammation, liver fibrosis and cirrhosis, and liver cancer. It is normal for the liver to contain some fat. However, if more than 5% – 10% % of the liver’s weight is fat, then it is called a fatty liver (steatosis).[1]

NAFLD can be further classified into two sub-categories: nonalcoholic fatty liver (NAFL) and nonalcoholic steatohepatitis (NASH), which are silent diseases with few or no symptoms.

A. Nonalcoholic fatty liver (NAFL)

Simple fatty liver also called nonalcoholic fatty liver is a form of NAFL in which you have fat in your liver but little or no inflammation or liver cell damage. The simple fatty liver typically does not usually progress to cause liver damage or complications.

B. Non-Alcoholic Steatohepatitis (NASH)

NASH is a form of NAFLD in which you have inflammation of the liver and liver cell damage, in addition to fat in your liver. Some of these patients with hepatic steatosis develop hepatic oxidative stress and recruitment of various cytokines, leading to hepatic inflammation and/or fibrosis and thus to NASH, setting the stage for future complications, such as cirrhosis and liver cancer.

1.2 Global Scenario

Nonalcoholic fatty liver disease (NAFLD) is estimated to afflict approximately 1 billion individuals worldwide. NAFLD is a very common disorder affecting and may affect as many as 20-30% of the general population all over the world. About 2 to 5 % of adults and up to 20 % of those who are obese may develop NASH. Several factors contribute to the development of NAFLD or NASH and subsequent Hepato Cellular Carcinoma (HCC) development; these factors include genetic risk factors including a family history of NAFLD or metabolic syndrome and environmental modifiers such as diet, lifestyle, obesity, and the presence of diabetes, hypertension, and dyslipidemia. [2]

1.3 India Scenario

Nonalcoholic fatty liver disease (NAFLD) is emerging as an important cause of liver disease in India. Epidemiological studies suggest the prevalence of NAFLD in around 9% to 32% of the general population in India with a higher prevalence in those with overweight or obesity and those with diabetes or prediabetes.[3] According to NFHS-4 (2015-2016), 18-20% of adults are overweight/obese, 3-8% of adults suffer from deranged blood sugar levels.[4]

There is high prevalence of insulin resistance and nearly half of Indian patients with NAFLD have evidence of full-blown metabolic syndrome. Though oxidative stress is involved in the pathogenesis of NAFLD/nonalcoholic steatohepatitis, serum or liver iron and HFE gene mutations appear not to play a role in the pathogenesis of NAFLD in Indian patients.[5]

1.4 Causes of NAFLD/NASH

NAFLD is part of the metabolic syndrome characterized by diabetes, or pre-diabetes (insulin resistance), being overweight or obese, elevated blood lipids such as cholesterol and triglycerides, as well as high blood pressure. Not all patients have all the manifestations of the metabolic syndrome. Less is known about what causes NASH to develop.

Researchers are focusing on several factors that may contribute to the development of NASH.[6] These include:

- Oxidative stress (imbalance between pro-oxidant and anti-oxidant chemicals that lead to liver cell damage)
- Production and release of toxic inflammatory proteins (cytokines) by the patient's own inflammatory cells, liver cells, or fat cells
- Liver cell necrosis or death called apoptosis
- Adipose tissue (fat tissue) inflammation and infiltration by white blood cells
- Gut microbiota (intestinal bacteria) which may play a role in liver inflammation

1.5 Population at risk

NAFLD is more common in people who have certain conditions, including obesity, and conditions that may be related to obesity, such as type 2 diabetes. Researchers have found NAFLD in 40 to 80 % of people who have type 2 diabetes and in 30 to 90 % of people who are obese.[7]

Available literature shows that the majority of Indian patients with NAFLD have overweight or obese as per Asian Pacific criteria even though they do not have the kind of morbid obesity as seen in patients from the West.[8]

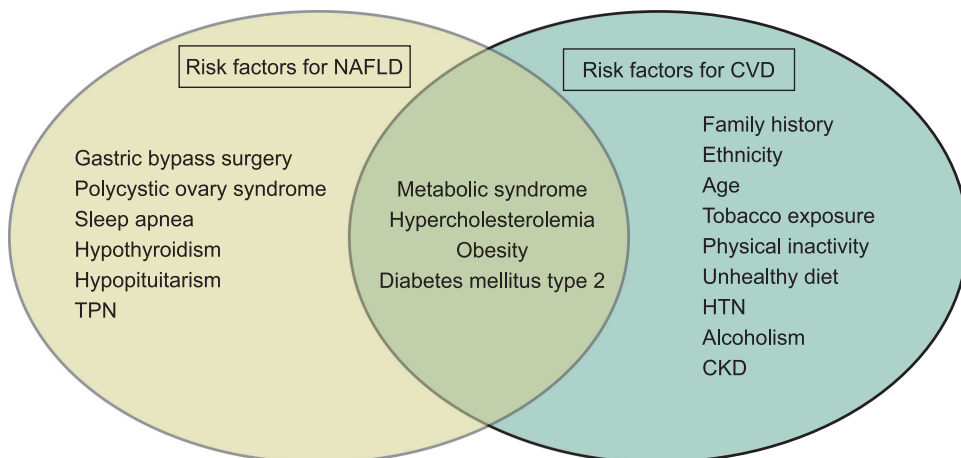
Other differences between Indian patients and those from the West include less metabolic syndrome including its components like diabetes mellitus and hypertension, fewer iron abnormalities and HFE gene mutations, and mild histological disease at presentation in Indian patients. More data is required to substantiate these findings and to prove if NAFLD patients in India are different at presentation.[9]

In research that tested for NAFLD in people who were severely obese and undergoing bariatric surgery, more than 90 % of the people studied had NAFLD.[10]

1.6 Complications of NAFLD and NASH

Most of people with NAFLD have simple fatty liver, and people with simple fatty liver typically don't develop complications.[11] NASH in turn can lead to complications, such as cirrhosis and liver cancer. People with NASH have an increased chance of dying from liver-related causes.[9] If NASH leads to cirrhosis and further complications like fluid in abdomen, altered mentation, jaundice, etc. one may need a liver transplant to survive. Studies also suggest that people with NAFLD have a greater chance of developing cardiovascular disease. Cardiovascular disease is the most common cause of death in NAFLD.[12]

Figure: 1 Confluence of the risk factors for both non-alcoholic fatty liver disease and cardiovascular disease.[13]



1.7 Screening & Diagnosis of NAFLD[14]

The diagnosis of NAFLD is usually first suspected in overweight or obese person who is found to have mild elevations in their liver tests during a routine blood testing or incidentally detected on radiologic investigations such as abdominal ultrasound or CT scan.

Experts are now recommending that every obese child, adolescent, or adult should have these liver enzymes checked. However, NAFLD can be present even if the liver function test within the normal range. The diagnosis of NAFLD is confirmed by imaging studies, most commonly a liver ultrasound, showing accumulation of fat in the liver.

Fat accumulation in the liver can also be caused by excess alcohol intake, certain medications, viral hepatitis, autoimmune liver disease, and metabolic or inherited liver disease. These need to be excluded as causes of fatty liver disease in order to confirm the diagnosis of NAFLD.

Key issues in NAFLD patients are the differentiation of NASH from simple steatosis and identification of advanced hepatic fibrosis. Given the huge number of at-risk patients, there is a substantial unmet need for efficient and cost-effective means for risk stratification of NAFLD patients for these 2 critical endpoints.

Currently, the only reliable way of telling whether a person has NASH or simple fatty liver is by a liver biopsy. In this procedure, a small needle is inserted through the skin after local anesthesia is given to obtain a small piece of the liver for microscopic evaluation. NASH is diagnosed when examination of this piece of liver under the microscope shows fatty infiltration of the liver in addition to inflammation and different degrees of scarring. If only fat is present, then the diagnosis of simple fatty liver is made. The liver biopsy provides essential information regarding the degree of scarring within the liver, which would not be apparent on a blood test, ultrasound, or an x-ray alone. However, liver biopsy for diagnosis of NASH has well-known limitations, including invasiveness; rare but potentially life-threatening complications; poor acceptability; sampling variability; and cost. Furthermore, due to the epidemic proportion of individuals with NAFLD worldwide, liver biopsy evaluation is impractical, and noninvasive assessment for the diagnosis of NASH and fibrosis is needed.

The vast majority of NAFLD patients, however, will not progress, only a minority, namely those with NASH and advanced hepatic fibrosis, are at greatest risk of developing complications of chronic liver disease. Indeed, advanced fibrosis has been shown to be the major driver for long-term outcomes and mortality.

Among the serum biomarkers, FIB-4 and NFS are the most accurate with high negative predictive values (>90%) for ruling out advanced fibrosis. They could

therefore be used as first-line tools in a primary health care setting to identify patients without advanced fibrosis who do not need further assessment. In that respect, FIB-4 may be more attractive to general practitioners, as it is based on widely available and simple parameters (age, transaminases, and platelets) and easier to calculate than NFS.

In patients with intermediate or high risk on FIB-4 and NFS, non-invasive measurement of liver fibrosis using transient elastography (Fibroscan) is recommended. FibroScan measures scarring by measuring the stiffness of your liver. The fibrosis result is measured in kilopascals (kPa) The normal range is between 2 and 6 kPa and a value of 8 and above is suggestive of significant hepatic fibrosis. A value of <8 kPa has a 94-100% negative predictive value for the presence of cirrhosis of the liver.

In this regard inclusion of NAFLD will widen the scope of capturing the trend of NCDs. NAFLD is like the tip of the iceberg further research is needed to understand the disease in depth. In the epidemiological triad, the agent and host are identified but the environment which precipitates NAFLD is not very clear particularly in cases with genetic predisposition.

1.8 Management of NAFLD [15]

To date, no effective medical interventions exist that can completely reverse the disease other than lifestyle changes and dietary alterations to reduce weight and, possibly, bariatric surgery.

However, several strategies that target pathophysiological processes such as an oversupply of fatty acids to the liver, cell injury, and inflammation are currently under investigation.[16]

A few studies have suggested that weight loss may be associated with regression of fat and resolution of fat-related inflammation within the liver. Therefore, the most important recommendations for people with fatty liver are to lose weight if they are overweight or obese, increase their physical activity in routine daily life (Life style Modifications) , follow a balanced diet, and avoid alcohol and unnecessary medications.

New evidence suggests that the foods rich in monounsaturated fatty acids like Nuts, almonds, cashews , eggs, fish,Coconut oil, Safflower oil, etc may be more beneficial than a low-fat diet. Drinking coffee seems to decrease the risk of having a fatty liver in large cohort studies. In patients with NASH, the more severe form of NAFLD, these same recommendations may be helpful. It is also important to control diabetes and treat elevated cholesterol levels and hypertension when appropriate.



Chapter 2: Operationalisation of NAFLD

2.1 NAFLD as a component of NPCDCS: Broad Principles

The National Program for Prevention and Control of Cancer Diabetes Cardiovascular Diseases and Stroke (NPCDCS) is funded under the common NCD flexi-pool (consisting of NPCDCS, NMHP, NPCBVI, NTCP & NPHCE) of NHM. The States/UTs, while formulating their interventions for NCDs, incorporate the budget for the same in the State NHM Programme Implementation Plan (PIP). The 'flexi-pool' allows States sufficient flexibility in providing funds to various components within the overall NCD allocation. Even under, the States /UTs are permitted to reassign funds among the various components to a certain extent after obtaining approval from the Government of India, but within the broad framework of NPCDCS.

Broad Activities permissible under NCD flexi-pool for NPCDCS are as follows:

- Health promotion including, IEC / BCC / SBCC
- Screening and case detection including Population-based screening
- Management of NCDs
- Integration with other programmes
- Monitoring & evaluation
- Capacity building
- Public-Private Partnership
- Innovations for NCD control

NAFLD is designed and included within the above broad structure of NPCDCS at each level of health care delivery.

2.2 Community level:

Through Community Based Assessment Checklist (CBAC) form, ASHA will obtain the following details for NAFLD:

- Abdominal obesity (waist circumference of >90 cm in men or > 80 cm in women)
- Family history of diabetes, hypertension, coronary heart disease, liver diseases, gallstones, and cancers

Those who are at risk with a history of diabetes combined with abdominal obesity will be referred to Sub Health Centre – Health and Wellness Centre by the ASHA as suspected of NAFLD.

2.3 Sub Health Centre – Health and Wellness Centre level:

Multi-Purpose Worker (Female/Male) enters the details of Household survey in the NCD application

MPW (Female or Male) / Community Health Officer (CHO)

will validate all individuals referred by ASHA by assessing the presence of the following risk factors:

- Abdominal obesity (waist circumference of > 90 cm in men or > 80 cm in women)
- Personal & Family H/O diabetes, hypertension, heart diseases, and cancers
- Obesity (Classification based on BMI ≥ 23 kg/m²). It will require training along with the provision of auto calculation based on height (in meter) and weight (in kg) entered in the ANM application
- Screening of diabetes, hypertension, and cancers. If cancer screening facilities are not available, then ANM will search for symptoms of cancer and refer to the higher center where cancer screening facilities are available
- Presence of Pedal Oedema

NAFLD is included in Population-based screening subsequently.

Referral:

1. All the patients with obesity and/or diabetes, validated by ANM, will be referred to Primary Health Centre – Health and Wellness Centre for further management. The follow up will be done for those patients who are under treatment for NAFLD

2.4 Primary Health Centre – Health and Wellness Centre

level:

Diagnosis and management of common NCDs will be done either through PBS or direct at PHC.

The Medical Officer will examine the patient referred by Community Health Officer

1. Abdominal obesity (waist circumference of >90 cm in men or > 80 cm in women)
1. Family H/O diabetes, hypertension, heart diseases, and cancers
2. Obesity (Classification based on $BMI \geq 23 \text{ kg/m}^2$).
3. H/O or report of diabetes, hypertension, heart disease
4. The patient is provided with drugs for diabetes and hypertension
5. Emphasis on Signs of chronic liver disease like spider naevi, petechiae, purpura, palmar erythema, ascites, gynecomastia, asterixis, etc
6. Any patient with abnormal LFT report or incidental detection of hepatic steatosis on USG
7. The MO can undertake tele-consultation if needed. MOs may also utilize the hub and spoke model for diagnostics, if required.

Referral:

The patient will be referred to CHC Only if a specialist (MD Medicine) is available at the CHC. Otherwise, patient will be referred to the district hospital.

if there are any complications. No previously designed care is available for NAFLD. The Medical Officer will be sensitised through training.

2.5 CHC level:

Diagnosis and management of common NCDs will be done either through PBS or direct at CHC: The CHC Medical Officer will perform a clinical examination and rule out other causes of chronic liver disease through history and examination and further perform USG.

Those diagnosed with NAFLD:

- Perform LFT and CBC; input data into the app and calculate FIB-4 or NFS score and do risk stratification for advanced liver fibrosis and manage the patient accordingly
- Calculate FIB 4 or NFS score on the application

Low risk for advanced liver fibrosis:

- Refer patients back to PHC for management of Diabetes, Dyslipidemia, Hypertension, weight reduction
- The patient has to be reassessed after 3 years

High Risk for advanced liver fibrosis:

- Refer patients to the District Hospital or Tertiary care Centre for further management. Inclusion of NAFLD in patient referral card.

Indeterminate Risk for advanced liver fibrosis:

- Refer patients to the District Hospital for further evaluation. Inclusion of NAFLD in patient referral card.

2.6 District Hospital Level:

Detailed investigation and management of the patient which referred through PBS will be done in District Hospital: Risk stratification for advanced liver fibrosis will be done if no facility for the same at CHC

For a patient with indeterminate risk for advanced liver fibrosis, the doctor will perform a Fibroscan

Low risk for advanced liver fibrosis:

- Refer patients back to PHC for management of Diabetes, Dyslipidemia, Hypertension, weight reduction
- Patient to be reassessed after 3 years

High Risk for advanced liver fibrosis:

- Management of advanced fibrosis
- Screening and treatment of Portal hypertension
- Screening for HCC
- Referral to Tertiary care center for complicated cases or if facilities are not available at District Hospital. Inclusion of NAFLD in patient referral card.

2.7 State Level:

The State Level Centre of Excellence (SCoE) for NAFLD will be established. The following activities will be focused on:

- Implementation of National guidelines for Diagnosis and Treatment of NAFLD
- Adapt, translate, and dissemination plan for IEC

2.8 National Level:

Planning and implementation of NAFLD are started at the National level. The National Level Centre of Excellence (SCoE) for NAFLD will be established. The following activities will be focused on:

- National guidelines for Diagnosis and Treatment of NAFLD

Designing of the training manual of ASHA, Multi Purpose Worker (Female/Male), Community Health Officer, Staff Nurse and Medical Officer

- and capacity building of master trainers
- Design and dissemination of Information Education and Communication (IEC)
- Develop the Monitoring and Evaluation Framework for NAFLD component



Chapter 3 : Monitoring & Evaluation

3.1 Routine monitoring mechanism through formats and with the existing apps.

The routine monitoring mechanism which is being adopted for NPCDCS will now include the indicators for NAFLD. Therefore the following formats for monthly reporting from the facilities at various levels have been modified to include components of NAFLD:

Level	Reporting Form	Data generated from	Person responsible	Reporting to	Submission of previous month report by
Sub-centre	Form 1	ANM Screening Register	CHO of SHC-HWC	PHC	Last day of the month
PHC (including urban PHC-HWC)	Form 2 & 2 A	PHC-HWC OPD Register & Compiled all Form-1	MO I/c PHC-HWC	CHC NCD Clinic	5th of every month
CHC/ BPHC/ SDH	Form 3A	CHC NCD OPD Register	MO I/C CHC NCD Clinic/	District NCD Cell	7th of every month
	Form 3B	Compiled all forms 1 & 2	BPHC / SDH		
District Hospital	Form 4	DH-NCD OPD Register	MO I/C District NCD Clinic	District NCD Cell	7th of every month
District NCD cell	Form 5A	Form 5A Compiled all forms 3A & 4	District Nodal Officer (NCD)	State NCD Cell	10th of every month
State NCD Cell	Form 5B	Form 5B Compiled all forms 3B			
	Form 6	Form 6 Compiled all forms 5A & 5B	State Nodal Officer (NCD)	National NCD cell	15th of every month

3.2 Monitoring through the Population-Based screening for NCDs through CPHC NCD application

The system also allows monitoring of the activities of the PBS including the components included for NAFLD through the portal of the CPHC NCD application

3.3 Routine monitoring review meetings and visits

The review meetings held regularly with the States either through meetings or visits by the Officers in Dte GHS or MoHFW will also now include those parameters or indicators related to NAFLD.

Chapter 4 : Health Promotion

Behaviour Change Communication and IEC

Promoting healthy behaviours to effect lifestyle behaviour change, is critical for prevention and control of NAFLD. States would develop context specific strategies for lifestyle modification and for promoting healthy behaviours for primary prevention. Such strategies would need to be targeted at individuals, families, and communities. States should develop an Integrated health promotion strategy that envisages convergence, multitasking and pooling of resources from various programmes.

IEC messages would aim at increasing awareness on risk factors of NAFLD, healthy lifestyle and benefits of screening. They would also focus on the benefits of improving lifestyle behaviours such as poor dietary habits and lack of exercise. The district NCD cell will collect information on locally available healthy foodstuffs that should be encouraged and use this in the development of messages for healthy lifestyles. States must also use MMUs to display audio visual messages related to prevention and health promotion.

Individual and family counselling will be needed for those who are started on treatment for compliance to treatment and for lifestyle modifications. IEC material and patient brochures/ leaflets that promote healthy behaviours, exercise routines, dietary advice, avoiding substance abuse and compliance with treatment including through use of IT would need to be developed. IEC leaflets would be distributed to those who are diagnosed with NAFLD to enable them to develop individual health plans (diet/exercise).

States should make the effort to incorporate appropriate prevention and promotion strategies, including practice of Yoga and other wellness activities. For community level awareness raising, platforms such as meetings of Gram Sabha, SHGs, VHSNCs would be used. The use of traditional media such as Kala Jathas, use of folk/local media, and flip charts, flash cards, IT and social media etc, would be promoted. Local folk media could also be used creatively to raise community awareness and mobilize for screening and ensuring treatment compliance. States could also consider dissemination of NAFLD related communication messages at local gatherings, religious festivals, camps, and targeted messages using IT for patients and those at risk etc.

Among those diagnosed with NAFLD, patient support groups facilitated by the ASHA/ ASHA facilitator to improve motivation and share challenges and success related to life style changes, behaviour modification, reduction of substance abuse and adherence to treatment should be created.

The VHSNC and MAS which represents a community collective besides PRIs and ULBs would play an important role in raising community awareness about NCD screening among community leaders and influencers. Similar to the role in the Village Health and Nutrition Day, the VHSNC/MAS members would support the ASHA and Multi-Purpose Worker (Female/Male) during the screening day to help manage patient flows, support and direct referrals. In addition, the VHSNC would advocate with the block/district administration with the support of other community groups and influential leaders to heighten public understanding of the benefits of regular exercise and Yoga and create public parks and other spaces for exercise and encourage physical activity in schools.

The Jan Arogya Samiti in Ayushman Bharat - Health and Wellness Centres and Rogi Kalyan Samiti at the level of the Community Health Centre, would be sensitized to the intervention, to enable addressing issues of procurement and supply of drugs and diagnostics, support for diagnostics, and referral to secondary or tertiary care centres and follow up.

Chapter 5: Media plan for increasing awareness about NAFLD

Media planning for generating awareness regarding NCDs at the National, State, and District level will also address the issues of NAFLD along with the common NCDs. IEC material so produced for this objective will include matter which will not only increase awareness about healthy living, promotion of physical activities, eating right, and value of timely screening for NCDs.

These can be disseminated through There are several communication channels such as i) Mass Media (TV/Radio/Press advertisement/Announcementetc.), ii) Mid Media (Hoardings/Banners/Posters, etc.), iii) Interpersonal Communications (IPC) and iv) Social Media (Facebook, Twitter, WhatsApp, &Youtube, etc.) through which the messages can be disseminated at large.

A repository maintained at the National NCD Cell will be enriched with those contributions from the states. The same material would be shared with all the states so that they can borrow from each other.



Chapter 6: Capacity Building

Capacity building needs to be done with a well-designed training plan & programme for the identified health functionaries at identified levels of the healthcare delivery system. Proper training needs assessment will be carried out and accordingly a training plan, programme and a calendar would be worked out.

The broad areas of learning [either knowledge or skill] are given in the table below:

Level of Healthcare delivery system	Type of health manpower	Training Institutes to be involved
Master Trainers	Staff /Officers in National NCD Cell, NIHFW	DGHS, ILBS, NIHFW, NHSRC
Training of State Level Trainers	Medical Colleges	DGHS, ILBS, NIHFW, NHSRC
Faculty of Central Government Institutes, Medical Colleges	Clinicians involved in the management of NAFLD	State Level Trainers
District Hospital team including NCD Clinic	Doctors, nurses in DH and NCD clinic including counselors	State Level Trainers
CHC NCD Clinic	Doctors, nurses in CHC and NCD Clinic	District Level Trainers
PHC-HWC	MO and Staff Nurse	District Level Trainers
CHO and MPW (F/M)	ANM	District Level Trainers
Community-level	ASHA	District Level Trainers



References

1. Perumpail BJ, Khan MA, Yoo ER, Cholankeril G et al. Clinical epidemiology and disease burden of Non-Alcoholic fatty liver disease. *World Journal Gastroenterol.* 2017 Dec 21;23(47): 8263-76
2. Anstee, Q.M., Reeves, H.L., Kotsiliti, E. et al. From NASH to HCC: current concepts and future challenges. *Nat Rev Gastroenterol Hepatol*16, 411–428 (2019). <https://doi.org/10.1038/s41575-019-0145-7>
3. Duseja A. Nonalcoholic fatty liver disease in India - a lot done, yet more required! *Indian J Gastroenterol.* 2010 Nov;29(6):217-25.
4. American College of Gastroenterology <https://gi.org/topics/fatty-liver-disease-nafld/>
5. Ajay Duseja *Indian J Gastroenterol* 2010 Nov;29(6):217-25. doi: 10.1007/s12664-010-0069-1. Epub 2010 Dec 30. <https://pubmed.ncbi.nlm.nih.gov/21191681/>
6. American College of Gastroenterology <https://gi.org/topics/fatty-liver-disease-nafld/>
7. Brunt EM, Wong VW, Nobili V, et al. Nonalcoholic fatty liver disease. *Nature Reviews Disease Primers.* 2015;1:15080 <https://pubmed.ncbi.nlm.nih.gov/27188459/>
8. Ajay Duseja *Trop Gastroenterol* Oct-Dec 2006;27(4):142-6. <https://pubmed.ncbi.nlm.nih.gov/17542290/>
9. Chalasani N, Younossi Z, Lavine JE, et al. The diagnosis and management of non-alcoholic fatty liver disease: practice guideline by the American Association for the Study of Liver Diseases, American College of Gastroenterology, and the American Gastroenterological Association. *Hepatology.* 2012;55(6):2005–2023. <https://pubmed.ncbi.nlm.nih.gov/22488764/>
10. Spengler EK, Loomba R. Recommendations for diagnosis, referral for liver biopsy, and treatment of nonalcoholic fatty liver disease and nonalcoholic steatohepatitis. *Mayo Clinic Proceedings.* 2015;90(9):1233–1246. <https://pubmed.ncbi.nlm.nih.gov/26219858/>
11. Azzam H, Malnick S. Non-alcoholic fatty liver disease—the heart of the matter. *World Journal of Hepatology.* 2015;7(10)1369–1376. <https://pubmed.ncbi.nlm.nih.gov/26052382/>

12. Azzam H, Malnick S. Non-alcoholic fatty liver disease—the heart of the matter. *World Journal of Hepatology*. 2015;7(10)1369–1376. <https://pubmed.ncbi.nlm.nih.gov/26052382/>
13. American College of Gastroenterology <https://gi.org/topics/fatty-liver-disease-nafld/>
14. American College of Gastroenterology <https://gi.org/topics/fatty-liver-disease-nafld/>
15. Brunt EM, Wong VW, Nobili V, et al. Nonalcoholic fatty liver disease. *Nature Reviews Disease Primers*. 2015;1:15080 <https://pubmed.ncbi.nlm.nih.gov/27188459/>
16. Ajay Duseja *Indian J Gastroenterol* 2010 Nov;29(6):217-25. doi: 10.1007/s12664-010-0069-1. Epub 2010 Dec 30. <https://pubmed.ncbi.nlm.nih.gov/21191681/>

Meeting with DGHS on 12th November 2020

- ◆ Welcome of participants
- ◆ A brief on NPCDCS : Dr Sudhir Gupta, Team Lead Nat NCD Cell, MoHFW
 - Programme components
 - What is already existing at various levels [promotion, prevention, screening, management]
 - Frequent requests from various sectors
 - Holistic view under a common umbrella ‘National NCD Programme’
- ◆ A brief on Non-Alcoholic Fatty Liver Disease [NAFLD]: Dr Shiv K Sarin, Director, ILBS
 - Why NAFLD?
 - What is required at what level of healthcare delivery?
 - What changes are required?
- ◆ Future steps :Dr.L.Swasticharan, Addl DDG, Nat NCD Cell
 - Inclusion of NAFLD in the Operational Guidelines
 - FMR code examination
 - Advocacy to the States through virtual meeting
 - Seeking support through PIP by States
 - Implementation and monitoring
- ◆ Open discussion including the Plan for presentation to HFM

Minutes of the meeting held on 12th November 2020 under chairmanship of Director General of Health Services on inclusion of Non Alcoholic Fatty Liver Diseases (NAFLD) in National Program for Prevention and Control of Cancer Diabetes Cardiovascular Diseases and Stroke (NPCDCS) in India

A meeting was held under chairmanship of Prof. (Dr) Sunil Kumar, Director General of Health Services on 12th November 2020 at 1.00 PM in conference room via webexNirman Bhawan, New Delhi to discuss the proposal of inclusion of Non Alcoholic Fatty Liver Diseases (NAFLD) in NPCDCS program in India.

Following participated:

1. Dr Shiv Kumar Sarin, Professor & Director, ILBS
2. Dr Sudhir Gupta, Senior CMO (SAG) (Team Lead, NCD)
3. Dr L Swasticharan, Addl DDG (NCD)
4. Representative of NHSRC
5. Dr Umesh Kapil, Professor, ILBS
6. Dr J S Thakur, Professor, PGIMER
7. Dr Anil Gurtoo, Professor, Dept of Medicine, LHMC
8. Dr Y.C. Porwal, Professor & HOD, Dept. of Gastroenterology, Safdarjung Hospital
9. Dr Akash Malik, National Program Manager, UNDP
10. Dr Sunny Swarnakar, DADG (NCD)
11. Dr Harsavardhan Nayak, Tech Consultant (NCD TSU)
12. Dr Abhishek Khanna, Consultant (NPCDCS)

After welcoming the members and a round of introduction, the Chairman initiated the proceedings of the meeting and directed Dr. Sudhir Gupta to make the first presentation.

Dr Sudhir Gupta, by way of a ppt, talked about the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) in detail highlighting the objectives, support to the States for infrastructure, human resources provided, training, population-based screening, drugs and diagnostics & IEC for prevention and control of common NCDs.

It was followed by a presentation of Non Alcoholic Fatty Liver Disease [NAFLD] by Dr S K Sarin, Director, ILBS in which he described what is NAFLD and how it acts as a predisposing factor for non-communicable diseases and the importance of its inclusion in NPCDCS program.

Dr L Swasticharan pointed out the areas of integration in between NAFLD and NPCDCS program at each level of health care delivery system and highlighted the steps, strategies for the proposed integration.

Dr. J.S.Thakur expressed his concern for inclusion of alcoholic liver diseases as well in the NCD programme. The members also expressed the need for a holistic approach with emphasis on health promotion and prevention as well.

After much deliberations, the following decision points are emerged from the discussion:

1. The integration framework may be re-worked out with the scope of including vision, mission, objectives and strategies [promotive and preventive to be emphasized] with a holistic approach.
2. This may be launched in some selected pilot districts first before scaling up.
3. Another round of interaction may be planned after inclusion of the comments into the integration document.

FTS.21020/16/2020-NCD-II/NPCDCS
Government of India
Ministry of Health and Family Welfare
Directorate General of Health Services
(NCD Division)

Minutes of the meeting to discuss the inclusion of Non-Alcoholic Fatty Liver Disease (NAFLD) within the NPCDCS under the Chairmanship of HFM on 17.11.2020 at 02:00 pm in room no. 347, A-wing, Nirman Bhawan, New Delhi.

A meeting to discuss the inclusion of Non-Alcoholic Fatty Liver Disease (NAFLD) within the NPCDCS under the Chairmanship of HFM on 17.11.2020 at 02:00 pm in room no. 347, A-wing, Nirman Bhawan, New Delhi.

The list of participants is annexed.

After welcoming the participants, HFM directed Sh. Nilambhuj Saran, EA (NS) to initiate the discussion. Sh Saran highlighted Non-Alcoholic Fatty Liver Disease [NAFLD] as one common disease which has not been addressed adequately in the NPCDCS and NAFLD health promotion and prevention aspects seem to be the mainstay of the disease. He further indicated that as per the directions of the HFM, DGHS was requested to examine the matter through a committee.

Dr. Sunil Kumar, DGHS indicated that as per instructions of the office of HFM, a committee has already worked on the proposed integration and directed Dr.L.Swasticharan, Addl DDG (NCD) to make a presentation which has been prepared based on inputs of the members and the team from Institute of Liver and Biliary Diseases [ILBS].

Dr. L. Swasticharan made the presentation highlighting the burden of NAFLD, its need for inclusion in the NPCDCS so as to have an impact on overall prevention and control of NCDs in the country. He indicated the areas of integration for NAFLD purposes with those of the NPCDCS activities at the level of community, sub-centre, primary health centre, community health centre and district hospital explaining the feasibility.

DGHS further re-emphasised the merits of the proposed integration and that the doable needs having been identified, he will direct his team to fast track the process, once the integration is approved by HFM.

Dr. S.K. Sarin, Director [ILBS] appreciated the efforts made by the MoHFW which are practical and feasible for the integration. Dr. Umesh Kapil also pledged all necessary support from ILBS on any role given by the Ministry. Dr Anil Gurtoo, Professor (Medicine), LHMC submitted that it is high time that a new catchy name for all NCDs replace the current name of the programme which is NPCDCS.

HFM agreed that the integration, as presented, is doable and efforts should be immediately initiated with the main focus mainly on health promotion and prevention of common NCDs which would also specifically cater to the identified needs of NAFLD.

After due deliberations, the following decisions were taken:

1. HFM has approved the integration of NAFLD with NPCDCS and necessary activities to be initiated immediately in a time-bound manner for an early launch.
2. Operational Guidelines for the integration is to be prepared by the NCD team in MoHFW and Dte GHS with support from ILBS, NHSRC or any other identified organisations. Thereafter, necessary training modules, integration in HMIS [of PBS etc], adaptation in PIP guidelines etc are to be prepared subsequently.
3. All necessary efforts to emphasise and prioritise NAFLD such as letters to the States, webinars, workshops, meetings at various levels including the Central Council for Health and Family Welfare are to be taken up in a planned manner.
4. Prevention, control and management of NCDs including NAFLD should be a people's movement so that healthy living becomes a way of life for all the citizens. Media campaigns to be aligned towards this common objective.
5. A new name to address all the NCDs may be coined in lieu of the current name of the NCDs which is NPCDCS.

The list of participants:

To,

1. Sh Rajesh Bhushan, Secretary (H&FW)
2. Dr. Sunil Kumar, DGHS
3. ShNilambhuj Saran, Economic Adviser, MoHFW
4. Dr. (Prof.) S.K. Sarin, Director, Institute of Liver and Biliary Sciences, Delhi
5. Dr. L. Swasticharan, Addl. DDG, Dte. GHS
6. Dr. J. S. Thakur, Professor, Community Medicine and School of Public Health, PGIMER, Chandigarh through V.C.
7. Dr. Anil Gurtoo, Professor Medicine, Lady Hardinge Medical College
8. Dr. Y.C. Porwal, Professor & HOD, Department of Gastroenterology, Safdarjung Hospital
9. Dr. J.N. Srivasatava, Executive Director i/c, NSHRC.
10. Dr. Umesh Kapil, Professor, ILBS
11. Dr. Akash Malik, National Manager, HSS, UNDP India office

Annexure-I

Community based assessment checklist (CBAC)*revised draft 6 October 2020 V.5***Date: DD/MM/YYYY**

General Information	
Name of ASHA:	Village/Ward:
Name of MPW/ANM:	Sub Centre:
	PHC/UPHC:
Personal Details	
Name:	Any Identifier (Aadhar Card/ any other UID – Voter ID etc.):
Age:	State Health Insurance Schemes:Yes/No If yes, specify:
Sex:	Telephone No. (self/family member / other - specify details):
Address:	
Does this person have any of the following? Visible defect /known disability/Bed ridden/ require support for Activities of Daily Living	If yes, please specify

Part A : Risk Assessment			
<i>Name of ASHA:</i>	<i>Range</i>	<i>Circle Any</i>	<i>Write Score</i>
1. What is your age? (in complete years)	0 – 29 years	0	
	30 – 39 years	1	
	40 – 49 years	2	
	50 – 59 years	3	
	≥ 60 years	4	
2. Do you smoke or consume smokeless products such as gutka or khaini?	Never	0	
	Used to consume in the past/ Sometimes now	1	
	Daily	2	
3. Do you consume alcohol daily	No	0	
	Yes	1	

4. Measurement of waist (in cm)	Female	Male		
	80 cm or less	90 cm or less	0	
	81-90 cm	91-100 cm	1	
	More than 90 cm	More than 100 cm	2	
5. Do you undertake any physical activities for minimum of 150 minutes in a week? (Daily minimum 30 minutes per day – Five days a week)	At least 150 minutes in a week		0	
	Less than 150 minutes in a week		1	
6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?	No		0	
	Yes		2	
Total Score				
Every individual needs to be screened irrespective of their scores.				
A score above 4 indicates that the person may be at higher risk of NCDs and needs to be prioritized for attending the weekly screening day				

Part B: Early Detection: Ask if Patient has any of these Symptoms			
B1: Women and Men	Y/N		Y/N
Shortness of breath (difficulty in breathing)		History of fits	
Coughing more than 2 weeks*		Difficulty in opening mouth	
Blood in sputum*		Any ulcers in mouth that has not healed in two weeks	
Fever for > 2 weeks*		Any growth in mouth that has not healed in two weeks	
Loss of weight*		Any white or red patch in mouth that has not healed in two weeks	
Night Sweats*		Pain while chewing	

Are you currently taking anti-TB drugs**		Any change in the tone of your voice	
Anyone in family currently suffering from TB**		Any hypopigmented patch(es) or discolored lesion(s) with loss of sensation	
History of TB *		Any thickened skin	
Recurrent ulceration on palm or sole		Any nodules on skin	
Recurrent tingling on palm(s) or sole(s)		Recurrent numbness on palm(s) or sole(s)	
Cloudy or blurred vision		Clawing of fingers in hands and/or feet	
Difficulty in reading		Tingling and numbness in hands and/or feet	
Pain in eyes lasting for more than a week		Inability to close eyelid	
Redness in eyes lasting for more than a week		Difficulty in holding objects with hands/ fingers	
Difficulty in hearing		Weakness in feet that causes difficulty in walking	
B2: Women only	Y/N		Y/N
Lump in the breast		Bleeding after menopause	
Blood stained discharge from the nipple		Bleeding after intercourse	
Change in shape and size of breast		Foul smelling vaginal discharge	
Bleeding between periods			
B3: Elderly Specific (60 years and above)	Y/N		Y/N
Feeling unsteady while standing or walking		Needing help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet	
Suffering from any physical disability that restricts movement		Forgetting names of your near ones or your own home address	
<i>In case of individual answers Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available</i>			
<i>*If the response is Yes- action suggested: Sputum sample collection and transport to nearest TB testing center</i>			
<i>** If the answer is yes, tracing of all family members to be done by ANM/MPW</i>			

Part C: Risk factors for COPD
<i>Circle all that Apply</i>
Type of Fuel used for cooking – Firewood / Crop Residue / Cow dung cake / Coal / Kerosene / LPG
Occupational exposure – Crop residue burning/burning of garbage – leaves/working in industries with smoke, gas and dust exposure such as brick kilns and glass factories etc.

Part D: PHQ 2					
Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things?	0	+1	+2	+3
2.	Feeling down, depressed or hopeless?	0	+1	+2	+3
Total Score					
<i>Anyone with total score greater than 3 should be referred to CHO/ MO (PHC/UPHC)</i>					

Annexure-II

Form 1
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)
Reporting format for Sub Centre

Name of the sub-centre _____		PHC _____		Block/ Mandal _____		District _____		State _____						
Month _____	Year _____	PBS _____		Yes/ No _____	Population _____		Persons screened in previous month _____		Cumulative number of persons screened _____					
Part A: Hypertension and Diabetes Screening														
Name of the village	No. of eligible population for NCDs		Total No. of NCD Checkups Done		No. of new persons Suspected for DM and referred for Confirmation		No. of new persons Suspected for HTN and referred for Confirmation		No. of new persons Suspected for Both DM & HTN and referred for Confirmation		No. of known cases of HTN on Follow-up		No. of known cases of Both DM & HTN on Follow-up	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Total		Total		Total		Total		Total		Total		Total		
Part B: Screening for Common Cancers														
Name of the Village	No. of persons screened for cancers						No. of persons suspected with cancer and referred to PHC/ CHC/ GH							
	Oral		Breast		Cervical		Oral		Breast		Cervical		Total	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Total		Total		Total		Total		Total		Total		Total		
Part C: Screening for NAFLD														
Name of the Village	No. of Obese persons referred to PHC for Screening of NAFLD		No. of persons with suspected Diabetes and Obese referred to PHC		No. of persons with known/confirmed Diabetes and Obese referred to PHC		No. of persons referred by the Subcentre last month who underwent investigations at higher facility		Total No. of known Cancer patients in the Village		No. of known cases of HTN on Follow-up		No. of known cases of Both DM & HTN on Follow-up	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Total		Total		Total		Total		Total		Total		Total		
Signature _____														
Name and Designation _____														
Date of reporting _____														
PBS Data to be reported in this format. _____														
*The report should be filled by ANM of Sub centre and sent to MO /C PHC on last day of the same month.														

Annexure-III

Form 2A			
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)			
Reporting format for Primary Health Centre OPD			
Name and Address of the PHC _____ CHC _____ District _____ State _____			
Month _____	Year _____		
Indicator	Implementing PBS - Yes/ No		
	During the Reporting Month		
	Male	Female	Total
I. Common NCDs under NPCDCS			
1. Total no. of persons attended NCD Clinic (New and Follow up)			
2. No. newly diagnosed with	A. Diabetes Only		
	B. Hypertension Only		
	C. HTN & DM (both)		
3. No. of persons suspected and referred for	A. Cardiovascular diseases		
	B. Stroke		
	C. Oral Cancer		
	D. Breast cancer		
	E. Cervical cancer		
	F. Other cancers		
	G. NAFLD		
4. No of newly diagnosed patients initiated on treatment	A. Diabetes Only		
	B. Hypertension Only		
	C. HTN & DM		
5. Patients on treatment Follow Up	A. Diabetes Only		
	B. Hypertension Only		
	C. HTN & DM		
	D. Cardiovascular diseases		
	E. Stroke		
	F. Oral Cancer		
	G. Breast cancer		
	H. Cervical cancer		
	I. Other cancers		
	J. NAFLD		
6. Total No. of persons referred to CHC/ SDH/ District Hospital/ Higher Centres	A. Diabetes Only		
	B. Hypertension Only		
	C. HTN & DM		
	D. NAFLD		
7. No. of persons counselled for	health promotion & prevention of NCD		
II. Comorbid Conditions			
8. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (5A+5C)]	A. No. of known TB cases on ATT		
	B. No. screened for TB Symptoms		
	C. No. suspected for TB & referred to DMC/ PI		
Signature:			
Name and Designation			
Date of reporting _____			
*This report should be generated from PHC OPD screening data.			
This report should be verified and signed by Medical Officer I/c PHC.			
This report should be sent to Block PHC/CHC by 5th day of every month.			

Annexure-IV

Form 2 National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS) Reporting format for Primary Health Centre (PHC)	
Name of the PHC _____ Name of the linked Block PHC/CHC _____ District _____ State _____ Month _____ Year _____	
No. of Sub-centres & HWC/SCG under the PHCs _____ No. of Sub-centres/ HWC/SCG reported during the month:	
Part A (Screening for HTN and Diabetes)	
Name Of the Sub Centre / PHC PHC SC1 SC2 SC3 Data from PBS Grand Total	No. of eligible population for NCDs Male Female Total
	Total No. of NCD Checkups Done Male Female Total
No. of new persons suspected for DM and referred for Confirmation Male Female Total	
No. of new persons suspected for HTN and referred for Confirmation Male Female Total	
No. of new persons Suspected for Both DM & HTN and referred for Cumulative number of persons screened Male Female Total	
No. of known cases of DM on Follow-up Male Female Total	
No. of known cases of HTN on Follow-up Male Female Total	
No. of known cases of Both DM & HTN on Follow-up Male Female Total	
Part B: Screening for Common Cancers	
Name of the Sub Centre/ PHC SC1 SC2 SC3 Sub Centre total Data from PBS Grand Total	No. of persons screened for cancers Oral Breast Cervical Total Male Female Female Male Female Total
	Total No. of known Cancer patients in the Village Male Female Total
Part C: Screening for NAFLD	
Name of the Village Name Of the PHC SC1 SC2 SC3 Sub Centre total Data from PBS Grand Total	No. of persons with suspected Diabetes and Obese referred to CHC for screening of NAFLD Male Female Total
	No. of persons with suspected Diabetes and Obese referred to CHC Male Female Total
No. of persons with confirmed Diabetes and Obese referred to CHC Male Female Total	
No. of persons with confirmed Diabetes and Obese referred to PHC after PHC Male Female Total	
No. of persons with confirmed Diabetes and Obese referred to PHC after PHC Male Female Total	
Name and Designation Date of reporting *This report should be generated by compiling data of Form 1 of all sub-centres under the PHC and also patients referred by ASHA directly to PHC after PHC. This report should be verified and signed by Medical Officer /C- PHC. This report should be sent to Block PHC/CHC by 5th day of every month.	

Annexure-V

Form 3A				
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)				
Reporting format for NCD Clinic at Community Health Centre (CHC)/ Sub District Hospital(SDH)				
Name and Address of the SDH / CHC		Block/ Taluk/ Mandal/ Zone	District	State
Month	Year			
Indicator	During the Reporting Month			
	Male	Female	Total	
I. Common NCDs under NPCDCS				
1. Total no. of persons attended NCD Clinic (New and Follow up)				
2. No. newly diagnosed with	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
	D. NAFLD			
3. No. of persons suspected and referred for	A. Cardiovascular diseases			
	B. Stroke			
	C. COPD			
	D. CKD			
	E. Oral Cancer			
	F. Breast cancer			
	G. Cervical cancer			
	H. NAFLD			
4. No of newly diagnosed patients initiated on treatment	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
	D. NAFLD			
5. Patients on treatment Follow Up	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
	D. Cardiovascular diseases			
	E. Stroke			
	F. COPD			
	G. CKD			
	H. Oral Cancer			
	I. Breast cancer			
	J. Cervical cancer			
6. Total No. of persons referred to District Hospital/ Higher Centres	A. Diabetes Only			
	B. Hypertension Only			
	C. HTN & DM			
	NAFLD			
7. No. of persons counselled for health promotion & prevention of NCD				
II. Comorbid Conditions				
8. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (5A+5C)]	A. No. of known TB cases on ATT			
	B. No. screened for TB Symptoms			
	C. No. suspected for TB & referred to DMC/ PI			
Signature:				
Name and Designation				
Date of reporting				
*This report should be generated by compiling data from form 2A and CHC OPD screening data.				
This report should be verified and signed by Medical Officer i/c CHC.				
This report should be sent to District NCD Cell by 7th day of every month.				

Annexure-VI

Form 3B																											
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)																											
Reporting format for Community Health Centre (CHC)/Block PHC/ SDH																											
Name and Address _____ Block/ Taluk/Mandal/ Zone _____ District _____																											
Month _____ Year _____																											
Total No. of PHC/ HWC-PHCs in the Distr _____														Total No. Of PHCs reported _____			Population _____			Persons screened in previous month _____							
														Eligible population _____			Cumulative number of persons screened _____										
Part A : Screening for HTN and Diabetes																											
Source Of Data	No. of eligible population for NCDs			Total No. of NCD Checkups Done			No. of new persons Suspected for DM and referred for Confirmation			No. of new persons Suspected for HTN and referred for Confirmation			No. of new persons Suspected for Both DM & HTN and referred for			No. of known cases of DM on Follow-up			No. of known cases of HTN on Follow-up			No. of known cases of Both DM & HTN on Follow-up					
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
PHC 1																											
PHC2																											
PHC3																											
Overall Total																											
Part B: Screening for Common Cancers																											
Source of Data	No. of persons screened for cancers						No. of persons suspected with Cancer and referred to DH						No. of Known Cancer patients														
	Oral			Breast/ Cervical			Oral			Breast/ Cervical			Male			Female											
	Male	Female	Total	Female	Female	Total	Male	Female	Total	Female	Female	Total	Male	Female	Total	Male	Female	Total									
PHC 1																											
PHC2																											
PHC3																											
Overall Total																											
Part C: Screening for NAFLD																											
Name of the Village	No. of Obese persons referred to DH for screening of NAFLD			No. of persons with suspected Diabetes and Obese referred to DH			No. of persons with known/confirmed Diabetes and Obese referred to DH			No. of persons suspected for NAFLD & Referred to DH			No. of persons with known/confirmed NAFLD on follow up														
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total												
PHC 1																											
PHC2																											
PHC3																											
Overall Total																											
Signature: _____																											
Name and Designation _____																											
Date of reporting _____																											
*This report should be generated by compiling data of Form 2B of all PHCs under the Block/Taluk/Mandal.																											
This report should be verified and signed by Medical Officer I/c.																											
This report should be sent to District NCD Cell by 7th day of every month.																											

Annexure-VII

Form 4					
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)					
Reporting format for District NCD Clinic					
Name of Health Facility where located :		District	State	-	
Total No. of CHCs-					
Month		Year			
All information below are for the reporting month					
Indicator	During the Reporting Month				
	Male	Female	Total		
I. Common NCDs under NPCDCS					
1. Total no. of persons attended NCD Clinic in the reporting month (New and Follow up)					
2. No. newly diagnosed with	A. Diabetes Only				
	B. Hypertension Only				
	C. HTN & DM (Both)				
	D. CVDs				
	E. Stroke				
	F. COPD				
	G. CKD				
	H. Oral Cancer				
	I. Breast cancer				
	J. Cervical cancer				
	K. Other cancers				
	L. NAFLD				
	3. Suspected and referred cases of CVDs & Cancer (In Resource limited settings where there are No capacity to perform confirmatory diagnosis)	A. CVDs			
C. Stroke					
D. COPD					
E. CKD					
F. Oral Cancer					
G. Breast cancer					
H. Cervical cancer					
I. Other cancers					
4. No of newly diagnosed patients initiated on Treatment		A. Diabetes Only			
		B. Hypertension Only			
		C. HTN & DM (Both)			
		D. CVDs			
		E. Stroke			
	F. COPD				
	G. CKD				
	H. Oral Cancer				
	I. Breast cancer				
	J. Cervical cancer				
	K. Other cancers				
	L. NAFLD				
	5. No. of Patients treated at CCU/ SCCU				
6. No of patients on follow up	A. CVDs				
	B. Stroke				
	A. Diabetes Only				
	B. Hypertension Only				
	C. DM & HTN (Both)				
	D. CVD (Only OPD data)				
	E. Stroke (Only OPD data)				
	F. COPD				
	G. CKD				
	H. Oral Cancer				
	I. Breast cancer				
	J. Cervical cancer				
	K. Other cancers				
L. NAFLD					
7. No. of person referred to Tertiary hospital/TCCC	A. Diabetes Only				
	B. Hypertension Only				
	C. DM & HTN (Both)				
	D. CVD (Only OPD data)				
	E. Stroke (Only OPD data)				
	F. COPD				
	G. CKD				
	H. Oral Cancer				
	I. Breast cancer				
	J. Cervical cancer				
	K. Other cancers				
	L. NAFLD				
	8. Patients attended Day Care facility for Cancer care				
9. No. of persons counselled for health promotion & prevention of NCDs					
10. No. of patients underwent physiotherapy					
11. No. of persons with suspected for NAFLD & Referred from CHC OPD					
II. Comorbid Conditions					
11. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (6A+6C)]	A. No. of known TB cases on ATT				
	B. No. screened for TB Symptoms				
	C. No. suspected for TB & referred to DMC/ PI				
Signature: _____					
Name and Designation _____					
Date of reporting _____					
*This report should be generated from District NCD Clinic /OPD screening data of District Hospitals. This report should be verified and signed by Medical Officer /c. This report should be sent to District NCD Cell by 7th day of every month.					

Annexure-VIII

Form 5A							
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)							
Reporting format for District NCD Cell							
District _____				State _____			
Total SC/HWC-SC/PHC/HWC-PHC/CHC : _____ / _____ / _____ / _____							
Month _____		Year _____					
Indicator	During the Reporting Month			Cumulative since April during current Financial year			
	Male	Female	Total	Male	Female	Total	
I. Common NCDs under NPCDCS							
1. No. of persons attended NCD Clinics (New and follow up)							
2. No. newly diagnosed with	A. Diabetes Only						
	B. Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F. COPD						
	G. CKD						
	H. Oral Cancer						
	I. Breast cancer						
	J. Cervical cancer						
	K. Other cancers						
L. NAFLD							
3. Number of persons suspected (Confirmatory Diagnosis not available/ Pending)							
4. No. of newly diagnosed patients put on Treatment	A. CVDs						
	B. Stroke						
	C. Cancers						
	A. Diabetes Only						
	B. Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F. COPD						
	G. CKD						
	H. Oral Cancer						
I. Breast cancer							
J. Cervical cancer							
K. Other cancers							
L. NAFLD							
5. No. of persons on treatment follow up	A. Diabetes Only						
	B. Hypertension Only						
	C. HTN & DM						
	D. CVDs						
	E. Stroke						
	F. COPD						
	G. CKD						
	H. Oral Cancer						
	I. Breast cancer						
	J. Cervical cancer						
	K. Other cancers						
L. NAFLD							
6. No. of person referred to Tertiary hospital/TCCC	A. Diabetes (Complications)						
	B. Hypertension (Complications)						
	C. CVDs						
	D. Stroke						
	F. COPD						
	G. CKD						
	H. Oral Cancer						
	I. Breast cancer						
	J. Cervical cancer						
	K. Other cancers						
	L. NAFLD						
7. No. of Patients treated at CCU/SCCU	A. CVDs						
	B. Stroke						
8. No. of cancer patients treated in Day Care facility							
9. No. of persons counselled for health promotion & prevention of NCDs							
10. No. of patients underwent Physiotherapy							
11. No. of persons with suspected for NAFLD & Referred to DH							
II. Co-morbidities							
11. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (5A+5C)]	A. No. of known TB cases on ATT						
	B. No. screened for TB Symptoms						
	C. No. suspected for TB & referred to DMC/ PI						
Signature: _____							
Name and Designation: _____							
Date of reporting: _____							
*This report should be generated by compiling data of Form 3A (CHC NCD Clinics) and Form 4 (District NCD Clinic) data							
This report should be verified and signed by District Nodal Officer.							
This report should be sent to State NCD Cell by 10th day of every month.							

Annexure-IX

Form 5B National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS) Reporting format for District NCD Cell																											
Name and Address of the District NCD Cell		District			State																						
Month	Year	Total No. of PHCs in the District		Population		Persons screened in previous month																					
		Total No. of PHCs reported		Eligible population		Cumulative number of persons screened																					
Part A - Screening for HTN and Diabetes																											
Source of Data		No. of eligible population for NCDs			Total No. of NCD Checkups Done			No. of new persons Suspected for DM and referred for Confirmation			No. of new persons Suspected for HTN and referred for Confirmation			No. of new persons Suspected for Both DM & HTN and referred for Confirmation			No. of known cases of DM on Follow-up			No. of known cases of HTN on Follow-up			No. of known cases of Both DM & HTN on Follow-up				
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
DH1																											
DH2																											
DH3																											
Data from PBS																											
Overall Total																											
Part B- Screening for Common Cancers																											
Source of Data		No. of persons screened for cancers						No. of persons suspected with Cancer and referred to PHC/ CHC/ DH						No. of Known Cancer patients													
		Oral		Breast		Cervical		Oral		Breast		Cervical		Male		Female		Male		Female		Male		Female		Total	
DH1																											
DH2																											
DH3																											
Data from PBS																											
Overall Total																											
Source of Data		No. of persons suspected for NAFLD & referred to DH						No. of persons with known/confirmed NAFLD on follow up																			
		Male		Female		Total		Male		Female		Total		Male		Female		Total		Male		Female		Total			
DH1																											
DH2																											
DH3																											
Total																											
Signature:																											
Name and Designation																											
Date of reporting																											
*This report should be generated by compiling data of form 5B of all Blocks/Mandals/Talukas under the District																											
This report should be verified and signed by District Nodal Officer.																											
This report should be sent to State NCD Cell by 10th day of every month.																											

Annexure-X

Form 6						
National Programme on Prevention & Control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)						
Reporting format for State NCD Cell						
Name of the State:			Reporting Month:Year.....			
No. of district NCD Cells.....			No. Of District NCD Cells reported			
Population			Persons screened in previous month		Cumulative number of persons screened	
Eligible population						
Part A. Programme Data (Compiled data of Form 5A)			During the Reporting Month		Cumulative since April (Financial Year Data)	
Indicator			Male	Female	Male	Female
			Total	Total	Total	
i). Common NCDs under NPCDCS						
1. Total no. of persons attended NCD Clinics (New and Follow Up)						
A. Diabetes Only						
B. Hypertension Only						
C. HTN & DM (Both)						
D. CVDs						
E. Stroke						
F. COPD						
G. CKD						
H. Oral Cancer						
I. Breast Cancer						
J. Cervical Cancer						
K. Other Cancers						
L. NAFLD						
2. No. newly diagnosed with						
A. Diabetes Only						
B. Hypertension Only						
C. HTN & DM (Both)						
D. CVDs						
E. Stroke						
F. COPD						
G. CKD						
H. Oral Cancer						
I. Breast Cancer						
J. Cervical Cancer						
K. Other Cancers						
L. NAFLD						
3. No of new patients Initiated on treatment						
A. Diabetes Only						
B. Hypertension Only						
C. HTN & DM (Both)						
D. CVDs						
E. Stroke						
F. COPD						
G. CKD						
H. Oral Cancer						
I. Breast Cancer						
J. Cervical Cancer						
K. Other Cancers						
L. NAFLD						
4. No of Patients on Follow up						
A. Diabetes Only						
B. Hypertension Only						
C. HTN & DM (Both)						
D. CVDs						
E. Stroke						
F. COPD						
G. CKD						
H. Oral Cancer						
I. Breast Cancer						
J. Cervical Cancer						
K. Other Cancers						
L. NAFLD						
5. No. of Patients Referred to Tertiary Care/TCCC						
A. Diabetes Only						
B. Hypertension Only						
C. HTN & DM (Both)						
D. CVDs						
E. Stroke						
F. COPD						
G. CKD						
H. Oral Cancer						
I. Breast Cancer						
J. Cervical Cancer						
K. Other Cancers						
L. NAFLD						
6. No of patients treated at CCU						
A. CVDs						
B. Stroke						
7. No. of persons attended day care centre						
8. No. of Persons counselled for health promotion and prevention of						
9. No. of patients attended physiotherapy						
ii). Comorbid Conditions						
10. Among all confirmed Diabetic patients [New (2A+2C) & Follow up (4A+4C)]						
A. No. of known TB cases on ATT						
B. No. screened for TB Symptoms						
C. No. suspected for TB & referred to DMCC/ PI						
B. Other Programme Markers (Compiled data of Population based Screening (PBS))						
Total No. of NCD check ups done						
Diabetes only						
Hypertension Only						
HTN & DM (Both)						
Oral Cancers						
Breast Cancers						
Cervical Cancers						
Other Cancers						
NAFLD						
Total No. Of Persons Suspected and referred for						
Diabetes only						
Hypertension Only						
HTN & DM (Both)						
Oral Cancers						
Breast Cancers						
Cervical Cancers						
Other Cancers						
NAFLD						
No. of diagnosed patients on follow up in CHC, PHC and Sub centres						
Diabetes only						
Hypertension Only						
HTN & DM (Both)						
Oral Cancers						
Breast Cancers						
Cervical Cancers						
Other Cancers						
NAFLD						
C. Physical targets and achievements						
Name of Facility		Annual Target for 2020-21	Achievement during the reporting month	Cumulative achievement since 1st Apr 2020	Cumulative achievement since beginning of program	Remarks
District NCD Cells						
District NCD Clinics						
District CCU facilities						
District Day Care Centres						
CHC NCD Clinics						
Others						
Signature:						
Name and Designation						
Date of reporting						
<i>This report should be generated by compiling data of Form 5A & Form 5B of all Districts in the State</i>						
<i>This report should be verified and signed by State Nodal Officer.</i>						
<i>This report should be sent to National NCD Cell by 15th day of every month.</i>						
**Data for COPD/CKD is mandatory from all districts with functional COPD/CKD Units						







Ministry of Health and Family Welfare
Government of India