"Concurrent Evaluation of Home Based Postnatal Care in District Yamunanagar, Haryana"

A Dissertation Proposal for

Post Graduate Diploma in Health and Hospital Management

by

Dr.Reema Chahal

Roll No. PG/11/078

International Institute of Health Management Research

New Delhi -110075

February-April 2013

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Certificate of Approval

The following dissertation titled **"concurrent evaluation of home based post natal care** "is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post-Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
DR. BRIJENDER SINGH DHILLON	
Prof. Minakshi Gautam	3/5/13

Certificate from Dissertation Advisory Committee

This is to certify that **Dr.Reema Chahal**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled **"Concurrent Evaluation Of Home Based Postnatal Care In District Yamunanagar, Haryana"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor Mr. Anupam Srivastava

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Certificate of Internship Completion

Date:...12/5/13...

TO WHOM IT MAY CONCERN

This is to certify that Dr. Reema Chahal has successfully completed her 3 months internship in our organization from February 11, 2013 to May 11, 2013. During this intern she has worked on home based post natal care, facility readiness and essential new born care and resuscitation under the guidance of me and my team at National Rural Health Mission,Haryana.
During the internship period her work was satisfactory

We wish him/her good luck for his/her future assignments

(Signature)

Dr. Suresh Dalpath (Name)

Dy. DIR Child Health Designation

12th, May, 2013.

Acknowledgement

From the bottom of my heart, I would like to express my sincere thanks to Dr. Rakesh Gupta (Mission Director, NRHM, Haryana) for giving me opportunity to work with the dedicated staff of NRHM, Haryana.

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I would always remember NRHM staff for their corporation extended to me at all the times, and sharing their thoughts and providing information relating to my project.

I would also like to thank to my family and friends. They were always supporting me and encouraging me with their best wishes

Dr.Reema Chahal

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List of Abbreviations

1. ANM - Auxilliary Nurse Midwifery
2. ASHA - Accerited Social Health Activist
3. CHC - Community Health Centre
4. HBPNC - Home based post natal care
5. IMR - Infant Mortality Rate
6. LBW - Low Birth Weight
7. MCH - Maternal and Child Health
8. NFHS - National Family Health Survey
9. NMR - Neonatal mortality rate
10. NRHM - National Rural Health Mission
11. PHC - Primary Health Centre
12. RCH - Reproductive and Child Health
13. SBA - Skilled Birth Attendant

PART I

INTERNSHIP REPORT

Organization: National Rural Health Mission, Haryana

Designation: Intern Child Health

1. *Supportive supervision of home based post natal care(HBPNC):*

   In district Karnal, Yamunanagar, Bhiwani and Palwal. I visited Government hospitals, community health centers, primary health centers and sub centers and households in all the district allotted. During visit I assessed knowledge attitude and practices of ASHA for HBPNC and supervisory status of supervisors (ANM, M.O in charge, district programme manager). Find out the gaps in implementation of the programme and helped the staff for proper implementation of the programme.

2. *facility readiness assessment*

   4 days training was given to me along with other team members by trainers from USAID-MCHIP (maternal and child health integrated programme) India. For facility readiness team visits facilities (Government hospitals, community health centers, primary health centers and sub centers) in planned district with a checklist (Readiness assessment tool). Assess the facility completely in terms of infrastructure, delivery and newborn care services, human resources and signal function, essential drugs equipment and supply, register and client case record review, protocols and guidelines, infection prevention and hygiene and provider knowledge and competency for maternal and newborn care

3. *Essential Newborn Care And Resuscitation*

   Three days training was given to me along with other team members by trainers from USAID-MCHIP (maternal and child health integrated programme) India. For Essential Newborn Care And Resuscitation team visits facilities (Government

hospitals, community health centers, primary health centers and sub centers) in planned district with a checklist (tool). Under this programme team assess infrastructure of labor room, human resources, infection prevention and control practice, and provider knowledge and competency for newborn care. After assessing, team train the providers for Essential Newborn Care and Resuscitation in chronological pattern and motivate not to follow wrong and old practices which providers are following.

4. Currently I am doing *facility readiness assessment* and supportive supervision for *Essential Newborn Care And Resuscitation* in Haryana as Intern Child Health.

PART II

Dissertation on "Concurrent Evaluation of Home Based Postnatal Care in District Yamunanagar, Haryana"

CHAPTER 1

INTRODUCTION

Globally major changes are taking place in the area of maternal and child health to achieve the goals set out in international declarations and country commitments. Over 130 million babies are born every year, and almost 8 million die before their first birthday1. According to recent international estimates, a quarter of the world's births which occur unattended take place in India. India contributes to about a quarter of the global number of neonatal deaths and has a high neonatal mortality rate (NMR) of 32 per 1000 live births[1]. It is evident from these statistics that progress in India is key to the global achievement of MDGs 5. The launch of the National Rural Health Mission (NRHM) in 2005 has led to a significant expansion in maternal and child health programs across India as well as formulation of concrete quality assurance strategies[2]. Under the second phase of the Reproductive and Child Health programme (RCH-II), place of childbirth has seen a major change owing to the Janani Suraksha Yojana (JSY) scheme providing cash incentive for births at health facilities[3]. The Integrated Management of Maternal, Neonatal and Childhood Illnesses (IMNCI) approach initiated in 2004 has strengthened both home-based newborn care through the training of community health workers and facility-based care through the introduction of special units in health centres for sick newborns[4].

The decline in Infant Mortality Rate (IMR) has been slow in the last decade. NMR contributes to 68% of the IMR and any further reduction in IMR can only come from declines in NMR[5]. In 1999, Dr. Abhay Bang and his team at a local Indian NGO(SEARCH) in Gadchiroli Maharastra demonstrated a 62-percent reduction in neonatal mortality through multiple home visits by trained community level health workers [6]. In Shivgarh block in Uttar Pradesh state, India, Johns Hopkins University and local investigators of the Community Empowerment Lab in Lucknow worked together to implement a package of preventive care focused on exclusive breastfeeding ,umbilical cord and skin care newborn thermal care, including skin-to-skin contact, and prevention of neonatal infections, advise referral for prompt medical care if necessary; and encourage timely vaccination by multiple home visits[7]. The investigators documented a 54-percent reduction in neonatal mortality, corroborating the

analyses of the Lancet Neonatal Survival Series that preventive interventions at home can make a substantial impact on reducing neonatal mortality. The common causes of neonatal deaths are prematurity and low birth weight(14%), infections (12%) and birth asphyxia (8%)5.Evidence clearly suggests that, along with the WHO and UNICEF recommendations a program of home-based newborn care by a cadre of community-based link workers like the Accredited Social Health Activists (ASHAs) under NRHM can avert 30 to 60 percent of all newborn deaths[8].

Haryana presently stands at a crossroads where though visible progress has been made in reducing these health indicators there is scope for improvement. In Haryana the IMR is 44 per 1000 live births (SRS 2010) and Neonatal mortality Rate (NMR) is currently 33 per 1000 live births[9] . The Government of Haryana is determined to achieve the MDG target of reduction of IMR<25 by 2015 by focussing on reduction of the Neonatal mortality Rate.

1a) *AIM AND OBJECTIVE*

Aim

To find out the gaps in Home Based Postnatal Newborn Care programme in district Yamunanagar, Haryana

Objective

- To identify the strengths and weaknesses of the programme.
- To identify the factors responsible for such strengths and weaknesses.
- To suggest corrective and remedial measures.

1b) Review of Literature

1. Home-based versus hospital-based postnatal care: a randomised trial(2009)

Boulvain M, Perneger TV, Othenin-Girard V, Petrou S, Berner M, Irion O did a study with randomized controlled trial with an objective to compare a shortened hospital stay with midwife visits at home to usual hospital care after delivery in Maternity unit of a Swiss teaching hospital. Women in the home-based care group had shorter hospital stays (65 vs 106 hours, $P < 0.001$) and more midwife visits (4.8 vs 1.7, $P < 0.001$) than women in the hospital-based care group. Prevalence of breastfeeding at 28 days was similar between the groups (90%vs 87%, P= 0.30), but women in the home-based care group reported fewer problems with breastfeeding and greater satisfaction with the help received. There were no differences in satisfaction with care, women's hospital readmissions, postnatal depression scores and health status scores. A higher percentage of neonates in the home-based care group were readmitted to hospital during the first six months (12%vs 4.8%, P= 0.004). Results shows that women in the home-based care group had shorter hospital stays and more midwife visits than women in the hospital-based care group. In low risk pregnancies, early discharge from hospital and midwife visits at home after delivery is an acceptable alternative to a longer duration of care in hospital. Mothers' preferences and economic considerations should be taken into account when choosing a policy of postnatal care.

2. **Utilisation of postnatal care among rural women in Nepal(2006)**

A descriptive, cross-sectional study was carried out in two neighbouring villages in early 2006 by Sulochana DhakalGlyn N Chapman, Padam P Simkhada, Edwin R van Teijlingen,Jane Stephens and Amalraj E Raja. The proportion of women who had received postnatal care after delivery was low (34%). Less than one in five women (19%) received care within 48 hours of giving birth. Women in one village had less access to postnatal care than women in the neighboring one. Lack of awareness was the main barrier to the utilization

of postnatal care. The prevalence of postnatal care was 34% (95% CI = 27% – 42%) within 42 days after delivery, and 19% within 48 hours. Women reported that they had postnatal care from a doctor (65%) rather than a nurse (20%) or other health workers (16%). Similarly, the majority of women (78%) had received their care in hospital.

Perceived health problems occurring during the postnatal period were found to be low (about 10%) in our study. Possible explanations were that women and their families were not aware of signs of health problems or that they did not perceive minor illness as a health problem. The most commonly mentioned health problems were weakness, breast infection and vaginal bleeding. Although the great majority of women (87%) had sought help, some had sought care from a traditional healer.

3. Women's views of postnatal care in the context of the increasing pressure on postnatal beds in Australia(2006)

   Helen L. McLachlan, Lisa Gold, Della A. Forster, Jane Yelland, Joanne Rayner, Sharon Rayner studied Eight focus groups and four interviews were held in rural and metropolitan Victoria in 2006 with participants who had experienced a mix of public and private maternity care. These included 8 pregnant women, 42 recent mothers and 2 male partners. Key conclusions and implications for practice were women were concerned about shortened postnatal length of hospital stay and these concerns must be considered when changes are planned in maternity service provision. Any moves towards shorter postnatal length of stay must be comprehensively evaluated with consideration given to exploring consumer views and satisfaction. There is also a need for flexibility in postnatal care that acknowledges women's individual needs

4. Effect of timing of first postnatal care home visit on neonatal mortality in Bangladesh

A observational cohort study was done by Abdullah H Baqui, Saifuddin Ahmed, Shams El Arifeen with objective to assess the effect of the timing of first postnatal home visit by community health workers on neonatal mortality. Analysis of prospectively collected data using time varying discrete hazard models to estimate hazard ratios for neonatal mortality according to day of first postnatal home visit was done Data from a community based trial of neonatal care interventions conducted in Bangladesh during 2004-05. Results shows 9211 live births were included. Among infants who survived the first day of life, neonatal mortality was 67% lower in those who received a visit on day one than in those who received no visit (adjusted hazard ratio 0.33, 95% confidence interval 0.23 to 0.46; P<0.001). For those infants who survived the first two days of life, receiving the first visit on the second day was associated with a 64% lower neonatal mortality than in those who did not receive a visit (adjusted hazard ratio 0.36, 0.23 to 0.55; P<0.001).

First visits on any day after the second day of life were not associated with reduced mortality. As per Abdullah H Baqui, Saifuddin Ahmed, Shams El Arifeen in developing countries, especially where home delivery with unskilled attendants is common, postnatal home visits within the first two days of life by trained community health workers can significantly reduce neonatal mortality. This study adds Receiving a visit on the day of birth reduced the risk of neonatal mortality by two thirds among neonates who survived the first day of life. Among infants who survived the first two days of life, receiving a visit on the second day reduced the risk of neonatal mortality by 64%. No significant reduction in neonatal mortality was measured among neonates receiving the first home visit after day two of life. Home visit and assessment of neonates by a trained health worker within two days of birth should be made a priority in settings where health systems are weak and coverage of skilled birth attendance is low.

5. Socio-Economic Inequalities in the Use of Postnatal Care in India(2008)

A study was conducted by Abhishek Singh mail, Sabu S. Padmadas, Udaya S. Mishra, Saseendran Pallikadavath, Fiifi A. Johnson, Zoe Matthews with objective to estimate socio-economic inequalities in the use of postnatal care (PNC) compared with those in

the use of care at birth and antenatal care. Second, to compare inequalities in the use of PNC between facility births and home births and to determine inequalities in the use of PNC among mothers with high-risk births. Rich–poor ratios and concentration indices for maternity care were estimated using the third round of the District Level Household Survey conducted in India in 2007–08. Binary logistic regression models were used to examine the socio-economic inequalities associated with use of PNC after adjusting for relevant socio-economic and demographic characteristics. PNC for both mothers and newborns was substantially lower than the care received during pregnancy and child birth. Only 44% of mothers in India at the time of survey received any care within 48 hours after birth. Likewise, only 45% of newborns received check-up within 24 hours of birth. Mothers who had home births were significantly less likely to have received PNC than those who had facility births, with significant differences across the socio-economic strata. Moreover, the rich-poor gap in PNC use was significantly wider for mothers with birth complications.

1c) *INTRODUCTION TO HOME BASED POST NATAL CARE (HBPNC)*

HBPNC Background/ Rationale

A high proportion of the infant death burden is related to newborn deaths, and further gain in reducing IMR are likely only through a focused effort that affects neonatal outcomes. Out of total infant deaths 2/3 deaths are in neonatal period (upto 28 days). So, first month of life is very crucial time for the newborn and baby may die if proper care is not provided timely during this period.

The State is creating a structure of facility based new borne care in the form of SNCU, Stabilizing unit and Newborn Care Corners. To fill the gaps in provision of services at home, the State already launched the HBPNC in a big way. ASHA is the critical link between the community and the health system at the grass root level. The HBPNC package has been designed to enable ASHA workers to provide post natal services to newborns and mothers at home and birth preparedness with the family of pregnant women as well.

The HBPNC is a concerted strategy for promoting improvement in household behaviours through home visits by ASHA at critical times. This HBPNC Package consists of three parts:-

1. A special training to ASHA (2+5 days, Round-I & II) for home based postnatal care of mother & newborn.
2. An incentive to ASHA (Rs. 250/-) for completing PNC routine checkups of newborn and mother by way of conducting 01+06 home visits*.
3. Linkages with existing free Referral Transport System.

Skills Imparted to ASHA under HBPNC

- Identification of danger signs among pregnant women during pregnancy
- Identification of danger signs among mother/newborn during/after delivery
- Weighing the newborn through the Salter Scale
- Temperature taking through the Digital Thermometer
- Proper wrapping the newborn to avoid hypothermia
- Hand Washing to avoid infections

Key Activities in HBPNC (Roles & Responsibility of ASHA under HBPNC)

- Home visit schedule

Table1. Home visit schedule by ASHA

VISIT	TIMEPERIOD
Birth Preparedness Visit	Between 8th to 9th month of pregnancy
1st visit	Day 1- Day of birth
2nd visit	Day 2-3 after birth
3rd visit	Day 5-7 after birth
4th visit	Day 14-17 after Birth
5th visit	Day 23-28 after Birth
6th visit	42-45 days after Birth

- Care for every newborn and mother through a series of home visits by ASHA in the first six weeks of life.
- Information and skills to the mother and family of every newborn to ensure better health outcomes.
- Examine the baby for Alertness, Activity, Breathing, Color, Temperature, Jaundice, Skin and Umbilical Sepsis, weight etc.
- Early identification of illness in the newborn and provision of appropriate care at home or referral, if needed.
- Examine every newborn for prematurity and low birth weight. Referral for appropriate care, if needed.

- Counsel pregnant woman/mother/family member/caregiver(s) on early and proper breastfeeding, keeping baby warm, cord care, hygiene, delayed bathing, nutrition, and spacing.
- Counsel the pregnant woman/mother/family member/caregiver(s) about the importance of BCG, OPV, DPT, Hep-B or Pentavalent to be given to the newborn.
- Follow up for sick newborns after they are discharged from facilities.
- Examine the pregnant women/mother for bleeding/excessive vaginal bleeding, foul smelling, fever, pain and any other problem during pregnancy/after delivery and enabling referral, if needed.
- Counseling 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.
- Look for danger signs in mother and baby and decide and counsel on referral.

Material & Booklets that should be available with ASHA for HBPNC-

- 1. HBPNC cards
- 2. Referral cards
- 3. ASHA Drug kit (should be replenished regularly)
- 4. Functional Digital Thermometer, Salter weighing scale(and the equipment should be reviewed and refurbished as required)
- 5. Booklets (Flip Chart, Bal Poshan Pustika, Prasavotter Gharelu Sampark)

Designated Nodal officers & Supervisors under HBPNC at every level--

- DIO (District Immunization Officer) at district level, SMO at CHC level, MOI/c at PHC level are the designated Nodal officers for HBPNC overall & ANM will look after the HBPNC at sub centre level.
- DPM, computer assistant to DIO & computer assistant to DPM (Both CA) OR HBPNC software master trainers under supervision of DIO at district level, Information Assistant under Supervision of SMO/MOI/c at CHC/PHC level are

designated persons for entry of HBPNC cards in HBPNC software.

- HBPNC Supervisors at every level are mentioned below—
  - HBPNC Implementation unit under Director(MCH) at State level
  - DyCS(NRHM),DIO,DTO & DPM at district level
  - SMO,PHN & BEE at CHC level
  - MOI/c & LHV/MPHS at PHC level
  - Both ANMs at sub centre level

Work flow of Processes under HBPNC

1. ASHA's home visit forms (HBPNC Cards) can be used to assess the number and content of ASHA visits.
2. ASHAs have to fill the home visit form (HBPNC card) during every visit to the household with a newborn.
3. ANM will crosscheck & verify and MO will countersign HBPNC card for payment & entry of card in the software. Ensure that HBPNC cards filled by ASHA should be crosschecked & verified by ANM along with countersigned by MO. Only after that card should come to information assistant for entry in the software to avoid submission of fake HBPNC cards by ASHA to information directly.
4. After that the PNC card should reach to Information Assistant of concerned PHC and then Information Assistant at PHC will enter the PNC card data into the HBPNC software (offline) on regular basis i.e. http://www.microwarecorp.com/clients/UNOPS/Asha-Des_Setup31082012.zip
5. MO at PHC should crosscheck whether the information assistant are filling the right information in the software from the submitted cards.
6. Information Assistant at PHC will send the work area/file monthly to the concerned CHC. Information assistant at CHC will compile the work areas/files received from PHC's & also do the entries of PNC cards of CHC outreach area. Information Assistant at CHC will send compiled work area/file to the district.
7. To avoid workload of Information Assistant of PHC at end of the month, it should be ensured by all MOI/c & ANM that HBPNC Cards should reach PHC on weekly basis for entry in HBPNC software. LHV/ANM may bring these cards to PHC on day of

immunization on weekly basis to avoid bulk of cards entry at the month end.

8. HBPNC cards should not come to accounts section. Payment to ASHA should be made on the basis of name of beneficiary mentioned on self appraisal form.

9. Master trainers at district for HBPNC software (DPM, Computer assistant to DIO & DPM) will compile the files/work area received from CHC's and then will upload these on the online web portal after necessary crosscheck & validations, i.e. hbncinfo.in .Online username & password of district are already available with DPM.

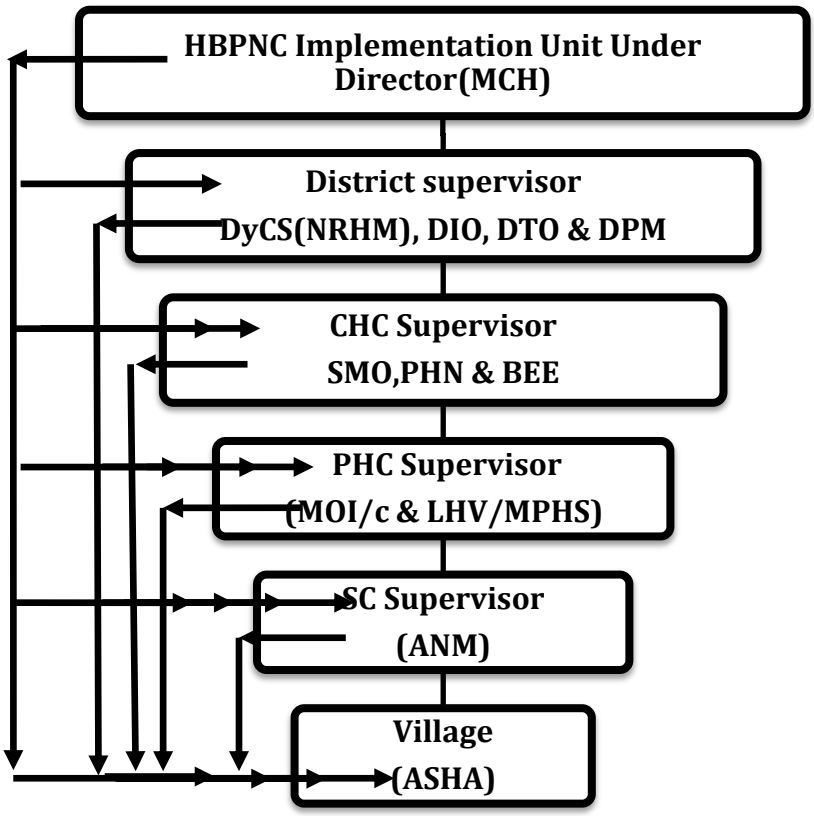
Payment to ASHA under HBPNC

Payment to ASHAs should be made through Self Appraisal Form (SAF) submitted to MOI/c based on the no. of HBPNC cases ASHA eligible for payment under HBPNC.

Under HBPNC Strategy, care and counseling is to be provided by ASHA to all pregnant women/mothers irrespective of where the birth takes place. ASHA is required to ensure 7 (1+6) home visits of particular newborn/mother. Special attention is required to be given to home deliveries, the most vulnerable population, like the SC, BPL, migratory population, etc.The main purpose of this visit is to motivate the pregnant woman/her family members for an institutional birth and to make sure that she/they are aware about the Janani Suraksha Yojana (JSY–State as well as GoI) and Janani-Shishu Suraksha Karyakaram (JSSK) benefits.

HBPNC SUPERVISORY STRUCTURE

Diagram1. HBPNC supervisory structure



Arrows at left side simply mean supervisor at a particular level have to monitor the ASHA PNC visits as well as work of supervisors below that level. e.g. CHC supervisor have to monitor ASHA PNC visits as well as work of PHC supervisors.

Instructions regarding the filling of Supervisory format (Form A-E)

Table2. Instructions regarding the filling of Supervisory format

Form	To be filled by
Form-A (PNC Review Checklist)	ANM at Sub centre
Form-B (Home visit checklist)	• ANM • MOI/c & LHV/MPHS • SMO,PHN & BEE • DyCS(NRHM),DIO,DTO & DPM
Form-C (Supervisor's Advance Monthly Tour Programme)	• MOI/c & LHV/MPHS • SMO,PHN & BEE • DyCS, DIO,DTO & DPM
Form-D (CHC,PHC,SC Supervisor's Monthly supervision report)	• Every HBPNC Supervisor at SC, PHC, CHC will submit his/her Monthly Supervisory report to respective incharge or Nominated Nodal officers at each level in Form "D
Form-E (District Supervisor's Monthly supervision report)	• District supervisors to submit their monthly supervision report to DIO (District HBPNC Nodal officer).

Form "A" (PNC Review Checklist)- (i) ANM will review each & every PNC card & fill the form "A" to crosscheck all the cards submitted by a ASHA in a month..

(ii) Few PNC cards submitted by ASHA to be cross checked by ANM along with ASHA for cross validation of ASHA visit as well as health care of mother & new born & based on observations fill the form "B". ANM is also required to verify the PNC cards for quality of entries made in PNC card & provide handholding support to ASHA.

Form "B" (Home visit checklist) - is to be filled by all Supervisors at every level (SC, PHC, CHC, District, State) during their home visits to cross check their below supervisors &

ASHA visits as per monthly tour program. Problem/issues observed by supervisors during their home visits are to be mentioned in form "D" at all level (SC, PHC, CHC).

In Form "C" (Supervisor's Advance Monthly Tour Programme)-Supervisors at PHC, CHC, District level will make advance monthly tour programme for home visits & submit to their concerned incharge. One copy is to be kept with themselves.The ANM's need not to fill form "C"(Advance monthly tour programme) as they have to make home visit & cross check ASHA as per their routine duty.

Form "D" (CHC, PHC,SC Supervisor's Monthly supervision report)) – Every HBPNC Supervisor at SC, PHC, CHC, District will submit his/her Monthly Supervisory report to respective incharge or Nominated Nodal officers at each level in Form "D. District supervisors will submit to DIO(District HBPNC Nodal officer) ,CHC supervisors to SMO(CHC HBPNC Nodal officer),PHC supervisors to MOI/c(PHC HBPNC Nodal officer) & SC supervisor-ANM to MOI/c as well. On the basis of these submitted reports respective Nodal officers will look after to fill up the gaps identified in their area.

In **Form "E" (**District Supervisor's Monthly supervision report) District supervisors will submit their **supervision monthly report** to the DIO (District HBPNC Nodal officer). On the basis of these submitted reports DIO will look after to fill up the gaps identified in the district area.

FLOW OF INFORMATION UNDER HBPNC SUPERVISORY STRUCTURE

DD (CH)	**STATE**	**State Official will submit monthly supervision report to DD(CH)**
DIO	**DISTRICT**	**District supervisors will submit their Monthly Supervision report to DIO in Form "E".**
SMO	**CHC**	**PHN/BEE will submit his/her Monthly Supervision report to SMO in Form "D".**
MOI/c	**PHC**	**LHV will submit her Monthly Supervision report to PHC MOI/c in Form "D"**
		ANM will submit her Monthly Supervision report to PHC MOI/c in Form "D" through LHV.
ANM	**SUB CENTRE**	**Form A to be filled by ANM to review PNC cards**
ASHA	**VILLAGE**	**HBPNC Card to be filled by ASHA**

Please make clear that form A-E is for the purpose of use in field for supervisors reporting to their respective incharges or HBPNC Nodal officers. State will capture the supervision report through single reporting (DHIS-2). So, ANM at sub centre will also submit HBPNC supervision report to PHC in format of HBPNC supervision single reporting(DHIS-2)-which

is attached with these guidelines separately, which will be entered in single reporting software(DHIS-2) as such by information assistant at PHC. Also the HBPNC cards will be entered in HBPNC software by information assistant at PHC as per HBPNC-Info software. It should be made clear that HBPNC software captures HBPNC programme (ASHA PNC visits) report only & not the supervision report. Supervision report is captured through single reporting format only. So, both are required to have better implementation of HBPNC. To avoid workload of Information assistant of PHC at end of month, it should be instructed to all MOI/c & ANM that HBPNC cards should reach PHC on weekly basis for entry in HBPNC software. LHV/ANM may bring these cards to PHC on day of immunization on weekly basis to avoid bulk of cards entry at month end. It should be ensured to get entry of all the HBPNC cards given by ANM to MOI/c in HBPNC software.

Chapter 2

Data and Methods

Study area

District Yamunanagar of state Haryana.

Study population

Mothers of children born in the period of November 2012 to January 2013 who received home based post natal care

Sample size

100 mothers of children born in the period of November 2012 to January 2013 who received home based post natal care

Sampling method

Multistage Sampling and convenient sampling

Study design

Cross Sectional study

Data collection tool

Checklist (Refer Annexure)

Type of data & Source of data

Quantitative data from Primary source and secondary source

Study Period

February-April 2013

Statistical software used for data analysis

MS Excel 2007, Epi Info software

Chapter 3

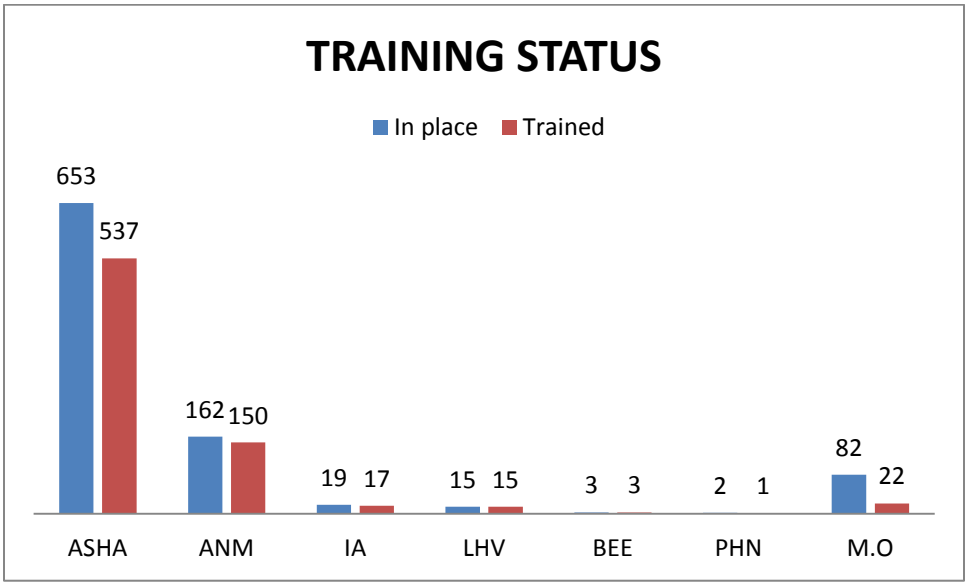
Results and Findings

1. Training status of HBPNC in Yamunanagar district

Table3. Training status of HBPNC in Yamunanagar district

	In place	Trained
ASHA	653	537
ANM	162	150
IA	19	17
LHV	15	15
BEE	3	3
PHN	2	1
M.O	82	22

Fig.2. Training status of HBPNC in Yamunanagar district



ASHA training status:-

82.25% ASHA's have been trained in HBPNC.

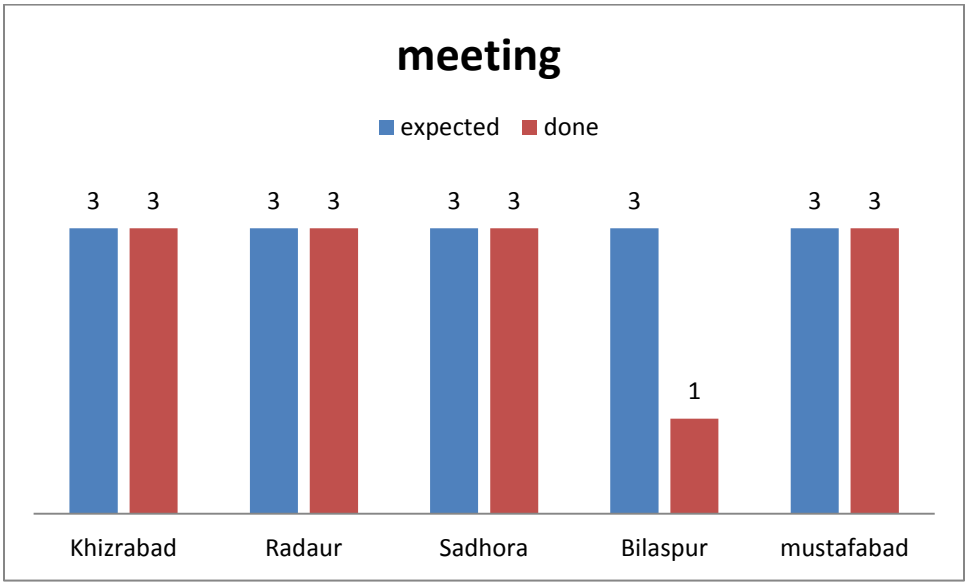
Supervisory training status:-

Only 26.83% M.O. have been trained in HBPNC supervisory training whereas 92.59% of ANM's have been trained.

2. Documentation

2 a)Review meetings held at CHC

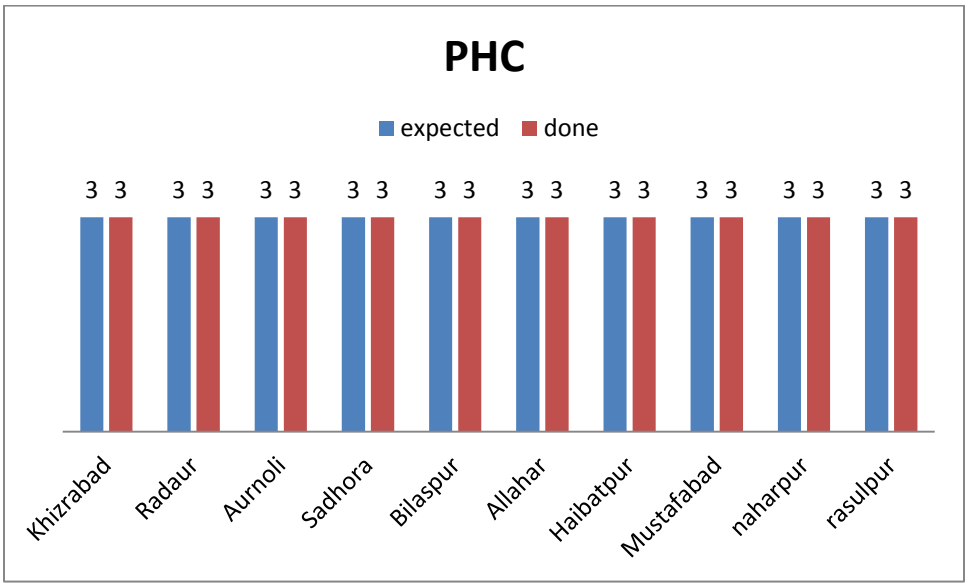
Fig.3. Review meetings held at CHC



At CHC level, the minutes of meeting were observed regularly except CHC Bilaspur

2 b) Review meetings held at PHC

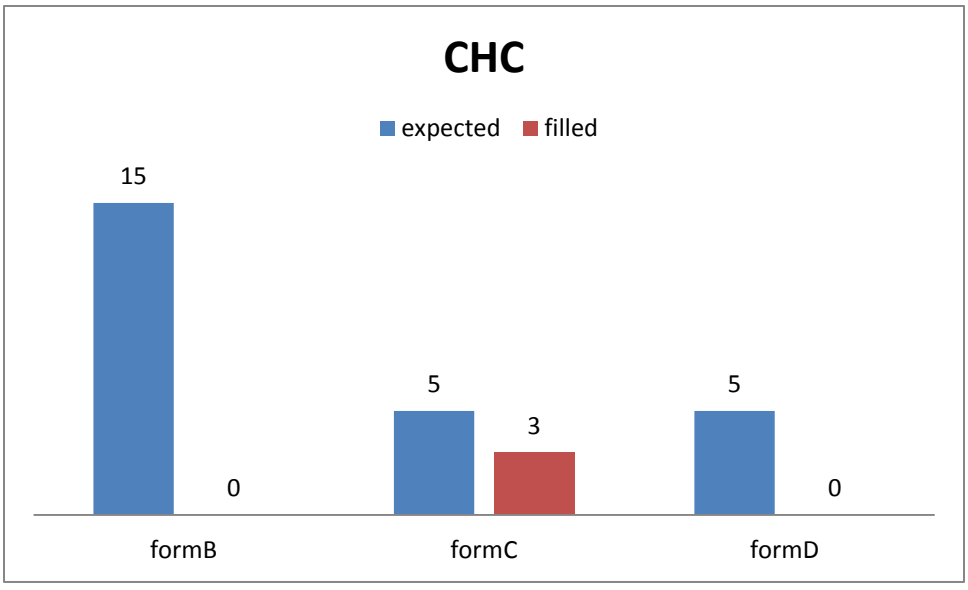
Fig.4. Review meetings held at PHC



Regular documented meeting schedule present at all the visited PHC's

2 c) Supervisory forms

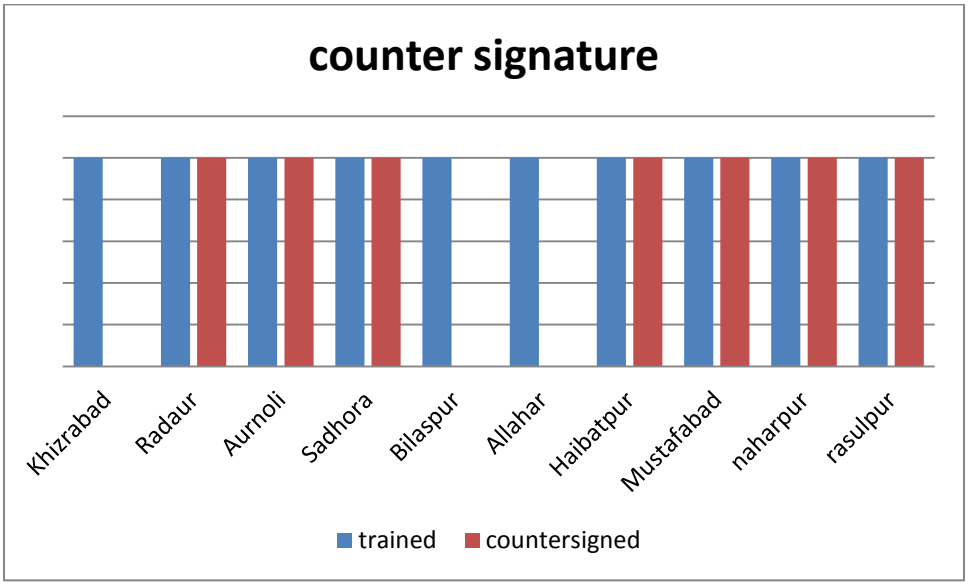
Fig.5. Supervisory forms



3 of the visited CHC's Khizrabad, Saddhora and bilaspur were found having form C (supervisory advance monthly tour programme). Neither form B nor Form D are available with the sample size.

2 d) counter signature by supervisor on HBPNC cards

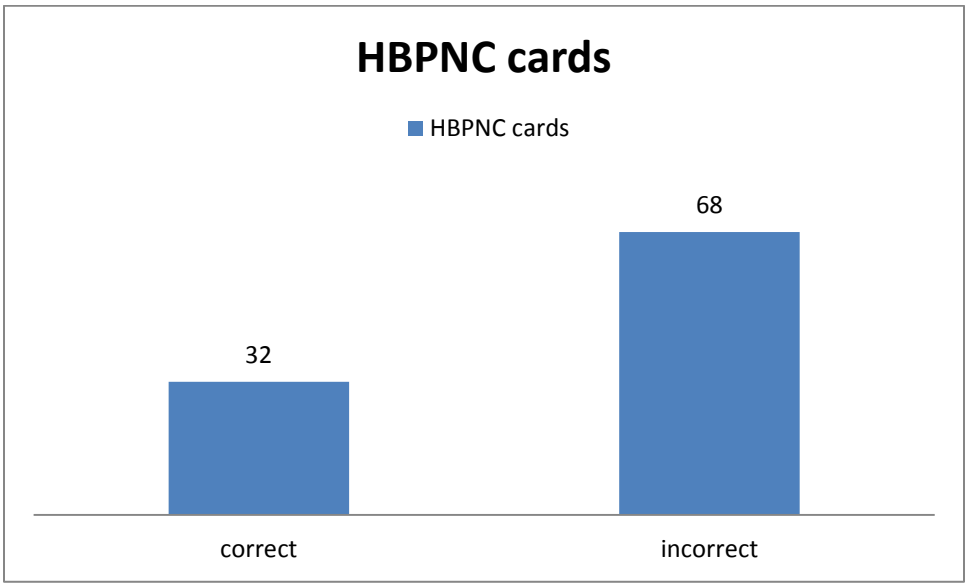
Fig.6. counter signature by supervisor on HBPNC cards



All the visited PHC (constituting sample size) the Supervisors (MO and LHV) are trained in HBPNC supervisory training. All the PHC's except PHC khizrabad, allahar and Bilaspur are practicing the correct procedure of counter signature of HBPNC card.

2 e) HBPNC Cards

Fig.7. HBPNC Cards



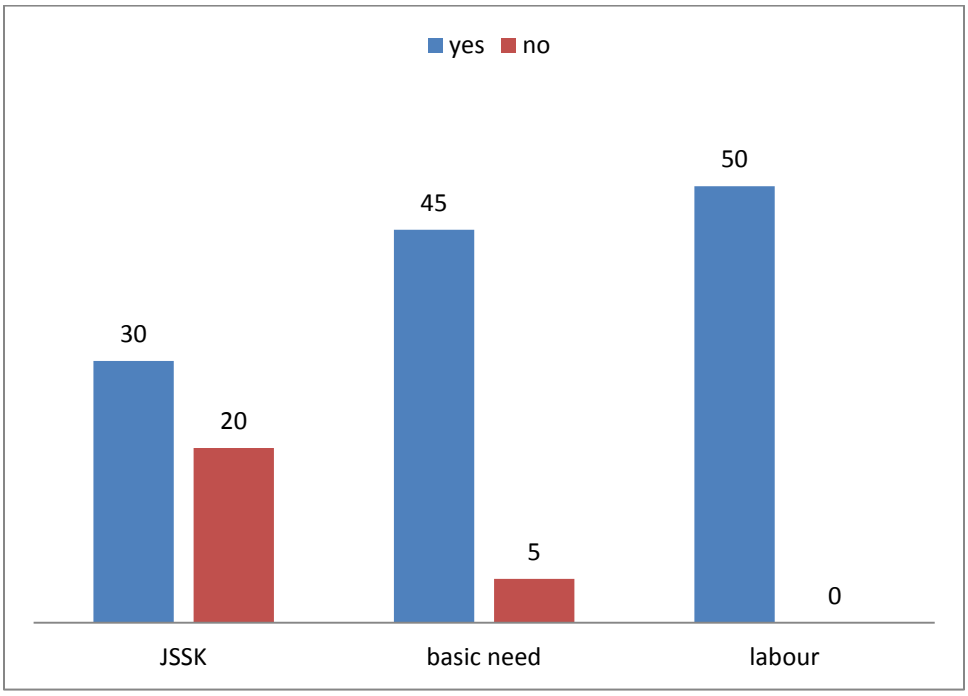
Out of sample under consideration, 68% of HBPNC cards are incorrectly filled.

The major findings include wrong filling of Respiratory rate, weight, Temperature, still birth etc.

3. ASHA knowledge and practices

3 a) Birth preparedness by ASHA

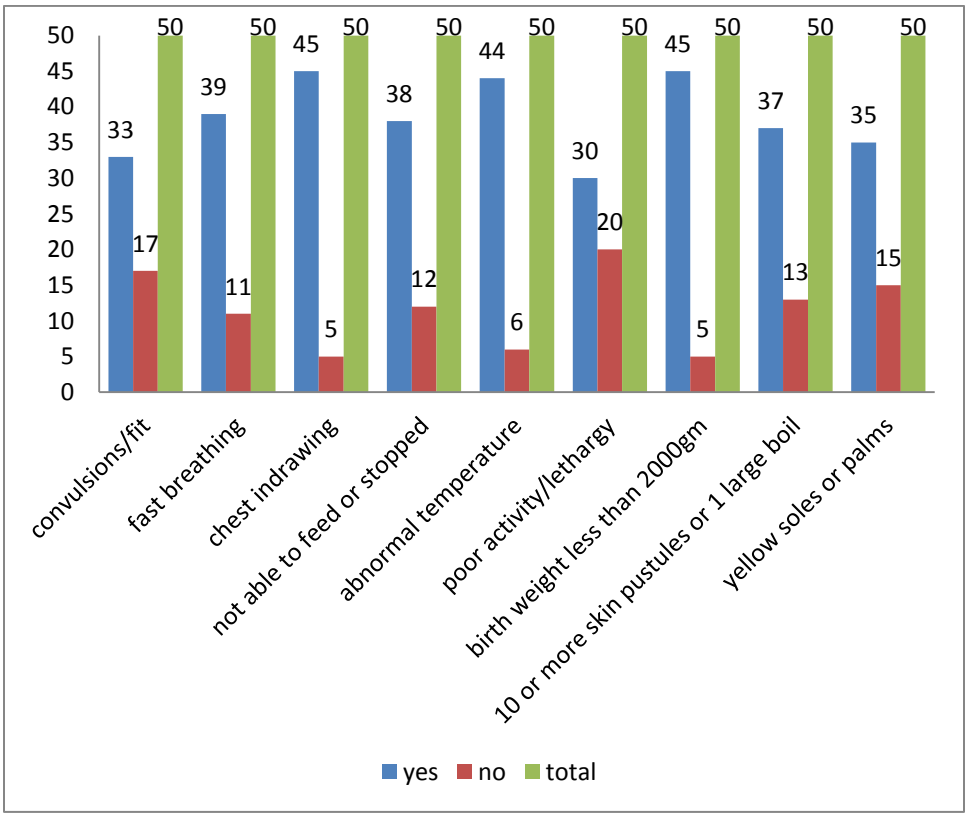
Fig.8. Birth preparedness by ASHA



During birth preparedness visit to household, 60% of interviewed ASHA, able to tell about JSSK scheme. 90% ASHA about basic needs (cloth, money and attendant). All the ASHA's were able to tell the mother that they should ask for help during her labour pain.

3 b) Danger signs of new born

Fig.9. Danger signs of new born

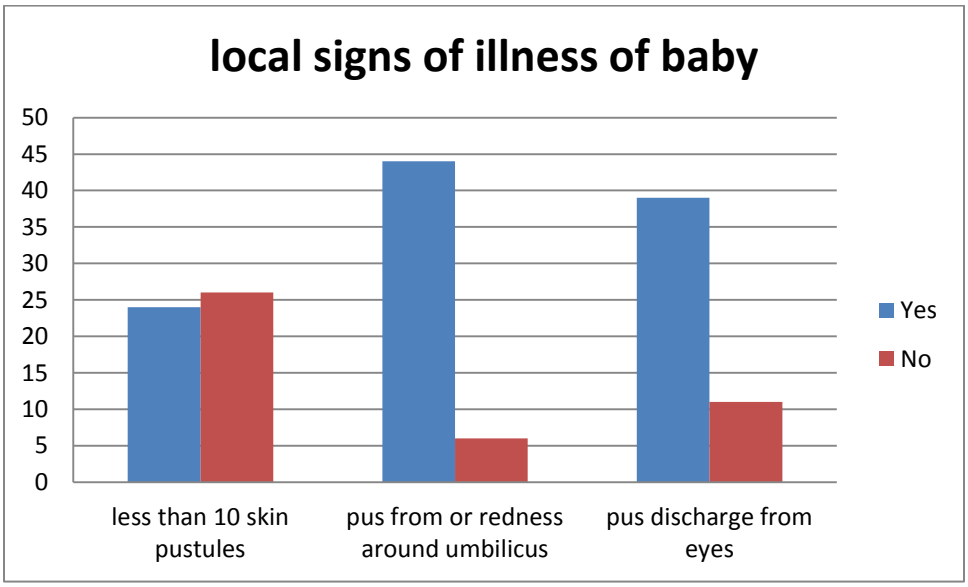


80-90% of ASHA when inquired about danger signs of newborn, were able to tell about chest indrawing, abnormal temperature, birth weight less than 2000gm as the danger signs of newborn.

60- 80% of ASHA were able to tell about convulsions, fast breathing, not able to feed or has stopped feeding, poor activity/ lethargy, 10 or more skin pustules or 1 large boil and yellow soles and palms as the danger signs.

3 c) The local signs of illness of baby

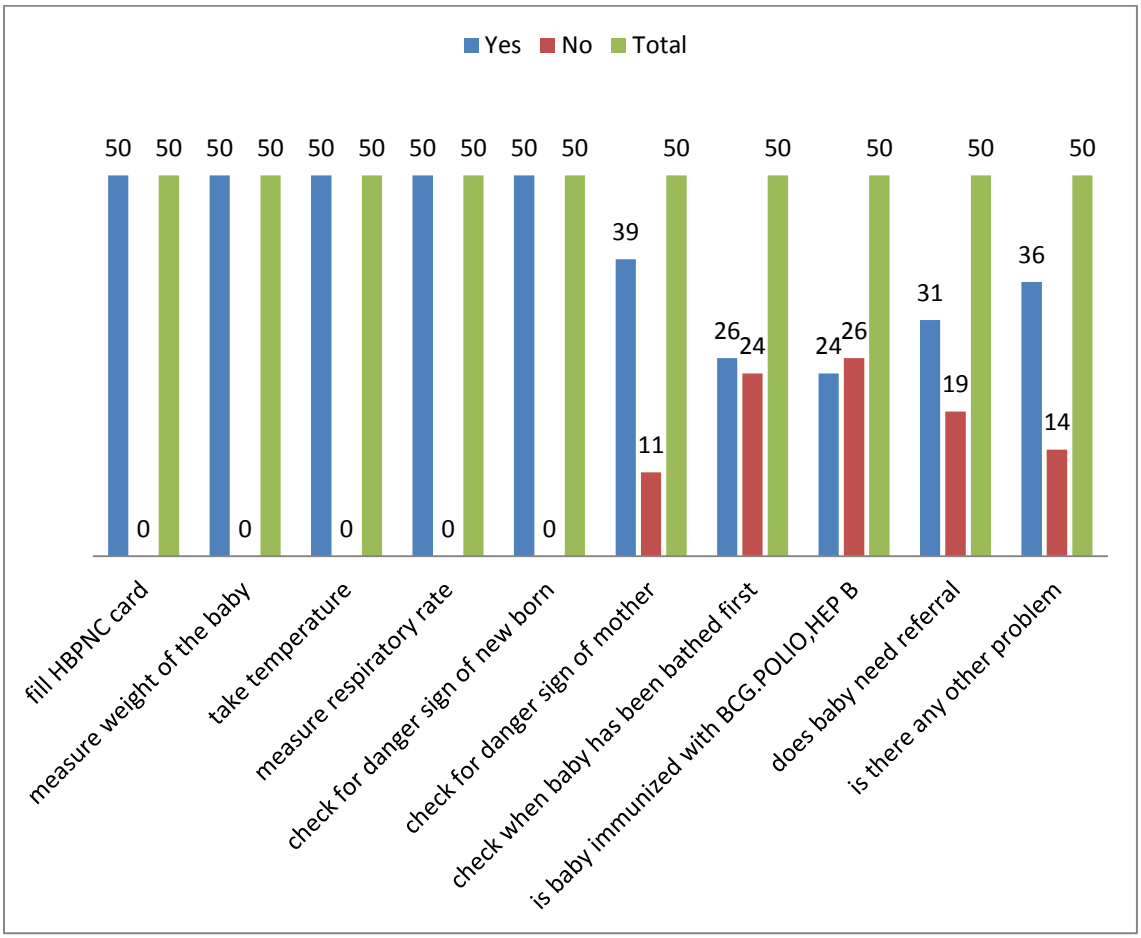
Fig.10. The local signs of illness of baby



88 % of ASHA were able to tell pus from or redness around umbilicus as local signs of illness of baby. 78% of ASHA were able to answer pus discharge from eyes and 56% about symptoms of less than 10 skin pustules as local signs of illness of baby

3 d) What to do at home visit for HBPNC

Fig.11. What to do at home visit for HBPNC



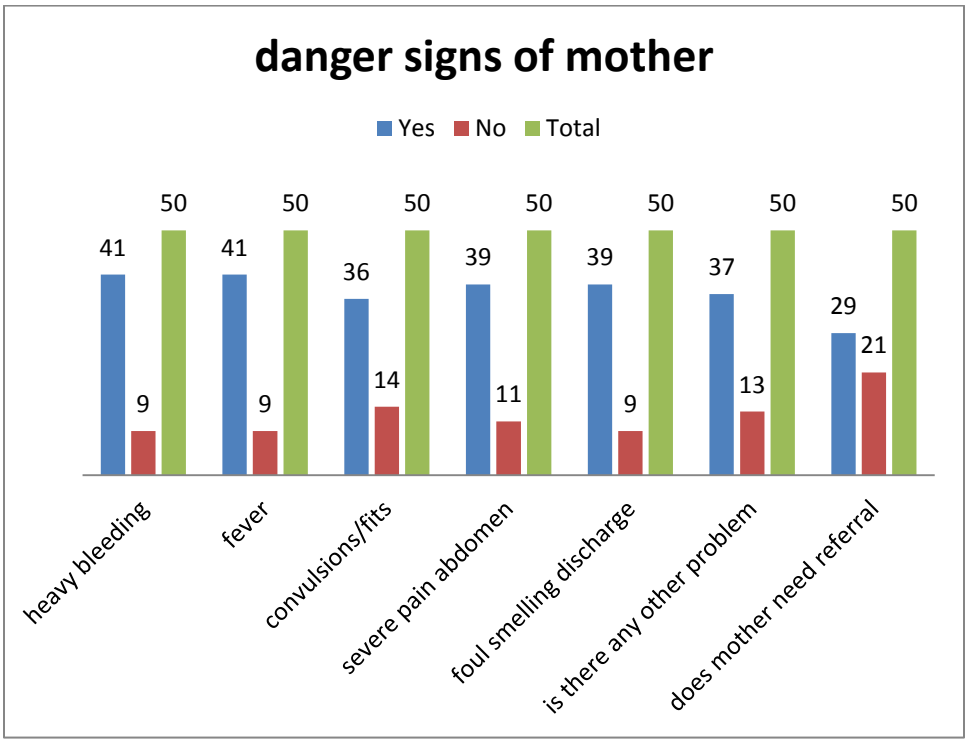
100% of ASHA were able to tell that they fill HBPNC card, measure weight of the baby, take temperature, measure respiratory rate and check for danger sign of new born during their home visit.

60- 80% of ASHA were able to tell that they check for danger signs of mother and inquire that does child need referral.

50% were able to tell about whether baby is immunized with BCG, polio and Hep B and check when baby is bathed for the first time.

3 e) The danger signs of mother

Fig.12. The danger signs of mother

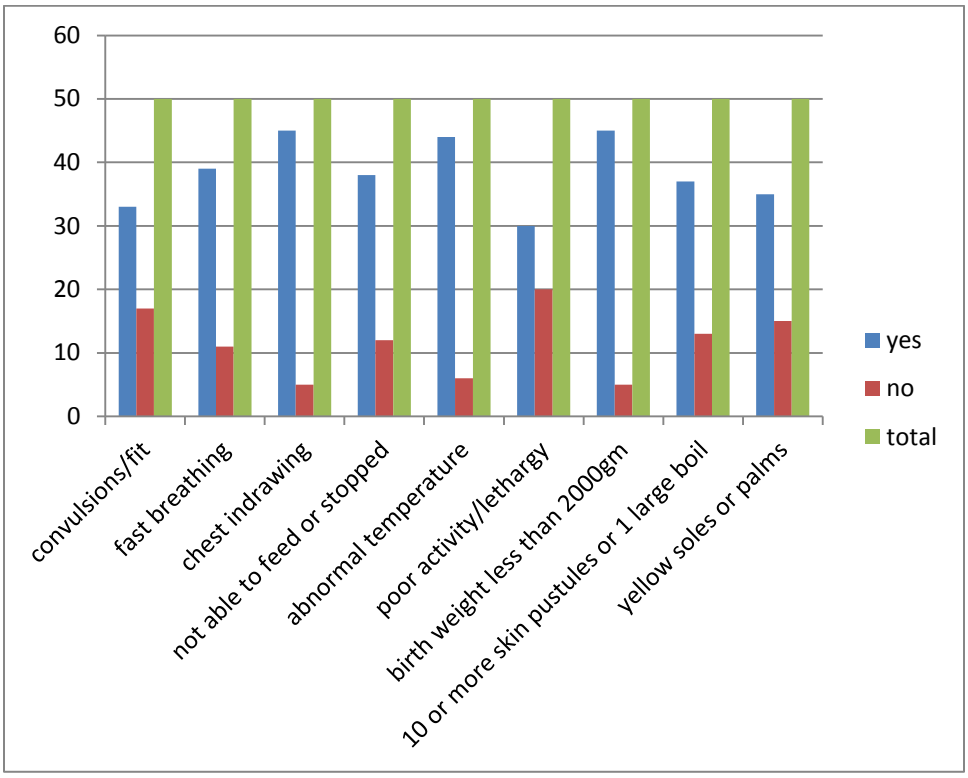


84 – 90% of ASHA were able to answer about danger signs of mother – heavy bleeding, fever, convulsions/fits, severe pain abdomen, foul smelling discharge from vagina, any other problem of mother.

58% of ASHA told about does mother need referral as the danger sign of mother.

3 f) Counseling and assistance

Fig.13. Counseling and assistance



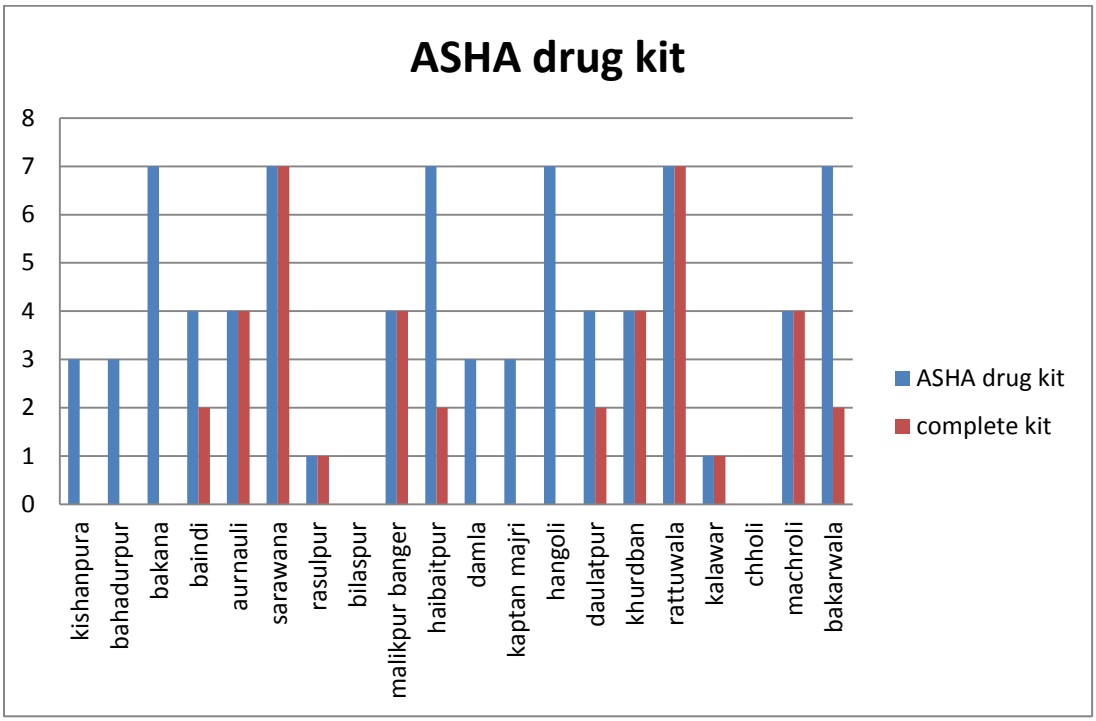
Approximately about 80- 90% of ASHA were able to counsel to mother about chest in drawing, abnormal temperature, low birth weight as danger signs.

60-80% of ASHA told mother about convulsions/fit, fast breathing, not able to feed or stopped, 10 or more skin pustules and yellow soles as danger signs where as only 40% of ASHA told about poor activity/lethargy as danger sign.

4. Logistic

ASHA drug kit completeness at PHC

Fig.14 ASHA drug kit completeness at PHC

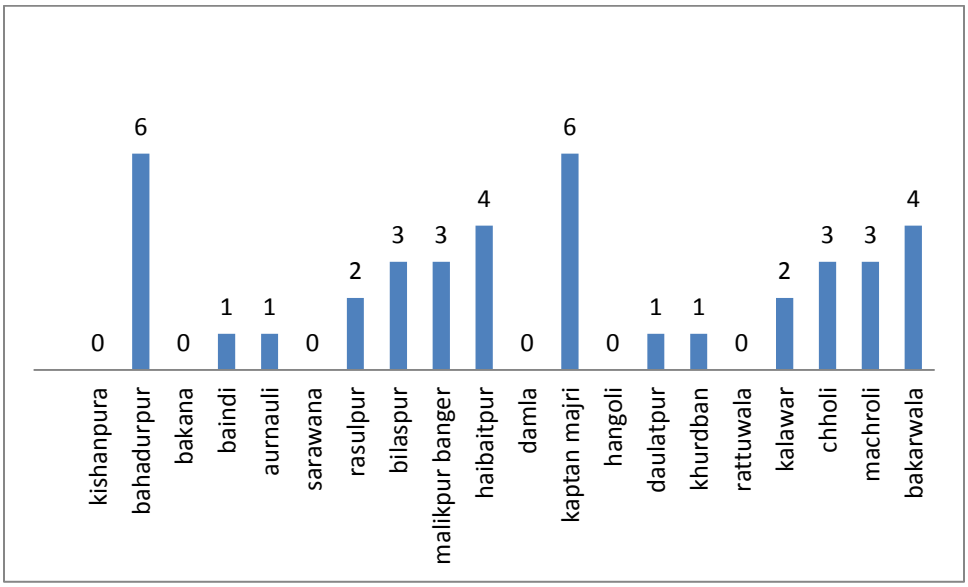


Among sample size 44.44% PHC have complete drug kit with trained ASHA.

5. Referral

Newborns referred at sub centre level

Fig.15 Newborns referred at sub centre level



During 3 months bahadurpur and kaptan majra have high rate of referral, where as sub centres like kishanpura, bakana, sarawn damla, hangoli and rattuwala have 0 referral.

6. Household

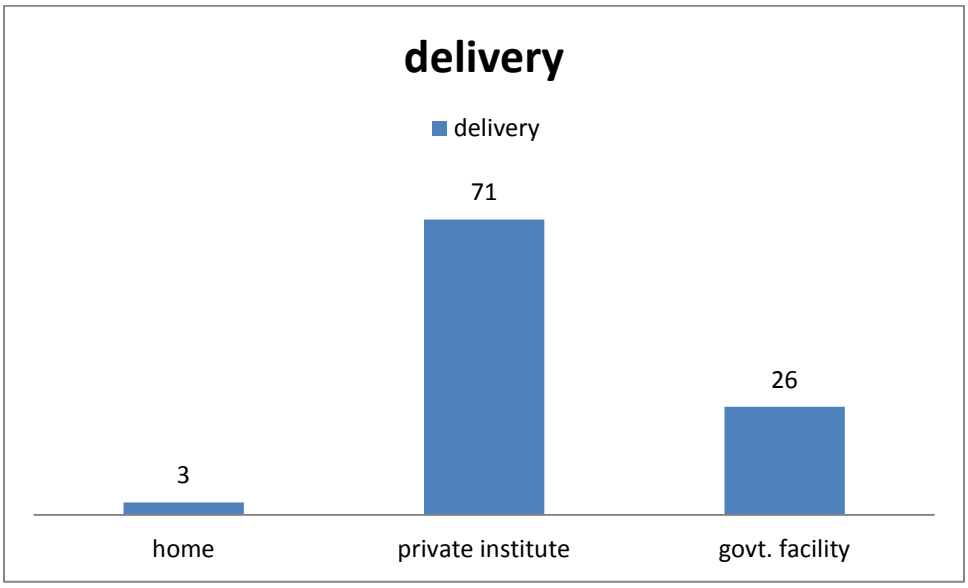
6a) birth preparedness visit

Fig.16. birth preparedness visit

Among the sample size 82% of mothers were provided with birth preparedness visit by ASHA

6b) Place of delivery

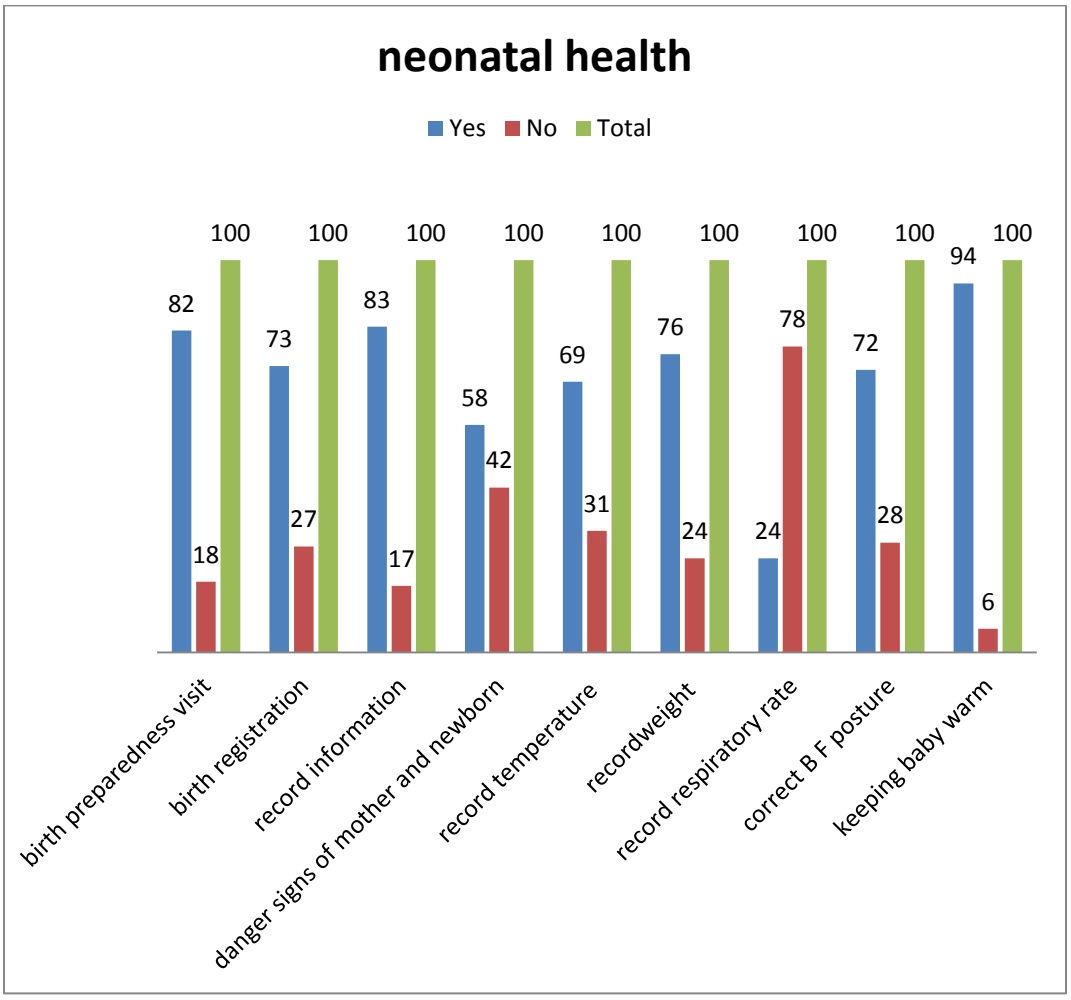
Fig.17. Place of delivery



71% of the mothers delivered at private institution. 26% at government facility and 3% of mother had home delivery

6 c) Neonatal Health

Fig.18. Neonatal Health

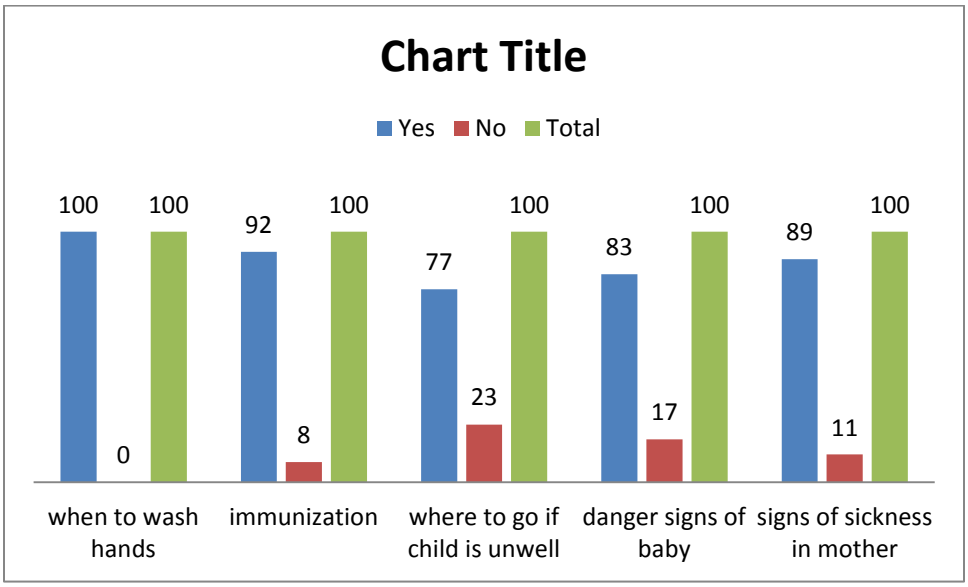


More than 80 mother contacted were provided birth preparedness visit, were aware of keeping the baby warm and information was recorded in front of them.

Only 24 of the mothers visited said that ASHA record respiratory rate.

6d) mother knowledge

Fig.19. mother knowledge



More than 80% of mothers were aware about immunization of their infant, where to go if child is unwell, danger signs of baby and signs of sickness of mother.

All mothers were able to answer that when they should wash their hands

Chapter 4

DISCUSSION

Study findings suggests that only 32% of HBPNC cards are filled correctly and 68% of HBPNC cards are either incomplete or have incorrect information.

Among the sample size 82% of mothers were provided with birth preparedness visit by ASHA in contrast to study Effect Of Timing Of First Postnatal Care Home Visit On Neonatal Mortality In Bangladesh by Abdullah H Baqui total of 31% pregnant women received their birth preparedness visit[6] .

71% of the mothers delivered at private institution. 26% at government facility and 3% of mother had home delivery where as, as per USAID study Community-Based Postpartum Care Services in Mother NewBorNet Member Programs 70% of births took place in the home. Only 10% were reported to be assisted by skilled birth attendants, and 37% were assisted by traditional birth attendants[4].

During birth preparedness visit to household by ASHA 60% of them were able to tell about JSSK scheme to the mother, 90%ASHA told about basic needs (cloth, money and attendant). All the ASHA's were able to tell the mother that they should ask for help during her labor pain.

Home based post natal visits are 80% in District Yamunanagar in contrast to study Socio-Economic Inequalities in the Use of Postnatal Care in India by Abhishek Singh mall, the use of postnatal care was limited for mothers who gave birth at home[7]. During postnatal visit 85% ASHA have practice to ensure chest in drawing, abnormal temperature, birth weight less than 2000gm as the danger signs of newborn where as 65%ASHA ensure about convulsions, fast breathing, not able to feed or has stopped feeding, poor activity/ lethargy, 10 or more skin pustules or 1 large boil and yellow soles and palms as the signs of sickness in newborns. 88% ASHA were able to tell pus or redness around umbilicus as local signs of illness of baby. 78% ASHA were able to answer pus discharge from eyes and 24 (56%) about

symptoms of less than 10 skin pustules as local signs of illness of baby. As per Socio-Economic Inequalities in the Use of Postnatal Care in India by Abhishek Singh mall Only 44% of mothers in India at the time of survey received any care within 48 hours after birth. Likewise, only 45% of newborns received check-up within 24 hours of birth[7]

All ASHA measure weight of the baby and take temperature. Only 24 of ASHA record respiratory rate accurately. 70% ASHA were able to check for danger signs of mother and inquire about child needs referral or not. 74% ASHA knows about need of referral and the danger sign of mother. During 3 months bahadurpur and kaptan majra have high rate of referral, where as sub centres like kishanpura, bakana, sarawn damla, hangoli and rattuwala have 0 referral. As reported by survey participants in study Community-Based Postpartum Care Services in Mother NewBorNet Member Programs, effective practices include: presence of referral mechanisms, home visits, community care starting from ANC, establishing community support systems, and focusing on activities valued by the family[4]. 50%ASHA ensure about immunization with BCG, polio and Hep B and check when baby is bathed for the first time.

85% ASHA were able to counsel to mother about chest in drawing, abnormal temperature, low birth weight as danger signs and 70% ASHA told mother about convulsions/fit, fast breathing, not able to feed or stopped, 10 or more skin pustules and yellow soles as danger signs where as only 40% of ASHA told about poor activity/lethargy as danger sign
44.44% facility have complete logistic with trained ASHA.

More than 80% of mothers were aware about immunization of their infant, where to go if child is unwell, danger signs of baby and signs of sickness of mother.95% mothers were aware about when they should wash their hands. As per study Increasing postnatal care of mothers
and newborns including follow-up cord care and thermal care in rural Uttar Pradesh by deepthi s. varma, m.e. khan and avishek hazra 47 percent of women were aware that women need a check-up within a week of delivery[8].

Chapter 5

Conclusion and Recommendations

5a) ***Conclusion***

The Government of India has recommended that all mothers and newborns receive three postnatal (PNC) checkups within 42 days of delivery. Majority of ASHA of district are trained in HBPNC. There is a direct correlation between the training status and proper implementation. The District heads- civil surgeon, deputy CS, program manager and immunization officer are very enthusiastic for the implementation of the program. The hierarchy which needs to be followed is very clear from the state level and is equally followed in the district. The budget spent on training of ASHA, procurement of ASHA drug kits act as strength of the programme. Online mechanism of entry of cards into the HBPNC software by the information assistant leads to reduction in the time taken for analysis of cards.

Training status of HBPNC supervisory training is poor. The training of supervisors has been done after the training of ASHA. So, there is a lack in proper supervision of the ASHA.

The MO's of PHC are not aware about the proper chain of the filled HBPNC Cards which needs to be followed. This leads to improper tracking in the process of programme. ASHA do not fill the self appraisal form related to HBPNC. So, the payment of ASHA is delayed. The skills of trained ASHA are not up to the mark, there is incomplete and incorrect information on HBPNC cards. ASHA drug kit replenishment guidelines are not available with the supervisors. The documentation of the supervisory visits is not done. Newly recruited ASHA are not trained. There is gap in knowledge attitude and practices of ASHA for HBPNC programme. High quality postnatal care is crucial to both monitoring the health of the mother and baby and delivering important messages concerning family planning, child health and other key health areas. Despite substantial efforts toward home based new-born care, opportunities have been missed to deliver adequate PNC and to enable linkages across other components of the continuum of care, such as family planning.

5b) ***RECOMMENDATIONS***

1. Training: Pending training of the ASHA should be done with maximum priority specially newly recruited ASHA. Supervisory trainings should be conducted at the earliest.
2. Logistic: The in-completed kits should be refilled immediately. Drug kit replenishment guidelines should be made available down the stream.
3. The hierarchy of command needs to be followed from the district level up to ASHA.
4. The cards should reach the information assistant as soon as they are completed. So that the delay can be avoided.
5. The monthly meetings at the PHC level should have HBPNC as an agenda. The MO should address the problems faced by ASHA in that monthly meeting. Proper supervision by supervisors is recommended.
6. The pending payments of ASHA should be made which will aid as motivating factor.

REFERENCES

1. Organization WH. WHO:Neonatal and Perinatal mortality trends,Country,Regional and Global estimates.; 2006.

2. MOHFW GoI. Guidelines of RCH-II under National Rural Health Mission (Mission Document). In: MOHFW, editor. New Delhi; 2005-12. p. 4-6.

3. *MOHFW GoI. Reproductive and child health (RCH-II) operational guidelines under NRHM.* In: MOHFW, editor. NEW DELHI: MOHFW; 2005-2012. p. 7-10.

4. *Operational guidelines for implementation of Integrated Management of Neonatal and Childhood Illness (IMNCI).* 2005-2012

5. *MOHFW GoI. Operational Guidelines for Home Based Newborn Care under NRHM. . New Delhi: MOHFW*; 2011. p. 8-10.

6. Bang AT, Reddy HM, Deshmukh MD, Baitule SB, Bang RA. *Neonatal and infant mortality in the ten years (1993 to 2003) of the Gadchiroli field trial: effect of home-based neonatal care*. California. 2005

7. Darmstadt GL. *Newborn Thermal Care Practices in Rural India:A Community-based Programto Prevent and Improve Recognition and Management of Hypothermia Shivgarh UP HBNC.* Uttar Pradesh, India, 2009

8.Registrar general India. *SRS Bulletin*. 2011 26/11/2012 (http://pib.nic.in/archieve/others/2012/feb/d2012020102.pdf)

9.Berry, N. "*Kaqchikel midwives, home births, and emergency obstetric referrals in Guatemala: Contextualizing the choice to stay at home", Social Science & Medicine*. 62: 8, pp. 1958-1969. 2006

10. De Brouwere, V., Tonglet, R. & W. Van Lerberghe. "*Strategies for reducing maternal mortality in developing countries: what can we learn from the history of the industrialized West*?" *Trop Med Int Health* 1998

11. Mumbai IIoPS. Haryana District Level Household Survey report. Mumbai: International Institute of Population Sciences Mumbai; 2004-2008 2010.

12. NIPI. Resources ReportsAndAssessments NIPIAnnualReport2011.pdf: Norway India partnership initiative

13. UNOPSNIPI. Resources of Capacity Building Materials for Home Based Postnatal Newborn Care(HBPNC) visits. In: NFW N, editor. New Delhi: Norway India partnership Initiative National Institute of Health and Family Welfare; 2009. p. 1-3.
14. WHO-UNICEF , Save the children. UNICEF-WHO joined statement on Home visits for the newborn child: a strategy to improve survival. . Geneva; 2009.

ANNEXURES

ANNEXURE1. CONSENT FORM

I am studying home based post natal care in Yamunanagar district. I request the participant to cooperate in this regard. It will assist in knowing the magnitude of the problem and in planning for the prevention of the condition.

Neonatal mortality is a serious problem which is an indicator of general health status of the community. However early prevention may lead to decline in neonatal mortality rate.

The information received will be strictly kept confidential and will not be shown to any other person.

Do you have any question that you will like me to answer?

May I ask you to give your consent to participate in this study?

If you decide not to participate in study, it is your right and I respect your decision.

After explaining the above, I have found (name of respondent)_____ agreed to participate in study.

Annexure2. CHECKLIST

DISTRICT HOSPITAL(DIO/DPM)

Section 1.

Name of District ……

Name of respondent …….

Designation …….

Contact no. ……..

Date ……..

Section2 .

HR & Training Status	Sanctioned	In place	Trained
ASHA			
Supervisor for HBPNC (ANM,LHV,PHN,BEE)			
SMO & Medical Officer			
Information Assistant (PHC & CHC) Trained in HBPNC Software			

1. No. of supervisory home visits conducted by district team (DyCS, DIO, DTO,DPM) in previous 3 months as per form B
    1) O ☐
    2) 1-5 ☐
    3) 6-10 ☐
    4) >10 ☐

2. Form “C” filed at CHC during current month
    1) Y
    2) N

3. No of form “E” received by DIO
    1) 0
    2) 1
    3) 2
    4) 3
    5) >3

CHC

1. SMO/PHN/BEE received HBPNC supervisory training
    1) Y
    2) N

2. Monthly review meeting for HBPNC held in last 3 month
    1) O ☐
    2) 1 ☐
    3) 2 ☐
    4) 3 ☐

3. No. of Form “D” received at CHC in last 3 months
    1) 0
    2) 1-10
    3) 11-20
    4) >20
4. Form “C” filled at CHC during current month
    1) Y
    2) N

5. No. of Form “B” filled at CHC level in last month
    1) 0
    2) 1-10
    3) 11-20
    4) >20

PHC

HR & Training Status	Sanctioned	In place	Trained
ASHA			
Supervisor for HBPNC (ANM,LHV,PHN,BEE)			
Information Assistant Trained in HBPNC Software			

1. MO & LHV received HBPNC supervisory training
    1) Y
    2) N

2. Monthly review meeting for HBPNC held in last 3 month
    1) 0
    2) 1

3) 2
4) 3
5) >3

3. No. of form B filled on supervisory visits conducted by PHC team(MO,LHV) during previous month
    1) 0-10
    2) 10-20
    3) 20-30
    4) >30

4. Form C filled for Supervision/monitoring plan for HBPNC for the current month
    (1) Y
    (2) N
5. No. of form D filled by PHC team(MO,LHV) during previous 3 month
    1) 0
    2) 1
    3) 2
    4) 3
6. No. of form D submitted by HBPNC trained ANM's during last month
    1) 0
    2) 1-5
    3) 6-10
    4) >10

7. No. of cards received during previous month ……

8. No. of cards pending to be entered in the software by Info. asst during previous month
    1) 0
    2) 1-50

3) 51-100
4) All

9. No. of Self appraisal form (for HBPNC payments) submitted in previous month by HBPNC trained ASHAs
    1) 0-10
    2) 10-20
    3) 20-30
    4) >30
10. No. of Self appraisal form (for HBPNC payments) whose payment has been done in previous month
    1) 0-10
    2) 10-20
    3) 20-30
    4) >30
11. As per DHIS-2 reports No. of ASHA provided supervision in last month by ANMs(I/A)
    1) 0-10
    2) 10-20
    3) 20-30
    4) >30
12. Do all ANMs submit DHIS-2 (single reporting) report of HBPNC regularly (I/A)
    1) Y
    2) N
13. Are all PNC cards countersigned by MO after submission by ANMs
    1) Y
    2) N
14. ASHA drug kit replenishment guidelines available with PHC
    1) Y
    2) N

15. No of ASHA drug kits refilled in last 6 months at PHC
    1) 0
    2) 1-10
    3) 10-20
    4) 20-30
    5) >30

SUB CENTRE

HR & Training Status	Sanctioned	In place	Trained
ASHA			

1. Total population of the subcentre ----------
2. The number of ANM trained in HBPNC supervisory training?
    1) 0
    2) 1
    3) 2
3. Out of the trained ANM's, no. of ANM with Supervisory forms?
    1) 0
    2) 1
    3) 2
4. No. of supervisory forms "B" filled by trained ANM's
    1) 0
    2) 1-10
    3) 11-20
    4) 21-30
    5) >30
5. Out of trained ASHA's no. of ASHA with drug kits?

1) Less than 3
2) 3-5
3) More than 5

6. No. of ASHA's with original (printed) HBPNC cards?
    1) 0
    2) Less than 3
    3) 3-5
    4) More than 5
    5) All

7. No. of trained ASHA's with complete kit with drugs and consumables and stock upto 3 months?
    1) 0
    2) Less than 3
    3) 3-5
    4) All
8. No. of documented supervisory visits conducted by MO/LHV/ DyCS,DIO,DTO,DPM?
    1) Less than 2
    2) 2-5
    3) More than 5
9. No. of referrals done from the sub centre in last 3 months
    1) Less than 3
    2) 3-10
    3) More than 10

    REASON ……

ASHA(HBPNC trained)

	Question	Response	R	R

.NO.			esponse(yes)(1)	esponse(No)(2)
.	What to do at birth preparedness visit	a.inform about JSSK b.inform about basic need(clothes, Money) c.to inform when labour pains start		
.	What are the danger signs of new born	a. convulsions/fit b.fast breathing c.chest indrawing d.not able to feed or stopped feeding well e.temperature more than 99.5F or less than 95.7F f.poor activity/lethargy g.birth weight less than 2000gm h.10 or more skin pustules or 1 large boil i.yellow soles or palms		
.	What are the local signs of illness of baby	a.less than 10 skin pustules b.pus from or redness around umbilicus c.pus discharge from eyes		
.	What to do at home visit for HBPNC	a.fill HBPNC card b.measure weight of the baby c.take temperature d.measure respiratory rate e.check for danger sign of		

		new born f. check for danger sign of mother g.check when baby has been bathed first h.is baby immunized with BCG.POLIO,HEP B i.does baby need referral i.is there any other problem		
.	What are the danger signs of mother	a.heavy bleeding b.fever c.convulsions/fits d.severe pain abdomen e.foul smelling discharge f. is there any other problem g. does mother need referral		
.	Counseling & assistance	a.baby care b.mother care including adequate food & rest c.exclusive breast feeding d.family planning e.hygiene f.birth/death registration		

HBPNC HOUSEHOLD CHECKLIST

1. Did ASHA visit for birth preparedness before delivery
    1) Yes
    2) No
2. Did ASHA told the mother about registration of birth
    1) Yes

2) No

3. Where did you have your last delivery?
   1) Home
   2) Govt.Hospital
   3) Private hospital
   4) Other(specify)
4. While on home visit, did ASHA record information in front of mother
   1) Yes
   2) No
5. Did ASHA told the mother for danger signs of newborn & mother
   1) Yes
   2) No
6. Did ASHA take temperature of Newborn during previous visits
   1) Yes
   2) No
7. Did ASHA take weight of Newborn during previous visits
   1) Yes
   2) No
8. Did ASHA take respiratory rate of Newborn during previous visits
   1) Yes
   2) No
9. Did ASHA told about breastfeeding/correct position of breastfeeding
   1) Yes
   2) No
10. Did ASHA told about keeping baby warm
    1) Yes
    2) No
11. Was the mother able to answer the following:
    a. When to wash hands
    1) Yes
    2) No

b. When to immunize the child

1) Yes

2) No

c. Where to go if child is unwell

1) Yes

2) No

d. What are the danger signs in baby

1) Yes

2) No

e. What are signs of sickness in mother

1) Yes

2) No