HOME BASED NEWBORN CARE

Operational Guidelines

(Revised 2014)

Ministry of Health and Family Welfare

Government of India

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Preface

India contributes to one-fifth of global live births and more than a quarter of neonatal deaths. About 7.6 lakh infants die within the first four weeks of birth in India, the highest for any country in the world. The NMR in rural areas is more than double of urban areas. About three-fourths of total neonatal deaths occur in the first week of life.

Home based newborn care (HBNC) is a strategy adopted by Government of India to overcome the burden of newborn deaths in the first weeks of life and to reach the unreached. It provides the "Continuum of Care" for Newborn and post-natal mothers as envisaged under RMNCH+A strategy.. HBNC introduced since 2011 is centred around ASHA worker and is the main community based approach to new-born health now. More than 5.6 lakh ASHAs have been trained in Module 6 & 7 of ASHA training and started making home visits.

The HBNC Operational Guidelines provides the framework and guidance to enable the states to implement home based newborn care. During various reviews with States many issues regarding the programme have been raised for clarification which have been addressed in this revised version of HBNC Operational Guidelines.

I am sure that these revised operational guidelines will prove to be very useful for programme officers in reviewing the planning, implementation and monitoring of home based newborn care programme. I urge the States to implement HBNC programme with vigorous monitoring of quality of care being provided during the home visits by ASHAs.

Ms Anuradha Gupta

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FOREWORD

The Home-based Newborn Care (HBNC) Scheme has been under implementation across the country since the year 2011, as one of the key components of the Newborn Care continuum. India is currently investing in both community and facility based components so as to address neonatal mortality and meet MDG 4 targets. Effective implementation of community based interventions on a large scale, as a countrywide programme depends on appropriate design and planning, monitoring and support systems.

The impact on neonatal mortality rate will be determined to a large extent by the coverage and quality of essential new-born care delivered by ASHAs and ANMs at community level. Over the past 3 years, experiences from various states have brought forth the need to monitor the implementation and outputs of this programme component. The revised guidelines are now being disseminated to the States and will further structure the implementation and monitoring processes.

I hope that these Guidelines will help Child Health Programme Managers, ASHAs and ASHA mentors in strengthening the monitoring and supportive supervision of this critical intervention and thus improving neonatal survival.

(Dr. Rakesh Kumar)

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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 Child hood 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.

The HBNC guidelines released in August 2011 have been revised based on the lessons learnt from the field and key policy changes related to incentive payments. These guidelines revised as on March 31st, 2014 supersede the earlier HBNC guidelines.

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 42 in 2012. 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 26.5 million infants born in the country, about 0.78 million die before they complete one month of life and a total of million die before their first birthday. NMR therefore now constitutes nearly 69 % 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 Twelfth Five-Year Plan.

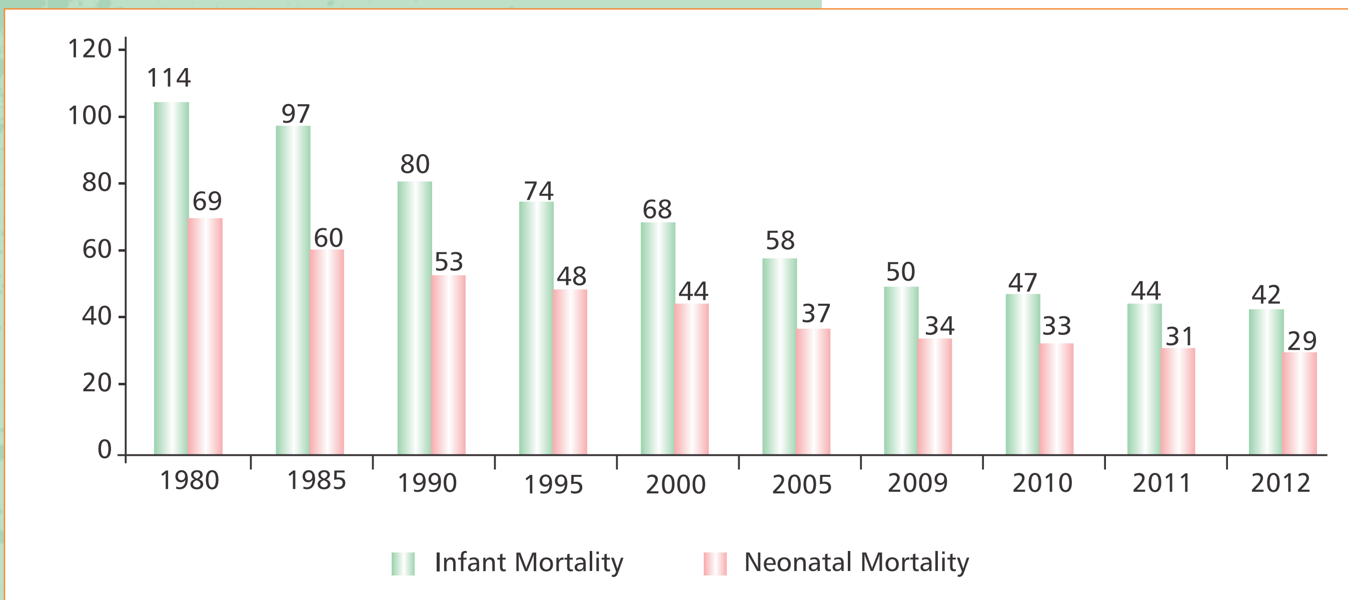


Figure 1: Five year trends in overall Infant Mortality Rate and Neonatal Mortality Rate (per 1000 live births)

Indicator*	Goals	Target	Status
Under-5 Mortality Rate	MDG-4 for 2015	38	52
Infant Mortality Rate	National Population Policy, NRHM, and RCH II for 2010	<30	42
	XI Plan goal for 2012	28	
Neonatal Mortality Rate	National Plan of Action for Children goal for 2010	18	29
	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 2012 (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. As per the recent World Health Organization: Child Health Epidemiology Reference Group report the estimated under five deaths are nearly two million per year. It also shows that neonatal deaths constitute 52% of under 5 mortality in India. The main causes of death in order of frequency are preterm complications and intrapartum related events such as birth asphyxia.

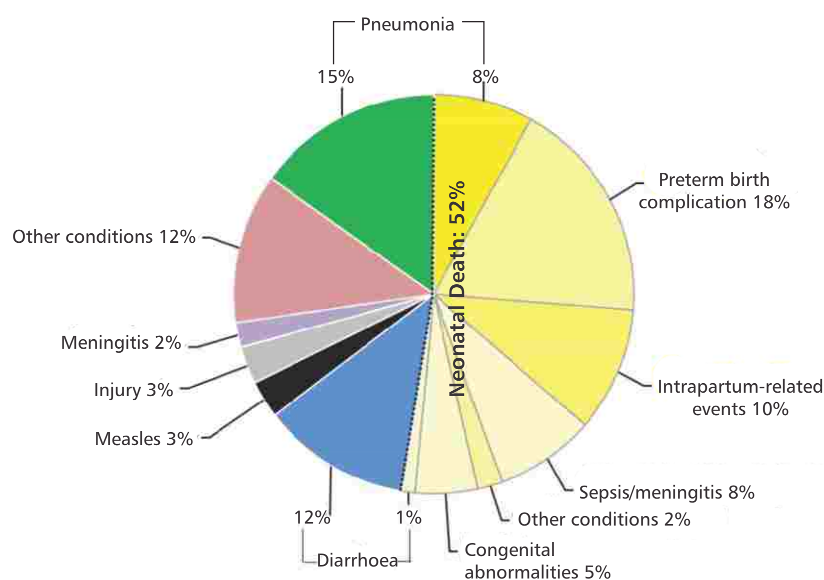


Figure 4: Causes of Neonatal and Child Mortality in India-

Source: WHO - Child Health Epidemiology Reference Group Report - Causes of Under Five Deaths India (2012)

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.

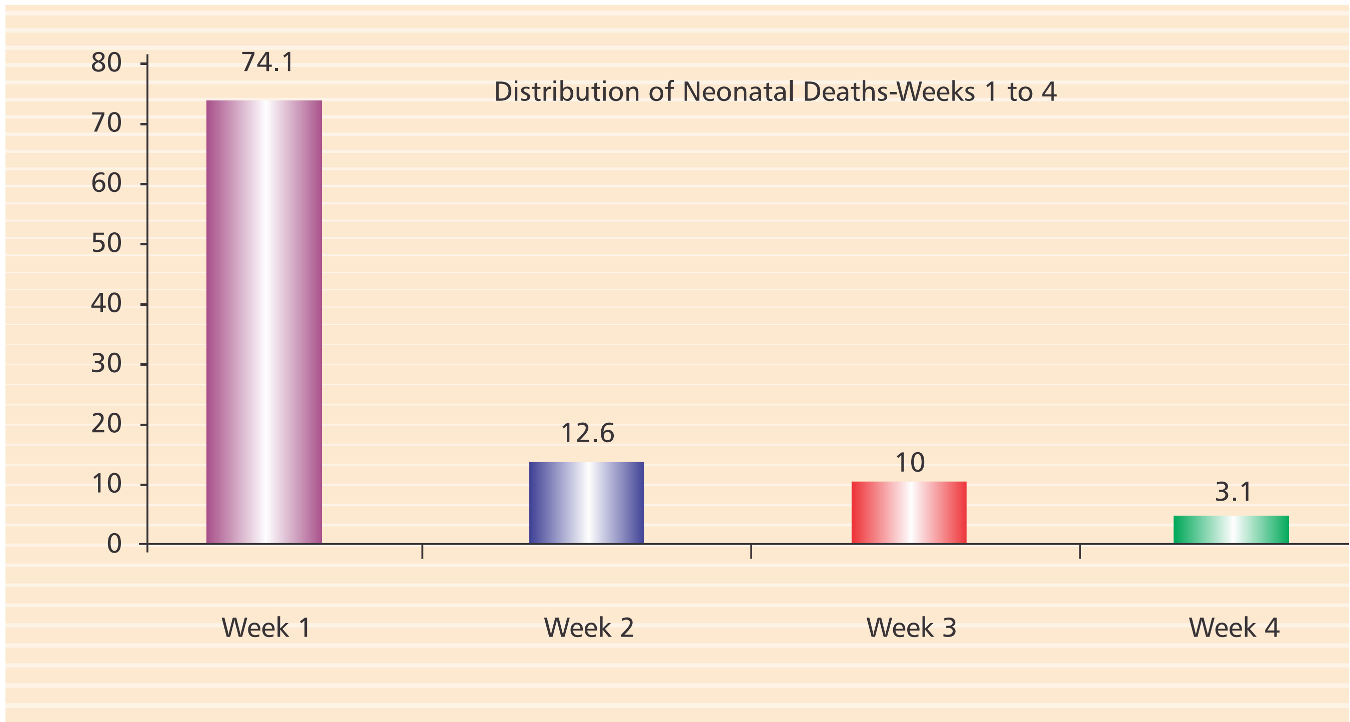


Figure 5a: Distribution of Newborn deaths in the first four weeks

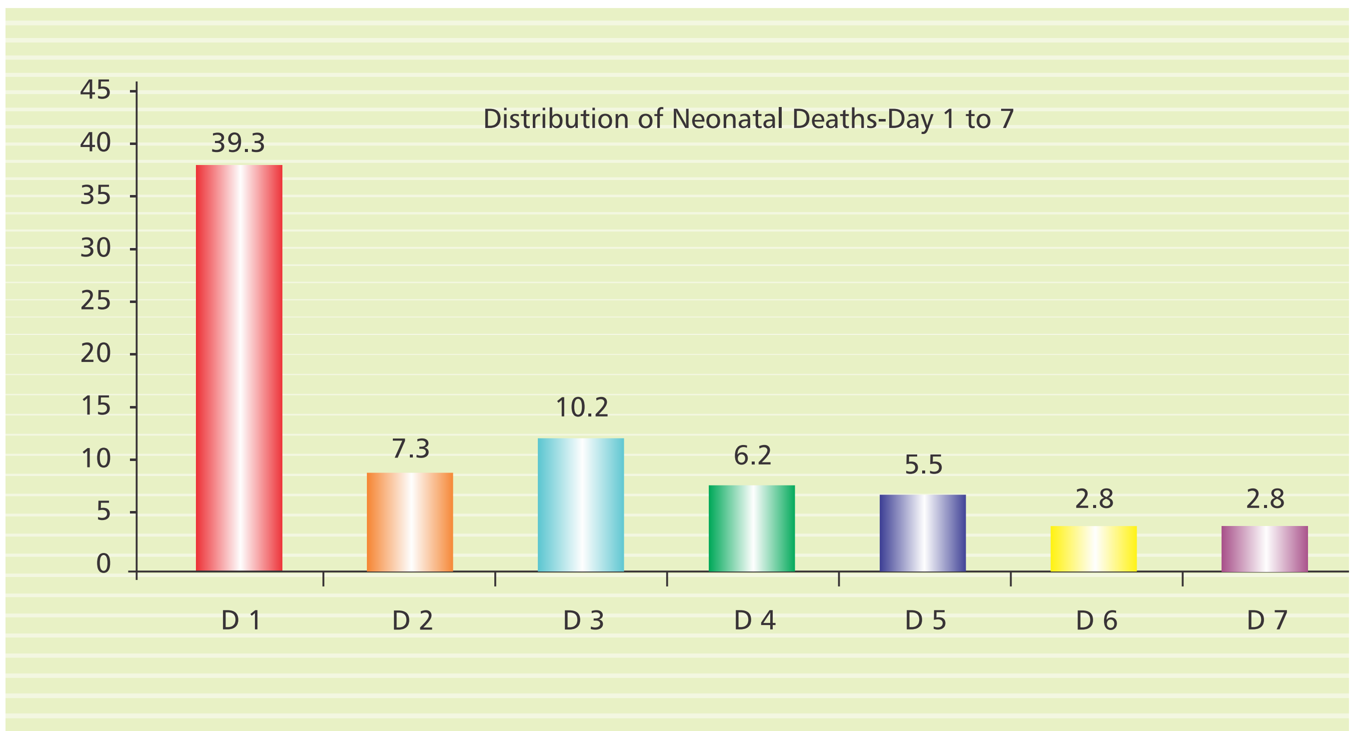
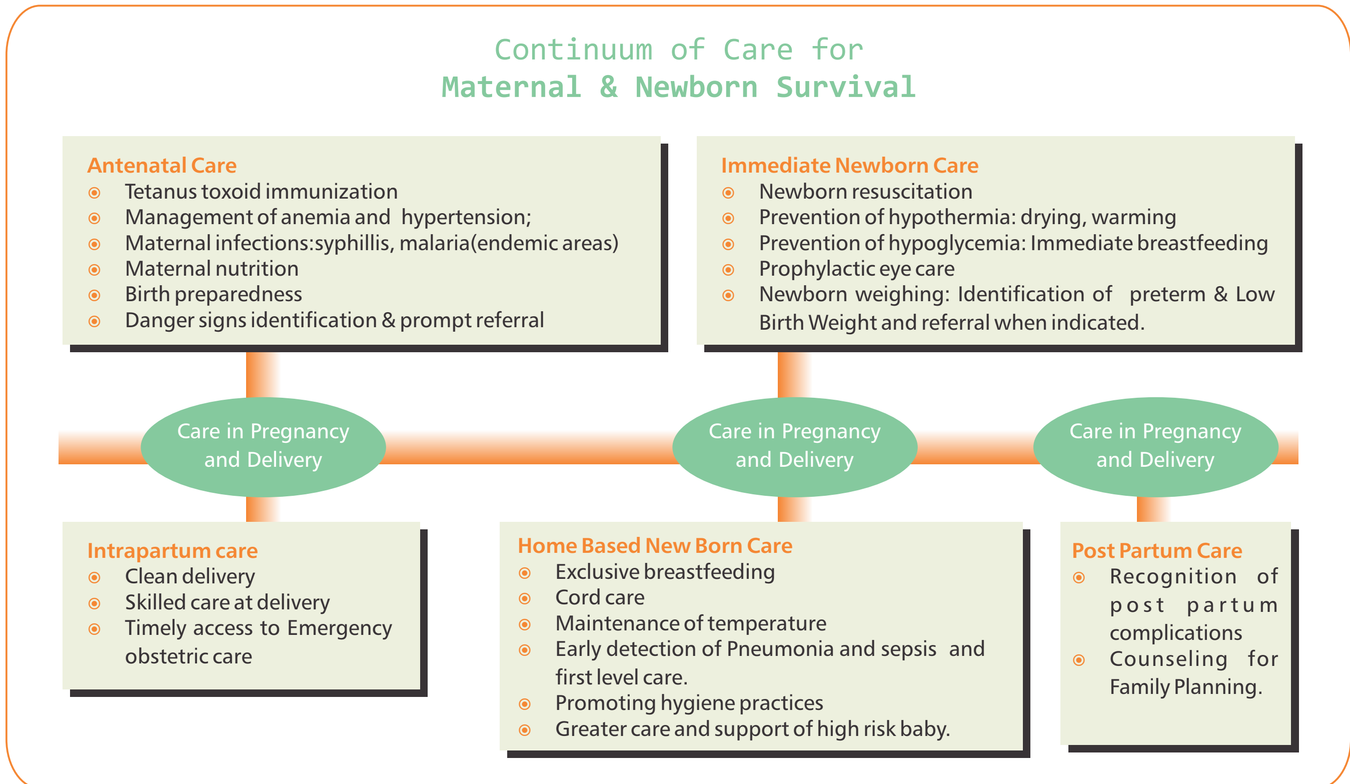


Figure 5b: Distribution of Newborn deaths in the first week of life

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 (June, 2011)
"....""The proposal as recommended by the Empowered Programme Committee (Agenda item No. 11- propsed 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 ASHA 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 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 identification and prompt referred 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,after counseling the mother to keep the baby warm. 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 1b)and Home visit form (Annexure 1c) 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 instituions (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. This requires that the Asha is supplied with the HBNC kit at onset of training to familiarize her in its use. 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: Training in round one of Module 6 &7 equips ASHAs with the skills required for Home based new born care such as hand washing, measuring temperature of newborn, weighing of new born, post natal care, managing hypothermia etc. All ASHAs who have completed training of Round one of Module 6 &7 are eligible to undertake the HBNC visits and are entitled for the HBNC incentive. The ASHA is to be paid Rs. 250 for conducting home visits for the care of the newborn and post partum mother. HBNC incentive is applicable per newborn, thus in cases of twins or triplets the incentive amount for ASHA would be two times of the regular HBNC incentive of Rs. 250 (i.e, Rs.500) or three times of Rs. 250 (i.e,Rs. 750) respectively.

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).
- In cases of Caesarean section delivery, where the mother returns home after 5-6days, ASHAs are entitled to full incentive of Rs. 250 if she completes all five visits starting from Day 7 to Day 42.
- In cases when a newborn is discharged from SNCU, ASHAs are eligible to full incentive amount of Rs. 250 for completing the remaining visits. In addition, ASHAs are also eligible for an incentive of Rs. 50 for monthly follow up of low birth weight babies and newborns discharged from SNCU (as approved by MSG of the National Health Mission on December 6th , 2013). The low birth weight are followed up for two years and SNCU discharged babies for one year.
- In cases where the woman delivers at her maternal house and returns to her husband's house, two ASHAs

undertake the HBNC visits i.e, one at maternal house immediately after delivery and another one at husband's house when the newborn returns home or vice versa. In such cases the HBNC incentive of Rs. 250 can be divided in to two parts in a way that each ASHA who completes 3 visits or more is entitled to Rs. 125. This would be done only after ANM/ASHA Facilitator have visited the household and verified the home visits. In these instances, if an ASHA undertakes less than 3 visits she would not be entitled for the HBNC incentive. The other ASHA completing five or more visits in this case would get the whole amount of Rs. 250.

In order to claim the HBNC incentive, ASHAs are expected to fill and submit two forms – First examination of newborn form and Home Visit form for each newborn. The HBNC card (Annexure 1 a) can be used as a voucher for the purpose of payment and verification by ASHA facilitator/ ANM.

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

(i) Enabling 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/Pentavalent *, and entered into the MCP card
(iii) Enabling 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 ASHA 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.
- ANM should also mentor and support the ASHAs in tasks requiring technical skills such as HBNC. ANM should undertake joint home visits with ASHAs to at least 10% newborns in her Sub centre area. She should also review the HBNC forms filled by ASHAs.
- The platfrom of Village Health and Nutrition Day where newborn come for routing immunization should be used by ANM to review the coverage and quality of care provided by ASHAs to newborns. This activity of ANM should be monitored by MO and reviewed at highest level.
- 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 2 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

* ASHA should submit the HBNC form for payment only after the child has received DPT/Pentavalent vaccination.

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 should be supported by 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 replenis-hments 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 export and a stock card with each ASHA.
- Ensure that first expiry drugs and consumables are used first at every level.

(iii) Janani Sishu Suraksha Karyakaram (JSSK) – Under the JSSK, free referral transport (pick and drop back), drugs, diagnostics and treatment services are available at all public health facilities for all women during antenatal, intrapartum and postpartum period; newborns and infants with any complications or illnesses. ASHAs are expected to identify sick / high risk newborns during HBNC visits and refer them for treatment at appropriate facilities. ASHAs should be informed about the provisions under JSSK and availability of referral transport services during their monthly meetings and training sessions.

(iv) 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.

(v) Listing of Institutions - ASHAs should be informed about the health institutions where a sick or high risk newborn should be referred. Each district should prepare a list of public institutions where a Newborn Stabilization Corner and/or a Sick Newborn Care Unit is functional. This should be provided to all ASHAs during their monthly meetings or trainings along with details of the distance to be travelled and expected time of travel from their villages

(vi) 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.

(vii) Funds

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

Monitoring

The progress of implementation of the HBNC programme will be closely monitored by the MoHFW on a quarterly basis. States would be expected to provide details of the status of ASHA training and equipment related to HBNC along with details of the HBNC visits and referrals made by ASHAs and the total expenditure on HBNC by the state. (Annexure 4 – HBNC Quarterly Progress Report)

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

Indicators		
Process Indicators	**Output indicators**	**Outcomes**
1. Percentage of ASHA trained in Round 1of Module 6 &7 2. Percentage of ASHA trained in Round 2 of Module 6 &7 3. Percentage of ASHA trained in Round 3 of Module 6 &7 4. Percentage of ASHA trained in Round 4 of Module 6 &7 5. Percentage of ASHA with complete HBNC kit.	1. Percentage of Newborns who were visited in the first two days of birth at home. 2. Percentage of newborns who received full schedule of HBNC visits 3. Percentage of newborns who were weighed at birth 4. Percentage of low birth weight recorded 5. Percentage of sick newborns referred 6. Percentage of SNCU discharged babies visited as per schedule	1. Percentage of New born received home visit for HBNC by ASHA against total estimated live birth 2. Percentage of newborns who were breastfed in the first hour 3. Percentage of Low Birth Weight /Preterm (high risk) babies reported 4. Percentage of sick newborns admitted at referral sites – (SNCU) 5. No. of newborns deaths

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/ANM 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/ANM 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

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

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

Supervisor Signature: ______________________ Date : ______________

Mother -Newborn Home Visit Card
(To be filled by the ASHA during home visits and handed over to ANM/ASHA facilitator after completion of home visits)

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

Supervisor Signature: ______________________ Date : ______________

Annexure 1b

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

Part II: Date of Home Visit	Day1(one hour after birth)	For Supervisor/ASHA Facilitator
1. Tempreture of the baby (Measure in axilla and record):		Yes/No/NA
2. Eyes: Normal / Swelling or oozing pus		Yes/No/NA
3. Is umblical cord bleeding(Yes/No)		Yes/No/NA
If yes, either ASHA,ANM or TBA can tie again with clean thread. Action taken (Yes/No)		Action taken (Yes/No)
4. Weight:	________Kg _______ Gm	Weighing matches with the colour? Yes/No
Colour on scale: (Red/Yellow/Green		
5. Record (Yes/No)		Yes/No/NA
a. All limbs limp (Yes / No)		
b. Feeding less/stop (Yes / No)		
c. Cry weak/stopped (Yes / No)		
6. Routine Newborn Care: whether the task was performed		Yes/No/NA
a. Dry the baby (Yes/No)		
b. Keep warm, do not bathe, wrap in cloth, keep closer to mother (Yes/No)		
c. Initiate exclusive breast feeding (Yes/No)		
d. Keep the cord clean and dry (Yes/No)		
7. Anything unusual in baby?(curved limbs/cleft lip/other)		Yes/No/NA

Annexure 1c

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

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

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

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

E. Check now for the following signs of sepsis: if sign is present mention-Yes, if absent, mention-No									
Visit	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42		
Date of Visit									
Ask/examine (Yes / No)									
1. All limbs limp (Yes / No)								Consider first three signs as criteria for diagnosing sepsis only if the sign was absent previously and then it newly developed.	
2. Feeding less/stopped (Yes / No)									
3. Cry weak / stopped (Yes / No)									
4. Distended abdomen or mother says baby vomits often (Yes / No)								If at least two criteria are present on the same day, diagnose as sepsis and start with first dose of cotrimoxazole i.e, 1/4th of teaspoon of Cotrimoxazole and refer the newborn immediately to SNCU at the nearest health facility.	
5. Mother says baby is 'cold to touch' or baby has fever with a temperature>99 degree F (37.2 degree C)									
6. Chest in drawing (Yes / No)								If only one sign is present you should visit the newborn every day (using the home visit form for high risk baby) to check appearance of any other sign. Meanwhile provide management for the existing problem.	
7. Respiratory rate more than 60 per minute (Yes / No)									
8. Pus on umbilicus (Yes / No)									
Supervisor's note : Incomplete work/Incorrect work/ Incorrect record/									
Name of ASHA								Signature of ASHA	
Name Of the ASHA Facilitator/ANM			Observations					Signature of Asha Facilitator / ANM	
Name of the ANM			Has the baby received the DPT 1 vaccination?					Write the age of the baby when DPT vaccination was done?	________ days (write in days)
Observations								Signature of ANM	

Annexure 2
Additional contents of ASHA kit to facilitate HBNC

A. Equipment

1. Digital Watch: (Rs. 50-70)*
- Date and Time, (in Hours, Minutes, and seconds)
- Illuminated dial
- Standard Numerals (not Roman or others) – stop watch function is not essential
- Battery life of at least one year,
- Readily available battery

2. Digital Thermometer: (Rs. 100-120)*
- Range of temperature measurement 32^{0}C- 42^{0} (89.6^{0}F-109.4^{0}F)
- Can be calibrated in both centigrade and Fahrenheit, but if only one option is available, then Fahrenheit is preferable.
- Easy to read LCD display
- Buzzer signal function
- Takes 60-90 seconds to measure temperature
- Can be used in the armpit/axilla, orally and rectally
- Accuracy of temperature $\pm 1^{0}$C and $\pm 0.2^{0}$F

3. Neonatal weighing scale- Tubular spring type with sling: (Rs. 300- 350)*
- Hanging tubular handheld type
- Plastic tubular body
- Able to weigh weights between 0 to at least 5000 grams
- Clear and easy to read measurement panel with specific colour coded graduation at 100 grams difference (green- >2500 grams, yellow- 2000-2500 grams and red- <2000 grams)
- Zero adjustment facility
- Corrosion protected load hook and suspension ring/hook: at top for holding while weighing and at lower end for hanging the baby holding sling
- Soft durable sling material for holding the baby
- Guarantee – 3 years

4. Sling of the weighing scale –
- Sling should be made of parachute cloth. Cloth and stitching of the sling should be smooth and soft for the baby
- Size of the sling should be big enough to hold a newborn and a maximum weight of 5 kg.(Approximate length -74cms and breadth - 54 cms)
- Sling should have two loops, one at each end, which can be hanged in the hook of spring scale (as shown in picture).

5. Blankets for neonates: two per ASHA – (Rs. 70-80)*
- Blanket dimensions: 3 ft 2 inches x 3 ft 2 inches x ¼ inch
- Washable
- Meant for demonstration and immediate use. Family would then make their own arrangements

6. Baby feeding spoon: Rs.(6-10)*
- Long handled, and easy to clean
- Made of stainless steel
- Front end of the spoon should be shallow, not flat or too deep, less than 5 ml.

B. Medications
1. Gentian Violet paint (0.5% and 0.25% IP)
2. Syrup Paracetamol
3. Syrup Cotrimoxazole

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

*Cost is illustrative

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 4
HBNC QUARTERLY PROGRESS REPORT

NAME OF STATE	
Name of State Nodal Officer for HBNC	
Email id	
Contact details	
Name of State Nodal Officer for ASHA programme	
Email id	
Contact details	
Part A: Programme status – to be submitted by the State electronically and physically to DC(CH)- ch.mohfw.trainings@gmail.com FROM ………. (DD/MM/YY) to ………… (DD/MM/YY)	
HBNC KIT	
Number of ASHAs who have received all components of HBNC kit	
Please provide the list of equipment provided to ASHAs	
Level of procurement of the kit	1. State 2. District 3. Block 4. Specify the details if the procurement was done with assistance from other agency
Number of ASHAs who were provided with the HBNC kit during Round 1 training of Module 6 & 7	
Was there any time lag between training of ASHAs in Round 1 of	
Module 6 &7 and distribution of the HBNC kit? Specify the duration	
Number of support staff oriented in HBNC	1. At district level - ____________ 2. At block level - ____________ 3. At sub-block level - ____________ 4. Others - ____________

Part B: Status of ASHA HBNC visits - (to be submitted by the State electronically and physically to DC(CH)-ch.mohfw.trainings@gmail.com at the end of each quarter)
FROM .... (DD/MM/YY) TO .... (DD/MM/YY)

Name of the District.	No. of ASHAs (in place)	ASHA trained in module 6 & 7				No. of ASHA started doing home visits	No. New-borns visited for HBNC	No. of low birth weight / preterm (high risk) babies reported out of those visited	No. of sick new-borns referred	No. of New-born death reported	No. of ASHAs who have received the HBNC pay-ment in last quarter	HBNC Payment expend-iture in this quarter (Rs.)	HBNC allocation in current F.Y. (Rs. Lakhs)	HBNC expend-iture for current F.Y. (Rs. Lakhs) Cumula-tive	% ex-pendi-ture	Re-marks (If Any)	SNCU discharges followed up	No. of low birth weight babies followed up
		R-1	R-2	R-3	R-4													

List of Important modifications in the Revised Operational Guidelines for Home Based New born Care:

1. Section 2.5; Page: 11 Certain modifications and addition of new specifications in Part 1 detailing ASHA Payments are as follows:
   a. Under the section on schedule of payments a specification has been added –that even in case of Caesarean Section delivery, where the mother returns home after 5-6 days, ASHAs are entitled to full incentive amount of Rs. 250 for completing the remaining visits.
   b. In addition a new specification pertaining to an incentive of Rs 50 for undertaking follow up visits for low birth weight/preterm or sick new born discharged from SNCU has been added. For low birth weight babies the follow up is to be undertaken for two years and for sick new born the follow up visits are to be made for a period of one year.
   c. This section also specifies that in cases where the woman delivers at her maternal house and returns to her husband's house, two ASHAs undertake the visits for HBNC, ie. one in maternal house immediately after the delivery and another one at the husband's house when the new born returns home or vice versa. The guidelines now lays down a norm that in such cases the HBNC incentive of Rs 250 in such cases can be divided in two parts in a way that each ASHA who completes 3 visits or more is entitled to Rs 125. This would be done only after ANM/ ASHA Facilitator have visited the household and verified the home visit. Also in these instances, if an ASHA undertakes less than three visits she would not be entitled to for the HBNC incentive. On the other hand ASHA completing five visits or more would get the whole amount of Rs 250.
   d. The conditionalities (i) and (iii) of payments to ASHA have been changed and word "ensuring" has been replaced with "enabling" for- record of birth weight in the Maternal and Child Protection Card and birth registration.
2. Section 2.5; Page: 12 - Part 2: Ensuring Field level Support- In addition to visits by ASHA facilitators now also mandates: Mentoring and support to the ASHA by ANM for reviewing technical skills related to HBNC. ANM should undertake joint home visits with ASHAs to at least 10% new borns in her sub-centre area and should review the HBNC forms filled by ASHAs.
3. Section 2.6; Page –14- Under the heading "Implementation of the scheme is supported by the following" two additional points regarding updated details of services under JSSK (point iii) and institutions with functional Newborn Stabilization Corners and Sick Newborn Care units (point v) to be provided to all ASHAs during monthly meetings and / or training sessions have been added.
4. Section 3; Page –15 - Monitoring includes the following changes:
   a. The last process indicator specifically seeks information on: Percentage of ASHAs with complete HBNC kit
   b. Two new output indicators: Percentage of low birth weight recorded and Percentage of SNCU discharges visited have been added.
5. Annexure 1-
   i. Annexure 1a; Page – 16- HBNC card has been added which is to be used as a voucher for the purpose of payment and verification by ASHA facilitator/ANM.
   ii. Annexure 1b- First Examination New Born Form
      - Part I; Page 17- New points for recording maternal and infant death have been added to capture the cause of deaths.
      - Part II; Page 18- Keeping the cord clean and dry has been added to routine new born care under point 5

iii. Annexure 1c – Home visit form-

- Action points have been added for all the previously mentioned tasks which ASHA undertakes for mother and newborn care during home visits.
- Part C ; Page -21- Status of vaccination of the newborn for BCG, OPV and Hep B has been added
- Part D; Page - 21- New points regarding details of any referral of mother or newborn has been added to capture reasons, time and place of referral
- Part E; Page 22 –Respiratory rate of more than 60 has been added as a sign of sepsis
- Supervisor's note; Page 22- Provision to capture the status of DPT vaccination has been made.

6. Annexure 2; Page – 23- Details of contents of HBNC kit have been added with illustrative costs of each equipment.
7. Annexure 4 ; Page – 25 – Format for quarterly progress of HBNC has been added with Part A covering details of ASHA training and HBNC kit details and Part B capturing details of HBNC visits, referrals and follow ups done by ASHA.

Notes

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