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राष्ट्रीय स्वास्थ्य मिशन

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POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

HANDBOOK FOR ASHA FACILITATOR AND ANM/MPW

ON HOME BASED NEWBORN CARE AND HOME BASED CARE FOR YOUNG CHILD

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwifery
MPW	Multi Purpose Worker
ACT	Artemisinin-Based Combination Therapy
ACT -AL	Artemisinin-Based Combination Therapy-Artemether-Lumefantrine
ACT -SP	Artemisinin-Based Combination Therapy (Artesunate+ Sulfadoxine- Pyrimethamine)
AIDS	Acquired Immunodeficiency Syndrome
AEFI	Adverse Effects Following Immunization
AF	ASHA Facilitator
ANC	Antenatal Care
AS	Artesunate
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacille Calmette Guerin
BCM	Block Community Mobilizer
CHC	Community Health Center
COC	Combined Oral Pill
CQ	Chloroquine
DH	District Hospital
ECD	Early Childhood Development
EBM	Expressed Breast Milk
ENT	Ears, Nose, Throat
FP-LMIS	Family Planning Logistics Management Information System
FSSAI	Food Safety and Standard Authority of India
FRU	First Referral Unit
HBNC	Home Based Newborn Care
HBYC	Home Based Care for Young Child
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
I-NIPI	Intensified- National Iron Plus Initiative
ITN	Insecticide-Treated Net
IUCD	Intra-Uterine Contraceptive Device
KMC	Kangaroo Mother Care
LHV	Lady Health Visitor
LBW	Low Birth Weight
LT MA	Learning Tool for Milestone Assessment
MAS	Mahila Arogya Samiti
MDM	Mid-Day Meal
CHO	Community Health Officer
MCP	Mother and Child Protection
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MCTS	Mother and Child Tracking System
MI	Mission Indradhanush
MPW	Multi-Purpose Worker
NBCC	Newborn Care Corner
NBSU	Newborn Stabilization Unit
NFHS	National Family Heath Survey
NGO	Non-Governmental Organization
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Salt
PHC	Primary Health Centre
PF	Plasmodium falciparum
PAIUCD	Post-Abortion Intra-Uterine Contraceptive Device
PPIUCD	Post-Partum Intra-Uterine Contraceptive Device
POP	Progestin Only Pill
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PQ	Primaquine
PV	Plasmodium Vivax
RDT	Rapid Diagnostic Test
RI	Routine Immunization
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SBM	Swachh Bharat Mission
SHC	Sub-Health Centre
SHG	Self-Help Group
SNCU	Special Newborn Care Unit
SP	Sulphadoxine-Pyrimethamine
SRS	Sample Registration System
TB	Tuberculosis
TT	Tetanus Toxoid
THR	Take Home Ration
UHND	Urban Health Nutrition Day
UPHC	Urban Primary Health Centre
VISHWAS	Village Based Initiative to Synergise Health, Water and Sanitation
VHSND	Village Health Sanitation and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

INTRODUCTION

Over the past few years, the health indicators of the country have improved substantially specially in the area of maternal & child health and communicable diseases. Significant achievements have been made in improving access for institutional delivery, immunization, contraceptive services etc. In addition to strengthening of public health facilities under the National Health Mission, most of these achievements can be attributed to the efforts made by ASHAs at the community level.

You, as ASHA facilitators and ANMs/MPWs, have supported ASHAs and played a major role in improving their performance and thus, improving the health outcomes in your service area. However, despite these improvements, there are still some unresolved challenges. The burden of infant and child deaths is still high. There is a high prevalence of malnutrition and anaemia among children. The Children from marginalized and vulnerable sections of the community have limited access to health care. The delays in recognizing illnesses, disabilities, developmental delays and defects among children are contributing to their poor health status.

You know that the government had launched the Home-Based Care for Newborn (HBNC) programme in 2011. The key objective of the HBNC is to reduce newborn death and supportthe families to adopt healthy child rearing practices through a set of home visits by ASHAs. In addition, ASHAs also undertake four follow up visits for SNCU discharged and LBW newborns up to 1 year of age, each at the intervals of the 3rd, 6th, 9th and 12th month. However, ASHAs are able to reach about 60-70% of the newborns through these visits. 30-40% of newborns are still not being listed and visited by ASHAs. The poor referral rates of sick newborns recorded at the health facility indicate that quality of home visits delivered by ASHAs needs to improve.

Recently, a new initiative of providing Home Based Care for Young Child (HBYC) has also been launched by the MoHFW. As part of this programme, ASHAs are expected to provide care to all young children aged up to 15 months through a set of five structured visits in the 3rd, 6th, 9th, 12th and 15th month. The HBYC aims to reduce child mortality and morbidity, improve nutrition status, growth and early childhood development in young children upto 3-15 months. During these visits, ASHAs will follow up for child status related to health, nutrition, early childhood development and WASH, will counsel family members on adopting healthy practices, undertake early identification and referral of sick children.

The roll out of HBYC programme will expand the tasks of an ASHA. The success of an ASHA to deliver effective home-based care for the newborn and young child will depend to a large extent on the nature of support and on the job mentoring provided to her. As a mentor for the ASHAs, you will play a critical role in further improving the performance of an ASHA in the provision of newborn care and at the same time support her in effectively reaching out to children of 3-15 months of age under HBYC.

You will need to build capacities of ASHAs, support them by resolving challenges they face in the community and serve as an interface between ASHAs and the health system. With the expansion of tasks expected from ASHAs, it is even more important now to understand your role in supporting the ASHAs and address the anticipated challenges.

Your earlier training in the Handbook for ASHA Facilitators has already trained you for your role as ASHA supervisor.

This handbook will :

- Revisit the role of ASHA facilitator and ANM as a supervisor and this will help you in further improving your skills as supervisors.
- Help you understand all key tasks related to supportive supervision of ASHAs on HBNC and HBYC.
- Enable you to improve the quality of supportive supervision to help ASHAs cover all marginalised households and ensure universal coverage of all newborns and young children.
- Guide you on how to do effective on-the-job mentoring to ASHAs which in turn helps them to improve their skill and service delivery to children of HBNC and HBYC age group.

This handbook is divided into the following sections -

1. Principles of supportive supervision
2. Key task for Supportive Supervision for ASHAs relating to HBNC and HBYC
3. Programme Management and Monitoring
4. Annexures

SECTION-1

PRINCIPLES OF SUPPORTIVE SUPERVISION

ASHAs perform a wide range of tasks related to reproductive, maternal, newborn and child health including communicable diseases at the community level. Based on your experience you know that on the job supportive supervision for an ASHA enhances the quality of services provided by her.

Supportive supervision gives you an opportunity to recognize good practices and help ASHAs to maintain a high-level of performance.

From your previous trainings, recall the following principles of Supportive Supervision-

- It is carried out in a respectful and non-authoritarian way.
- It uses field visits, home visits and cluster meetings to improve knowledge and skills of ASHAs.
- It encourages open, two-way communication.
- It builds team approaches that facilitate problem-solving.
- It focuses on monitoring performance towards goals, uses data for decision-making, and depends upon regular follow-up with ASHAs to ensure that new tasks are being implemented correctly.

Supportive supervision is helping to make things work, rather than checking to see what is wrong.

To effectively support the ASHAs in the provision of HBNCand HBYC you would need to be cautious in not using traditional/autocratic supervision that is focused more on inspection and fault inding rather than on problem solving to improve performance.

Always remember to use the tools such as checklists and protocols that will support systematic performance assessment and provision of feedback.

Try to find out the areas where ASHAs need support and provide guidance through on-the-job mentoring to improve their capacity and performance.

Let us now understand the key tasks that you will need to undertake to enhance the quality of supportive supervision for ASHAs to perform HBNC and HBYC.

SECTION-2

KEY TASKS FOR SUPPORTIVE SUPERVISION FOR HOME BASED NEWBORN CARE AND HOME BASED CARE FOR YOUNG CHILD

You will need to undertake the following tasks to support the ASHAs for delivering HBNC and HBYC services-

1. Plan Visits for supportive supervision with ASHAs-

- You should plan the field visits with every ASHA in your area in advance as per mutually convenient time and date.
- This allows ASHAs to update list of service users, their relevant records and formats.
- Meetings at cluster or block level are the ideal platform where the supervisor can get a chance to meet all the ASHAs and discuss the schedule of the visits.
- The plan should be such that more frequent visits are included for ASHAs who require more handholding and are facing constraints in providing services to the mothers/newborns or young children. Problems could be on account of their own skills or could be due to geographic, cultural barriers prevalent in the community or any other factors.
- Interviewing few families will help to learn about the quality of visits made by ASHAs. The reports and records of each ASHA should also be reviewed in detail. Always praise her in public for good performance but correct her only in private. The Supervisor should inform ASHA in advance if there are any changes in the scheduled visit.
- Plan of visits should also be such that all 20 ASHAs meet over a period of one month either during village visits or during joint home visits.
- Stick to the schedule of the visit and always inform ASHAs about your visit in advance.

2. Prioritize and identify households requiring more attention-

- Remember to prioritize home visits to those households where the ASHA needs additional support in motivating these families to adopt healthy behaviours.
- Identify houses jointly with the ASHAs where ASHAs/beneficiary need additional support /care.

- Enlist the number of the following beneficiaries–
  - i) Preterm or Low Birth Weight (LBW) or sick newborn.
  - ii) Newborn who was delivered at home.
  - iii) Newborn discharged from Government or Private NBSU/SNCU/NICU
  - iv) Household where child death /still birth has occurred.
  - v) Young child with developmental delays/any illness/defects/malnutrition or disabilities.
  - vi) Woman with maternal complication.
  - vii) Preference should also be given to mothers and children from–
    - a) Hard to reach areas, families in distant hamlets.
    - b) Marginalized sections, migrants, destitute, labourers, slum dwellers, disabled and workers from unorganised /informal sectors etc.
    - c) Houses where ASHAs find it difficult to counsel the families about referral to health facilities for care seeking or for adoption of healthy practices.
    - d) Households where adequate attention and care is not given to the girl child.

In addition to the above-mentioned categories, you may also plan to visit houses which have a TB or HIV/AIDS or a Leprosy or Malaria patient or any other households where ASHAs are finding it difficult to help the family members.

- Always remember to include households where the ASHA has not visited in past one month or found it difficult to counsel the families about referral to health facility for care.
- Do plan to conduct joint visit to the household where maternal or newborn death has happened within two weeks after the notification of death by ASHA, to assess the reasons of death as well as categorize the death.
- Try to understand the reason behind this exclusion of house and try to resolve the gap so that both ASHA and you, as a team can counsel them to improve their care seeking behaviour and thus contribute towards improving the health outcomes in the community.
- Spend time in understanding specific constraints and help them to access health care services, especially for the children.

Marginalized section may include-

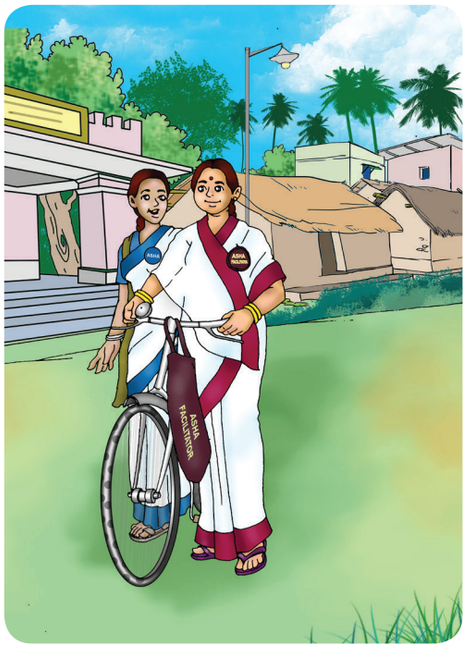
- Families such as -
  - a. Landless / daily wage labourers / recently migrated/seasonal migrants who go to other cities for work for some part of the year and later return home.
  - b. Single / deserted / widow / female headed household where the husband is working outside the village.
  - c. living in distant hamlets, whose houses lie between villages or in the fields.

- Households -
  a. With disabled children or where some member is handicapped.
  b. Households/communities seen as lower status in the village and hence isolated.

Remember the eight-fold path to reach out to these marginalized families and support ASHAs in identification of such families. The eight-fold path includes-

1. **Mapping of all** vulnerable and marginalised families having children that do not access health services readily.
2. **Prioritizing those** where there are children below 2 years of age.
3. **Communicate using** job aid provided in the module, inform them about why these services are needed, where they are available, and what their health entitlements are. Ensure that you do not miss any important messages for the mother and child during the scheduled home-visits.
4. **Understanding and not being judgmental** : Explore options for changing the way existing services are being provided.
5. **Counselling :** Listen to people's problems and work with them to find solutions to build trust and confidence, e.g., accompany them to the health facility so that they feel comfortable and confident about accessing them on their own in the future.
6. **Persisting** through repeated visits and counselling initially to let the families overcome their reluctance to adopt preventive and promotive health behaviours and begin to access health services. Finally, the need for frequent visits will reduce.
7. **Coordinating with** members of the Village Health Sanitation and Nutrition Committee (VHSNC), Mahila Arogya Samiti (MAS), Self Help Groups (SHGs), who may be in a position to influence these families, to accompany you on a home visit.
8. **Mobilizing people/community by** leadership/community meetings, join together to sing songs, take out a rally, and celebrate survival etc. Mobilization is the most important tool of all.

3. Undertake Joint Household Visits-



Joint household visits with ASHAs during the monthly village visit or after the monthly Village Health Sanitation and Nutrition Day (VHSND) and urban Health Sanitation and Nutrition Day is one of your most essential tasks as a mentor of the ASHAs.

The joint household visit will help you to-

i) Understand the challenges faced by ASHAs in undertaking the home visits and delivery of services.

ii) Review the quality of home visits made by ASHAs by using the checklist mentioned in Annexure 6 and see whether ASHA is using respective formats mentioned in Annexure 1, 2, 3, 4 and 5.1

iii) Assess the skills and knowledge of ASHAs by using checklist mentioned in Annexure 6 and by observing how she is using formats mentioned in Annexure 1, 2, 3, 4 and 5.1

iv) Assess the coverage of ASHAs to identify the barriers faced in reaching the vulnerable and marginalized houses.

v) Support the ASHAs in overcoming the challenges faced by them and support them in the effective delivery of services.

It is important to note that you should visit at least one house with a newborn and with a young child each during the monthly village visit.

Joint visits should be planned such that you are able to cover around 30%[1]* of the newborns and children under 15 months over a period of one year in your catchment area.

The ASHA facilitator and the ANMs/MPWs should plan for monthly joint visits with ASHAs to different houses to eliminate duplication of efforts and optimum use of each functionary's time (review the indicators by using checklist mentioned in Annexure-7 for HBNC/HBYC Supportive Supervision Reporting Format). This decision should however be made at the local level based on ASHA's suggestions and requirements noted at the field level.

Knowledge and skill enhancement- During the home visits, you should allow the ASHA to undertake counselling and advice, including demonstration as appropriate to HBNC or HBYC. Observe, whether and how ASHA is using Job Aid, ASHA kit and materials as per the list. You may refer to the checklist mentioned in Annexure 6 to see if ASHAs are following all the steps and taking appropriate action as per the forms in Annexure 1, 2, 3, 4 and 5.1. ASHAs are dedicated to their work and it is important that they are acknowledged for their hard work in the community. You should be cautious while correcting her errors or while adding points missed by ASHAs in a manner that you do not embarrass or humiliate her in front of the beneficiary/community. This is also an opportunity to strengthen ASHA's knowledge and skills and to identify the areas where the ASHAs need additional / refresher training. Therefore, it is important that after the completion of each visit, you should review the checklist with the ASHA and give her the appropriate feedback.

Review of formats- You should undertake joint household visits or make additional visits to the beneficiary's house if major gaps are noted in the format. In case of identification of gaps, you should explain the error to the ASHAs, talk about the purpose of the format and also support them in completing the format before onward submission.

4. Gather Information About Neonatal, Infant and Child Death In Community-

All cases of neonatal, infant and child death needs to be reported in a timely manner so that preventable causes of these deaths could be identified. This would help the block / district officials to take the corrective measures to avert deaths caused by preventable causes.

Since ASHAs work in their communities, it is expected that they would be the "first reporter" of such events. They should be encouraged to report all events of death within a maximum of 24 hours of death especially if any maternal, neonate, infant and child death that has happened in their coverage area.

As an ASHA Facilitator and ANM/MPW, you both should conduct a joint visit to the household where death has happened within two weeks after the notification of death by ASHA, to assess the reasons for death as well as categorize the deaths according to age at death (neonates, infant and child deaths). This should be followed by the facilitation of timely review of the deaths at the community level as per the Maternal and Child Death review guidelines (Annexure 5 - for ASHA 5.1 and for ANM/MPW 5.2).

[1] 30% - Newborns - prioritising all high risk and sick newborn and children under 15 months of age - malnourished children and children identified with some defects/ deficiencies / delays or diseases.

5. Ensure Logistics – Supply of Medicines and Equipment-

One of the key challenges, that has been documented in several reviews and evaluations, is the non-availability of functional equipment or adequate stock of medicines with ASHAs. This affects their performance and credibility in the community.

Thus, it is important to review the availability of the critical equipment, job aids and medicines with ASHAs during the monthly cluster or SHC meeting. You should consotidate this information about the gaps for all ASHAs under your coverage area and share it with the SHC-HWC CHO, the PHC MO as well as the Block ASHA Nodal Officer on a monthly basis. This would help in streamlining the replenishment process and reduce stock outs.

6. Strengthening Referral Services-

The key objective of the HBNC and HBYC programme is timely identification of any illness/danger signs/pre-existing condition in the child and immediate referral to appropriate health facilities. However, often you must have noted that ASHAs and families are faced with the challenge of non-availability of the desired services at the referral health facility.

Hence, it is important that you raise these issues at the block/district level review meetings about the gaps in the availability of services and also inform the ASHAs about the list of services available across different levels of health facilities in the district. This information needs to be updated on a periodic basis, as per requirement during the PHC or SHC level meeting. Further, ANM/AF should also discuss with ASHA the previous referrals and try to make ASHA understand home-based pre-referral procedures and learn appropriate time and place of referral.

7. Building Community Level Support For ASHA Through VHSNC/MAS-

The Village Health Sanitation and Nutrition Committees (VHSNCs) and Mahila Arogaya Samitis (MASs) are the community based platforms to enable identification of community level issues and to undertake community based planning and action to resolve them.

These Samitis should be informed by ASHA and you, about the HBNC and HBYC related activities during monthly meetings. The VHSNC/ MAS members can play an important role in supporting the ASHAs in providing HBNC and HBYC services. Their participation in the VHSND and overall monitoring of the services delivered can prove to be critical for the implementation of the HBNC and HBYC.

Most ANMs/MPWs participate in the VHSNC/MAS either as members or special invitees while ASHA Facilitators support the functioning of VHSNC/MAS. You can use this opportunity to inform the VHSNC/MAS about the importance of HBNC and the new intervention of HBYC. Few important indicators related to coverage of HBNC and HBYC can be added to the monthly public services monitoring checklist of VHSNC and MAS.

8. Cluster, Sub-Health Center (SHC), Primary Health Center (PHC) Level meetings to Provide Additional Support to ASHA-

a) Cluster meeting by ASHA Facilitators for all ASHAs under the ASHA Facilitators coverage area-

Organize a monthly meeting of all ASHAs under the coverage area of ASHA Facilitators. These meetings can be used to-

1. Conduct performance review and planning.
2. Discuss common issues and problems faced by ASHA during the month.

3. Identify issues that need to be discussed at the monthly PHC review meeting.
4. To collect data from the ASHAs to enable consolidation at the block level.
5. Keep the ASHAs updated about guidelines and other technical details about programmes related to health and their work.
6. Discuss issues relating to the supply of logistics and payment of incentives.

b) SHC level meeting by ANMs/MPWs for all ASHAs and AWWs under the SHC's catchment area-

A monthly meeting of ANM/MPW with all AWWs and ASHAs of the SHC catchment area can facilitate and improve the coordination between them on a routine basis. The meeting can be used to –

a) Assess delivery of health care services and planning for universal coverage.

b) Develop strategies to reach the marginalized sections.

c) Provide technical support.

d) Verification of formats/ vouchers filled by ASHAs.

e) Problem solving for any other issue.

ASHA facilitators should attend these meetings whenever it is feasible for them, at least one meeting per month can be attended as a sample.

Such meetings are an excellent forum for building solidarity among the ASHAs and AWWs. ASHAs should be encouraged to share successes and challenges related to their work during the meeting. Meetings can also be used as a forum for peer learning among all frontline workers facilitated by ANM/MPW and ASHA Facilitator.

c) Monthly PHC level meeting-

The monthly meetings of ASHAs at PHCs are currently focused on the submission of payment vouchers. The PHC monthly meetings can be used for the following-

i. As an opportunity to ensure skill building of ASHAs on a regular basis.
ii. Replenishment of ASHA's kits and problems solving.
iii. Submission of ASHA's payment vouchers.
iv. Sharing of new and updated information related to the Programmes.
v. Problem-solving for issues encountered in the meeting.

vi. Coordination between ICDS and other Departments.

vii. Highlighting success stories from the field (separate time should be allocated to teach ASHA for hands on skill in the meeting).

Supervisors (ANMs/MPWs and ASHA Facilitators) should support the PHC MOs, SHC-HWC CHOs and LHVs in undertaking all these activities during the PHC monthly meetings rather than just doing it for submission of payment vouchers. The important insights gained from joint visits with ASHAs and participation in VHSNC/ MAS meetings should be shared with the PHC MOs, SHW-HWC CHO and LHVs to identify the areas of capacity building/refresher training of ASHAs including topics related to HBNC and HBYC and problem solving.

You should facilitate a meeting between PHC MOs, SHW-HWC CHO, CDPO-ICDS for effective convergence work between ASHA, ANM/MPW and AWW and also for the refresher training/ discussion on monthly basis.

9. Payment and Grievance Redressal-

a. Supporting in the Payment Process-

Since ASHAs receive incentives linked with the activities that they perform, it is essential that the payments for each activity is made in a timely manner.

With regards to payment for HBNC and HBYC, ASHAs are expected to fill and submit the formats in time. As her mentor, the verification of the formats would be your responsibility. While verification of the formats, you should review the formats carefully to understand the common errors made by ASHAs while filling the forms. Each format acts as a tool for ASHAs with reminders about the essential tasks they need to undertake during the household visits. Thus, it is important to note that the formats should be checked to assess if they have been filled completely. They can prove to be a useful tool to assess and identify the gaps in ASHA's performance. Joint household visits or additional visits can be made to beneficiary's house if, major gaps are noted in the format. In case of identification of any gaps, you should explain the error to the ASHAs, tell them about the purpose of the format and support them in completing the format before submission.

Since the format submission is linked with the payment process, the formats should be submitted after verification in a time bound manner to the next level (which can be the PHC MOs, SHC-HWC CHO or the Block ASHA Nodal Officer, as per the State's requirement). To enable timely payment to ASHAs, you may plan for monthly collection, verification and submission of forms with a gap of 10-15 days from the monthly payment cycle of ASHAs (e.g. – all formats should be submitted to the next level between 15th- 20th of every month, if the payment is to be released on 1st of every month.)

b. Support in Grievance Redressal-

As the first line of support for ASHAs, you may also be faced with high levels of expectations of ASHAs to resolve the issues faced by them. These could vary from matters such as non-availability of printing formats to grievance of serious nature. Try to address the grievance as quickly as possible and encourage ASHA to give all complaints in writing.

According to the guidelines of the ASHA programme (Community Processes - 2014) each district should formalize the process of reporting and redressing ASHA's grievances in a time-bound manner. This could be done by constituting a district level committee or creating a toll-free number for ASHAs. Based on the process applicable in your district/city, you should disseminate the information to all the ASHAs. In case of absence of any such mechanism mishaps, you may advocate for creating a grievance redressal mechanism with the block and district officials.

You should ensure that the grievances of ASHAs are reported as per the defined process and followed up with the block/district officials to facilitate appropriate redressal to the ASHA's concerns within 21 days.

SECTION-3

PROGRAMME MANAGEMENT AND MONITORING

The HBNC and HBYC initiatives would be jointly managed and monitored by the nodal officials of ASHA and Child Health programme at all levels i.e; at state, district and block level. The progress made under HBNC and HBYC along with the field level challenges faced and best practices by ASHAs at the community level should be discussed during the monthly meetings organized at block level for ASHA facilitators with block ASHA nodal officials and for ANMs/MPWs at the block PHC/ CHC meeting. The following indicators should be used to review the progress made on a monthly basis –

Home Based Newborn Care (HBNC)-

S. No.	Indicator	Numerator	Denominator
1	Proportion of newborns visited by ASHAs	Number of newborns visited by ASHAs	Number of expected live births
2	Proportion of newborns visited on 1st day of birth in case of home delivery	Number of newborns visited on 1st day of birth in case of home delivery	Number of newborns delivered at home
3	Proportion of newborns received complete schedule of home visits by ASHAs under HBNC in case of home delivery	Number of newborns visited as per schedule in case of home delivery	Number of newborns delivered at home
4	Proportion of newborns received complete schedule of home visits by ASHAs under HBNC in case of institutional delivery	Number of newborns visited as per schedule in case of institutional delivery	Number of newborns delivered at institution
5	Proportion of high risk / sick newborns referred for care to health institution	Number of newborns referred by ASHAs to seek care at health institution	Number of newborns who were sick or weighed less than 1.8 kg.
6	Proportion of ASHAs trained in all four rounds of Module 6-7	Number of ASHAs trained in all four rounds	Number of ASHAs in position since last one year or more
7	Proportion of ASHAs who have fully functional HBNC kit	Number of ASHAs who have functional HBNC kit	Number of ASHAs trained in round 1 of Module 6 &7

Home Based Care for Young Child (HBYC)-

S. No.	Indicator	Numerator	Denominator
1	Proportion of young children visited by ASHAs	Number of young children visited by ASHAs as per HBYC schedule	Number of young children (age 3-15 months)
2	Proportion of young children who were sick / LBW as newborns visited by ASHAs	Number of young children who were sick / LBW as newborns visited by ASHAs as per HBYC schedule	Number of young children who were sick / LBW as newborns (Age 3-15 months)

S. No.	Indicator	Numerator	Denominator
3	Proportion of young children (age 6-15 months) identified* as SAM, referred by ASHAs	Number of young children (6-15 months) with SAM/malnutrition referred to NRC or health institution by ASHA	Number of young children identified with SAM/ malnutrition (age 6-15 months)
4	Proportion of young children (age 6-15 months) for whom complementary feeding was initiated at 6 months of age	Number of young children/ infants for whom complementary feeding was started at 6 months of age	Number of young children/ infants (age 6-15 months)
5	Proportion of young children (3-15 months age) who received age appropriate immunizations	Number of young children age 3-15 months received age appropriate immunizations	Number of young children (age 3-15 months)
6	Proportion of young children (3-15 months age) who referred for care seeking in case of developmental delays or disabilities	Number of young children who were referred for care seeking in case of developmental delays or disabilities	Number of young children (age 3-15 months) identified with developmental delays or disabilities
7	Proportion of ASHAs trained in HBYC	Number of ASHAs trained in HBYC	Number of ASHAs trained upto 3rd round of module 6 & 7

** Community level Severe Acute Malnutrition (SAM) identification is done by AWW. ASHA can refer for identification and follow-up of SAM child to appropriate health facility.*

The information on these indicators should be collected during the monthly cluster/SHC meeting with ASHAs and submitted to the Block Nodal Officials on a monthly basis during the block level meeting. The reports would then be compiled at the district and state level for regular monitoring and review.

Get acquainted with the supervisory checklist using Annexure 6. It contains list of priority issues to be reviewed by the supervisor and helps to decide the corrective action to be taken, and issues to be followed up in the longer term.

Specific role of ASHA Facilitator and ANM/MPW to support ASHA in improving HBNC and HBYC activities-

Sl No	*Activity*	*ASHA Facilitator*	*ANM/MPW*
1	Household visit	Focus on equity and coverage of services provided by ASHAs. Ensure that all houses specifically from marginalized communities receive services from ASHAs. Identify the gaps where ASHAs need additional hand-holding and provide on-the-job mentoring support to ASHAs.	Focus on improving technical skills and knowledge of ASHAs to ensure the quality of visits. Review and give feedback about the accuracy of identification of illness and referral decisions taken by ASHAs. Provide care to the children at home in cases where families are not willing to seek care at the health facilities.

Sl No	*Activity*	*ASHA Facilitator*	*ANM/MPW*
2	Ensure Logistics – Supply of Medicines and Equipment	Collect and submit information about the availability of equipment and medicines with ASHAs to the next level. Support the process of replenishment through PHC.	Support the replenishment process by providing medicines from SHC, whenever feasible. Support the process of replenishment through PHC.
3	Support the payment process	Review and verify the payment vouchers and submit them on a timely basis as per the defined process in the district/ state.	Review and verify the payment vouchers and submit them on a timely basis as per the defined process in the district/ state. Keeping a record of service delivered and keep health events to be matched with MCP card. Signing of forms for payments of ASHA and submit then timely at PHC for timely payment.
4	Grievance Redressal	Address the grievance immediately and facilitate quick redressal as per guideline.	Discuss the issue and provide technical support immediately.
5	Death reporting	Collect death reports in ASHA Form- 1 in Annexure 5.1, find out causes of death visiting householding Form- 2 in Annexure 5.2, support ASHA for preventing any such death further, share information with ANM/MPW, CHO & MO.	Collect information and conduct joint visit to families, support ASHA for addressing such issues to reduce death.
6	VHSNC/VHND / MAS	See regularity of meeting, fund utilization and involvement of community for developing health plan. Support ASHA to conduct meetings.	Inform and deliver services on VHND to women and children when ASHA & AWW mobilizes them.
7	Referral Services	Motivate ASHA to identify sick child and refer to the health facility. If families are rigid, you should accompany ASHA to convince them and can take the support from VHSNC members.	Conducting joint visit to family, conducting Checkup of sick child and refer to facility after basic treatment.
8	Monthly cluster meeting with ASHA	Conduct meeting for review, planning and to solve issues. Highlight issues for PHC meeting, obtaining data from ASHA and bring solidarity among ASHAs.	Discuss the issue and its solution for benefit of all ASHAs.
9	PHC/CHC level meeting with MO	Attend meeting to facilitate for proper incentive payment to ASHA under various program.	Provide technical input in monthly training refresher on HBYC.
10	Selection, training and support to ASHA	Select new ASHA if the position is vacant or she is non-performing, ensure ASHA attend rounds of training, support ASHA trainer for conducting effective training, support ASHA to improve their effective functionality, mentoring ASHA to conduct VHSND and other village meetings.	Provide hand-holding knowledge to ASHA to gain her knowledge, confidence for better service delivery.

SECTION-4

LIST OF ANNEXURES

Annexure - 1a

Mother-Newborn Home Visit Card
(This part is to filled and retained by the ASHA as reference copy)

Village		Sub-Health Center		Block			
Mother's Name		Father's Name		ASHA's Name			
Date of Delivery		Place of Delivery	Health Facility - Public / Private/Home	Sex of Baby	Male / Female		
Mode of Delivery	Normal/Assisted/ C Section	Still Birth	Yes/No	Breast Feeding Started	< 1 hr, 1 - 4 hrs, 4.1 hrs to 24 hr, > 24 hr		
Date of Discharge of Institutional Delivery		Mother		Baby			
Birth Weight	gms.	Birth Registration	Yes/No	MCTS ID No.			

Supervisor Signature: _____ Date : _____

Mother-Newborn Home Visit Card

(To be filled by the ASHA during home visits and handed over to ANM/MPW, ASHA Facilitator after completion of home visits)

Village		Sub-Health Center		Block			
Mother's Name		Father's Name		ASHA's Name			
Date of Delivery		Place of Delivery	Health Facility - Public / Private/Home	Sex of Baby	Male / Female		
Mode of Delivery	Normal/Assisted/ C Section	Still Birth		Breast Feeding Started	< 1 hr, 1 - 4 hrs, 4.1 hrs to 24 hr, > 24 hr		
Date of Discharge of Institutional Delivery		Mother		Baby			
Birth Weight	gms.	Birth Registration	Yes/No	MCTS ID No.			

Supervisor Signature: Date :

Annexure - 1b

First Examination of New Born (Examine one hour after the birth but in any case within six hours from the birth. If ASHA is not present on the day of delivery. Fill this section on the day of visit & write the date of her visit		
Part I: Date of Home Visit	**Day1(one hour after birth)**	**For Supervisor/ASHA Facilitator**
1. Is the baby alive? (Yes/No), If not, then note the Date, time and place of Death *(In case of still birth/Newborn death, do not perform further examination of baby but complete the examination of the mother as per home visit form on day 1,3,7,14,21,28,42)*		Cause of death to be reported to ANM/ MPW/PHC for infant death review
2. Is the baby preterm (if yes , then write the preterm cut off date)		Correct/Incorrect
3. Date of First examination		First examination done
(Time: Early morning/Morning/Afternoon/Evening/Night)	_____hr_____	Days: ____Hrs: ____ After birth ____
4. Is the Mother alive? (Yes/No), If not, then note the Date, time and place of Death (in case Mother is dead, do not perform further examination of mother but complete the examination of the baby as per home visit form on day 1,3,7,14,21,28,42)		Report to ANM/PHC for maternal death review
5. Does the mother have any of the following problems		
a. Excessive Bleeding (Yes/No)		Yes/No/NA
b. Unconscious/Fits(Yes/No)		Yes/No/NA
If yes, refer immediately to a hospital		Action taken(Yes/No)
6. What was given as the first feed to baby after birth?		Correct/incorrect
7. At what time was the baby first breastfed?	Hrs _____Min _____	Correct/incorrect
8. How did the baby take feed? Mark-		Correct/incorrect
a. Forcefully (Yes / No)		
b. Weakly (Yes / No)		
c. Could not breastfeed but had to be fed with spoon (Yes / No)		
d. Could neither breast-feed nor could take milk given by spoon (Yes / No)		
9. Does the mother have breastfeeding problem ?Yes/No		Yes/No/NA
Write the problem , if there is any problem in breast feeding, help the mother to overcome it		Yes/No/NA

Part II: Date of Home Visit	Day 1 (within one hour after birth)	For Supervisor/ASHA Facilitator
1. Temperature of the baby (Measure in axilla and record):		Yes/No/NA
2. Eyes: Normal / Swelling or oozing pus		Yes/No/NA
3. Is umbilical cord bleeding(Yes/No)		Yes/No/NA
If yes, either ASHA, ANM/MPW or TBA can tie again with a clean thread. Action taken (Yes/No)	_____	Action taken (Yes/No)
4. Weight:	_____ Kg Gm	Weighing matches with the colour? Yes/No
Colour on scale: (Red/Yellow/Green)		
5. Record (Yes / No)		Yes/No/NA
a. All limbs limp (Yes / No)		
b. Feeding less/stop (Yes / No)		
c. Cry weak stopped (Yes / No)		
6. Routine Newborn Care: whether the task was performed		Yes/No/NA
a. Dry the baby (Yes / No)		
b. Keep warm, do not bathe, wrap in cloth, keep closer to mother (Yes/No)		
c. Initiate exclusive breast feeding (Yes/No)		
d. Keep the cord clean and dry (Yes/No)		
7. Anything unusual in baby? (curved limbs/cleft lip/other)		Yes/No/NA

Annexure - 1c

HOME VISIT FORM-(Examination of Mother and New Born)									
Ask/Examine	**Day 1**	**Day 3**	**Day 7**	**Day 14**	**Day 21**	**Day 28**	**Day 42**	**Action taken by ASHA**	**Supervisory Check**
Date of ASHA's visit									**Action Taken (Yes/ No)**
A. Ask mother									
1. Is the baby alive? (Yes/No)								If not, then note the Date, time and place of Death. In case of Newborn death, do not perform further examination of the baby but complete the examination of the mother.	
2. No. of times mothers takes a full meal in 24 hrs								If less than 4 times or if meals not full, advise mother to do so.	
3. Bleeding: how many pads are changed in a day								If more than 5 pads, refer the mother to a hospital.	
4. Is the baby being kept warm (near mother, clothed and wrapped properly) (Yes / No)								Advise the mother to do so, if not being done.	
5. Is the baby being fed properly (whenever hungry or at least 7-8 times in 24 hrs) (Yes / No)								Advise the mother to do so, if not being done.	
6. Is the baby crying incessantly or passing urine less than 6 times a day (Yes / No)								Advise mother to feed the baby after every 2 hours.	
B. Examination Mother									
1. Temperature: Measure and record								Temperature up to 102 degree F (38.9 degree C)- treat with paracetamol, and if the temperature is above it, refer to hospital	
2. Foul smelling discharge and fever more than 100 degree F^0 (37.8 degree C) (Yes /No)								If yes, refer the mother to a hospital	
3. Is mother speaking abnormally or having fits? (Yes/ No)								If yes, refer the mother to a hospital	
4. Mother has no milk since delivery or if perceives breast milk to be less (Yes/No)								Ask the mother to feed the baby more often and counsel her for proper attachment and positioning during breast feeding.	

Ask/Examine	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action taken by ASHA	Supervisory Check
5. Cracked nipples/painful and /or engorged breast (Yes/No)								In case of cracked nipples, advise the mother to keep the breast clean and lubricated. If nipples are red/ shiny/ flaky/ itchy etc, and the condition persists,refer to a hospital. In case of engorged breasts, advise mother to feed the baby frequently to empty out the breasts. if this is not possible teach the mother to express the milk herself. If breasts are hard then warm compression and gentle massage towards nipples can help. If the mother has fever then, refer to a hospital.	
C. Examination of baby	**ASHA should wash hands with soap and water before touching the baby during each visit**								
	Day 1	**Day 3**	**Day 7**	**Day 14**	**Day 21**	**Day 28**	**Day 42**		
1. Are the eyes swollen or with pus (Yes/No)								If there is pus in the eye then antibiotic ointment can be applied.	
2. Weight								If the weight of the baby is less than 2.5kg, then advise the mother to provide extra warmth to the baby and feed the baby more frequently. If the weight is less than 1.8kg then refer the baby to Sick New born care unit at the nearest health facility and also conduct extra home visits as per the high risk baby form. If the baby (low birth weight or normal) is not gaining weight then refer to SNCU at the nearest health facility.	

Ask/Examine	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action taken by ASHA	Supervisory Check
3. Temperature: measure & record								If the temperature is <97 degree F^{o} then advice the mother to keep the baby warm by increasing the room temperature, providing skin to skin contact, putting the baby in a warm bag and frequently feeding the baby. If the temperature is <95.9 degree F^{o}, then give the above mentioned advice and once the baby is warmer then clothe the baby and place in a pre warmed bed close to the mother. If the temperature is >99 degree F^{0} (fever) then look for signs of sepsis. In case signs of sepsis are not present manage only with 1/4th of a spoon of paracetamol and immediately refer to the SNCU at the nearest health facility.	
4. Yellowness in eyes or skin: jaundice (Yes / No)								If the baby has jaundice since first day or jaundice persists even after 14 days of birth then refer to Newborn Stabilization Unit (NBSU) and/or SNCU at the nearest health facility	
5. Has the baby received BCG? (Yes/No)									
6. Has the baby received OPV? (Yes/No*)									
7. Has the baby received Hept B (0)? (Yes/No)									
D. Referral of Mother & Baby									
1. Baby referred for any reason ? (Yes/No) if yes then write date, reason and place of referral									
2. Mother referred for any reason ? (Yes/No) if yes then write date, reason and place of referral									

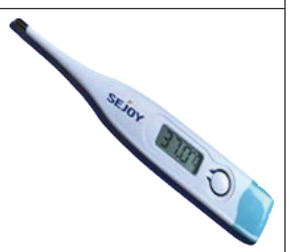
*If not then needs to be given within the first 8 hours

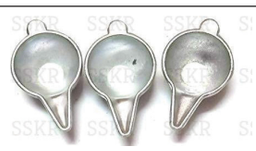
E. Check now for the following signs of sepsis: if the sign is present mention-Yes, if absent, mention-No									
Visit	**Day 1**	**Day 3**	**Day 7**	**Day 14**	**Day 21**	**Day 28**	**Day 42**		
Date of Visit									
Ask/examine (Yes / No)									
1. All limbs limp (Yes / No)								Consider first three signs as criteria for diagnosing sepsis only if the sign was absent previously and then it newly developed. If any one feature of sepsis is present on the same day, diagnose as sepsis and start with first dose of Amoxicillin as per the weight of the baby and refer the newborn immediately to SNCU at the nearest health facility: Less than 2.0 Kg - 2m1 Between 2.0 to 3.0 kg-2.5 ml Between 3.0 to 4.0 kg- 3m1 Between 4.0 to 5.0 kg-4m1	
2. Feeding less/stopped (Yes/ No)									
3. Cry weak / stopped (Yes / No)									
4. Distended abdomen or mother says baby vomits often (Yes / No)									
5. Mother says the baby is 'cold to touch' or baby has fever with a temperature>99 degree F^0 (37.2 degree C)									
6. Chest in drawing (Yes/ No)									
7. Respiratory rate more than 60 per minute (Yes / No)									
8. Pus on umbilicus (Yes / No)									
Supervisor's note ; Incomplete work/Incorrect work/ Incorrect record/									
Name of ASHA								**Signature of ASHA**	
Name Of the ASHA Facilitator/ANM / MPW				**Observations**				**Signature of ASHA Facilitator / ANM / MPW**	
Name of the ANM/MPW				**Has the baby received the Penta-1, PCV and Rota -1 vaccinations?** **days (write in days)**				**Write the age of the baby when Penta-1, PCV and Rota-1 vaccinations were done?**	**days (write in days)**
Observations								**Signature of ANM/MPW**	

Annexure 2: ASHA Kit checklist for HBNC and HBYC (for both ASHA and ASHA Facilitator)

2.1 Contents of ASHA kit to facilitate HBNC

A. Equipment

1.	Digital Watch	
2.	Digital Thermometer	
3.	Neonatal Weighing Scale with Sling	 

4.	Baby Blankets	
5.	Baby feeding spoon/Paladi	 
6.	Warm Bag	
7.	Bag for kits	

B. Medications

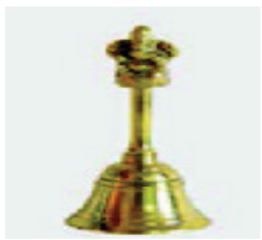
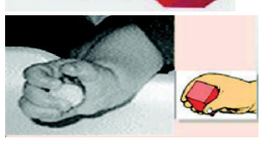
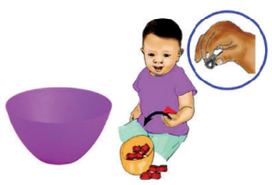
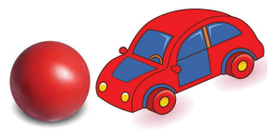
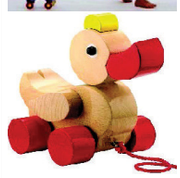
1. Gentian violet paint (0.5% and 0.25% IP)
2. Syrup Paracetamol
3. Syrup Amoxicillin
4. ORS

C. Consumables

1. Cotton
2. Gauze
3. Soap and Soap Case

2.2 Contents of ASHA kit to facilitate HBYC

Items Required for Early Childhood Development (ECD) Screening

1.	Red Ring (diameter 2-3") with red string	
2.	Hand-Bell	
3.	Torch (appropriate size for eye examination)	
4.	Small Mirror with plastic cover	
5.	1-inch cubes: 6 pieces	 
6.	Few Beads or Raisins (Kishmish)	
7.	Tea Plastic Cup or Plastic Bowl	
8.	1 packet Crayons (Wax)	
9.	Writing Pad	
10.	Red Ball or Any Toy like Car	
11.	Small Cloth to Cover Toys	
12.	Pull Toy with a String	 
13.	Doll (new born/ infant (1made of cloth and 1 of plastic)	
14.	Picture Book (with 1 Pictorial per page)	
15.	Screening kit bag (The screening kit bag contains all the materials used for the ECD screening)	

Annexure-3, Home Based Care for Young Child (HBYC) card: Recording format (ASHA)

ASHA to verify at age (write Yes/No)		3 Months	6 Months	9 Months	12 Months	15 Months
Whether the child is sick (Yes/No)						
If yes, Did she/he referred to the nearest health facility (Yes/No)						
Breastfeeding continued (Yes/No)						
Complementary food given	2-3 tablespoons of food at a time, 2-3 times each day	X		X	X	X
	½ cup/katori serving at a time, 2-3 times each day with 1-2 snacks between meals	X			X	X
	½ cup/katori serving at a time, 3-4 times each day with 1-2 snacks between meals	X	X			X
	¾ to 1 cup/katori serving at a time, 3-4 times each day with 1-2 snacks between meals	X	X	X		
Recording of weight-for-age by AWW (Yes/No)						
If yes, record weight (in kg) as per MCP card						
Recording of weight-for-length/height by AWW (Yes/No)						
If yes, record length/height (in cm) as per MCP card						
Identified as underweight (Yellow) (Yes/No)						
Identified as severe underweight (Red) (Yes/No)						
If severe underweight, Did child referred to NRC? (Yes/No)						
Any developmental delay identified? (Yes/No)						X
If yes, Did s/he referred to ANM/Health Facility (Yes/No)						X
Age appropriate complete immunization received (Yes/No) (as per MCP card)						
Measles vaccine given (as per MCP card) (Yes/No)		X	X			
Vitamin A given (Yes/No)		X	X		X	
ORS at home (Yes/No)		X				
IFA syrup at home (Yes/No)		X				
ASHA to provide services at age (write Yes/No)		**3 Months**	**6 Months**	**9 Months**	**12 Months**	**15 Months**
Counsel for exclusive breast feeding (Yes/No)			X	X	X	X
Counsel for complementary feeding (Yes/No)		X				
Counsel for hand washing (Yes/No)						
Counsel on parenting (Yes/No)						
Family planning counselling (Yes/No)						
ORS given (Yes/No)		X				
IFA syrup given (Yes/No)		X				
Name and Signature of ASHA with Date of completion of activities (DD/MM/YYYY)						
Name and Signature of ASHA Facilitator or ANM/MPW with Date of verification of card (DD/MM/YYYY)						
Amount of incentive paid to ASHA and date of payment (DD/MM/YYYY)						

Village/Slum:	Block:	District:
Sub- Health Centre:	HC/UPHC:	
Name of Child:	Sex of child: Female	Male
Mother's Name:	Father's Name:	
Date of Birth of Child (DD/MM/YYYY):		MCTS/RCH ID No.
Date of submission of HBYC Card to ASHA Facilitator or ANM/MPW (DD/MM/YYYY):		

Home Based Care for Young Child visits after 6 weeks (To be filled by the ASHA during home visits, verified by ASHA Facilitator or ANM/MPW after completion of each scheduled home visits-3 months, 6 months, 9 months, 12 months and 15 months and submitted to ASHA Facilitator or ANM/MPW after completion of each visit).

HOME BASED CARE FOR YOUNG CHILD (HBYC) CARD - ASHA COUNTER FOIL

Home Based Care for Young Child visits after 6 weeks *(To be Filled by the ASHA during home visits and retained by the ASHA as reference copy).*

Village/Slum: Block: District:

Sub-Centre: PHC/UPHC:

Name of Child: Sex of child- Female Male

Mother's Name: Father's Name:

Date of Birth of Child (DD/MM/YYYY): MCTS/RCH ID No.

Name and Signature of ASHA

Amount of incentive paid to ASHA and Date of payment (DD/MM/YYYY)

Date of submission of HBYC Card after verfication by ASHA Facilitator or ANM/MPW

(DD/MM/YYYY)

Annexure-4: Equipment and Medicine Stock Card (for both ASHA and ASHA Facilitator)

Equipment	Available and functional	Replenishment required	Remarks
Neonatal Weighing Scale with Sling			
Digital Thermometer			
Paladi / Baby Feeding Spoon			
Baby Blanket			
Digital Watch			
Warm Bag			
Medicines	**Available/ Balance – (quantity)**	**Replenishment given (quantity)**	**Remarks**
Syrup Amoxicillin			
Tablet Amoxicillin			
Syrup Cotrimoxazole			
Tablet Cotrimoxazole			
Syrup Paracetamol			
Tablet Paracetamol			
Albendazole			
Antimalarial*			
IFA syrup			
ORS			
Zinc			
OCP			
CC			
ECP			
RDK			
Nishchay kit			

***As per requirement**

Annexure-5: Child Death Review (CDR) format

5.1 For ASHA

FORM 1:
NOTIFICATION CARD

For Office Use Only	
Date on which notification was received	
Name of the person who received the notification	

Instructions:

1. *To be filled by the primary informant*
2. *Two copies should be filled in case of Community Based Child Death Review (CBCDR) (one to be submitted to ANM/MPW and one handed over to the family)*
3. *For Facility Based Child Death Review (FBCDR) only one copy needs to filled and handed over to Facility Nodal Officer (FNO)*
4. *If the notification card is already filled, address the bereavement issues, offer support and leave (CBCDR only)*
5. *Write in capital letters*
6. *Circle the appropriate response (or) place a ✓ (tick) wherever applicable*

1. Name of the Child: _____
   (In case of a newborn, name of the mother should be used e.g. Baby of Nirmala)
2. Date of Birth (If available) D D / M M / Y E A R
3. Age ☐☐ Years ☐☐ Months ☐☐ Days ☐☐ Hours
4. Sex ☐ Male ☐ Female
5. Mother's Name : _____
6. Father's Name : _____
7. Complete Address : _____
   House Number : _____
   Mohalla/Colony : _____
   Village/Town/City : _____
   Block : _____
   District/Tehsil : _____
   State : _____
   Pincode : ☐☐☐☐☐☐
8. Landmarks, if any : _____

9. Phone number of parents/family member (living in same household):

☐ Landline: _____

☐ Mobile Number: _____

10. Date of Death: D D / M M / Y E A R

11. Place of Death

a) Home ☐ b)Hospital ☐ (If hospital, mention the name_____)

c) In transit ☐

Name of First Informant _____ **Time** _____

Signature _____ **Date of Notification** _____

Hand over this card to the parents of the child. The purpose is to provide verification of the fact that the family has been visited by the primary informant, and to inform others (the Informant/s) visiting the family subsequently that the death has already been informed and to not repeat the process

Dear Parents,

We express our profound grief on the loss of your child. We will like to know more from you about the factors that could have contributed to the death of your baby so that steps can be taken to prevent Such deaths in the future. In this context, some of health staff members may visit you in coming weeks.

You are requested to please retain all the documents pertaining to the health condition of the baby and the mother.

Please show this card to the health staff, who comes to collect further details about the illness.

Signature of the Informant

Designation _____

Date _____/_____/_____

5.2 For ANM/MPW

FORM 2:
FIRST BRIEF INVESTIGATION REPORT

Instructions:

1. *To be filled by the ANM/MPW*
2. *Write in capital letters*
3. *Circle the appropriate response (or) place a ✓ (tick) wherever applicable*

Section A. Background Information

1. Name of the Child : _____
2. Date of Birth (if Available) [D][D] / [M][M] / [Y][E][A][R]
3. Age: ☐ Years ☐☐ Months ☐☐ Days (if age less than 1 month)
   ☐☐ Hours (If age less than one day)
4. Sex: ☐ Male ☐ Female
5. Address: _____
6. Name of Area PHC _____
7. Name of Area Sub-center _____
8. Order of Birth: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
9. Belongs to: SC/ST ☐ OBC ☐ General ☐
10. Does the family have a Below Poverty Line (BPL) card: Yes ☐ No ☐
11. Immunization Status:

At Birth :	BCG ☐	OPV 0 dose ☐	Hep Birth Dose ☐						
6 weeks :	OPV-1 ☐	Penta-1 ☐	FIPV-1 ☐	PCV-1** ☐	RVV -1 ☐				
10 weeks :	OPV-2 ☐	Penta-2 ☐	RVV -2 ☐						
14 weeks :	OPV-3 ☐	Penta-3 ☐	FIPV-2 ☐	RVV -3 ☐	PCV-2** ☐				
9-12 months :	MR-1 ☐	JE-1* ☐	PCV Booster** ☐						
16-24 months :	MR-2 ☐	JE-2* ☐	DPT Booster-1 ☐	OPV Booster ☐					

12. Weight (if recorded in the MCP card): ☐☐.☐☐ Kg
13. Growth Curve (fill for child less than 3 years; check MCP Card):
    a. Green Zone ☐ b. Yellow Zone ☐ c. Orange Zone ☐
14. Any h/o illness/injury: Yes ☐ No ☐ (if No. go to Sec. B)
15. If yes, Nature of illness: ☐

* JE in endemic districts
**PCV in selected states/districts : Bihar, Himanchal Pradesh, Madhya Pradesh, Uttar Pradesh (19 districts) & Rajasthan and Haryana (State initiative)

16.	Symptoms during illness	Circle the app. response	If yes, Duration of sym ptoms
a.	Inability to feed	Yes/No	☐☐ days
b.	Fever	Yes/No	☐☐ days
c.	Loose Stools	Yes/No	☐☐ days
d.	Vomiting	Yes/No	☐☐ days
e.	Fast breathing	Yes/No	☐☐ days
f.	Convulsions	Yes/No	☐☐ days
g.	Appearance of Skin Rashes	Yes/No	☐☐ days
h.	Injury (like fractures, wounds)	Yes/No	☐☐ days
i.	Any Other symptom (if yes) specify.....	Yes/No	☐☐ days

17. Details of treatment:

1) Whether Treatment for illness was taken or not? Yes ☐ No ☐ (if No, go to sec. B)

2) If yes, Where was the child treated:

a. Public Health Facility: PHC ☐ CHC ☐ DH ☐ SDH/Taluka Hospital ☐

b. Private Hospital/Nursing Home ☐

c. Qualified allopathic private practitioner ☐

d. AYUSH practitioner ☐

e. Unqualified provider (quack, informal provider ☐

f. Traditional Healer

Section B. Probable cause of death:

a. Diarrhoea ☐ b. Pneumonia ☐ c. Malaria ☐

d. Measles ☐ e. Septicemia (Infection) ☐ f. Meningitis ☐

g. Injury ☐ h. Any other cause (specify) ..... ☐

i. No identifiable cause ☐

Section C. According to the respondent (parent, close family member), what was the cause of death?

Section D. At which level do you think the delay occurred?

1. Delay at home (e.g. seriousness of illness not recognized, treatment not sought, treatment sought at a late stage, family members did not allow treatment seeking) ☐

2. Delay in transportation (e.g. transport facility not available, could not afford local transport, difficult/hilly terrain, long distance to the health facility) ☐

3. Delay at facility level (e.g. doctor/staff not available, drugs & equipment not available, delay in initiation of treatment) ☐

Section E. Based on your analysis of the situation in which the death took place, what according to you could have been done to avert this death?

1. _____

2. _____

3. _____

Name of ANM/MPW ..... **Signature .....**

Sub Health Centre ..... **Date .....**

Annexure-6: Checklist for home visits for ASHA Facilitators and ANMs/MPWs

	Parameters	Assessment – Yes/ No/ Partial	Remarks (record specific points that need discussion and follow up)
I. Home Based Newborn Care (HBNC)			
	General		
1.	Check for the functioning status of the equipment-		
a	Neonatal Weighing scale with Sling		
b	Digital Thermometer		
c	Digital watch		
d	Baby Feeding Spoon/ Paladai		
e	Baby Blanket		
f	Warm Bag		
2.	Check for the status of completion of visits made by ASHAs so far - as per the schedule		
	Did the ASHA do the following -		
i	Greeted the family properly?		
ii	Checked if the mother is breastfeeding the newborn properly and counselled for proper attachment?		
iii	Checked about signs for heavy bleeding and referred mother if required?		
iv	Asked about/observed the mother/family for their hygienic Practices in handling the baby?		
v	Measured the temperature of the mother?		
vi	Checked if the mother is having foul smelling discharge?		
vii	Checked if the mother is speaking abnormally or having fits?		
viii	Asked about any problems related to breast feeding and provided counselling to resolve them?		
ix	Wash hands properly before checking the baby		
x	Checked the eye of the newborn?		
xi	Weighed the newborn correctly?		
xii	Measured the temperature of the newborn?		
xiii	Counselled about keeping the baby warm		
xiv	Reinforced the message of exclusive breast feeding for first six months?		
xv	Demonstrated the Correct way of - a. Positioning for Breastfeeding b. Wrapping the Baby		
xvi	Checked for signs of sepsis in the newborn correctly – (Limp limbs, less/ stopped feeding, weak / stopped cry, distended abdomen, pus on umbilicus, chest indrawing, checked for temperature of the newborn)		
xvii	Gave the first dose of amoxicillin to the newborn with the correct dosage in case of signs of sepsis?		
xviii	Gave the right advice for management of newborn in case of signs of sepsis?		
xix	In case if the newborn's weight is less than 2.5 kgs, did ASHA counsel the family about keeping the baby warm and extra care practices?		
xx	In case if the newborn's weight was less than 1.8 kgs, did the ASHA refer the newborn and counsel the family about keeping the baby warm		
xxi	Was the newborn referred by ASHAs correctly as per the requirement?		
xxii	Checked the immunization status of the newborn?		
3.	Check with the family members about their levels of understanding about		

	Parameters	Assessment – Yes/ No/ Partial	Remarks (record specific points that need discussion and follow up)
i	Danger signs and how to manage diarrhoea at home		
ii	Danger signs and how to manage pneumonia at home		
iii	Was the counselling provided by ASHA, relevant to the family's needs?		
4.	Check if the next visit planned by ASHA for the newborn is according to the health status (i.e alternate days visit planned for a high risk/sick newborn or visits planned as per normal schedule for the normal newborn)		
	Check for the filled HBNC format and explain the gaps to the ASHAs if required		
II. Home Based Care for Young Child (HBYC)			
	At 3rd Month		
1.	Check for the status of completion of visits made by ASHAs so far - as per the schedule (Assessed if the child was LBW / sick newborn)		
	Did the ASHA do the following -		
i	Greeted the family properly		
ii	Checked the overall health status of the child?		
iii	Checked the Mother and Child Protection (MCP) card for the immunization status of the child?		
iv	Checked the Mother and Child Protection (MCP) card for growth monitoring – weight against age of the child		
v	In case of the growth faltering, assessed the reasons of growth faltering?		
vi	Counselled the family about feeding practices and reinforced the message about exclusive breastfeeding?		
vii	Assessed the development of the child appropriate to the age as per early childhood development milestone		
viii	Counselled the family to communicate / play with the child to stimulate growth as per early childhood development milestone		
ix	Checked for signs of illness in the child -		
a	Fever		
b	Diarrhoea		
c	Pneumonia		
x	Provided the medicine (Cotrimoxazole/Amoxicillin/ PCM) for management correctly as per the protocols for -		
a	Fever		
b	Diarrhoea		
c	Pneumonia		
xi	Counselled the family appropriately about management of the illnesses at home		
xii	Counselled the family about continued breast feeding during illness		
xiii	Counselled the family appropriately about referral (if required)		
xiv	Checked with the couple about the adoption of contraceptive methods and counselled them about the appropriate method of contraception?		
xv	Counselled the family about promotion of WASH practices-		
a	Safe Drinking water		
b	Sanitation		
c	Hand washing		
d	Hygiene		
xvi	Was the ASHA able to demonstrate to the family the use of household objects to play with the child if the family is not able to afford toys for the child (as per the items required for ECD Screening)		
	Check for the filled HBYC format and explain the gaps to the ASHAs if required		

	Parameters	Assessment – Yes/ No/ Partial	Remarks (record specific points that need discussion and follow up)
	At 6th/ 9th/12th and 15th Month		
1.	Check for the status of completion of visits made by ASHAs so far - as per the schedule (Assessed if the child was a LBW / sick newborn)		
	Did the ASHA do the following -		
i	Greeted the family properly		
ii	Checked the overall health status of the child?		
iii	Checked the Mother and Child Protection (MCP) card for immunization status of the child?		
iv	Checked the Mother and Child Protection (MCP) card for growth monitoring – weight against age of the child		
v	In case of malnutrition, did the ASHA refer the child to NRC/ appropriate health institution?		
vi	Counselled the family on timely initiation of complementary feeding		
vii	Reinforced the messages of continued breast-feeding		
viii	Assessed the development of the child appropriate to the age - as per early childhood development milestone		
ix	Counselled the family to communicate/play with the child to stimulate growth - as per early childhood development milestone		
x	Checked for signs of illness in the child -		
a	Fever		
b	Diarrhoea		
c	Pneumonia		
xi	Provided the medicine (Cotrimoxazole/Amoxicillin/ PCM) for management correctly as per the protocols for -		
a	Fever		
b	Diarrhoea		
c	Pneumonia		
xii	Counselled the family appropriately about management of the illnesses at home		
xiii	Counselled the family about continued feeding during illness		
xiv	Counselled the family appropriately about referral (if required)		
xv	Checked with the couple about the adoption of contraceptive methods and counselled them about the appropriate method of contraception?		
xvi	Counselled the family about promotion of WASH practices-		
a	Safe Drinking water		
b	Sanitation		
c	Hand washing		
d	Hygiene		
xvii	Gave the prophylactic IFA to the family and explained to the family about its appropriate usage		
xviii	Was the ASHA able to demonstrate to the family the use of household objects to play with the child if the family is not able to afford toys for the child (as per the items required for ECD screening)		
xix	In case the child was referred the child by the RBSK team, then did the ASHA follow upabout the status of the completion of treatment and informed the family about the next scheduled visit of the RBSK team.		
xx	In case the child has any form of disability, did the ASHA check about the health status of the child and inform the family about appropriate referral facilities / RBSK team.		
	Check for the filled HBYC format and explain the gaps to the ASHAs if required		

Annexure-7: HBNC /HBYC Supportive Supervision Reporting Format for ASHA Facilitators and ANMs/MPWs

Period of reporting: Q1, Q2, Q3, Q4 Year: 20.....

Name:

District: Block: SHC/HWC:

Name of the supervisor: Designation: AF/ ANM/ MPW

Total No. of ASHA: No of ASHAs visited during reporting period:

Sl	Major Activities	HBNC (Birth to 42 days)	HBYC (3-15 months)	Total
1	No. of children available in the catchment area			
2	No. of children received joint home visits			
3	No of children visited for;			
a	Low Birth Weight (LBW)/premature			
b	High risk sick children			
c	Malnourished Children			
d	Identified defects/ deficiencies/delays/diseases			
4	No. of children referred to a facility out of home visit			
5	No. of child death reported by ASHA			
6	No. of child death covered with First brief investigation report by ANM			
7	No. of ASHA given on-the-job mentoring and handholding support during home visit (household visits, skill, use of kit, filling formats, records etc.)			
8	No. of formats submitted to PHC/CHC for ASHA's incentive payment			
9	No. of meeting attended and discussed on HBNC & HBYC issues	At facility (SHC/ HWC/PHC) - At community (VHSNC/ MAS) -		

** Joint visits should be planned such that AF/ANM/MPW are able to cover around 30% of the newborns and children under 15 months over a period of one year in the catchment area.*

Remarks

Signature with date

List of Contributors

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Reviewed by States/Union Territories - Assam, Chandigarh, Chhattisgarh, Meghalaya and Gujarat

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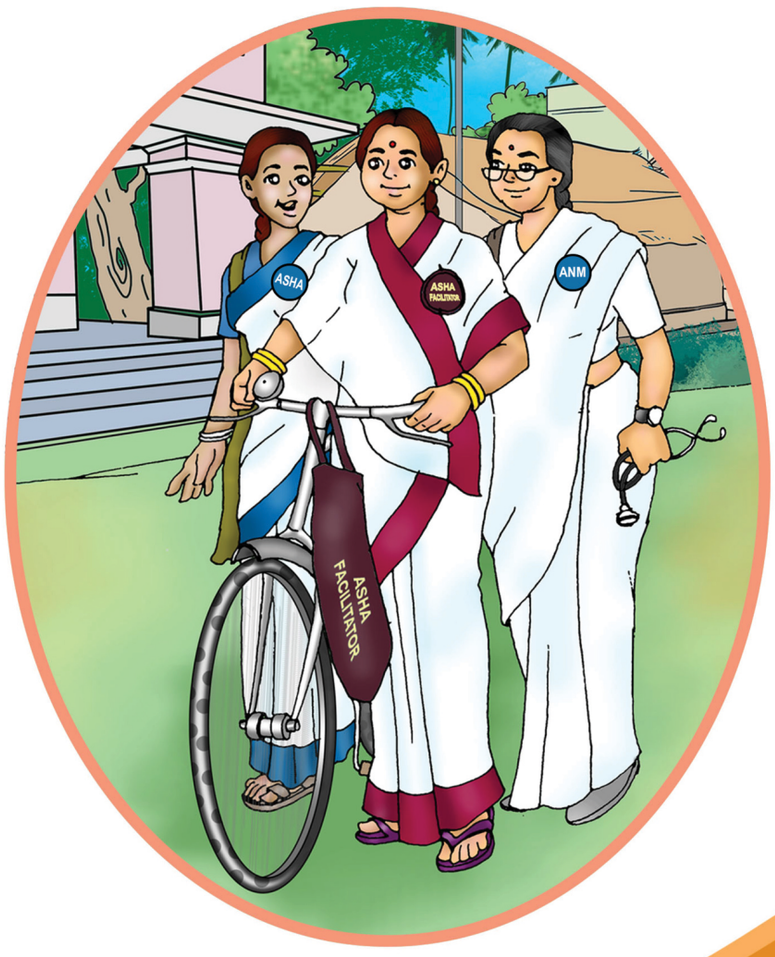

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

National Health Mission, Ministry of Health & Family Welfare
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