



# HOME BASED NEWBORN CARE Operational Guidelines



Ministry of Health and Family Welfare  
Govt. of India, **2011**



## Acknowledgements

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## Foreword

Reducing infant and child mortality is one of the foremost goals of National Rural Health Mission. The country as a whole has made significant progress in reducing Infant Mortality Rates, (IMR). However it is now clear that a high proportion of the infant death burden is related to newborn deaths, and further gains in reducing IMR are likely only through a focused effort at implementing evidence based cost effective interventions that affect neonatal health outcomes. There is sufficient evidence to demonstrate that despite the increasing numbers of institutional deliveries a substantial proportion of neonatal deaths occur in the home. Thus the provision of Home Based New Born (HBNC) care is critical.

The NRHM offers several existing platforms that need to be used more effectively to promote HBNC. The presence of a trained ASHA in every village in most parts of the country, a second ANM at the sub-centres in several areas, increasing numbers of women accessing health care facilities for delivery, and the institutionalization of the monthly Village Health and Nutrition Days provide unprecedented opportunities for making quantum improvements in infant, newborn and child health in India.

These Operational Guidelines provide the framework and guidance to enable a coherent home based newborn care strategy. The guidelines are expected to serve as a reference tool and facilitate the states in planning necessary interventions. They are based on sound public health evidence for effectiveness, efficiency and equity, and list the tasks and activities to be undertaken at each level. The states will need to ensure appropriate training of ASHA in the competencies required, as her services are at the core of the strategy. I am confident that these operational guidelines will prove to be very useful for programme officers in planning; implementing and monitoring home based newborn care. I hope that these guidelines assist the states to rapidly scale up home based newborn care as this will prove to be critical in enabling the country to achieve its child survival goals.

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## Abbreviations

ANC	Antenatal Check-Up
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
CES	Coverage Evaluation Survey
DLHS	District Level Household and Facility Survey
FRU	First Referral Unit
ICMR	Indian Council of Medical Research
IEC	Information Education and Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
JSSK	Janani-Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
MDG	Millennium Development Goal
MOHFW	Ministry of Health and Family Welfare
NBCC	Newborn Care Corner
NBSU	Newborn Stabilization Unit
NFHS	National Family Health Survey
NIHFW	National Institute of Health and Family Welfare
NHSRC	National Health System Resource Centre
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karaykram
OPD	Out Patient Department
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PNC	Postnatal Check-Up
RCH-II	Reproductive and Child Health Programme Phase II
SNCU	Special Newborn Care Unit
SRS	Sample Registration System
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

## Purpose of the Guidelines

The purpose of these guidelines is to enable the states to develop and operationalize a strategy to ensure that all newborns are provided with home based care, through a series of visits by the ASHA, and ensuring that she has the skills and support to do so. Together with the Janani Suraksha Yojana (JSY) and the Janani Shishu Suraksha Karyakaram (JSSK), the HBNC ensures that mother and newborn have access to services in order to ensure positive health outcomes. The guidelines are divided into two sections. The first section discusses the trends, rationale and the policy frameworks for HBNC. The second section discusses the skills and support that the ASHA requires, actions to be taken at state and district levels, and monitoring of the programme. The annexures consist of the ASHA's home visit form, the first visit to the newborn form, material for IEC displays and the contents of the ASHA kits and communication package to enable the provision of HBNC.





## **Section 1**

### **Rationale for Home Based**

### **New Born Care**

## 1.1 Defining Neonatal and Infant Deaths

1. **Neonatal Mortality:** Deaths occurring during the neonatal period, commencing at birth and ending 28 completed days after birth.
  - a) **Early Neonatal mortality:** Deaths occurring during the neonatal period, from birth to seven days after birth.
  - b) **Late neonatal mortality:** Deaths of the infants occurring during the neonatal period, from the eighth day after birth to 28 completed days after birth.
2. **Still Births:** Death of foetus after 28 completed weeks of pregnancy, or the birth of a dead fetus which weighs over 1000 gms or is more than 35 cm body length.
3. **Perinatal Mortality:** Deaths occurring after 28 completed weeks of gestation (still births) and upto seven completed days (early neonatal deaths) after birth..
4. **Infant Mortality:** Death occurring in a child before it reaches the age of one year.

All these are expressed per 1000 live births in one year, which is defined as the rate. Thus for example, Neonatal Mortality Rate is the number of neonatal deaths in a given year per 1000 live births in that year.

## 1.2 Trends in Neonatal and Infant Mortality

Infant Mortality Rate (IMR) has declined from 146 in 1951 to 50 in 2009. However, as the data in Figure 1 show, the decline in neonatal mortality rates have been slow in the last two decades. Each year, of the almost 27 million infants born in the country, about 0.88 million die before they complete one month of life and a total of million die before their first birthday. NMR therefore now constitutes nearly 68 % of the total IMR. Any further reductions in IMR reduction can only come from declines in NMR.

The country has laid down ambitious goals for reduction of infant and child mortality. (Table 1). The current status of the key national infant and child health indicators is summarized below. At the present rate of progress, it is unlikely that the country will achieve the national goals laid out in the Eleventh Five-Year Plan.

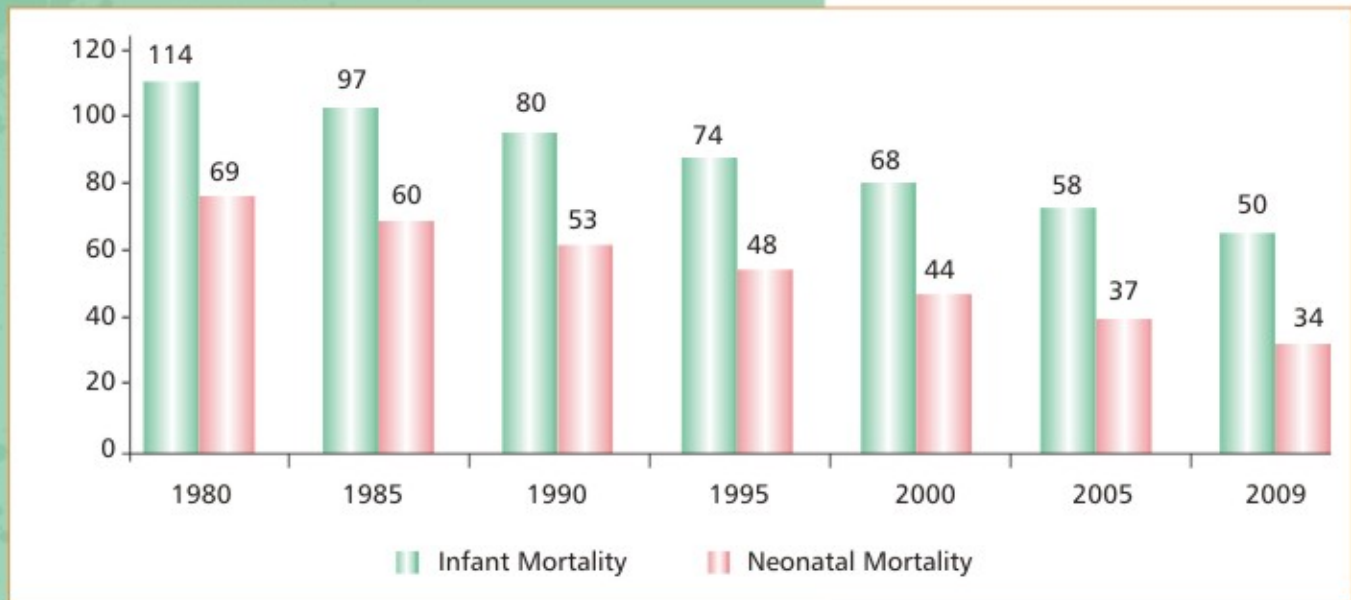


Figure 1: Five year trends in overall Infant Mortality Rate and Neonatal Mortality Rate (per 1000 live births)

Indicator*	Goals	Target	Status
Under-5 Mortality Rate	MDG-4 for 2015	38	64
Infant Mortality Rate	National Population Policy, NRHM, and RCH II for 2010	<30	50
	XI Plan goal for 2012	28	
Neonatal Mortality Rate	National Plan of Action for Children goal for 2010	18	34
	Enabling goal for RCH II programme for 2010	<20	

Table 1: National goals for neonatal, infant and under five mortality  
Source: IMR, NMR and U5MR - SRS 2009 (Mortality rate per 1000 live births)

### 1.3 What do newborns die of?

Infections (including sepsis, pneumonia, diarrhoea and tetanus), prematurity, and birth asphyxia, are the major causes of death in the neonatal period. The recent Lancet Million Death Study, in which about 2.35 million estimated number of under five deaths, were reviewed, showed that of the neonatal deaths, the main causes of death in order of frequency were preterm and low birthweights, neonatal infections, and birth asphyxia.

### 1.4 When do Newborns Die?

The most vulnerable period of a newborn's life is the period during birth and the first week of life. This is illustrated by Figures 5a and 5b, which are based on an ICMR study. As Figure 5a shows, nearly three-quarters of all neonatal deaths occur during the first week of life, The remaining 25% of deaths occur between weeks two to four. Figure 5b, shows that nearly 40% of deaths occurring within the first 24 hours of life, or on the first day, with the next vulnerable period being around Day 3 which accounts for about ten percent of deaths. This distribution of neonatal deaths is also borne out by other studies at national and global levels.

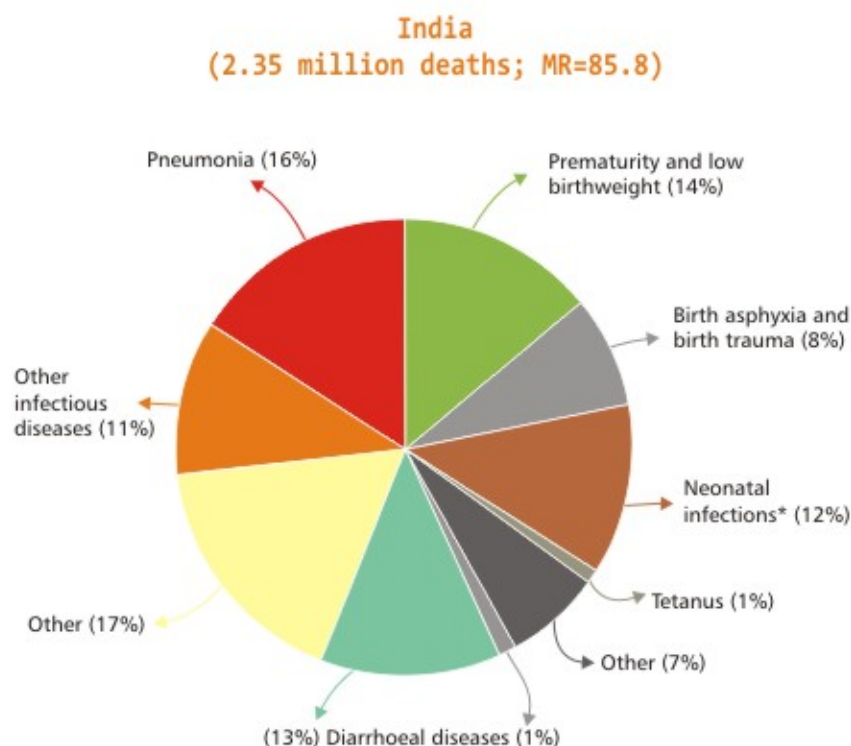


Figure 4: Causes of Neonatal and Child Mortality in India-

Source: Causes of Neonatal and Child Mortality in India: a nationally representative mortality survey – Lancet November 12, 2010 DOI: 10.1016/S0140-6736(10)614614

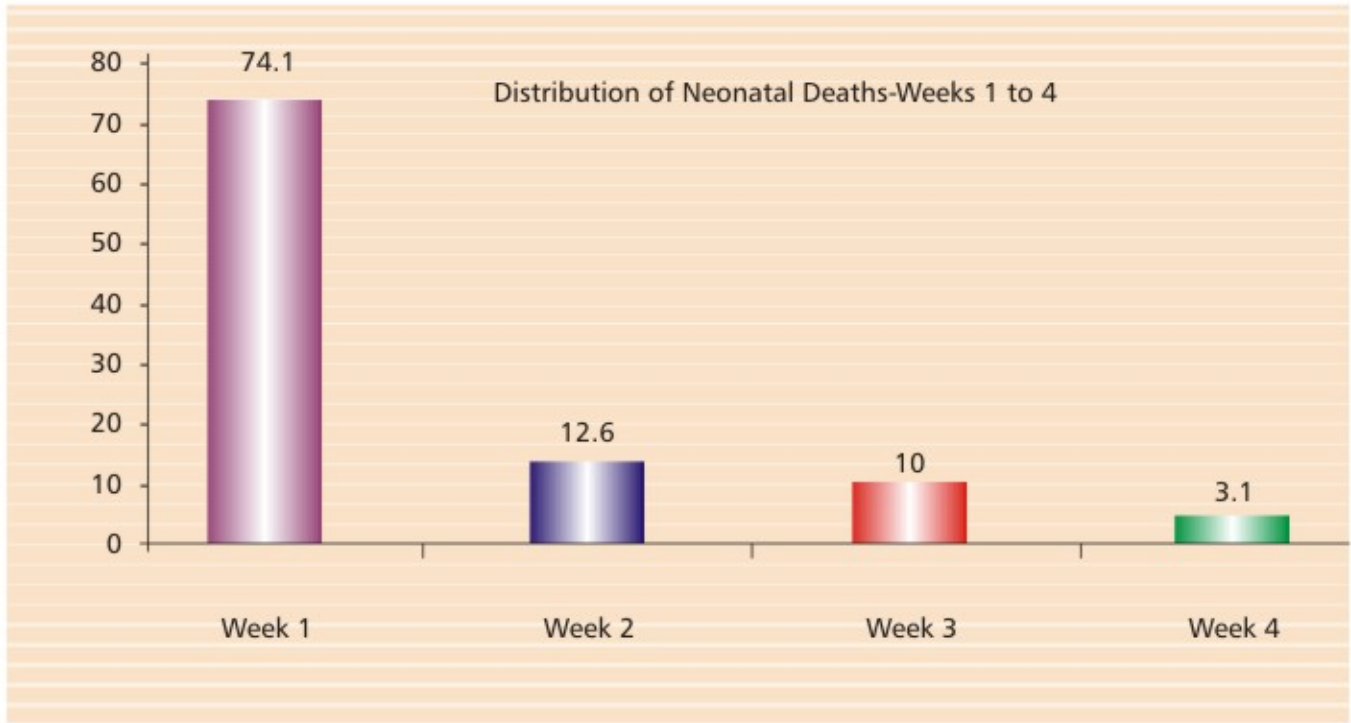


Figure 5a: Distribution of Newborn deaths in the first four weeks

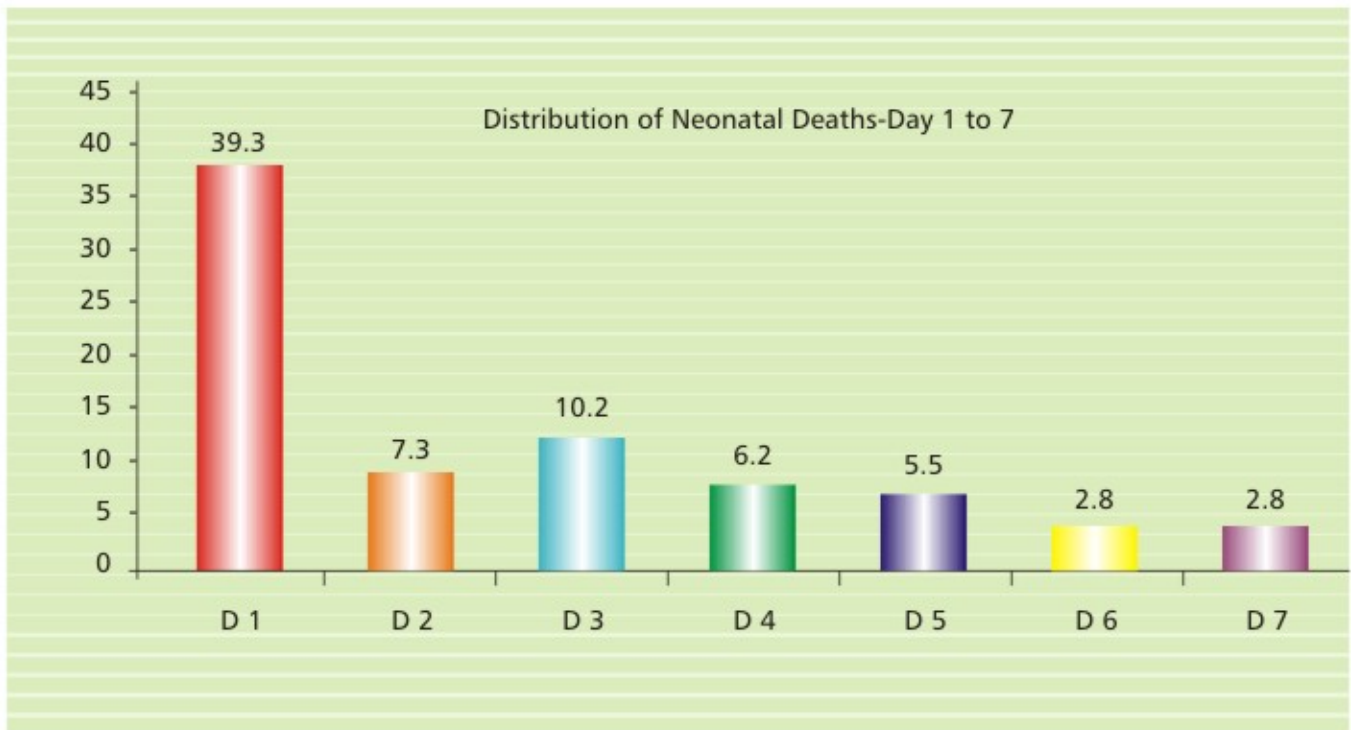
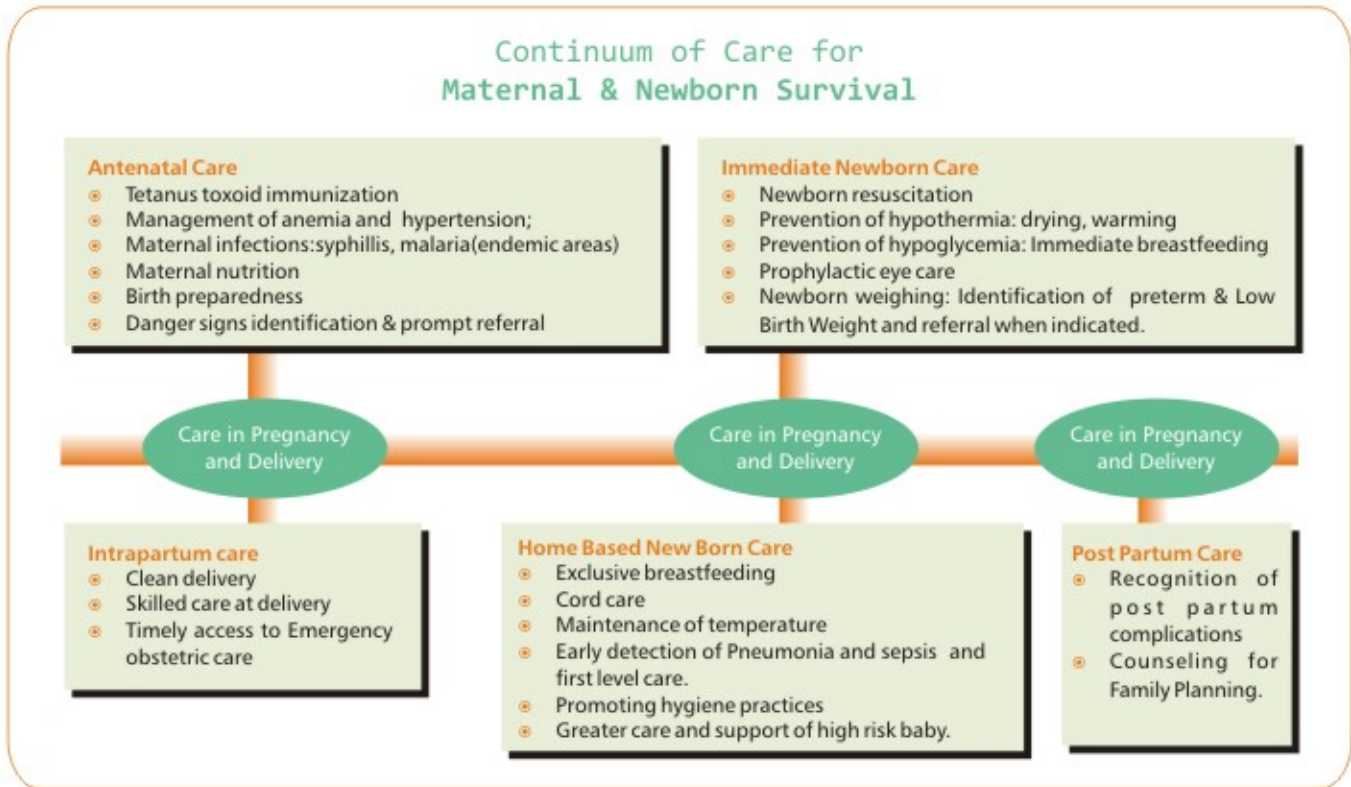


Figure 5b: Distribution of Newborn deaths in the first week of life



## 1.5 What are effective technical interventions to reduce Neonatal Mortality

Effective interventions to reduce neonatal deaths span both maternal and neonatal care and encompass interventions for appropriate care during pregnancy, care for the mother and newborn during and immediately after delivery, and care for the newborn during the first weeks of life.



## 1.6 Rationale for Home Based Newborn care.

⇒ In cases of institutional delivery, where the baby and mother are discharged after 48 hours according to current guidelines, it is expected that care for the newborn during this period is provided in the institution. When the mother and baby return home, although the newborn has crossed the critical first day, there is still the remainder of the first week and month during which neonatal mortality could be as high as 54%, and for which care has to be provided. Any illness during this period could result in the newborn dying at home, unless the baby is provided with appropriate care or referred to a facility equipped to treat sick newborns.

⇒ A significant proportion of mothers prefer to return home within a few hours after delivery, which means that home based newborn care needs to be available even for such babies born in institutions to tide them over the first day and thereafter. Although this is not desirable and all efforts should be made to convince the mothers to stay in the institutions for the first 48 hours, existing evidence shows that while at an all India level nearly 45% of mothers return home before 48 hours. However in this percentage is very low in states of Bihar (15.3%), Haryana (29.2%), Nagaland (21.1%) and Orissa (28.3%). ( Coverage Evaluation Survey, 2009, UNICEF)

⇒ Despite the impressive increases in institutional deliveries there is a persistence of home deliveries ranging from between 25% to 50% across the states. For such deliveries, home based newborn care, is essential even on the first

day There is evidence that many home deliveries are not conducted by skilled birth attendants, particularly in underserved areas, and among the marginalized.

The strategy of universal access to home based newborn care must necessarily complement the strategy of institutional delivery to achieve a significant reduction in postpartum and neonatal mortality and morbidity. Even in institutional deliveries, the quality and access to skilled care during the critical period of birth, immediately after birth and on the first day should be ensured, to ensure positive health outcomes. HBNC also needs the ready access and backing from Sick Newborn Care Units (SNCU) and New born Stabilization Units (NBSU) that are well staffed, well equipped and are functioning effectively.

## 1.7 Policy Frameworks for the provision of Home Based New Born Care

Home Based Newborn Care is well articulated in government policy aimed at improving newborn survival. The key policy documents that articulate this are the XI plan document (2007-2012) and the Minutes of meeting from the Mission Steering Group, dated June 21, 2011.

### Excerpts from the XI Plan Document

"3.1.130 Home-based neonatal care will be provided, including emergency life saving measures."..... During the Eleventh Five Year Plan, ASHAs will be trained on identified aspects of newborn care during their training. .... To supervise and provide onsite training and support to ASHAs, mentor- facilitators will be introduced for effective implementation. The national strategy during the Plan will be to introduce and make available high-quality HBNC services in all districts/areas with an IMR more than 45 per 1000 live births. Apart from performance incentive to ASHAs, an award will be given to ASHAs and village community if no mother–newborn or child death is reported in a year."

### Excerpts from the Mission Steering Group Minutes

"...."The proposal as recommended by the Empowered Programme Committee ( Agenda item No. 11- propped incentive of Rs.250 for a set of six home visits to assess the new born as well as post partum care of mother) was approved by MSG. MSG also decided that the incentive amount would be paid one time after 45 days of delivery subject to the following:

- Recording of weight of the new born in MCP card
- Ensuring BCG, 1st dose of OPV and DPT vaccination
- Both the mother and the newborn are safe till 42 days of the delivery, and
- Registration of birth has been done.

## 1.8 Who is the provider of HBNC?

It is important for all peripheral providers of services to be aware of the principles and practice of Home Based Newborn care. This includes the AWW, the ANM and the Medical officers. However, as envisaged in the XI plan, the main vehicle to provide this is the ASHA. The reasons for this include:

1. She is resident and available in every village.
2. She is being equipped with the skills and support to provide such care.
3. The findings of a recent evaluation show that the ASHA is much more likely to visit the newborn and post-partum mother at home than the ANM or AWW, and is also more likely to be consulted for care of the sick child. The ASHA is emerging as the first port of call for sick newborns and children.
4. The ASHA is supported and guided by the health system which is directly responsible for newborn and child survival. This relationship with the health system is essential for facilitating referral.



## Section 2

# Operationalizing HBNC

## 2.1 Objectives of HBNC

The major objective of HBNC is to decrease neonatal mortality and morbidity through:

- ▶ The provision of essential newborn care to all newborns and the prevention of complications
- ▶ Early detection and special care of preterm and low birth weight newborns
- ▶ Early identification of illness in the newborn and provision of appropriate care and referral
- ▶ Support the family for adoption of healthy practices and build confidence and skills of the mother to safeguard her health and that of the newborn.

## 2.2 Key activities in HBNC

The key activities in HBNC constitute the provision of:

1. Care for every newborn through a series of home visits by a trained health worker in the first six weeks of life. In most state contexts this health worker is the ASHA.
2. Information and skills to the mother and family of every newborn to ensure better health outcomes.
3. An examination of every newborn for prematurity and low birth weight.
4. Extra home visits for preterm and low birth weight babies by the ASHA or ANM, and referred for appropriate care as defined in the protocols.
5. Early identification of illness in the newborn and provision of appropriate care at home or referral as defined in the protocols..
6. Follow up for sick newborns after they are discharged from facilities.
7. Counselling the mother on postpartum care, recognition of postpartum complications and enabling referral
8. Counselling the mother for adoption of an appropriate family planning method.

In case of those deliveries that occur on the way to the health institutions or at home out of choice, despite motivation for institutional delivery, the ASHA must be equipped with the skills and competencies required to provide appropriate newborn care.

*This would exclude the states of Himachal Pradesh, Goa, Puducherry, Daman and Diu, and the non tribal areas of Tamil Nadu*

## 2.3 Skills needed by the ASHA in the provision of HBNC

1. Mobilize all pregnant mothers and ensure that they receive the full package of antenatal care
2. Undertake birth planning and birth preparedness with the mother and family to ensure access to safe delivery.
3. Provide newborn care through a series of home visit which include the skills for:
  - a. Weighing the newborn,
  - b. Measuring newborn temperature,
  - c. Ensuring warmth,
  - d. Supporting exclusive breastfeeding through teaching the mother proper positioning and attachment for initiating and maintaining breastfeeding,
  - e. Diagnosing and counselling in case of problems with breastfeeding
  - f. Promoting hand washing,
  - g. Providing skin, cord and eye care,
  - h. Health Promotion and counseling mothers and families on key messages on newborn care which includes discouraging unhealthy practices such as early bathing, and bottle feeding,
  - i. Ensuring prompt identification of sepsis or other illnesses.
4. Assessing if the baby is high risk (preterm or low birth weight), through the use of protocols and managing such LBW or pretem babies through
  - a. Increasing the number of home visits,
  - b. Monitoring weight gain,
  - c. Supporting and counseling the mother and family to keep the baby warm and enabling frequent and exclusive breastfeeding,
  - d. Teaching the mother to express breastmilk and feed baby using cup and spoon or paladai, if required.

5. Detect signs and symptoms of sepsis, provide first level care and refer the baby to an appropriate center. If the family is unable to go, the ASHA should ensure that the ANM visits the sick newborn on a priority basis.
6. Recognize postpartum complications in the mother and refer appropriately.
7. Counsel the couple to choose an appropriate family planning method.
8. Use the checklist for first Visit to the Newborn (Annexure 1a) and Home visit form (Annexure 1b) to remind her to ask the key questions and ensure that she follows the steps of examination and counseling the mother.
9. Provide immediate newborn care, in case of those deliveries that do not occur in institutions (home deliveries/deliveries occurring on the way to the institution)

## 2.4 Capacity Building of the ASHA

The activities to be provided as part of home based care for the newborn and the skills that the ASHA is expected to acquire are taught in Modules 6 and 7. The content of these modules cover the skills listed in the section above. The ASHA is trained in these skills through four rounds of training of five days each by ASHA trainers using a trainer module. All four rounds are expected to be completed within one year. After each round of training the ASHA is evaluated for knowledge and skills. This is followed by the process of certification of the ASHA. There is a gap of about ten to twelve weeks between each round of training during which she is supported and mentored to practice the skills learnt during the training. The ASHA is to be provided on the job support and mentoring by the facilitators. Facilitators are trained in the use of supervisory checklists to ensure accurate application of skills by the ASHA to provide HBNC.



## 2.5 Support to the ASHA to ensure positive newborn health outcomes

For the ASHA to be effective in providing HBNC and to enable reductions in neonatal mortality, the following support needs to be provided:

1. **Payments:** The ASHA is to be paid Rs. 250 for conducting home visits for the care of the newborn and post partum mother. The schedule of payment is as follows:
  - Six visits in the case of institutional delivery (Days 3, 7, 14, 21, 28 and 42), and
  - Seven visits in the case of home delivery (Day 1, 3, 7, 14, 21, 28, and 42).

The amount is to be paid based on the completed home visit form and first examination of the newborn, forms, validated by the facilitator. The payments to the ASHA should be made on time and with dignity. The payments are made on the 45th day (using the state mechanism for JSY payment) subject to the following:

- (i) Ensuring that birth weight is recorded in the Maternal and Child Protection (MCP) Card
- (ii) Ensuring that the newborn is immunized with: BCG, first doses of OPV and DPT, and entered into the MCP card
- (iii) Ensuring Birth Registration
- (iv) Both mother and newborn are safe until the 42nd day of delivery

### 2. Ensuring field level support:

- The ASHA should be visited at least twice a month by the facilitator to provide on the job mentoring, monitoring, and support.
- Use of supervisory checklists by the facilitators is important to support the ASHA in providing HBNC.
- Monthly review meetings at the level of the PHC are to be held for problem solving and building the linkages for referral support.

- Refresher trainings should be held at least once every three months to ensure knowledge and skill retention.
- The ASHA's kit should be replenished regularly and the equipment should be reviewed and refurbished as required. (Annexure 3 has a list of the drugs and equipment needed by the ASHA to provide HBNC).

**3. Enabling Health Promotion by the ASHA:** The ASHA is expected to provide interpersonal one communication to the mother and health education to the family, and community to promote positive health practices for the care of the newborn and postpartum mother. The ASHA is expected to be equipped with a communication package to enable such health education.

**4. Other forms of support:** At the village level the ASHA is to be supported by a functional Village Health, Sanitation and Nutrition Committee/Women's health committee. She also needs the encouragement and support from the ANM and the Medical officers particularly to ensure responsive referral which will add to her credibility and improve her performance. She is also to be provided with an ID card and there needs to be official acknowledgement of her contribution through the institution of awards, for specific outcomes, e.g no newborn deaths in an entire year. Any grievances are to be addressed promptly through grievance redressal mechanisms

## 2.6 Actions at the state and district levels

States will ensure that the scheme is widely publicized, that the drugs and consumables are available, that transport to an appropriate referral facility is readily available, and a grievance redressal facility is established at all health care institutions. The key steps to be taken at the state and district levels are listed below:

### I. Actions at State level:

- Issue Government order on Home Based New born Care and nominate a State Nodal Officer.
- Ensure that a state level resource center/centers are created to provide the training support for district and block levels to ensure high quality training of ASHA and facilitators.
- Ensure that training of ASHA in Modules 6 and 7 is completed within one year and that she is certified to provide HBNC.
- Ensure support and supervisory mechanisms for the ASHA to undertake HBNC with at least two on site mentoring visits every month by a supervisor/facilitator
- Institute a grievance redressal mechanism for ensuring that the commitments are fulfilled in letter and spirit.
- Ensure regular procurement and availability of drugs and consumables for the ASHA kit and in the public health institutions.(Annexure 2)
- Establish district wise assured referral linkages
- Provide required finances and necessary administrative steps/G.O.s for the above activities.
- Financially empower the district and facility in-charges for the above activities.
- Regularly monitor and report on designated formats at specified periodicity.
- Review the implementation status during district CMOs meetings and quarterly review meetings of district nodal officers and district community mobilizers

### II. Actions at District level:

- Nominate a District Nodal Officer.
- **Ensure that the support system for ASHA:** district community mobilizer, block community mobilizer and facilitators are in place.
- Circulate the G.O. on free entitlements to all facility in-charges.
- Widely publicize free entitlements in public domain.
- Institute a grievance redressal mechanism for ensuring that the commitments are fulfilled in letter and spirit.
- Enable and monitor the quality of ASHA training in Modules 6 and 7
- Regularly review the stocks of drugs & consumables for ensuring availability at the in the ASHA kit and in public

health institutions.

- Review referral linkages and their utilisation by beneficiaries.
- Provide required finances / empowerment for utilisation of funds to the Block MOs and facility in-charges for the above activities, particularly in emergency situations / stock outs.
- Regularly monitor & report on designated formats at specified periodicity.
- Review the implementation status during Block MOs/MOs meetings.

## Implementation of the scheme is expected to ensure the following

### (i) Dissemination of the entitlements in the public domain:

- Widely publicize these entitlements through print and electronic media.
- Display them prominently in all Government health facilities e.g. SCs, PHCs, CHCs, SDHs and DHs/FRUs (main entrance, neonatal wards and outside outpatient areas) as per the enclosed format at Annexure – 3).
- IEC budget sanctioned in the Project Implementation Plan (PIP) under RCH/NRHM can be utilised for this.

### (ii) Ensure regular and timely supply of drugs and consumables:

- Ensure regular procurement, uninterrupted supply and availability of drugs & consumables and regular replenishments for ASHA drug kits..
- Empower the head of the District / health facility to procure drugs & consumables in case of potential stock outs.
- Ensure the quality and shelf life of drugs supplied to the ASHA.
- Ensure a proper inventory of drugs and consumables at each health facility for timely reporting on stock outs and expiry and a stock card with each ASHA.
- Ensure that first expiry drugs and consumables are used first at every level.

### (iii) Referral and Transport:

- Ensure universal reach (no area left uncovered), with 24 x 7 referral services for and providing assured referral transport.
- State is free to use any suitable model of transportation e.g. Government Ambulances, EMRI, referral transport PPP model etc.
- Establish call centre (s) with a single toll free number, at district or State level.
- May provide ambulances / vehicles with GPS, for effective tracking and management.
- Establish linkages for the inaccessible areas (hilly terrain, flooded or tribal areas etc) to the road head / pick up points.
- Widely publicize the free & assured referral transport through print and electronic media.
- Monitor and supervise services at all levels, including utilization of the each vehicle and number of cases transported.

### (iv) Grievance Redressal:

- Prominently display the names, addresses, emails, telephones, mobiles and fax numbers of grievance redressal authorities at health facility level, district level and state level, and disseminate them widely in the public domain.
- Set up help desks and suggestion / complaint boxes at Government health facilities.
- Keep fixed hours (at least 1 hour) on any two working days per week, for meeting the complainants and redressing their grievances related to free entitlements.
- Take action on the grievances within a suitable timeframe, and communicate to the complainants.
- Maintain proper records of actions taken.

### (v) Funds

- Reflect the requirement of funds in the state PIP under NRHM in addition to resources available from State budget.

## Monitoring

The following indicators will be used to measure the programmatic outcomes.

Indicators		
Process	Output	Outcomes
No. of ASHAs trained in Module 6 & 7	<ul style="list-style-type: none"> <li>Percentage of newborns who were visited on the first day at home</li> <li>Percentage of newborns who received full schedule of home visits by ASHA</li> <li>Percentage of newborns who were weighed at birth</li> <li>Percentage of newborns who were breast fed in the first hour</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of LBW reported</li> <li>Percentage of LBW referred</li> </ul>
	<ul style="list-style-type: none"> <li>Percentage of newborns who were referred for illness</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of sick newborns admitted at the referral sites</li> <li>No. of newborn deaths.</li> </ul>

### Steps of monitoring -

1. ASHA's home visit forms can be used to assess the number and content of her visits. ASHAs have to fill the home visit form during every visit to the household with a newborn.
2. ASHA facilitator should verify and sign the home visit forms filled by ASHA during the monthly meeting with the ASHAs.
3. Based on the performance of the ASHAs, the ASHA facilitator should issue and submit a signed token/ slip to the PHC staff (clerk/ accountant)
4. The ANM should review the performance of all ASHA with respect to home visits for newborns in her sub center area during the VHND/village visit.
5. Payment to ASHAs should be made by the PHC staff (clerk/accountant) after taking approval from the MO/PHC who will review the implementation during meetings.
6. At district level, the district nodal officer should monitor and follow up on the implementation on the programme. The CMOs would also review the progress during the CMO's meeting at district level.
7. The State nodal officer will monitor the implementation and effectiveness of the programme. State Mission Director would also review the progress of the programme in each district with district CMOs at the CMOs meeting held at state level.
8. At the National level, the scheme will be monitored by National Health System Resource Centre, under guidance and support from Child Health Division, Ministry of Health & Family Welfare, Government of India.



## Annexure 1a First examination of the newborn

(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 then fill the form on the day of her visit and write the date of her visit).

**Part I:**

- 1) Date of Birth \_\_\_\_\_
- 2) Pre-term cut-off date: \_\_\_\_\_ Is baby pre-term? Yes/No
- 3) Date of first examination \_\_\_\_\_

**Time:** Early morning Morning Afternoon Evening Night \_\_\_\_\_ Hrs \_\_\_\_\_

- 4) Does mother have any of the following problems?
  - a. Excessive bleeding Yes/No
  - b. Unconscious/fits Yes/No

**Action:** If yes, refer immediately to hospital Action taken Yes/No

(In case of stillbirth, do not perform further examination but complete the examination of the mother as per home visit form on day 2, 3, 7, 14, 21, 28)

- 5) What was given as the first feed to baby after birth? \_\_\_\_\_
- 6) At what time was the baby first breastfed? Hrs \_\_\_\_\_ Min \_\_\_\_\_

**How did baby take feed? Mark \_**

- 1) Forcefully
- 2) Weakly
- 3) Could not breastfeed but had to be fed with spoon
- 4) Could neither breastfeed nor take milk given by spoon
- 7) Does the mother have breastfeeding problem? Yes/No

Write the problem \_\_\_\_\_

If there is problem in breastfeeding, help the mother to overcome it

**Part II:**

First examination of the baby

- 1) Temperature of the baby (Measure in axial and record): \_\_\_\_\_
- 2) Eyes: Normal
- Swelling or oozing pus

**For Supervisor#**

Correct/Incorrect  
 Correct/Incorrect  
 First examination done  
 Days: \_\_\_ Hrs: \_\_\_  
 After birth  
 Yes/No/NA

Correct/Incorrect

Correct/Incorrect

Correct/Incorrect

Yes/No/NA

Yes/No/NA

Yes/No/NA

3) Is umbilical cord bleeding : Yes/No

**Action:** If yes, either ASHA, ANM or TBA can tie again with clean thread.

Action taken: Yes/No

Yes/No/NA

4) Weight: Kg \_\_\_\_ Gm \_\_\_\_ Colour on scale: Red/Yellow/Green

Weighing matches with the colour? Yes/No

#Mark yes if necessary and possible action has been taken without any mistake

5) Record



Correct/Incorrect

1. All limbs limp	
2. Feeding less/stop	
3. Cry weak/stopped	

Yes/No/NA

**Routine Newborn Care**

Whether the task was performed

1) Dry the baby Yes/No

2) Keep warm, don't bathe, wrap in the cloth, keep closer to mother Yes/No

3) Initiate exclusive breastfeeding Yes/No

Yes/No/NA

6) Anything unusual in baby? Curved limbs/Cleft lip/Other \_\_\_\_\_

Yes/No/NA

### For Supervisor

Form checked by: Name \_\_\_\_\_ Date \_\_\_\_\_

Corrections: \_\_\_\_\_

\_\_\_\_\_

Unusual or different observation: \_\_\_\_\_

Whether the form has been completed?

Yes/No

Signature \_\_\_\_\_

Name of ASHA \_\_\_\_\_ Date \_\_\_\_\_

Name of Trainer \_\_\_\_\_ Total Score \_\_\_\_\_

Block \_\_\_\_\_

## Annexure 2 Additional contents of ASHA kit to facilitate HBNC

1. Equipment:	No.
• Baby weighing scale with sling	1
• Digital thermometer	1
• Digital watch/ timer device	1
2. Medications:	
• Gentian violet paint (0.5% and 0.25% IP)	
• Syrup Paracetamol	
• Syrup Cotrimoxazole	
3. Consumables:	
• Cotton	
• Gauze	
• Soap and soap case	
4. Baby Blankets, Locally made and locally procured	2
5. Spoon –stainless steel	1

**Annexure 3**  
**Format for dissemination of HBNC IEC material**



Logo Of The State Govt.



# Home Based Newborn Care



Care of the **Newborn baby** and mother by ASHA through regular home visits on

1st, 3rd, 7th, 14, 21st, 28 and 42nd day for Home deliveries

3rd, 7th, 14, 21st, 28 and 42nd day for Institutional deliveries

**Services offered:** Essential care of the newborn, examination of the newborn, Early recognition of danger signs, stabilization, and referral, Counseling of mother for Breastfeeding, Warmth, Care of the baby, Immunization, Post Partum Care and use of Family Planning Methods

In case of any grievances,  
**please contact**  
(Name & telephone No.)  
& Dial (Telephone no.)  
for referral services

### Annexure 1b: Home Visit Form (Examination of Mother and Newborn)

Ask/Examine Date of ASHA's visit	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Supervisory Check	
								Y/N	Action Taken
A. Ask Mother								Y/N	Y/N
No. of times mother takes full meal in 24 hrs							If less than 4 times or if meals not full, advise mother to do so		
Bleeding: How many pads are changed in a day							If more than 5 pads, refer mother to hospital		
During the cold season, is the baby being kept warm (near mother, clothed and wrapped properly)	Yes/ No/ NA	Yes/ No/ NA	Yes/ No/ NA	Yes/ No/ NA	Yes/ No/ NA	Yes/ No/ NA	Advise the mother to do so, if not being done		
Is the baby being fed properly (whenever hungry or at least 7-8 times in 24 hrs)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise the mother to do so, if not being done		
Is baby crying incessantly or passing urine less than 6 times a day	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise mother to feed the baby after every 2 hours		
B. Examination of mother									
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)		
Foul smelling discharge and fever more than 100 degree F (37.8 degree C)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital		
Is mother speaking abnormally or having fits?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital		
Mother has no milk since delivery or if perceives breast milk to be less	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No			
Cracked nipples/painful and/or engorged breast	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No			

Ask/Examine Date of ASHA's visit	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Supervisory Check	
								Y/N	Action Taken
C. Examination of Baby								Y/N	Y/N
Are the eyes swollen or with pus									
Weight (on day 7, 14, 21 and 28)									
Temperature: Measure and Record									
Skin: Pus filled pustules									
Cracks or redness on the skin fold (thigh/Axilla/Buttock)									
Yellowness in eyes or skin: Jaundice									


D. Check now for the following signs of sepsis: If sign is present mention - Yes, if it is absent, mention - No Record the observations on Day 1 from the first examination of newborn form

Ask/Examine Date of ASHA's visit	Day 1	Day 2	Day 3	Day 7	Day 14	Day 21	Day 28	Action by the ASHA	Supervisory Check	
									Y/N	Action Taken
All limbs limp									Y/N	Y/N
Feeding less/Stopped										
Cry weak/Stopped										
Distended abdomen or mother says 'baby vomits often'										
Mother says 'baby is cold to touch' or baby's temperature										
>99 degree F (37.2 degree C) Chest indrawing										
Pus on umbilicus										

**Supervisor's note:** Incomplete work/incorrect work/incorrect record/incorrect record

Name of ASHA: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Trainer/Facilitator: \_\_\_\_\_



Ministry of Health & Family Welfare  
Government of India  
Nirman Bhavan, New Delhi