

डॉ० प्रणब ज्योति भुइयां

अंपर निदेशक

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सत्यमेव जयते

भारत सरकार

राष्ट्रीय वैक्टर जनित रोग नियंत्रण केंद्र

(स्वास्थ्य सेवा महानिदेशालय)

स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार

22, शाम नाथ मार्ग, दिल्ली-110054

Government of India

NATIONAL CENTER FOR VECTOR BORNE DISEASES CONTROL

(Directorate General of Health Services)

Ministry of Health & Family Welfare, Govt. of India

22, Sham Nath Marg, Delhi -110054

D.O. No. 14-4/2023-24/NCVBDC/MTD/Malaria Advisory

Dated: 26.09.2025

Dear SPOs,

India has made significant strides in reducing malaria burden, achieving a decrease of 78.1% in cases and 77.6% in deaths in 2024 compared to 2015. Taking the progress forward towards our goal of malaria elimination by 2030, the states/UTs have to achieve zero indigenous cases by 2027. The recording and reporting for surveillance & diagnostic protocol should be carried out as per programme guidelines:

1. Surveillance: Active surveillance is carried out by trained community level health care workers (ASHA/MPHW/ANM) through fortnightly house-to-house visits and testing people with current or recent fever and chills in past 14 days with bivalent antigen detecting RDTs. If the RDT result is positive, treatment appropriate to the plasmodium species should be initiated. Passive surveillance is the detection of malaria cases among people who go at their own initiative to a health volunteer (CHV) or health facility (AAM/PHC etc.) to get treatment, usually for a febrile illness.

2. Microscopy: Microscopy is the gold standard for malaria diagnosis. Availability of quality microscopy for malaria diagnosis is always preferable at all health facilities with laboratory, provided the results are made available at the earliest (within 24 hours of sample collection) to start prompt treatment. States/UTs should ensure the strengthening of the capacity of their existing laboratory facilities.

3. Rapid Diagnostic Tests (RDTs): In resource-limited settings where slide examination results cannot be delivered within 24 hours, RDTs should be prioritized and following conditions should be practiced:-

- If RDT is positive, blood slide should not be collected for the same case & treatment should be initiated at the earliest as per RDT result.
- Health facilities having laboratory services should regularly use microscopy test except emergency situations/ odd hours in which RDT may be used.
- Out of the total diagnostics 70% would be done using RDT and remaining 30% by microscopy

4. Asymptomatic cases which are tested and found positive for Malaria during Mass Surveys, Ante-natal screening, Blood donation screening etc. should not be included in the calculation of malariometric indices like ABER, API etc.

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Swachh Bharat : Let us join hands to bid adieu to Kala-azar and Lymphatic Filariasis from the country.

Website : www.nvbdcp.gov.in



5. All States/UTs should maintain ABER as per national guidelines to reflect adequate surveillance as per categorization of states/UTs:

Category 0 States/UTs: 1-3%

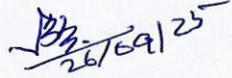
Category 1 States/UTs: 5-7%

Category 2 & 3 States/UTs: minimum 10%

6. All positive blood smears are cross checked in the CML/Zonal Lab, State Govt. and ROHFW shared in the ratio of 50:50 and 5% of the negative slides in the ratio of 4 : 1 between former and latter.

With regards,

Yours sincerely


(Dr. P. J. Bhuyan)

Copy to: -

1. SRDs/RDs of all ROHFW
2. PA to Director, NCVBDC

Copy for information to:

1. MD-NHM of all States/UTs
2. DHS of all States/UTs