NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE
सत्यमेव जयते

पहले तीन साल, सम्पूर्ण देखभाल
Samagra Shishu Bal Swasthya Karyakram

Samagra Shishu Bal Swasthya Karyakram (SSBSK)

पहले तीन साल, सम्पूर्ण देखभाल

Operational Guidelines
2026

पहले तीन साल, सम्पूर्ण देखभाल

Samagra Shishu Bal Swasthya Karyakram

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Operational Guidelines 2026

जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA

सत्यमेव जयते

मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार
Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

Maternal and Child Health is fundamental to India's journey towards a healthier, stronger and more prosperous nation. As we advance towards the vision of Viksit Bharat 2047, prioritizing maternal and child health is both a healthcare necessity and a vital investment in India's future. It serves as a cornerstone for building the robust human capital required to drive the nation forward.

During last decade the country has made remarkable progress in reducing maternal, newborn and child mortality through sustained investments in health systems, community-based interventions and social development programs.

Building on the foundation of the Home-Based Newborn Care (HBNC) and Home-Based Care for Young Children (HBYC) programs, which utilize ASHAs and frontline workers to deliver essential health, nutrition and early caregiving services at home, the Ministry of Health and Family Welfare has released "समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल" Guidelines, 2026. This initiative creates a single, integrated framework to deliver seamless, home-based care from birth up to three years of age. By strengthening care within homes and communities, these guidelines promote a continuum of support for mothers, newborns and young children during the most critical early years of life and would further accelerate the efforts to achieve SDG Targets.

The success of these guidelines will depend on the commitment of States and Union Territories, the dedication of frontline workers and health-care providers and the active participation of families and communities. The effective implementation will further strengthen our efforts to ensure that every child receives the best possible start in life.

(Jagat Prakash Nadda)

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राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

MINISTER OF STATE
HEALTH & FAMILY WELFARE
AND CHEMICALS & FERTILISERS
GOVERNMENT OF INDIA

अनुप्रिया पटेल
ANUPRIYA PATEL

MESSAGE

The foundation of a healthy and prosperous India is built in its homes and communities. The care that a mother receives after childbirth, the attention given to a newborn, and the nurturing environment provided during the early years of life have a profound influence on a child's health, growth, learning, and future potential. Strengthening support for mothers and children during this critical period is therefore essential to achieving our vision of a healthier and more developed nation.

"समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल" Guidelines 2026 provide a comprehensive framework for delivering essential maternal, newborn, and child health services closer to the community. By integrating essential newborn care after birth, nutrition, growth and developmental monitoring, responsive caregiving of young child, postpartum care and maternal mental health support, the guidelines promote a holistic and family-centered approach to care. A key focus of the guidelines is reaching vulnerable mothers and children through early identification of risks, timely referral, regular follow-up, and stronger linkages between communities and health facilities. These guidelines also reinforce the critical role of ASHAs, ANMs, Anganwadi Workers, Community Health Officers, and other frontline functionaries who serve as trusted partners for families across the country.

The implementation of these guidelines provides an opportunity to further strengthen service delivery at the community level and enhance support for mothers, newborns, and young children. Through coordinated efforts and sustained commitment, the actions outlined in these guidelines can help improve health, nutrition, and developmental outcomes, laying a strong foundation for a healthy, productive, and empowered generation that will contribute to Viksit Bharat 2047.

(Anupriya Patel)

June 25, 2026
New Delhi

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सचिव
PUNYA SALILA SRIVASTAVA, IAS
Secretary

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

The strength of a nation rests on the health, development, and well-being of its children. The foundation for these outcomes is established in the earliest years of life, making the first three years a critical window for investments that yield lifelong benefits for individuals and society. Ensuring that every child thrives during this period is both a public health imperative and a National development priority.

Under the National Health Mission, the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy has played a pivotal role in strengthening the continuum of care across the life course. It focuses on improving maternal and child health outcomes through integrated service delivery at facility and community levels. Within this strategy framework, the Home-Based Newborn Care (HBNC) and Home-Based Care for Young Children (HBYC) programmes have further strengthened community-level support through ASHAs and frontline workers, extending essential health, nutrition and caregiving services to newborns and young children during the critical early years.

These sustained efforts are reflected in India's continued progress in child survival, with the Sample Registration System (SRS) 2024 reporting a decline in the Neonatal Mortality Rate (NMR) from 26 to 18 per 1,000 live births and the Under-Five Mortality Rate (U5MR) from 45 to 28 per 1,000 live births between 2014 and 2024.

Building upon these efforts, the Ministry of Health and Family Welfare is pleased to release "**समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल**" Guidelines, 2026, which provide a unified framework for home-based care from birth to three years of age. The guidelines emphasize early identification and longitudinal follow-up of 'At-risk' newborns and young children through structured home visits, strengthened supportive supervision, and digital tracking through the **Digital App** integrated with the **JANANI portal**. By reinforcing linkages between families, communities, and health facilities, the guidelines aim to ensure continuity and quality of care while promoting optimal health, nutrition, nurturing care, and early childhood development.

I am confident that these guidelines will serve as a valuable resource for programme managers, healthcare providers and frontline workers in delivering integrated, family-centred care during the most critical period of child development.

Punya Salila

(**Punya Salila Srivastava**)

#StopObesity

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FOREWORD

Ensuring the survival, health, nutrition, growth, and development of mothers and children remains a core priority under the National Health Mission (NHM). Over the past decade, India has made significant progress in maternal and child health through strengthened health systems, expanded access to comprehensive primary healthcare, and community-based interventions. These efforts have contributed substantially towards achieving Sustainable Development Goal (SDG) Targets 3.1 and 3.2. As per the latest Sample Registration System (SRS) Report of the Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) has declined to 87 per 100,000 live births (2022–24), while the Neonatal Mortality Rate (NMR) and Under-Five Mortality Rate (U5MR) reduced to 18 and 28 per 1,000 live births, respectively (2024).

Despite these gains, the period immediately after childbirth i.e. first 28 days remains the most vulnerable phase for mortality reduction, of which first week accounts for nearly 70% of neonatal deaths, while the postnatal period is also critical for maternal health and well-being. At the same time, the first three years of life are the most critical for a child's brain development. Nearly 80% of brain growth occurs by age three; nurturing care in this window shapes a child's lifelong health, learning, and helps to reach their full potential. This underscores the need for timely identification, follow-up, referral, and management of newborns and young children requiring additional care and support.

Taking learnings of the key programmatic interventions of Home-Based Newborn Care (HBNC) and Home-Based care of Young Children (HBYC), a consolidated programmatic framework namely "**समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल**" has been introduced. These guidelines establish a continuum of home-based care from "birth until three years of age". The updated framework introduces a risk-differentiated approach with intensified follow-up for 'At-risk' newborns and children, strengthens convergence through joint home visits by ANMs and CHOs along with ASHAs for timely referral with digital tracking through Shaishav App. There is also greater emphasis on postnatal maternal care, including maternal mental well-being and nurturing care of children with active family participation.

The guidelines provide a practical roadmap for translating policy into action and ensuring equitable as well as high-quality care for every mother and child. I am hopeful that through the collective efforts and sustained commitment, these guidelines will further contribute in reducing preventable morbidity and mortality serving a healthier future.

Dated: 22nd June, 2026

(Aradhana Patnaik)

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PREFACE

Prevention and Promotive Care remains fundamental in design of any policy framework in augment the health and well-being of our children. Strong, early steps pave the way for a strong edifice, thereby ensuring that the citizens of our country remain empowered and resilient.

India's progress in maternal, newborn, and child health is central to our broader commitment to inclusive development and the well-being of every family. Over the past decade, significant gains have been achieved through expanded access to institutional deliveries, strengthened facility-based care), and community-based programmes like Home-Based Newborn Care (HBNC) and Home- Based Care for Young Child (HBYC). "समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल" Guidelines 2026, built on the success achieved, recognize home as an extension of the health system and place frontline workers at the centre of delivering continuous family-centred care from birth through the first three years of life.

These guidelines integrate postpartum maternal care, newborn care, child health, nutrition, nurturing care, and psychosocial support within a single operational framework. A stronger focus is on risk-differentiated care for 'At -risk' children- low-birth-weight/ preterm & sick newborns, and vulnerable children along with screening of postpartum maternal mental health. The guidelines aim to improve both the quality and effectiveness of home-based care services through meaningful engagement with families, behaviour change communication, and coordinated action by ASHAs, ANMs, AWWs and CHOs.

The new initiatives taken in these guidelines are endeavoured to provide impetus and positive directions for achieving the SDG, 2030 goals.

Successful implementation will require sustained commitment from programme managers, health-care providers, frontline workers, and communities across all levels. I hope that States/ UTs will effectively adopt these guidelines within their implementation plans and strengthen systems for capacity building, supportive supervision, monitoring, and convergence.

मीरा श्रीवास्तव

(Ms. Meera Srivastava)

#Measles Rubella Elimination
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ACKNOWLEDGMENT

"समग्र शिशु बाल स्वास्थ्य कार्यक्रम (SSBSK): पहले तीन साल सम्पूर्ण देखभाल" Guidelines 2026 provide a comprehensive framework for postnatal mothers and children from birth to three years of age. The guidelines introduce a differentiated care approach based on At-Risk profiling, supported by intensified home-based care through additional joint visits by frontline workers. The guidelines further promote digital capture of service data to enhance tracking, monitoring and follow-up.

These guidelines have been shaped by the vision and leadership of the Secretary (Health & Family Welfare), the Additional Secretary & Mission Director (NHM), and the continued guidance of the Joint Secretary (RCH). I would like to acknowledge the contributions and support of colleagues from the Maternal Health, Nutrition, Urban Health and NHSRC. I also appreciate the technical support provided by development partners including NIPI, WHO, CIFF, UNICEF, UP-IHAT, AIF, MAMTA and others.

I also extend my gratitude to members of the Technical Advisory Groups, State Programme Managers, academic institutions, professional bodies, development agencies and civil society organizations whose valuable insights and field experiences have enriched this document. My sincere appreciation also goes to my team of the Child Health Division, MoHFW for their unwavering support.

I am confident that these guidelines will serve as a practical resource to ensure that every mother and child receives quality care and support during the most critical stages of life.

(Dr. Shobhna Gupta)

Executive Summary

India's National programmes for maternal, newborn, and child health has seen steady evolution, integrating survival focused approaches under a holistic framework to promote survival, growth and all-inclusive development. The Home-Based Newborn Care (HBNC) programme, introduced in 2011 and revised in 2014, significantly improved postnatal survival through structured home visits by Accredited Social Health Activists (ASHAs). In 2018, the Home-Based Care for Young Child (HBYC) programme expanded this continuum, with greater emphasis on nutrition, immunization, and early childhood development up to 15 months of age for continuity in care.

Building on these key policy interventions supported by recent evidence, programme learnings, and National priorities, these guidelines consolidate both the HBNC and HBYC programmes. This unified framework is now being delivered through the

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an expanded, family-centric, and transformative framework focusing on nurturing care from birth to 36 months of age. The revised guideline introduces newer components for policy reorientation towards strengthened continuity, quality, and equity in community-based care.

The introduction of the risk stratified and risk differentiated care approach, wherein newborns and young children with low birth weight, prematurity, or growth faltering are identified early through home visits and followed up with intensified care and counselling constitute a key innovative strategy. The guideline also strengthens linkages with Comprehensive Primary Health Care (CPHC) through Ayushman Arogya Mandirs (AAMs), thus enabling a team-based service delivery by ASHAs, Anganwadi Workers (AWWs), Auxiliary Nurse Midwives (ANMs), Community Health Officers (CHOs), and Medical Officers (MOs) to provide timely referral, supervision, and follow-up. The guideline clarifies roles and accountability mechanisms for frontline workers. Enhanced supervision, joint visits, and digital monitoring strengthen quality assurance, while performance-linked incentives, monthly review meetings, and capacity-building initiatives reinforce motivation and coordination across cadres.

Strengthened training cascades, refresher modules, and participatory learning tools aim to build competency and facilitate quality implementation at all levels.

The guidelines have been made contemporaneous with introduction of several new components in the programme. Recognising the importance of comprehensive care, maternal mental health has been newly incorporated into home-based care. ASHAs and ANMs are oriented to recognize symptoms of postnatal mental health concerns, provide empathetic counselling, and refer mothers for further assessment at AAMs as critical to health & wellbeing of both mother & child.

SSBSK incorporates climate-sensitive counselling as part of routine ASHA home visits, addressing the impact of extreme heat and air pollution (including indoor air pollution) on newborn and young child health. ASHAs to guide families on protective measures; keeping children cool and hydrated during heatwaves, and reducing indoor and outdoor air pollution exposure in alignment with the National Programme on Climate Change and Human Health (NPCCHH), 2019.

The SSBSK programme envisages the integration of digital technologies to strengthen efficiency, responsiveness, and continuity of care. Digital tools such as Decision-Support Systems (DSS), child tracking applications, referral loops, and alert mechanisms are envisioned to enhance monitoring and follow-up of 'At-risk' newborns and young children. These systems will be aligned with National digital health platforms such as platforms such as JANANI Portal, U-WIN Portal, MPCDSR Portal, RBSK 2.0 Portal and POSHAN Tracker to facilitate seamless data exchange and service continuity by the help of ABHA & Baal-ABHA IDs. It also addresses home-based care in urban settings, emphasizing tailored strategies for slum, migrant, and underserved populations.

These guidelines also address new age issues of the digital era. Excessive screen time and reduced physical interaction in early childhood are now recognised as significant risks to brain development, emotional health, and social skills. SSBSK actively promotes age-appropriate play, physical activity, and mental stimulation within the first three years of life. Such play helps familiarise the newborn with the physical surroundings around them. It also supports the growing newborn's cognitive, physical, and emotional well-being.

Together, these guidelines represent a paradigm shift towards a nurturing, inclusive, and digitally enabled system that helps every child not only survives but thrives, thereby contributing to India's commitment towards *Viksit Bharat*.

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Abbreviations

AAA	ASHA–ANM–AWW (Team Model)
AAM	Ayushman Arogya Mandir
ABHA	Ayushman Bharat Health Account
ABDM	Ayushman Bharat Digital Mission
AF	ASHA Facilitator
ANC	Antenatal Check-Up
ANM	Auxiliary Nurse Midwife
AMB	Anemia Mukt Bharat
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCM	Block Community Manager
BCPM	Block Community Process Manager
BPM	Block Programme Manager
BVS	Bal Vikas Samiti
CBAC	Community Based Assessment Checklist
CBE	Community-Based Event
CHO	Community Health Officer
CPHC	Comprehensive Primary Health Care
DCM	District Community Manager
DCPM	District Community Process Manager
DEIC	District Early Intervention Centre
DH	District Hospital
DSS	Decision Support System
EBM	Expressed Breast Milk
ECD	Early Childhood Development
ENMR	Early Neonatal Mortality Rate
FBNC	Facility Based Newborn care
FOGSI	Federation of Obstetric and Gynaecological Societies of India
FRU	First Referral Unit
GoI	Government of India
GP	Gram Panchayat
HBNC	Home-Based Newborn Care
HBYC	Home Based Care for Young Child
HRP	High-Risk Pregnancy
ICDS	Integrated Child Development Services
IDCF	Intensified Diarrhea Control Fortnight
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal Childhood Illnesses
IMR	Infant Mortality Rate
INAP	India Newborn Action Plan
IYCF	Infant and Young Child Feeding
JAS	Jan Arogya Samiti
JSY	Janani Suraksha Yojana
JSSK	Janani Shishu Suraksha Karyakaram
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
MAM	Moderate Acute Malnutrition
MAS	Mahila Arogya Samiti
MCP	Mother and Child Protection (Card)
MHT	Mobile Health Team
MNCU	Mother-Newborn Care Unit
MPW	Multi-Purpose Worker
MOIC	Medical Officer In-charge
MoHFW	Ministry of Health & Family Welfare
NBSU	Newborn Stabilization Unit
NFHS	National Family Health Survey
NHP	National Health Policy
NHSRC	National Health System Resource Centre
NICU	Neonatal Intensive Care Unit
NMR	Neonatal Mortality Rate

NRC	Nutrition Rehabilitation Centre
NUHM	National Urban Health Mission
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PHQ	Patient Health Questionnaire
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PNC	Postnatal Care
POSHAN	PM's Overarching Scheme for Holistic Nutrition
PPH	Postpartum hemorrhage
PRI	Panchayati Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RWA	Residents Welfare Association
SAANS	Social Awareness and Actions to Neutralize Pneumonia Successfully
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SD	Standard Deviation
SDG	Sustainable Development Goal
SHG	Self-Help Group
SHC	Sub-Health Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SNCU	Special Newborn Care Unit
SPMU	State Programme Management Unit
SRS	Sample Registration System
SSBSK	Samagra Shishu Bal Swasthya Karyakram
SUW	Severely Underweight
THR	Take Home Ration
U5MR	Under-Five Mortality Rate
UAAM	Urban Ayushman Arogya Mandir
UHIR	Urban Health Information Register
UHND	Urban Health and Nutrition Day
UHSC	Urban Health Sub Centre
UHSND	Urban Health Sanitation and Nutrition Day
UPHC	Urban Primary Health Centre
VHSND	Village Health Sanitation and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WASH	Water Sanitation and Hygiene
WLC	Ward Level Committees

पहले तीन साल, सम्पूर्ण देखभाल

Samagra Shishu Bal Swasthya Karyakram

At a glance

1. A Unified framework

Samagra Shishu Bal Swasthya Karyakram (SSBSK) integrates Home-Based Newborn care (HBNC) and Home-Based care for Young Child (HBYC) programmes into a single continuum from birth up to 3 years of age, with clearly defined health system personnel & field level referral contacts.

2. Risk stratification and differentiated care

Adopting a risk stratified approach to identify and manage newborns and children at higher risk of suboptimal growth and development – including: Low-Birth-Weight (LBW)/preterm newborns, Special Newborn Care Units (SNCU)/Newborn Stabilization Unit (NBSU)/Mother-Newborn Care Unit (MNCU)-discharged newborns, growth-faltering young children with recurrent illness or incomplete immunization or delay in achieving developmental milestone. It includes line-listing of 'At-risk' children at ASHA level and joint follow-up by the ASHA–ANM–CHO team, with clear entry and exit criteria from 'At-risk' category, ensuring longitudinal follow-up up to 36 months.

3. Utilization of existing service delivery platforms as contact points

Strengthening continuity of care between 42 days and 3 months by leveraging existing Village Health Sanitation and **Nutrition Day (VHSND)/Universal Immunization programme (UIP) contacts** at 1.5 and 2.5 months for screening, weight monitoring, and counseling on feeding, Early Childhood Development (ECD) and Safety & Security.

4. Rationalizing home visit schedules

Provision of differentiated care of 'At-risk' newborns and children. Additional contacts (up to Day 42) and joint visits on Day 3 and Day 7 by ASHA with ANM/CHO (or MO in urban areas) for 'At-risk' newborns, in view of high early neonatal mortality (in the first week of life), and during third and six month of life for 'At-risk' children in the young child period.

5. Extending home-based contacts

18, 24, 30 and 36 months visits with a focus on growth monitoring, booster immunization, **and promoting Early Childhood Development (ECD)**.

6. Maternal mental health

Focus through SSBSK which includes screening for maternal mental health conditions using simple tools (e.g. PHQ-2/ CBAC) and providing first-line counselling and linkage with Tele-MANAS/AAM.

7. Maternal Nutrition

Reinforcing maternal nutrition during lactation (diet diversity, IFA and Calcium supplementation) as a core component of home visits, in addition to child nutrition counselling.

8. Nurturing Care for Early Childhood Development (ECD) through Family/Community-Centred Approach

Integrating nurturing care for ECD more prominently across 0–3 years, including guidance on age-appropriate play, communication, and early stimulation during home visits and VHSND/Well-Baby sessions. Strengthening the family and community-centred approach by actively engaging fathers, grandparents and caregivers, and leveraging community platforms such as VHSND, Mothers' Groups, Self-help groups (SHGs), Mahila Arogya Samiti (MAS)/ Jan Arogya Samiti (JAS), and Gram Sabhas for promoting positive family practices and supportive environment.

9. Team-based service delivery and convergence (AAA model)

Operationalizing a team-based model at village level (ASHA–ANM–CHO–AWW with support from ASHA Facilitator, Block Community Process Manager/ Block Programme Manager (BCPM/ BPM), District Community Process Manager (DCPM) and Medical Officer In-charge (MO I/C), instead of ASHA working in isolation. Suggesting the use of an "AAA" team concept (ASHA–ANM–AWW) for accountability in convergent action with Integrated Child Development Services (ICDS), particularly for growth monitoring, complementary feeding, and community-based ECD activities. Clarifying and expanding roles and responsibilities of each cadre for home visits, joint visits, supervision, mentoring and grievance redressal.

10. Digital integration and child-wise tracking

Integration with digital platforms such as JANANI Portal, U-WIN Portal, RBSK 2.0 Portal and POSHAN Tracker for child-wise tracking and closing the referral loops for generation of longitudinal health records. "Shaishav App" enables differentiated care approach for 'At-risk' newborns and children using Decision Support System (DSS) for improved outcomes.

11. Expected Gains of SSBSK

SSBSK envisions every child's holistic development and well-being, leaving no newborn or child behind from essential services and required follow-up. It enables 'At-risk' newborns/children to exit that category and grow healthy, so that every child does not merely survive, but thrives and transforms.

Healthy Mother, healthy child, healthy nation

01 Chapter Introduction

1.1 Background on newborn and child health programme

Over the past decade, India's National programmes for maternal, newborn, and child health have evolved from focusing primarily on survival to embracing a more comprehensive **"Survive, Thrive, and Transform"** approach, integrating health, nutrition, early learning, and responsive caregiving.

The launch of Home-Based Newborn Care (HBNC) and Facility-Based Newborn Care (FBNC) in 2011 marked a major milestone in strengthening the continuum of care from birth to postnatal life. This was further advanced by the India Newborn Action Plan (INAP, 2014), which set the National roadmap for achieving single-digit neonatal mortality and stillbirth rates by 2030.

Building upon this foundation, the Home-Based Care for Young Child (HBYC) programme was launched in 2018 to extend care beyond the neonatal period, ensuring that every child continues to receive essential health, nutrition, and developmental support during the first two years of life. Anchored on four key pillars; (i) age-appropriate complementary feeding and nutrition (ii) prevention and management of common childhood illnesses, & complete immunization (iii) promotion of early childhood development, and (iv) promotion of WASH activities in home settings: the programme emphasized structured ASHA-led home visits from 3 to 15 months, supported by ANMs and AWWs. Complementary efforts through Rashtriya Bal Swasthya Karyakram (RBSK), Social Awareness and Action to Neutralize Pneumonia Successfully (SAANS), Intensified Diarrhoea Control Fortnight (IDCF) within the framework of the National Health Policy 2017 further reinforced the integrated continuum of care for child survival and development.

Subsequently, under the vision of Ayushman Bharat, Ayushman Arogya Mandirs (AAMs) started to deliver comprehensive primary health care, digital linkages, and teleconsultations, thereby strengthening access to maternal, newborn, and child health services at the community level. Collectively, these initiatives reflect India's strong commitment to achieving the Sustainable Development Goal (SDG) specifically targets of reducing neonatal mortality to equal to less than 12 per 1000 live births and under-five mortality to equal to less than 25 per 1000 live births by 2030 and to advancing the National vision of Viksit Bharat by 2047, ensuring that every child achieves full developmental potential.

The neonatal period (0–28 days) and infancy (0–1 year) remain the most critical phases of life in terms of mortality reduction. The neonatal mortality rate (NMR), defined as deaths within the first 28 days per 1000 live births, continues to account for the largest share of infant deaths, with the early

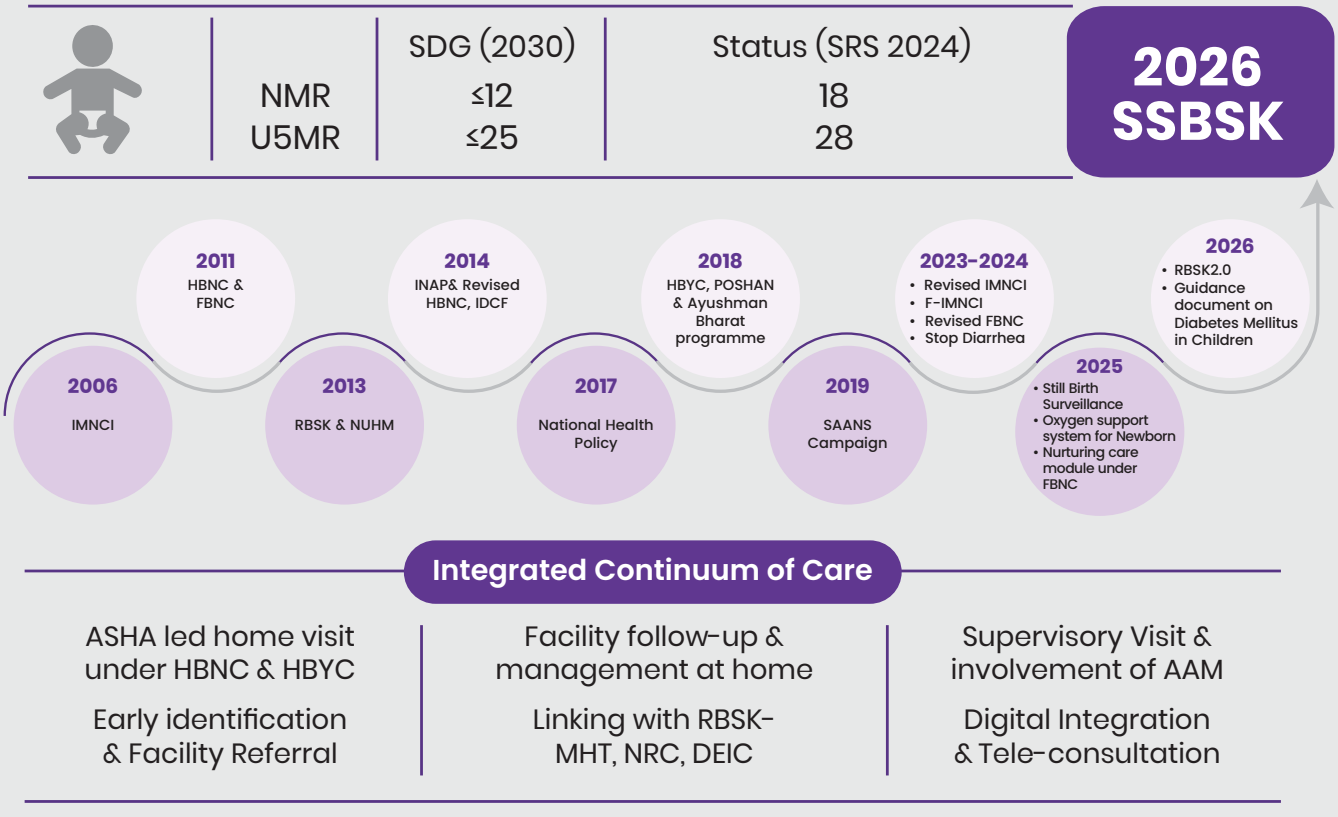
neonatal period (0–7 days) being the most vulnerable. While India has made steady progress in improving facility births (now at 90.6%), early neonatal deaths still contribute significantly to the total neonatal mortality, emphasizing the need for vigilant follow-up after discharge and continued support at the household level.

For early childhood development the first three years of life are crucial. Scientific evidence shows that nearly 80% of brain development occurs by the age of three years, a period of rapid physical, cognitive, and socio-emotional growth when neural connections form at unmatched speed. This stage directly influences developmental milestones, learning ability, and emotional resilience. Timely interventions for health, nutrition, responsive care early learning and child safety practices can substantially improve long-term outcomes. At the same time, developmental delays, if not addressed early, can become irreversible, **Mother's own wellbeing is quite crucial for optimal child care practices and developmental outcomes.**

Recognizing this, HBNC and HBYC programmes have been integrated into the unified 'Samagra Shishu Bal Swasthya Karyakram' (SSBSK) framework establishing continuum of home-based care from **birth up to 36 months**, focusing on survival, optimal nutrition and growth, early childhood development, mother's health and well-being.

Journey of India's Child Health Care programme

Key Milestones



1.1.1 Lifecycle approach ensuring Newborn survival

Reducing neonatal mortality requires a continuum of care across life stages. Optimal maternal health and wellbeing begin before conception with adequate nutrition, birth spacing, folic acid supplementation and management of pre-existing conditions. Quality antenatal care and timely identification and management of high-risk pregnancy, availability of emergency obstetrics care, essential newborn care and prompt management of complications promote maternal and newborn survival and prevents still births. Interventions such as Kangaroo Mother Care (KMC) for LBW, early initiation of breastfeeding, infection prevention, and early identification of danger signs for treatment play a key role in improving newborn survival.

Initial 48 hours - critical window for healthy birth outcomes

Figure 1.1: Package of services on Continuum of Maternal & Newborn Care

Antenatal Care

- Pregnancy registration in first trimester & issue of digital MCH card and Safe Motherhood booklet
- TT/Td Vaccination
- Maternal Nutrition & micronutrient supplementation (IFA, Calcium & Vit. D3), gestational weight gain tracking, adequate diets, physical activity
- Screening & treatment for High-Risk Pregnancies like Severe Anemia, hypertension & infections (syphilis, malaria, TB, HIV etc.), GDM, Hepatitis B, bad obstetric history, teenage pregnancy and others
- 5 ANC visits for normal pregnant woman (including PMSMA visit)
- 8 ANC visits for high-risk pregnant woman (3 additional visits under **E-PMSMA**)
- Birth preparedness and complication readiness
- Identification of danger signs & early referral
- Antenatal corticosteroids for mothers in case of preterm delivery, importance of breast feeding
- Encouraging family support
- Maternal wellbeing

Essential Newborn Care includes

- Newborn Resuscitation, when required
- Immediate Skin-to-Skin Contact & KMC for Low birth weight infants
- Early Initiation of breast feeding (within 1st hour)
- Prevention of Infection including clean & dry cord-care
- Delayed cord clamping
- Newborn Temperature maintenance & prevention of hypothermia
- Vit. K administration
- Newborn Weighing and recording

Intrapartum Care

- Clean and safe delivery with;
  - Use of partograph for monitoring stages of labour
  - Active Management of the Third Stage of Labour (AMTSL)
  - Skilled birth attendant
- Timely access to comprehensive Emergency Obstetric and Neonatal Care (EmONC)
- Referral preparedness
- Respectful and dignified maternity care

Post-Partum Care

- Postnatal check-ups in first 6 weeks
- Identification and appropriate referral for maternal danger signs
- Counselling on healthy birth spacing
- Postpartum depression screening and maternal mental health support
- Support in breast feeding along with maternal nutrition including micronutrient supplementation (IFA, Calcium & Vit. D3), adequate diets and physical activity
- Promotion of maternal self-care practices
- Encouraging family support

Immediate postnatal care for the newborn

- Thermal care, KMC
- Clean cord care
- Weighing
- Breastfeeding
- Immunization, Vit K

Home-based Newborn Care

- Counselling and support for Exclusive Breastfeeding (EBF) for 6 months & nurturing care
- Delayed bathing for LBW / pre-term
- Kangaroo Mother Care (KMC)
- Age-appropriate play and stimulation (Touch, Talk & Play)
- Early detection, referral in danger signs & treatment of infections
- Improving hygiene and sanitation practices
- Home-based follow-up for SNCU/ NICU/ NBSU discharged newborns

1.2 Status of Newborn and Child Health in India

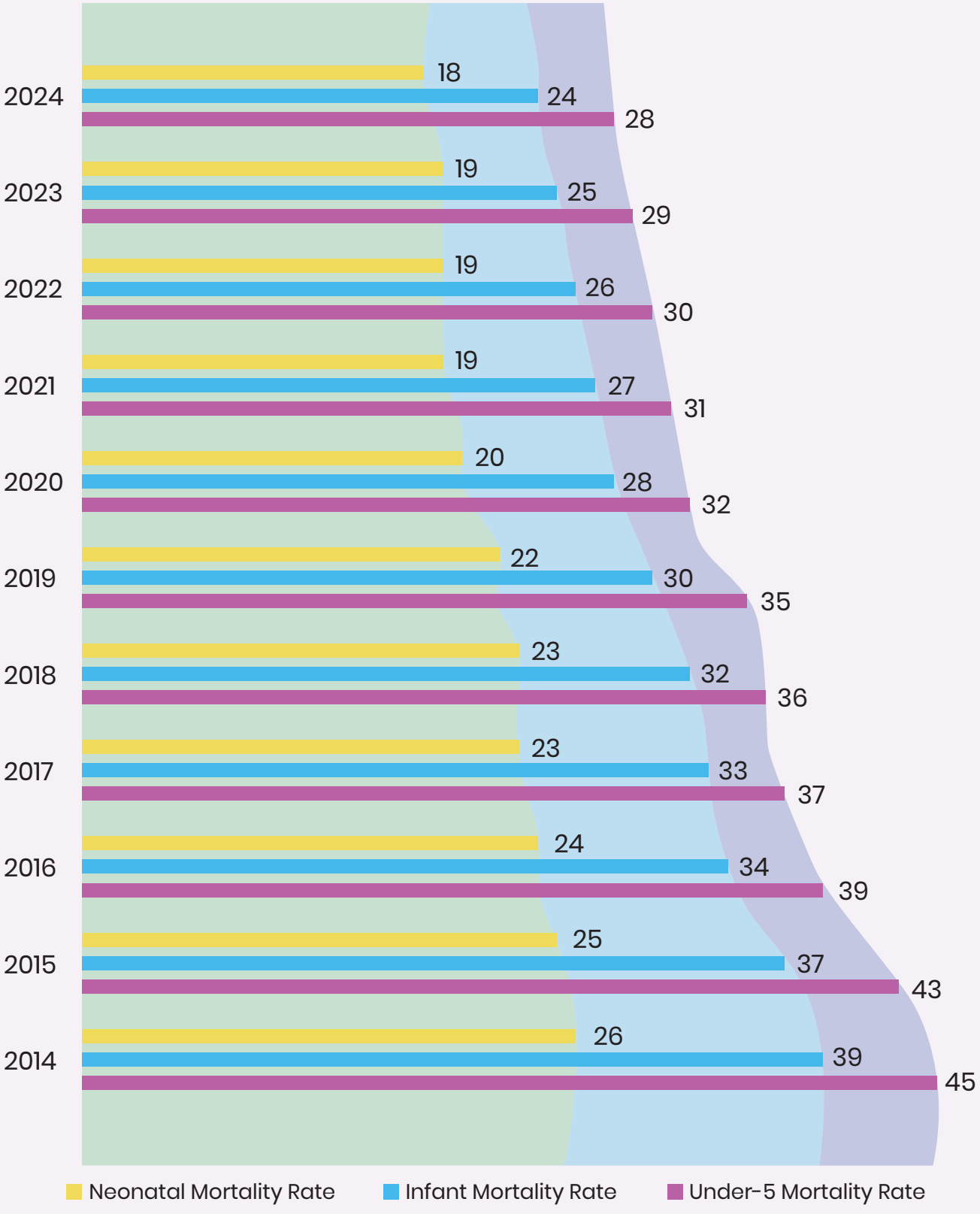
As per the Sample Registration System (SRS) Report 2024, the Neonatal Mortality Rate (NMR) in India stands at 18 per 1,000 live births and the Under-Five Mortality Rate (U5MR) is 28 per 1,000 live births. Currently, neonatal deaths constitute nearly 64% of total under-5 mortality in India, out of which 72% occur within first seven days of life in India (SRS 2024). From 1990 to 2024, India has outperformed global trends among child health indicators with Neonatal Mortality declining by 70% (compared to the global average of 54%) and under five mortality (U5MR) decline of 79% (versus 61% worldwide) [UNIGME, 2025].

The Early Neonatal Mortality Rate (ENMR) showed the most notable progress, falling from 24 to 13 per 1,000 live births during 2011-2024, representing an absolute reduction of 11 points and a gross decline of approximately 46%. These consistent downward trends highlight India's progress in strengthening maternal and newborn health services, improving facility-based care, and expanding home-based newborn and child care interventions over the last decade.

Ensuring essential newborn care in health facilities

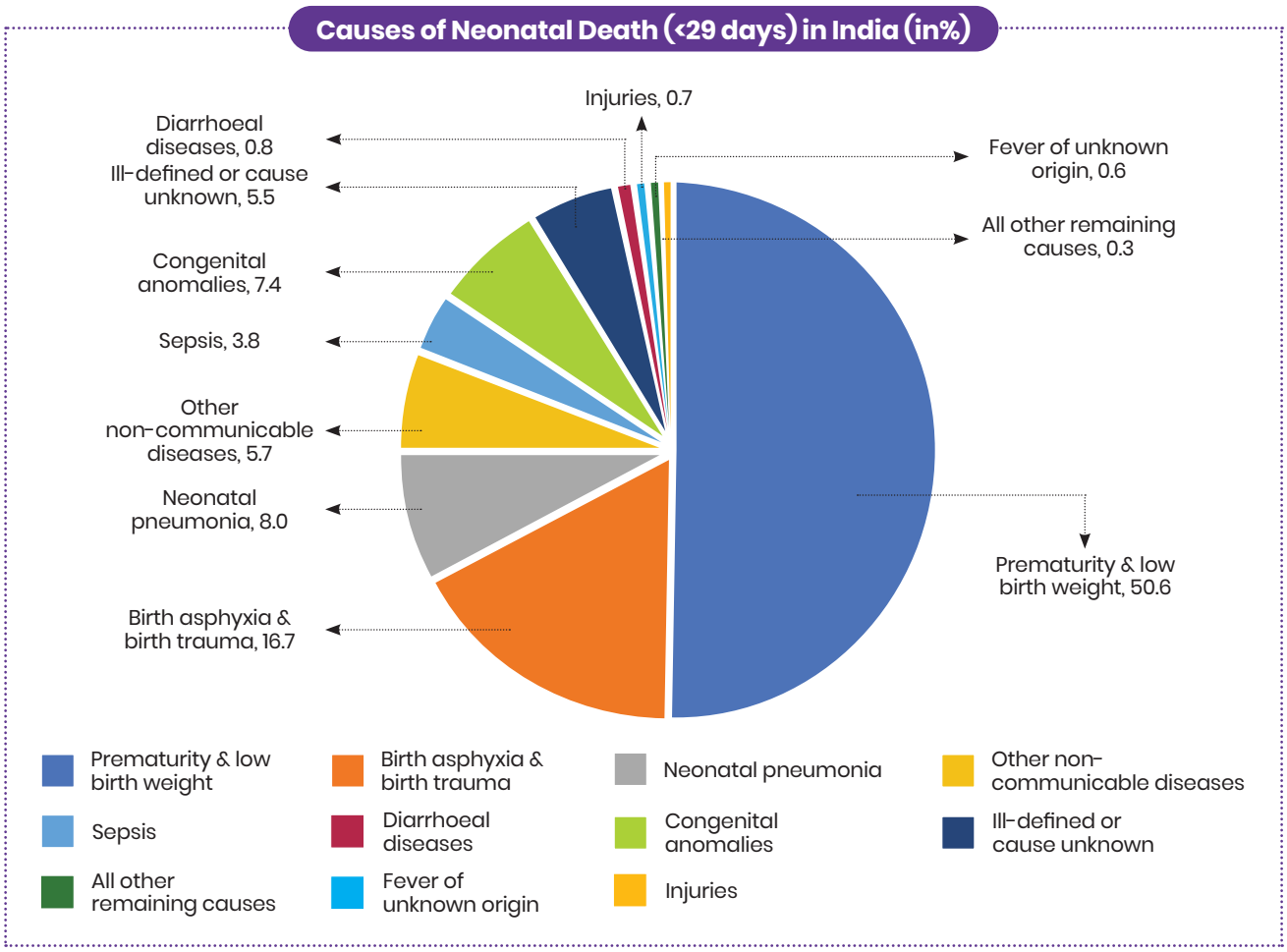
Nearly 80 percent neonates die of causes like complications of prematurity and low birth weight, intra-partum related causes (birth asphyxia, birth trauma), infections (including sepsis, pneumonia, and diarrhoeal diseases) and birth defects. Approximately 18.2 percent of newborns in India were classified as low birth weight (<2500 grams) many of whom were born preterm (before 37 completed weeks of gestation), overall preterm birth being 12% of all births, as per National Family Health Survey (NFHS-5).Nearly 1.4 million small and/or sick newborns are admitted to newborn care units for treatment & management in India every year.

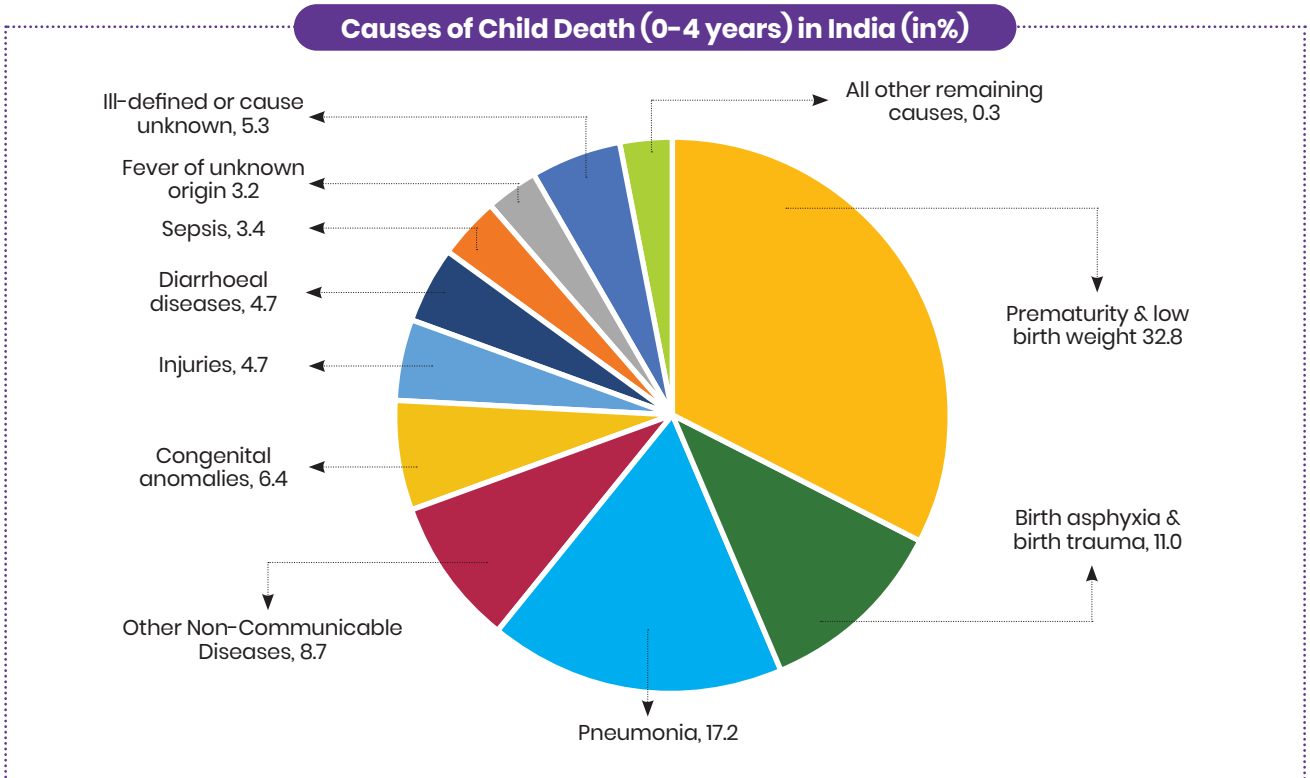
Figure 1.2: Trends in Neonatal Mortality Rate, Infant Mortality Rate & Under-5 Mortality Rate in India



Source: SRS 2024

Figure 1.3: Causes of Neonatal Death in India





SRS Causes of Death (Statistics) 2022-24

Coverage of newborn and child health programmes has improved significantly over the decade which is evident from the NFHS data given below in the table.

Table-1.1: Changes in child health and nutrition indicators over last decade

Indicators	NFHS 4 (2015-16)	NFHS 5 (2019-21)	NFHS-6 (2023-24)
 Children under 3 years breastfed within one hour of birth (%)	41.6	41.8	50.1
 Children under age 6 months exclusively breastfed (%)	54.9	63.7	55.8
 Children age 6-8 months receiving solid or semi-solid food and breastmilk (%)	42.7	45.9	59.5
 Breastfeeding children aged 6-23 months receiving an adequate diet (%)	8.7	10.8	15.1
 Children under 5 years who are underweight (weight-for-age) (%)	35.7	32.1	31.8
 Children under 5 years who are stunted (height-for-age) (%)	38.4	35.5	29.3
 Children under 5 years who are wasted (weight-for-height) (%)	21.0	19.3	19
 Children under 5 years who are severely wasted (weight-for-height) (%)	7.5	7.7	5.2

The importance of child nutrition and health, underscores the need to strengthen the infant feeding practices through the Home-Based Care for Young Child (HBYC) programme. There is an urgent need to strengthen household-level nutrition practices so that every child receives age-appropriate complementary food that supports dietary diversity, meal frequency, and acceptable diet. To further accelerate progress towards programme goals, it is essential to revitalize and strengthen implementation strategies that promote healthy growth and development among children.

According to the Nurturing Care Framework for Early Childhood Development, the first three years of life are a highly sensitive and critical period for brain development, when a child's foundations for health, learning, and behaviour are formed. Timely nurturing care during pregnancy to age three has the greatest impact on lifelong development, and the health system is uniquely positioned to reach and support children and caregivers during this period.

The period from birth to three years presents a window of opportunity to prevent malnutrition and growth faltering, while also laying the foundation for optimal early childhood development—encompassing cognitive, emotional, and motor skills.

1.3 Progress and Achievements under HBNC & HBYC

High coverage under HBNC

More than **1.5 Crore newborns** received home visits by ASHA annually achieving **nearly 90% coverage** across the country

Improved referral linkages

About **56%** of sick newborns identified during HBNC visits were referred to higher health facilities for appropriate management, though coverage varied across states annually

Continued child follow-up under HBYC

ASHAs carried out approximately **4.8 crore home visits annually** for children aged **3–15 months**, ensuring regular growth monitoring, health counselling, and linkage to essential child health and nutrition services

ASHA demonstrates how to keep the newborn warm to family members during home visit

1.4 Rationale for unification

Over the last decade, India's child health programmes have evolved from ensuring survival alone to adopting a holistic *"Survive, Thrive and Transform"* approach, emphasizing health, nutrition, development, and well-being.

Global and National evidence, including the India Newborn Action Plan (INAP) under its six pillars of "Care Beyond Survival", reinforces that the first 1,000 days from conception to two years are critical for shaping lifelong outcomes. However, this critical window does not end abruptly at two years. The first three years of life remain a per iod of rapid brain growth, during which nurturing care can make the difference between reaching or missing developmental milestones. For newborns born preterm, with low birth weight, or with birth complications the vulnerabilities extend far beyond the newborn stage. Small (low birth weight or preterm) and/or sick newborns, such as those admitted to SNCUs for management of sepsis, asphyxia, or congenital malformation, remain at greatest risk of mortality, growth failure and developmental delay. These newborns require vigilant follow-up to support survival and thriving, emphasizing the need for long-term monitoring and family support beyond the neonatal period.

Regular home visits by ASHAs provide a platform for health and nutrition support and the opportunity to counsel caregivers for early childhood development, promote maternal mental health, and link families to available social and health services.

पहले तीन साल, सम्पूर्ण देखभाल

The Samagra Shishu Bal Swasthya Karyakram (SSBSK) framework establishes a continuum of care by integrating the Home-Based Newborn Care (HBNC) and Home-Based Care for Young Child (HBYC) programmes into a unified programme optimised to provide continued and risk-stratified care from **birth to 36 months of age**.

SSBSK links maternal, newborn, infant, and young-child health through structured home visits, community platforms including VHSNDs and primary care at Ayushman Arogya Mandirs (AAMs).

New elements in the SSBSK programme

- Extended home visits from birth to 36 months and increased number of home visits
- Risk stratification and differentiated care approach: Identification and focused care for 'At-risk' newborns & children and their families
- Joint visits of ANM & CHO for strengthened supportive supervision of frontline workers
- Strengthened nurturing care elements and mother's health and wellbeing
- Integration with Comprehensive Primary Health Care (AAM and CHOs) and strengthened collaboration with ICDS
- Improved documentation: reporting and integration using digital platforms JANANI Portal, U-WIN Portal, MPCDSR Portal, RBSK 2.0 Portal and POSHAN Tracker

Every child is precious, every moment of care counts

02 Chapter Goal, Objectives, and Target Audience

This guideline has integrated the existing HBNC & HBYC frameworks in to a unified SSBSK framework to extend the community based services from 0 to 36 months and post-natal mothers, to strengthen the capacities of frontline health workers, improve linkages with Comprehensive Primary Health Care (CPHC) through Ayushman Arogya Mandirs (AAMs), and integrate digital and supportive supervisory innovations to achieve the National health and nutrition goals for children.

2.1 Goal of the Programme

To reduce newborn and child morbidity and mortality, and to promote optimal growth and development during the first three years of life through structured home visits, timely identification and management of 'At-risk' children, and strengthened linkages between community and facility-based services.

Risk stratification during home visit by ASHA

2.2 Specific Objectives

1. To improve survival, health, and nutritional well-being of mothers, newborns, and young children during the postnatal and early childhood period by providing essential care through structured ASHA-led home visits.

2. To facilitate early identification of complications (danger signs) in mothers, newborns, and young children and enable timely referral to appropriate health facilities.

3. To identify, track, and provide focused follow-up for 'At-risk' newborns (low birth weight, preterm, SNCU graduates, growth faltering and delayed development) in order to reduce adverse outcomes and preventable deaths.

4. Support family in adoption of evidence-based child care practices including exclusive breastfeeding, appropriate complementary feeding, WASH practices, and nurturing care practices Early Childood Development (ECD).

5. Integrate postnatal maternal nutrition and maternal mental health support into routine home visits to strengthen caregiver well-being and child development outcomes.

6. Establish effective team-based service delivery at the grassroots (ASHA, AF, ANM, CHO, MO) supported by digital innovations, supportive supervision, and linkages with Ayushman Arogya Mandirs.

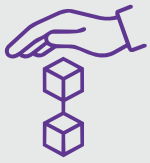
7. Strengthen convergence with Anganwadi services and other community-based platforms to promote comprehensive nutrition, health, and development support for children up to 36 months.

2.3 Target Audience

These guidelines are designed for use by a wide range of stakeholders engaged in newborn, child, and maternal health at different levels of the health system:

Administrators and Programme Managers

State Programme Managers, District Programme Managers, Child Health Nodal Officers, and Block-level officials responsible for planning, implementing, and monitoring SSBSK interventions.



Supervisory & Support Structures

Medical Officers In-Charge, Block and District Community Process Managers, State-level ASHA Resource Centres and who provide technical guidance, supervision, and mentoring.

Training Institutions & Academic Institutions

State Institutes of Health & Family Welfare (SIHFW), State Health Systems Resource Centres (SHSRC), and other training institutions engaged in capacity building, supportive supervision, and operational research.

Development Partners & Civil Society

UN agencies, technical support partners, Civil Societies, professional bodies like IAP, FOGSI providing technical assistance to the programme.

ASHAs, our formidable community based frontline worker for maternal and child health

03 Chapter Overview of the Programme

3.1 Conceptual Framework

India's child-health programmes have progressively evolved from survival-centric interventions to a holistic **"Survive---Thrive---Transform"** approach integrating health, nutrition, responsive caregiving, and early childhood development into overall wellbeing. The Samagra Shishu Bal Swasthya Karyakram (SSBSK) framework builds upon continuum of care by integrating the earlier Home-Based Newborn Care (HBNC) and Home-Based Care for Young Child (HBYC) programmes into a unified structure optimised to provide continued and risk-stratified care from **birth to 36 months of age**.

SSBSK aligning with the principle of **continuum of care** links maternal, newborn, and young-child health through structured home visits, outreach contacts, and various community platforms including VHSNDs.

Key features:

1. Risk stratification and differentiated care of newborns and young children (0-36 months)
2. Joint visits & team-based service delivery through AWW, ASHA, ANM, CHO and MO.
3. Post-natal care & maternal mental-health screening and support.
4. Family & community centric approach in newborn & child care.
5. Nurturing-care domains for responsive parenting and early learning opportunities.
6. Convergence with Anaganwadi services, RBSK, POSHAN Abhiyaan and other inter-sectoral initiatives.
7. Integration with digital health platforms JANANI, POSHAN Tracker, RBSK 2.0.

Figure 3.1: Conceptual Framework

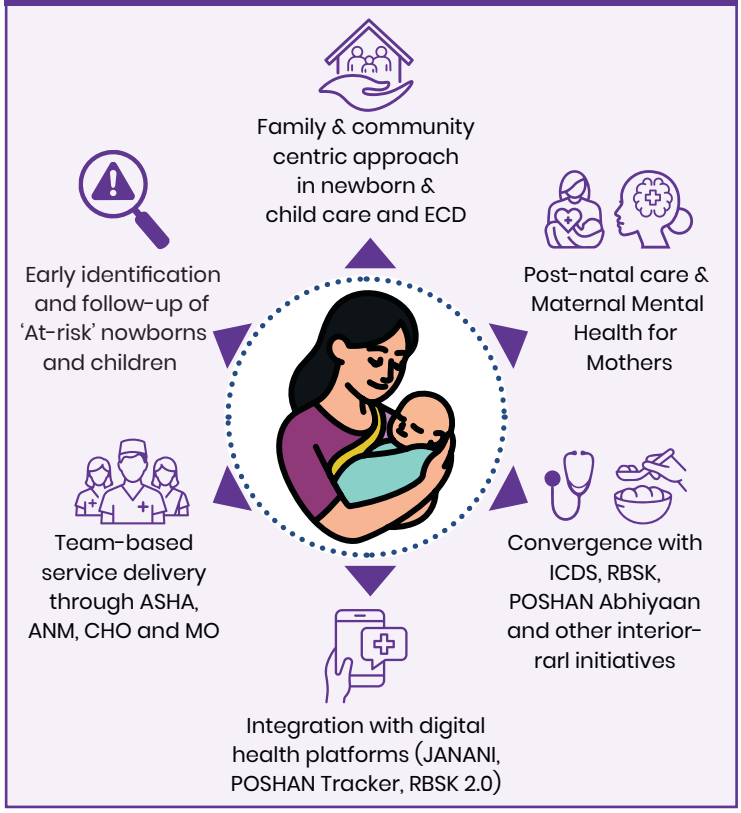
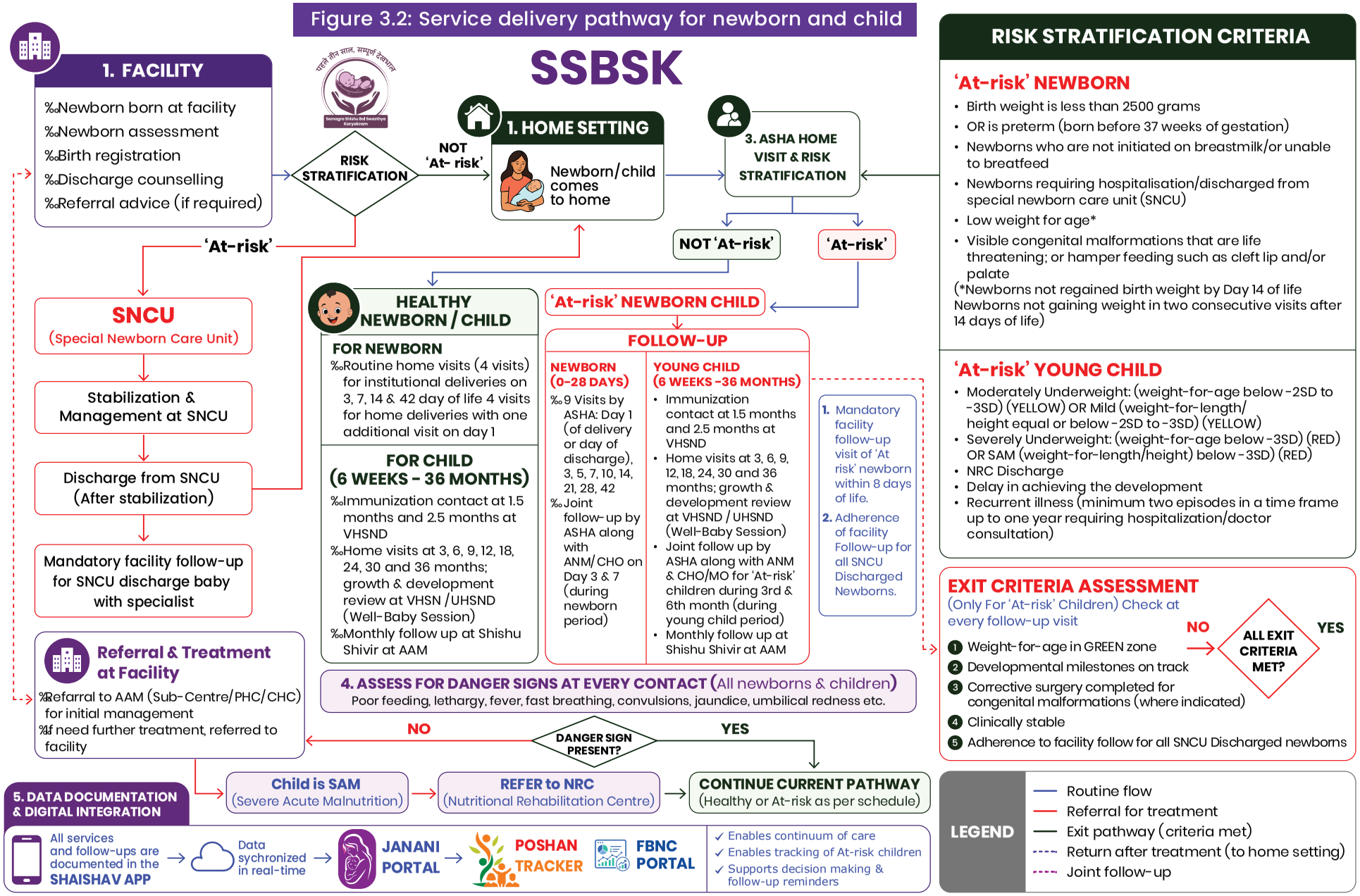


Figure 3.2: Service delivery pathway for newborn and child



3.2 Components of the programme

The programme encompasses a comprehensive package of promotive, preventive, and referral services delivered through home visits and community platforms, supported by institutional mechanism for capacity building, and supportive supervision and adoption of digital tools.

Table 3.1: What is different in SSBSK

Domain	HBNC & HBYC Approach	SSBSK Approach
Duration	HBNC (2011, revised 2014) focused on newborns 0–42 days, with ASHA-led home visits for essential newborn care & Young Child Care (HBYC, 2018) from 3 months till 15 months.	SSBSK integrates HBNC & HBYC into a single continuum from 0–36 months, covering newborn, and young child care under one framework.
Visit Schedule	**HBNC:** **Current Schedule:** 6 visits on days 3, 7, 14, 21, 28and 42 for institutional delivery with an additional Day 1 visit in case of home delivery (7 visits)	Updated schedule for **SSBSK**: **Healthy Newborn:** 4 visits (Day 3,7,14,42), with an additional day one visit in case of home delivery (5 Visits)**'At-risk' newborn** (Identified at birth or subsequent visits): 9 visits (Day 1/discharge, 3, 5, 7, 10, 14, 21, 28, and 42) **Joint Visit for 'At-risk' Newborns with ANM & CHO** at village level and ANM & MO at ward level in Urban areas: on Day 3 & 7 (during newborn period)
	HBYC **Current Schedule:** 3,6,9,12,15 months	Updated schedule extends visits to: 3, 6, 9, 12, 18, 24, 30, and 36 months for all young children. **'At-risk' young-child: Joint Visit with ANM & CHO at village level and ANM & MO** at ward level in urban areas: during **3rd month & 6th month**
Focus Area	Child Survival (under HBNC) Child Nutrition, child development, WASH & Immunization (under HBYC) Mother Centric Counselling Approach	Child Survival, Thrive, and Transform Nurturing care for ECD (Holistic approach) Family & Community Centric Approach Timely identification, referral and management of 'At-risk' newborn & children.
Risk Stratification	Limited attention to high-risk newborns beyond discharge.	Risk-stratified approach for LBW, preterm, early growth-faltering, SNCU graduates, delayed developmental milestones and recurring illness; differentiated care with additional visits and intensive follow up. Identification and referral of high-risk mothers with follow-up.

Domain	HBNC & HBYC Approach	New Approach (Integrated SSBSK 2026)
Supportive Supervision	Supervisory support mainly through ANMs and ASHA Facilitators.	Team-based approach with AAM Team by involving both ANM, CHO in rural area, and ANM & MO at AAM-UPHC/AAM-UHSC in urban area.
Maternal Mental health	Maternal mental health not a focus	Maternal mental health screening included in scheduled home visits; ASHAs/ANMs trained to screen, counsel, and refer
Digital Tracking	Paper-based reporting and limited tracking of referred children.	Digital integration with JANANI, JANANI Portal, U-WIN, RBSK 2.0 and POSHAN Tracker and referral loops for tracking 'At-risk' newborns/children. Tracking of High-Risk Pregnant/Postnatal Mothers till 42 days post-delivery.
Strengthened collaboration	Limited coordination with Anganwadi services.	Strengthened collaboration with, Anganwadi Services, Poshan Abhiyan, RBSK, WASH and other social services
Urban Component	Urban home-based care less emphasized.	Dedicated urban adaptation for slum, migrant, and floating populations, with inter-sectoral linkages.

Counseling of mother on how to keep the baby healthy by using MCP card by ASHA with the Supportive Supervision from ASHA facilitator

3.2.1 Risk stratification approach

Many newborns and young children are more vulnerable to illness, growth faltering and developmental issues. With timely and appropriate care, their outcomes can be significantly improved. They require closer tracking, proactive support for families, and timely linkage to appropriate services. A risk stratification approach enables frontline health workers to prioritize these newborns, young children and their families for additional follow-ups and intensified care, thereby optimizing the impact of available resources

Early identification of 'At-risk' newborns, especially through mother-infant dyad assessments during routine home visits is crucial.

Newborns born small; (either low birth weight or preterm birth) or sick (due to sepsis, birth asphyxia or congenital malformation) and admitted to newborn care unit remain at significantly higher risk of morbidity and mortality up to at least 12 months of age. Among various indicators, weight-for-age is considered the most reliable anthropometric parameter to detect infants under 6 months who may be at risk. Early identification and targeted follow-up can improve survival and developmental outcomes. All these criteria will therefore be used for identification of 'At-risk' young child.

The SSBSK programme establishes a seamless, risk-differentiated continuum of care for newborns and young children from birth to 36 months. Beginning at the health facility, every newborn at birth is assessed for risk factors and classified as either 'At-risk' or a 'Well Baby'. 'At-risk' newborns are digitally flagged (red) in the JANANI Portal, synchronized with the "Shaishav App". They would receive appropriate facility-based care, including admission to SNCU where required, followed by structured post-discharge follow-up. For all newborns delivered and discharged from facility, ASHAs conduct scheduled home visits to reassess risk status, provide age-appropriate care and counselling, monitor growth and development, and facilitate timely referral. 'At-risk' newborns and children receive intensified follow-up through additional home visits, joint visits by ASHA, ANM, AWW and CHO/MO, and monthly Shishu Shivirs at Ayushman Arogya Mandirs for assessment and management by specialists. Children identified with danger signs are promptly referred to health facilities and tracked until appropriate care is received. Healthy children continue to receive routine follow-up through home visits, immunization contacts, and Well-Baby Sessions at VHSNDs. At every contact, children are screened for illness, malnutrition, developmental concerns, and danger signs to enable early identification and timely intervention. All services, referrals, and outcomes are digitally tracked through the "Shaishav App" and integrated with the JANANI Portal and other national platforms, ensuring continuity of care and improved outcomes for every child.

Table 3.2: Criteria for identification of newborns 'At-risk'

Identification of 'At-risk' newborn

Birth weight is less than 2500 grams OR is preterm (born before 37 weeks of gestation)

Newborns who are not initiated on breastmilk/ or unable to breastfeed

Newborns requiring hospitalisation / discharged from special newborn care unit (SNCU)

Visible congenital malformations that are life threatening; or hamper feeding such as cleft lip and/or palate

Low weight for age*

*CHO/MO can use these additional criteria to identify "At- risk"newborns:

Newborns not regained birth weight by Day 14 of life

Newborns not gaining weight in two consecutive visits after 14 days of life

Table 3.3: Criteria for Danger Signs in newborn

Danger Signs in newborn

Movement only when stimulated or no movement at all

Not able to feed

Convulsion

Difficulty in breathing

Fast breathing (more than 60 breaths per minute)

Severe chest indrawing

Yellowness in palm and feet

Blood in stool

Axillary temperature 37.5° C or above (feels hot to touch)

Axillary temperature less than 35.5° C (feels cold to touch)

Table 3.4: Criteria for 'At-risk' Young Child

'At-risk' Young Child	
 Moderately Underweight (weight-for-age: below -2SD to -3SD (YELLOW) OR MAM (weight-for-length/ height: equal or below -2SD to -3SD) (YELLOW)	 NRC Discharge
 Severely Underweight (weight-for-age: below -3SD) (RED) OR SAM (weight-for- length /height: below -3SD) (RED)	 Recurrent illness (minimum two episodes in a time frame up to one year requiring hospitalization/ doctor consultation)
	 Delay in achieving the development milestone as per MCP Card

Again, to reiterate, 'At-risk' children are distinct from children with danger signs. While the presence of danger signs necessitates prompt clinical assessment, pre referral stabilization, and immediate referral, 'At-risk' children would be managed through home based care and routine monitoring, with scheduled reassessment at AAM or higher level centers and referrals only when indicated.

Under SSBSK, assessment of 'At-risk' newborns and young children is strengthened through mandatory joint home visits by the ANM and CHO; the detailed schedule for these visits are elaborated in Chapter 4.

Table 3.5: Criteria for Danger Signs in Young Child

Danger Signs in Young Child	
 Not able to feed/drink	 Fever (more than 37.5° C or 99.5° F) more than 7 days and no doctor consultation taken
 Vomits everything often	 Diarrhoea more than 14 days (Signs of dehydration like sunken eyes and skin pinch goes back slowly)
 Lethargy/ unconsciousness	 Blood in stools
 Convulsions/convulsing now	 Fast breathing (2 months to 12 months: more than 50 breaths per minute; 12 months to 5 years: more than 40 breath per minute)
 Difficulty in breathing	
 Severe chest in-drawing	

Risk identification is not limited to the newborn period; several children continue to remain vulnerable beyond the first 42 days of life due to biological, nutritional, developmental, or social risk factors. Under the SSBSK framework, the earlier categories of 'At-risk 'newborns are now followed up seamlessly into the post-newborn period continuum as 'At-risk' children. These children will be identified beyond the newborn period during home visits or community sessions. These children require closer follow-up through additional ASHA visits, regular growth and developmental assessments, and timely referral for specialized care.

3.2.2 Nurturing care for Early Child Development (ECD)

The SSBSK framework recognizes that nurturing care begins at birth and continues through the early years of life, forming the foundation for a child's health, growth, learning, and emotional well-being. SSBSK home visits shall systematically promote nurturing care across its five domains; **good health, adequate nutrition, responsive caregiving, early stimulation and learning, and safety and security**.

ASHAs and all frontline providers shall be oriented on these five domains and shall integrate nurturing care counselling into every home visit contact.

During the **newborn period**, counselling of mothers and family members shall emphasize:

1. Exclusive breastfeeding and responsive feeding practices
2. Skin-to-skin contact and Kangaroo Mother Care (KMC) where applicable
3. Talking, gentle interaction, and emotional engagement with the newborn
4. Creating a calm, clean, and safe home environment

These practices shall be guided by the Mother and Child Protection Card (MCP Card) and IMNCI charts, which serve as the primary counselling tools during home visits. During the **young child period (6 weeks to 36 months)**, ASHA shall promote nurturing care through structured quarterly home visits by counselling caregivers to:

1. Provide **age-appropriate play and communication** activities as outlined in the MCP Card.
2. Monitor and record **developmental milestones** at each contact.
3. Practice **responsive caregiving**; recognizing and appropriately responding to the child's hunger and satiety cues, feeding with patience, encouragement, and positive interaction.
4. **Safe home environment** and prevent injury.
5. **Adequate nutrition**, engage in responsive parenting and consistent **emotional engagement** with the child.
6. Responsive feeding shall be promoted as an integrated practice that supports not only adequate nutrition but also emotional security and early learning through shared, positive mealtime interactions.

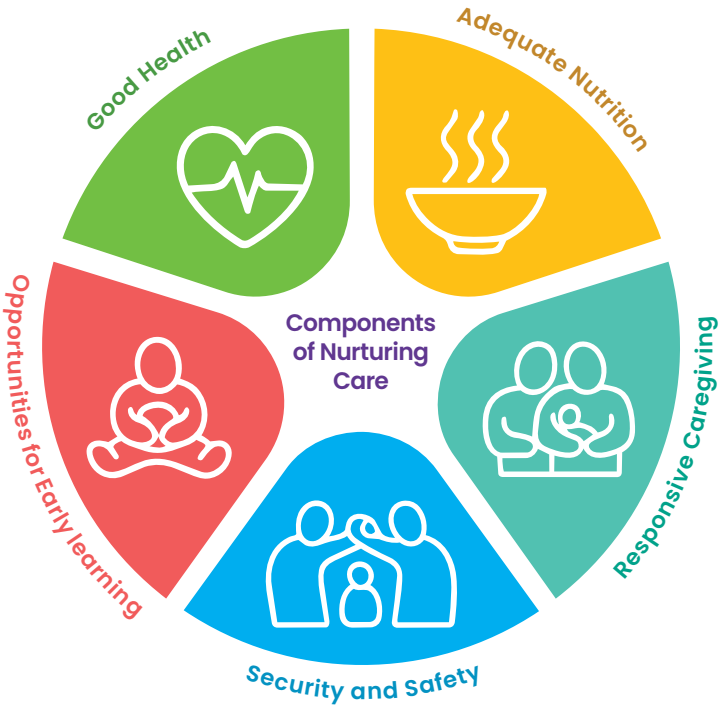


Figure 3.3: Components of Nurturing Care

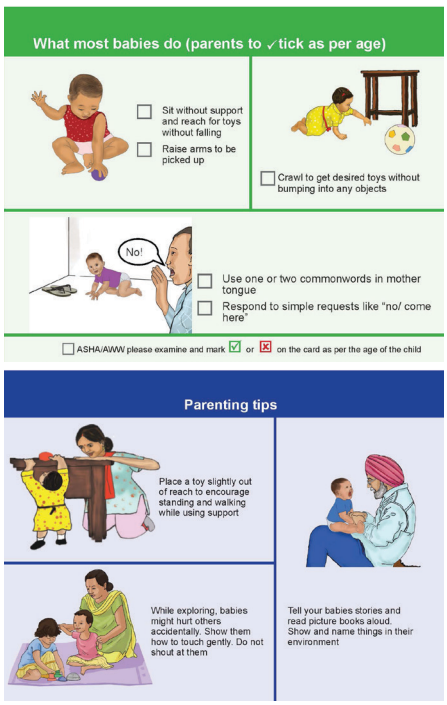


Figure 3.4: Development milestones in MCP card

3.2.2.1 Addressing New-Age issues in Early Childhood Care

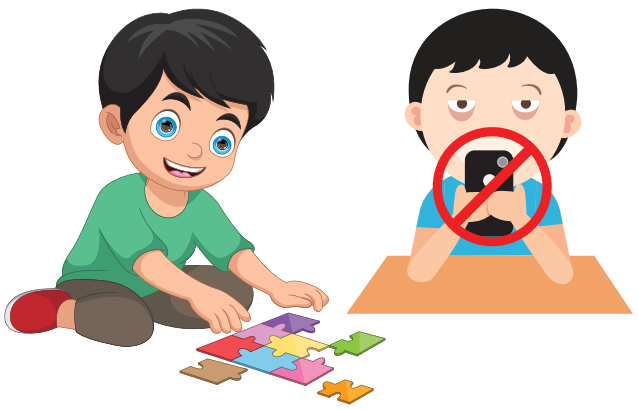
India's rapid demographic and economic advancement have brought significant changes to family structures and caregiving patterns. As family structures are evolving and daily life becomes increasingly fast-paced with more women work force & more nuclear families, the time available for direct, responsive interaction with young children at the household level has reduced considerably. This, combined with the growing proliferation of digital devices and screens, has led to increased screen exposure among children in the first three years of life; a period of rapid and irreversible neurological growth.

Excessive and unsupervised screen time during this critical window is increasingly associated with delays in language development, reduced attention span, impaired social interaction, and diminished physical activity. These concerns are no longer limited to urban or affluent settings and are now observed across all socioeconomic groups.

SSBSK recognises these emerging realities and places Early Childhood Development (ECD) at the centre of its response. The guidelines adopt a family-centred approach, actively engaging fathers, grandparents, and all family members as equal participants in a child's early care and development. This shared caregiving model facilitates that no child is left dependent on screens for stimulation, and that every child receives the responsive interaction, play, and emotional connection essential for healthy development.

- Frontline workers are oriented to counsel families on the following:
- Children under three years would have minimal screen exposure, particularly during mealtimes.
- Promoting age-appropriate play, physical activity, and face-to-face interaction as the primary modes of learning and stimulation
- Encouraging use of safe household items; containers, cloth, and natural objects: as play materials that support creativity, motor skills, and problem-solving
- Reinforcing storytelling, singing, and conversation as powerful tools for language and cognitive development
- Engaging all family members, including fathers and grandparents, in daily caregiving routines to build a nurturing and stimulating home environment

This approach contributes meaningfully to the mental, physical, social, and emotional health of young children; laying a strong foundation for lifelong learning, well-being, and human capital development.



बच्चों के हाथ में मोबाइल नहीं दें
छोटे बच्चों को स्क्रीन से दूर रखें

3.2.2.2 Addressing climate change and its impact on newborns & young children

Across the globe changing climate is emerging as a concern for having direct/ indirect consequences for the health and survival of people. Rising temperatures, recurrent heatwaves, and deteriorating air quality pose serious and disproportionate risks to newborns and young children, whose body systems are still developing and far less equipped to adapt to environmental stress than older children or adults.

In recognition of this, the Government of India launched the National Programme on Climate Change and Human Health (NPCCHH) in 2019 under the National Health Mission, with heat-related illnesses and air pollution identified as priority areas of action.

SSBSK in alignment with objectives of above programme, has integrated climate-sensitive counselling as a structured component of ASHA home visits.

ASHA counsels the families on two critical areas, protection from extreme heat and air pollution.

Protection from extreme heat: Keeping the newborn and young child indoors during peak heat hours; dressing them in light, loose cotton clothing; ensuring continuous hydration through breast milk or oral fluids; and recognising early warning signs of heat stress such as reduced feeding, excessive crying, and dry mouth.

Protection from air pollution: Avoiding burning of biomass, tobacco, or incense inside the home; keeping children away from areas with heavy traffic or industrial smoke; ensuring cross-ventilation while limiting direct outdoor exposure on poor air quality days; and seeking prompt medical attention if the child develops cough, rapid breathing, or eye irritation.

Through these simple practices, SSBSK brings climate resilience into the heart of every home ensuring that India's children are protected not just from traditional health risks, but from the emerging threats of a changing world.

Mother's meeting on how to take care of child in a healthy way

3.2.3 Family and community-centric approach in newborn and child care

SSBSK recognizes newborn and child care as a shared responsibility of the **family and community**, placing parents and family members at the centre of nurturing care. Active participation of all family members; particularly **fathers, grandparents, and other caregivers** is emphasized in supporting mothers to exclusively breastfeed, provide Kangaroo Mother Care (KMC) when indicated, and interact with the child for early learning and stimulation.

During home visits, ASHA shall counsel the entire household, encouraging **family members** to:

1. Support maternal rest and provide an emotionally secure home environment.
2. Accompany the mother and child for immunization or referral visits.
3. Sustain positive traditional practices and contribute to child supervision.
4. Actively participate in exclusive breastfeeding, KMC where indicated, and age-appropriate interaction with the child for early stimulation and learning.

Building on this family foundation, SSBSK further reinforces community engagement, acknowledging that a child's health and development depend on broader social determinants such as **nutrition, sanitation, safe housing, and caregiver education**. ASHAs, AWWs, and ANMs shall jointly mobilize communities through platforms such as VHSNDs, Mothers' Groups, Self-Help Groups (SHGs), and community-based parent education campaigns to:

1. Promote infant and young child feeding, especially timely initiation of complementary feeding.
2. Reinforce responsive caregiving and early learning through age-appropriate play and communication.
3. Facilitate access to social protection schemes including PMMVY, POSHAN 2.0, and Swachh Bharat Mission.

Family Participatory Care for every child

3.2.4 Post-natal maternal care & maternal mental health screening and support

Post-natal maternal care is an important component of SSBSK, ensuring timely identification and management of complications after delivery, including postpartum haemorrhage, and infections. Through regular home visits, ASHAs provide postnatal care, counselling on nutrition, hygiene, birth spacing, KMC and breastfeeding, enabling early recovery from childbirth and promoting the mother's overall well-being, which directly influences newborn health and wellbeing.

The SSBSK framework places strong emphasis on the mental well-being of mothers, recognizing that maternal emotional health is fundamental to young child's survival, nutrition, growth and development. Under the unified approach of SSBSK, maternal mental-health screening and support are now incorporated as part of all scheduled home visits.

Figure 3.5: Maternal Danger Signs

ASHAs and ANMs will screen mothers for signs of stress, anxiety, or postpartum depression using the Community-Based Assessment Checklist (CBAC) and brief enquiry tools such as PHQ-2. They will provide first-line psychosocial counselling, encourage rest, family support, and positive interaction with the baby, and link women requiring further support to Tele-MANAS or to Ayushman Arogya Mandirs (AAMs) for further evaluation by the CHO or MO I/C.

Prolonged Kangaroo Mother Care (KMC) is promoted as both a therapeutic and emotional-support intervention to enhance maternal bonding and reduce depressive symptoms. Integration with the National Mental Health Programme (NMHP) and Comprehensive Primary Health Care (CPHC) enables a continuum of mental-health care linking household-level screening with facility-based counselling and follow-up. Under SSBSK, these efforts are further reinforced through community platforms such as VHSNDs, Mothers' Meetings, and Well-Baby sessions, where maternal well-being is discussed alongside child health, nutrition and overall wellbeing.

Figure 3.6: Support for postpartum mental health concerns

3.2.5 Linkages with Comprehensive Primary Health Care for joint visits and team-based service delivery

SSBSK adopts a **team-based** approach to newborn and young child care, ensuring continuity and coordination across household, community, and facility levels. Roles are defined as follows:

1. ASHA serves as the first point of contact at the household level; conducting structured home visits, identifying 'At-risk' newborns and young children, counselling caregivers, and facilitating timely referral.

2. ANM provides clinical oversight, validates ASHA's findings through supportive supervision, and conducts joint home visits, particularly for 'At-risk' or sick newborns.

3. CHO positioned at the Ayushman Arogya Mandir (AAM), coordinates with ASHA and ANM, reviews follow-up lists, and undertakes joint home visits to 'At-risk' newborns and young children as per schedule.

4. Medical Officer In-Charge (MO I/C) at the PHC or UPHC serves as the nodal person for technical support, training, and supervision, and creates an enabling environment for the frontline team to function effectively.

Enhanced Role of Supervisors

Supervisors play a critical role in ensuring quality SSBSK services, particularly for 'At-risk' newborns and young children. ASHA Facilitators, ANMs, CHOs, AWW Supervisors, and Block Community Process Managers (BCPMs) are responsible for:

- Providing supportive supervision during home visits conducted by ASHAs and AWWs
- Organizing refresher trainings and reviewing quality of SSBSK services during AAM meetings
- Ensuring SSBSK kits are available, functional, and replenished as per guidelines
- Building capacity of ASHAs through regular monthly meetings, on-the-job mentoring, and field-level handholding

Detailed cadre-wise roles and responsibilities for supportive supervision are described in Section 6.5 of chapter 6 of this document.

3.2.6 Community engagement and inter-departmental linkages

Community participation is essential to promote a holistic approach that extends beyond healthcare services alone. ASHAs, AWWs, and ANMs shall actively mobilize communities and leverage relevant government schemes — including POSHAN Abhiyaan, Ayushman Bharat-PMJAY, Swachh Bharat Mission, Deendayal Antyodaya Yojana-NRLM, social and rehabilitation services, and state-specific schemes to strengthen multi-dimensional service access for children, particularly those identified as 'At-risk'.

Key departmental linkages under SSBSK include:

RBSK Convergence: The Rashtriya Bal Swasthya Karyakram (RBSK) plays a pivotal role in ensuring comprehensive screening, referral, and follow-up care for newborns and young children. As outlined in the guideline, ASHAs identify and mobilize eligible newborns and children during routine home visits for biannual RBSK screenings at Anganwadi Centres. The RBSK Mobile Health Teams (MHTs) assess children for the **4Ds (Defects at birth, Diseases, Deficiencies, and Developmental delays)**, and enable timely referral and management through the District Early Intervention Centres (DEICs). For 'At-risk' newborns ASHAs will share details with the RBSK-Mobile Health Team (MHT) and block teams to facilitate continuity of care and specialized follow-up at DEICs, including screening for hearing and vision for early detection of impairments.

ICDS Convergence: Convergence with the Integrated Child Development Services (ICDS) strengthens alignment of growth monitoring, **(POSHAN Tracker)**, complementary - feeding demonstrations, and early-childhood- development (ECD) activities conducted at Anganwadi Centres.

Taking child's weight and temperature at home

3.2.6.1 Key Community Platforms for Action

Community-Based Events (CBEs) & ECD campaign under POSHAN Abhiyaan

ASHA coordinated with AWWs in organizing Annaprashan Diwas and Suposhan Diwas for initiation of adequate complementary feeding by identifying eligible families and ensuring participation. She can use culturally relevant tools like food diversity demonstrations, promoting local low-cost nutritious food, storytelling, and songs to engage communities and reinforce messages.

Mothers' Groups and Self-Help Groups (SHGs)

ASHA and AWW jointly conduct Mothers' Group and SHG meetings to address challenges in newborn care, feeding practices, hygiene, and home-based play. ASHA informs women about benefits under schemes like PMMVY and JSY and seeks their support in linking group members to government entitlements and services.

Gram Sabha and Mahila Sabha Meetings

ASHA participates in Gram and Mahila Sabha meetings to raise issues around child health and development, undernutrition, WASH, and Anganwadi functioning. She coordinates with AWWs and ANMs to promote SSBSK priorities are reflected in the Village Health Action Plan (VHAP) and addressed through Panchayat-level planning.

Jan Arogya Samiti (JAS) and Village Health Sanitation and Nutrition Committee (VHSNC)

At the SHC-AAM level, ASHA supports VHSNCs and Jan Arogya Samitis by organizing biannual Jan Sunwais (community hearings), presenting data from home visits especially for 'At-risk' young children and VHSNDs to highlight gaps in health, nutrition, sanitation, and ECD. She facilitates community engagement and coordination with AAM/SHC staff for accountability and follow-up action.

Bal Vikas Samiti (BVS)

ASHA actively engages with the Bal Vikas Samiti to raise issues related to child nutrition, immunization, early learning, and entitlements under various schemes. In coordination with AWWs, she shares findings from home visits and community platforms to support BVS in planning and monitoring child development efforts at the village level.

Mahila Arogya Samiti (MAS)

Under SSBSK, ASHA works closely with MAS to mobilize women for newborn and young child health, promote early care-seeking, and support behaviour change on breastfeeding, KMC, nutrition, hygiene, and ECD. MAS acts as a community platform for identifying 'At-risk' young children, addressing social barriers, and facilitating linkages with AAM/SHC services.

3.2.7 Integration with digital health platforms (JANANI portal, POSHAN tracker & RBSK 2.0)

Digital integration is a transformative feature of SSBSK. New digital tool (Shaishav App) will facilitate tracking of every newborn irrespective of place of delivery with special emphasis on 'At-risk' newborns and young children.

Key features of the digital architecture include:

1. **Digital tracking:** A digital referral and tracking system will enable timely identification, follow-up, and management of sick or vulnerable children.
2. **Decision Support System (DSS):** Embedded DSS will guide ASHAs, ANMs, CHOs, and MOs in conducting age-specific assessments, providing pre-referral care, and making timely referrals during home visits or AAM-based follow-ups.
3. **JANANI portal integration:** All digital tools will be seamlessly integrated with JANANI portal for data flow, supervision, and reporting. Integration with the Ayushman Bharat Digital Mission (ABDM) through ABHA ID will enable linking of maternal and child health records across the continuum of care, ensuring portability and continuity of services.
4. **Tele-consultation:** e-Sanjeevani will support CHOs and MOs in accessing specialist consultation for high-risk newborns and young children requiring advanced management.
5. **JANANI-RBSK 2.0 Integration:** Integration of JANANI portal with RBSK 2.0 will enable early identification of nutrition, growth, and developmental risks, ensuring timely referral, follow-up, and continuity of care through coordinated community- and facility-based services.

Recording and reporting of home visit data through mobile based app

3.3 Need for special focus: urban poor, tribal and hard-to-reach areas

Urban vulnerable communities, particularly in slums and migrant settlements, face unique challenges of overcrowding, inadequate water and sanitation, and limited access to health services. Under the National Urban Health Mission (NUHM), the SSBSK framework prioritizes mobile outreach, digital tracking of 'At-risk' children, and stronger linkages with UPHCs and urban AAMs. In nuclear families, where care support is limited, counselling on nurturing care and parent-child interaction is essential to promote optimal development. It has been outlined in detailed manner in following chapter focusing on urban communities.

Similarly, for tribal and hard-to-reach areas, special strategies include context-specific planning, special awareness and mobilization plan, engagement of local community leaders, use of mobile medical units, and coordination with local Community Based Organization (CBO), research institutes, departments of tribal affairs and rural development to promote universal coverage and equity in **SSBSK services**.

Reaching to unreached in the remote tribal village

04 Chapter Implementation Plan of the Programme

SSBSK supports a continuum of care through a team-based, digitally enabled, and risk-stratified approach. The implementation focuses on strengthening linkages with Comprehensive Primary Health Care (CPHC) via Ayushman Arogya Mandirs (AAMs), with ASHAs and AWWs leading community outreach supported by ANMs, CHOs, and MOs for joint supervision, mentoring, and referral.

4.1 Risk assessment and risk stratification approach for newborns and children

A systematic risk-stratification approach lies at the core of SSBSK implementation. It enables that children requiring additional care and supervision to be identified early, tracked, and followed up at appropriate intervals.

Table 4.1 Classification of Risk Categories

Category	Child Characteristics	Level of Follow-up
Healthy newborns 	Birth weight ≥ 2.5 kg, term baby, no complications during delivery.	• Routine home visits (4 visits) for institutional deliveries on 3, 7, 14 & 42 day of life and 5 visits for home deliveries with one additional visit on day 1
At-risk newborns 	• Low birth weight (<2.5 kg) • Preterm (<37 weeks) • Congenital anomalies • Not breastfed • Discharged from newborn care units (SNCU/NICU/MNCU and NBSU).	• 9 visits by ASHA [Day 1 (of delivery or day of discharge) 3, 5, 7, 10, 14, 21, 28, 42] • **Joint follow-up by ASHA along with ANM/CHO on Day 3 & 7 (during newborn period)**
Young children (6 weeks to 36 months) 	• Growth faltering, low weight for age • Delayed milestones • Recurrent illness / hospitalization • Partial Immunization	• Immunization contact at 1.5 months and 2.5 months at VHSND • Home visits at 3, 6, 9, 12, 18, 24, 30 and 36 months; growth & development review at VHSND / UHSND (Well-Baby Session). • **Joint follow up by ASHA along with ANM & CHO/MO for 'At-risk' children during 3rd & 6th month (during young child period)** • Monthly follow up at Shishu Shivir at AAM

During antenatal care ANMs would identify families that have social and economic vulnerabilities that affect women's and children's health. Such families would be listed as vulnerable households and enhanced support would be provided.

4.2 Health system contacts during early childhood

Under SSBSK, ASHA as the key service provider in the village will conduct four home visits for newborns delivered at health facilities and five visits for those born at home within the **postnatal period (0–6 weeks).** These structured visits will focus on essential newborn care; exclusive breastfeeding promotion, screen 'At-risk' newborns, identify danger signs, counsel caregivers, and facilitate timely referral for any complications. The visits cover Day 3, 7, 14, and 42 (with an additional Day 1 visit for home deliveries).

For every 'At-risk' newborn, ASHA will conduct **nine intensive home visits on Day 1 (day of delivery or discharge from facility), 3, 5, 7, 10, 14, 21, 28, and 42.**

After the newborn period, ASHA shall conduct **quarterly home visit starting from 3 months till 12 months and then 6 monthly till 36 months (3,6,9,12, 18, 24, 30 and 36 months)**, total 8 home visits to promote continuity of care to all young children, improve child growth monitoring, nutrition counselling, strengthen disease prevention efforts, and increase family engagement in nurturing care.

Village Health, Sanitation, and Nutrition Day (VHSND)

ASHA mobilizes families with children under three to attend VHSNDs and health screening by RBSK-MHT while AWW and ANM provide delivery of services such as growth monitoring, immunization, take home ration (THR) distribution, deworming, diarrhoea management through the STOP Diarrhoea initiative, pneumonia prevention and control under the SAANS, Vitamin A, and IFA supplementation.

Utilization of VHSND/UHSND Platforms for Continuity of Newborn & Child Care

As per National guidelines, home visits under HBNC conclude at 42 days, while HBYC visits begin only at 3 months; leaving a service gap of over six weeks period. During this period, the health system already engages with caregivers through three scheduled contacts at 1.5 months, 2.5 months and 3.5 months of child's age under the Universal Immunization Programme (UIP) organised at VHSND/UHSND sites. These existing health system contacts would be leveraged to support continuity of care by incorporating screening for danger signs, weight measurement & recording, early detection of growth faltering, and reinforcement of exclusive breastfeeding practices through counselling by ASHA/ANM/AWW.

Figure 4.1: Proposed health system contacts for children 0–3years under SSBSK

HOME VISIT SCHEDULE UNDER SSBSK
ROADMAP: CONTINUUM OF CARE FROM BIRTH TO THREE YEARS

पहले तीन साल, सम्पूर्ण देखभाल
Samagra Shishu Bal Swasthya Karyakram

For newborn (age 0 to 6 weeks)

For young child (6 weeks to 36 months) Quarterly Home Visits

1. Institutional Delivery – Healthy Newborn
(4 Visits)

ASHA will conduct four home visits on Day of discharge/Day 3, Day 7, Day 14, and Day 42 after birth.

Days: 3, 7, 14, 42
Discharge

2. Home Delivery – Healthy Newborn
(5 Visits)

ASHA will conduct five home visits - one visit within 24 hours of delivery, followed by visits on Day 3, Day 7, Day 14 and Day 42.

Days: 3, 7, 14, 42
Within 24 hours of delivery

3. 'At-risk' Newborn
(9 Visits)

ASHA will conduct nine intensive home visits to every 'At-risk' newborn on Day1, Day 3, Day 5, Day 7, Day 10,Day 14, Day 21, Day 28, and Day 42.

Days: 1, 3, 5, 7, 10, 14, 21, 28, 42

VHSND contacts at 1.5 & 2.5 months

ASHA would conduct 8 quarterly home visits starting from 3 months till 36 months to promote continuity of care.

Visit 1 – 3 Months | Visit 2 – 6 Months | Visit 3 – 9 Months | Visit 4 – 12 Months | Visit 5 – 18 Months | Visit 6 – 24 Months | Visit 7 – 30 Months | Visit 8 – 36 Months

Regular home visits help in monitoring growth and development, promoting optimal nutrition, responsive caregiving, early identification of risks and timely linkages to services.

Joint Visits to 'At-risk' newborn: Home visits on Day 3 and Day 7 will jointly be carried out with ASHA + ANM/CHO (Rural) ASHA-ANM-MO (Urban) to facilitate timely interventions.

Joint Home-visit for 'At-risk' children: Joint Home visits during 3rd & 6th month of life will jointly be carried out with ASHA + ANM/CHO (Rural) ASHA-ANM-MO(Urban) to facilitate timely interventions.

KEY FOCUS DURING HOME VISITS

- Maternal well-being
- Nutrition & feeding
- Growth monitoring
- Early childhood development
- Responsive caregiving
- Early identification of risks
- Referral & follow-up
- Digital tracking through JANANI Portal

Note: Additional visits as per need. Sick newborns/children require immediate care and follow-up.

Timely care at home. Strong start for a bright future.

Well-baby Session (on VHSND day)

On every VHSND/UHND, ANM with the support from ASHA, AWW will conduct a dedicated Well-Baby Session for all newborns & young child residing within the catchment area. Besides routine work, VHSND/UHND would aim on two major aspects; A) Improving family care practices by counselling mothers on nurturing care, and feeding practices, and B) comprehensive health assessments covering post-natal care for mothers and all essential newborn health check points. This activity will serve as an additional contact point to the routine Samagra Shishu Bal Swasthya Karyakram (SSBSK) visits and facility-based follow-up visits, as envisaged under the Government of India guidelines and would be continued till baby reaches 3 years of age. The Well-Baby Session will strengthen early identification and management of health and nutrition concerns, reinforce post-natal care for mothers, and facilitate timely referral where required—thereby improving newborn survival and overall maternal health outcomes.

Focused Care for 'At-Risk' Newborns, Young Children, and Vulnerable Families

An essential feature of SSBSK is the shift from individual to team-based care for 'At-risk' newborns and young children. ASHA, ANM, AWW, CHO, and Medical Officer function as a coordinated care team, each with defined roles across the continuum of home- and facility-based services.

Line-listing Tracking

ASHA will prepare and maintain a dynamic line list of all 'At-risk' newborns and young children with their RCH Register IDs and in Shaishav App (details of the data flow is mentioned in Chapter 8). This list is updated continuously based on ongoing assessments; including identification of low weight-for-age or low weight-for-height during follow-up visits. Once an 'At-risk' newborn or child is identified, ASHA will share the line list with the ANM, ASHA Facilitator, CHO, and MO to enable coordinated scheduling of joint home visits.

Identification of Vulnerable Families

ASHAs will be oriented to identify vulnerable households, as these are disproportionately likely to have 'At-risk' newborns and limited capacity to manage complications, support early child development, or address maternal mental health concerns. Several social vulnerability markers are captured during antenatal care contacts and would be used to prioritize focused and intensified outreach for such families.

4.2.1 Joint home visits for 'At-risk' newborns and young children

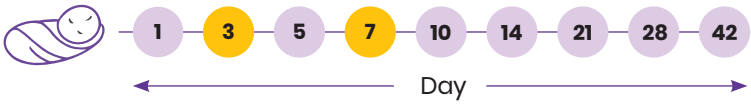
SSBSK introduces structured joint home visits by a team of frontline health workers for all 'At-risk' newborns and young children, ensuring timely clinical assessment, caregiver counselling, and continuity of care at critical developmental junctures.

A) For 'At-Risk' Newborns (0–6 weeks)

ASHA conducts 9 intensive home visits to every 'At-risk' newborn on Day 1, Day 3, Day 5, Day 7, Day 10, Day 14, Day 21, Day 28, and Day 42.

Of these, visits on **Day 3 and Day 7** are designated as joint visits:

- **Rural:** ASHA + ANM & CHO
- **Urban:** ASHA + ANM & MO



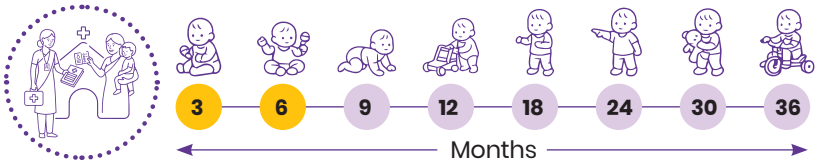
For neonates discharged from SNCUs or MNCUs, the day of discharge is treated as Day 1, and subsequent visits are scheduled accordingly.

Rationale for Joint Visits on Day 3 and Day 7: Early neonatal deaths account for nearly 72% of total neonatal mortality. Cultural practices in many communities also create hesitancy for families to leave home in the first week. Joint visits on Day 3 and Day 7 address this critical gap. Additional visits may be conducted if the newborn continues to remain at risk.

B) For 'At-Risk' Young Children (6 weeks to 36 months)

At the close of the neonatal period, ASHA and ANM support two bridging contacts with the child and caregiver at 1.5 months and 2.5 months of age through the Village Health, Sanitation and Nutrition Day (VHSND). These contacts bridge the gap between the newborn period (0–6 weeks) and the commencement of quarterly home visits during the young child period (6 weeks to 36 months), ensuring continuity of care and uninterrupted follow-up across the early childhood continuum.

ASHA conducts 8 quarterly home visits from 6 weeks to 36 months of age (at 3, 6, 9, 12, 18, 24, 30, and 36 months).



Of these, visits at **Month 3 and Month 6** are designated as joint visits:

- **Rural:** ASHA + ANM & CHO
- **Urban:** ASHA + ANM & MO

Rationale on joint visit on Month 3 & 6: Evidence indicates a marked decline in exclusive breastfeeding after 3 months of age; joint visits at Month 3 are critical to reinforce and sustain this practice among 'At-risk' children. At 6 months, timely initiation of appropriate complementary feeding is essential to support optimal growth and prevent growth faltering. Strategic joint visits at these two junctures promote both nutritional and developmental interventions are delivered when they are most impactful.

Exit from 'At-risk' Category: If the ASHA observes that the newborn has achieved appropriate weight gain for age (green zone), developmental milestones are on track, has undergone corrective surgery for congenital malformations (where indicated), and is clinically stable, then newborn/child would be removed from 'At-risk' list. Home visits would continue as per SSBSK guidelines. A newborn or young child who has previously met the exit criteria may subsequently re-enter the 'At-risk' category. Therefore, continuous assessment is essential to promote timely re-classification and appropriate management whenever criteria for 'At-risk' re-emerge till 36 months of age. However, ASHA must counsel parents/caregivers to promptly contact her or the ANM/CHO in case any danger signs or emergencies arise.

A happy and healthy baby is the lifeline for every family

Table 4.2: Domain specific actions under SSBSK

Key Domains	Specific Actions
Identify and follow up of 'At-risk' Newborn/Young Children 	• Identify 'At-risk' newborn/young children: identified in newborn period or added in subsequent visits • Follow up at newborn care unit, where indicated, and link them to health facility (CPHC) • Specific actions as per the identified 'risk' condition
KMC 	• KMC in home setting for low-birth-weight baby at least 8 hours a day or more • Counselling mother/caregivers to practice skin-to-skin contact along with exclusive breastfeeding, demonstrating correct positioning, and encouraging family involvement to facilitate continuity of KMC
Nutrition 	• Nutrition counselling: Exclusive breastfeeding for six months; including identification and management of breastfeeding problems • Adequate complementary feeding after completion of six months and continued breast feeding up to two years of age; Encouraging caregivers to feed the child with affection, observe hunger and fullness cues, and avoid force-feeding • Iron and folic acid (IFA), Vit A supplementation • IFA and calcium supplements for mothers upto 6 months post delivery • Hygienic food preparation, periodic deworming • Promote use of diverse diets, fortified food, local low-cost food and millets • Growth monitoring and referral to MO for assessment of severe acute malnutrition with medical complications and further referral to NRC, if needed.
Health 	• Full immunization in first year, boosters in second year • Appropriate use of Oral Rehydration Solution (ORS) and Zinc during diarrhoea episodes • Early identification and prompt care seeking for 'sick child'
Early Child Development (ECD) 	• Promote child development through nurturing care – responsive and positive parenting, age-appropriate play and communication activities by caregivers • Loving touch, father's participation, use of household item like Katori/ spoon or homemade toys for play activities • Assess and track child's developmental progress • Link children with delayed milestones to health facility, RBSK-MHT, DEIC or AAM • Children under three years would have minimal screen exposure, particularly during mealtimes.

Key Domains	Specific Actions
WASH	• Appropriate hand washing practices • Safe drinking water • Safe disposal of faeces, use of toilets
Safety & Security	• Promote a safe sleeping space — clean, flat surface, free from loose bedding or pillows, bednets to keep away mosquitoes. • Keep the child away from fire, smoke, mesh wires, electric gadgets, and open water containers like buckets or tubs. • Prevent falls and injuries by never leaving the baby unattended on beds, tables, or raised areas. • Maintain safe surroundings — store hot liquids, medicines, and sharp objects out of children's reach. • Promote clean, supervised feeding and play, ensuring constant adult attention during daily care. • Emotional safety like no quarrels at home, treating mother with respect and love, no domestic violence, no addiction (addiction (like smoking or consuming alcohol) in the home

Newborn and child assessment by ASHA during community outreach

4.3 Roles and responsibilities of frontline workers under SSBSK programme

The differentiated role of frontline workers - ASHA, ASHA facilitators, ANM- during home visits are listed in the tables below

Table 4.3: Roles & responsibilities of ASHA, ASHA facilitators & AWWs under SSBSK (for 0 to 6 weeks newborn)

Provider	ASHA	ASHA Facilitator	AWW
Level of Care/ Platform	**Home visits/ Community**	**Community (VHSND/Home visits)**	**Community (AWC)**
 Family Health & Risk Assessment	Assess the family for risk factors or worsening of existing factors	Provide support to ASHA in identifying and ensuring access to appropriate services for dropout individuals and resistant families/ households.	Identify BPL families and support regular follow-up, counselling, and linkage to child health, nutrition and development services.
 Birth preparedness	• Check and confirm if the mother is a High-Risk Pregnancy (HRP) and if yes, referred to FRU for delivery • Counsel on importance of at least 48 hours stay at the health facility post-delivery • Counsel on the importance of zero separation of mother baby dyad immediate skin to skin contact on mother's (or care giver's) chest soon after birth at least for one hour and continued KMC in preterm and LBW newborns. • Sensitize the family about Janani Suraksha Yojana (JSY) payments • Encourage and assist the family to complete birth registration of the newborn • Inform the family about free referral transport services for emergencies and follow-up visits	• Prepare ASHA-wise line list on the number of HRP women and facilitatetheir referrals to a FRU for delivery through regular follow-up with ASHAs; • Build knowledge of ASHAs on counselling skills on the birth preparedness checklist areas during cluster/ monthly meetings.	Counsel on early initiation of breast feeding (EIBF), appropriate facility delivery, birth spacing.

Provider	ASHA	ASHA Facilitator	AWW
Level of Care/ Platform	**Home visits/ Community**	**Community (VHSND/Home visits)**	**Community (AWC)**
 Newborn Care	• Check and record weight, temperature, and respiratory rate. • Assess breastfeeding, positioning & attachment • Assess for danger signs in newborn & if identified, make prompt referral to nearest health facility • Line lists all newborns & 'At-risk' newborns for additional home visits. • Examine & counsel on skin, eye, and cord care **Counsel mother & family on** • Exclusive breastfeeding (EBF) • Nurturing Care (provide parenting tips) -like bonding, identifying baby's cues, and demand feeding. • Making eye contact, talking, singing, and gentle massage of the newborn during feeding times and beyond • Keeping the newborn warm. • Hand washing and clean home environment. • Avoiding indoor smoke (from chulha, angithis) and smoking. • Orient family using MCP card on breastfeeding, danger signs, nutrition, immunization, play and communication activities. • Check immunization status. • Notify in case of newborn death.	• Capacity building of ASHAs on skills required to conduct assessments and counselling during home visit including danger signs, use of SSBSK formats, recording and reporting during monthly or cluster meetings • Maintaining ASHA-wise line list of newborns for tracking and follow-up • Check adherence to ad scheduled home visits Track health status of mothers and newborns through regular updates from ASHAs • Provide support and supervision during home visits	Breast feeding support to mother and counselling of family members to support the lactating mother with adequate nutrition and rest.

Provider	ASHA	ASHA Facilitator	AWW
Level of Care/ Platform	**Home visits/ Community**	**Community (VHSND/Home visits)**	**Community (AWC)**
 'At-risk' Newborn	Over and above the tasks mentioned above • Promote, counsel & demonstrate -KMC to mother/ care giver (Skin to skin contact for ≥8 hours/day or as much as possible); how to keep newborn warm -use 2-layer clothing with head and feet covered, and protect from direct airflow • If newborn is SNCU discharged, counsel family for medication as per discharge ticket, continue KMC and make SNCU follow-up visits as advised at discharge. • Counsel mother to breastfeed every 2 hours; check urine output. • If not feeding directly from breast, check for breast milk expression, demonstrate breast milk expression to mother including, collection and storage at room temp for 6 to 8 hours & in refrigerator for 24 hours; encourage katori-paladai feeding only (Advise against top feed & bottle feeding). • Focused counselling and reinforcement of nurturing care (Parenting Tips in MCP Card) • Notify in case of neonatal death	• Make home visit along with ASHA to vulnerable households with 'At -risk' children • Supervise ASHA home visit (30% of newborns who are sick/'at risk') and check for quality of visit. • Capacity building and mentoring of ASHA on simple skills like weighing and taking temperature, KMC etc. • Check availability of functional SSBSK kit and promote correct use of these kits; facilitate replenishment	• Record and track weight and length • Provision of THR for mother • Nutrition and health education for mother • Support for VHSND- help ASHA in mobilizing eligible mothers and newborns

Provider	ASHA	ASHA Facilitator	AWW
Level of Care/ Platform	**Home visits/ Community**	**Community (VHSND/Home visits)**	**Community (AWC)**
 Maternal Health (Post-natal care)	Identify maternal danger signs and refer promptly by availing free transport services under JSSK • Counsel mother on: self-care, nutrition, rest, sleep, danger signs of both mother and newborn, WASH practices, responsive caregiving and feeding practices, support for exclusive breast feeding. • Facilitate Tab IFA & Calcium supply for 6 months at the time of discharge at facility • Counselling on healthy spacing and support to choose appropriate method (followed by commodity distribution) • Enquire about the mother's mental health and social well-being • Notify maternal death	• Focus on mother's health, nutrition and family support. • Check if mother is receiving adequate food and rest, link the family to available government schemes / services for nutrition / social support • Assess home environment • Review quality of visits by ASHAs, based on field observations, during cluster meeting on	• Provide support to mothers for feeding; promote adequate maternal nutrition; identify early growth faltering. • Monitor mother's weight • Follow up PNC mothers as listed under PMMVY • Link mothers to Direct Beneficiary Transfer (DBT) scheme and Take Home Ration (THR)

Role of ASHA in case of Danger Signs

- Inform ANM/CHO
- Counsel family about need of immediate referral
- Arrange transport for referral of mother –infant dyad to a nearest health facility
- Advice how to prevent low blood sugar.
- Advise the mother how to keep the infant warm on the way to the hospital.
- Refer URGENTLY to hospital

Table 4.4: Supportive Role of ANM and CHO in Managing 'At-risk' Newborns

Provider	ANM	CHO Rural areas/MO Urban areas
Level of Care	**Home visit/ VHSND**	**Home visits/AAM**

 Newborn (0-6wks)	• Facilitate line listing of 'At-risk' newborns is maintained by ASHA and share with CHO/MO PHC
	• Make joint home visit with ASHA to 'At-risk' newborns and promote appropriate care
	• Identify newborn danger signs and facilitate prompt referral & follow ups
	• Provide sick newborn care as per IMNCI protocol
	• Refer 'At-risk' newborns to AAM/ CHO for further assessment during *Shishu Shivir*
	• Promote KMC for LBW newborns & support ASHA for KMC demonstration to mothers/ caregivers
	• Mentor ASHA & support mother to promote exclusive breast feeding (EBF), focused counselling on nurturing care (Parenting tips-MCP card)
	• Mentor ASHA & support mother for her own emotional wellbeing and counselling.
	• Counsel parent/ family on prompt referral of sick newborn
	• Link to RBSK-Mobile health Teams (MHT) newborns with birth defects
	• Joint visit with ASHA & CHO on 3rd & 7th day of life for 'At-risk' newborn
		• Facilitate line listing of 'At-risk' newborns
		• Early identification, screening and service provision for danger signs in new-born using IMNCI flowchart.
		• Follow up of mothers with post-natal complications and 'At-risk' newborns
		• NCD screening of postnatal mother
		• Coordinate referral for continuum of care such as post-natal mothers with complications, LBW newborns, SNCU discharged newborns, newborns with danger signs
		• Support to ANM/ASHA in child growth and development monitoring and providing expanded range of services
		• Counselling and provisioning of services for birth spacing
		• Use teleconsultation with PHC/ CHC Medical Officer to
		  ► Confirm initiation/ continuation of treatment
		  ► Maternal mental health support
		  ► Initiate pre-referral stabilization of sick mother/ newborn
		  ► Reinforce counselling for nurturing care and maternal anxiety/depression
		• Joint visit with ASHA & ANM on 3rd & 7th day of life for 'At-risk' newborn

Table 4.5: Tasks for ASHAs and AWWs for Young Children (6 weeks to 36 months)

Home visits	ASHA	AWW
 **3, 6, 9, 12, 18, 24, 30, 36 months**	**Household and Environment Assessment** • Assess home environment and risk factors (vulnerable households: Refer Annexure 1) • Counsel parent/ caregivers on benefits of handwashing, safe drinking water, safe feces disposal • Counsel on injury prevention, safe environment **Nutrition, Child Growth, Nutrition & Development** • Assess and promote exclusive breastfeeding and complementary feeding, dietary adequacy including food diversity, minimum meal frequency and minimum acceptable dietary practices • Assessment of child for optimal growth (weight for age) • Follow up actions for 'At-risk' child including those not gaining weight • Link 'At-risk' child to nearest AAM and RBSK's mobile health Team (MHT)/ DEIC • Assess development milestones — look for 'warning signs/red flag signs' in MCP card & link them with health facility & DEIC **Preventive and Curative Health Services** • Check for age-appropriate immunization (Refer MCP card) • Mobilize for immunization • Distribute ORS & Zinc, IFA and Vit A supplementation and deworming • Identification and prompt referral of sick child **Caregiver and Parenting Support** • Counselling for optimal Infant and Young Child Feeding Practices, responsive feeding • Parent counselling regarding age-appropriate play and communication activities by caregivers • Advise on responsive parenting **Support mother's own nutrition, health and wellbeing** **Notifications** • Notify maternal and child death	• Community Based Events (CBEs) through activities like Annaprasan Diwas, Suposan Diwas, Poshan Maah and Poshan Pakhwada, Wajan Diwas, promote Jan Andolan • Record weight of the child and plotting on growth chart (weight-for-age) • Record length/height and plotting on growth chart (weight-for length/height) • Identify underweight and wasting • Identify MAM children and mobilize them to VHSND • Nutrition and health education for mothers/ families • Supplementary nutrition support • Distribute 'Take Home Ration' to lactating mothers and counsel for nutrition • Early childhood care and preschool education

4.3.1 Joint home visits with AWW

"One Year – Five Joint Visits" strategy (Collaborative implementation with ASHA)

Key Responsibilities of the AWW

Visits 1-2 (On Day 28 & in between 42-60 day of life) – Home Visit

- Accompany ASHA for home visits to observe the condition of the newborn and mother.
- Register the baby's birth and record weight and length in the *Poshan Tracker* and *Mother–Child Protection Card (MCP)* and it would help in identification of 'At-risk' newborn and appropriate referral
- Observe breastfeeding position and attachment; identify any feeding difficulties and refer to ASHA/ANM for correction.
- Counsel the mother on exclusive breastfeeding and discourage bottle or animal milk use.
- Identify any illness signs and refer promptly to ANM or the nearest health facility.

Visit 3 (6 months) – Annaprashan Day / Community Event

- Counsel parents (along with ASHA) on preparing for initiation of complementary feeding at six months.
- Record the latest growth measurement and identify any 'At-risk' infants (moderate/severe underweight or illness).
- Encourage continuation of breastfeeding.
- Coordinate referral to NRC in case of growth faltering/SAM identification.
- Facilitate Annaprasan Day celebration at the Anganwadi Centre.
- Demonstrate safe and hygienic preparation of complementary foods.
- Record weight and update growth monitoring charts.
- Share list of 'At-risk' infants with ASHA and ANM for follow-up and referral.

Visit 4 & 5 (at 9 month and 11-12 month)

- Assess complementary feeding practices and counsel caregivers on age-appropriate feeding, including transition to family foods, while reinforcing continued breastfeeding.
- Undertake growth monitoring of the child, review growth trends, and identify early signs of growth faltering or undernutrition.
- Provide counselling to caregivers on early childhood development, responsive caregiving, and age-appropriate play and stimulation.
- Reinforce key messages on hygiene, safe feeding practices, safe environment and child care in coordination with ASHA.
- Update MCP records and coordinate with ASHA to promote continuity of care and follow-up actions.

Joint home visit of ASHA and CHO for sick child

Table 4.6: ANM and CHO role for Young Children (6 weeks to 36 months)

Home visits	ANM	CHO Rural areas/MO Urban areas
 **3, 6, 9, 12 18, 24, 30, 36 months**	• Support ASHA to identify danger signs in young children and facilitate prompt referral • Care of sick child as per IMNCI protocol • Extended care for 'At-risk' child included in the line list • Provide immunization services • Facilitate Vitamin A supplementation. • Provision of ORS, Zinc, IFA, deworming • Orient families on use of MCP Card to observe age-appropriate milestones • Help ASHA & ANM in linkages with Mobile health team and facility for 'At-risk' children • Counsel on a basket of choices for healthy spacing • Community-level screening of children with MAM and referral of children with SAM to health facilities for assessment of medical complications and referral of those with medical complications to NRC • Joint home visit with ASHA & CHO during 3rd & 6th month of life for 'At-risk' children	• Service provision for children using standard treatment guidelines (IMNCI chart booklet) and care pathways • Periodic assessment of 'At-risk' children to screen for growth and development related issues • Facilitate health education sessions for mothers and caregivers on infant and young child nutrition, play and communication for early childhood development, responsive caregiving, safety and security of young children, and information on developmental milestones that parents can observe and note using the MCP card. • Coordinate timely referrals of newborns and children to higher-level facilities. • Addressing maternal mental health issues. • Maintain communication with MOs and higher referral units for efficient case management. • Undertake teleconsultation services for cases needing specialist advice • Facilitate contraceptive basket of choice at AAM level and counsel regarding spacing methods & choices. • Joint home visit with ASHA & CHO during 3rd & 6th month of life for 'At-risk' children

Pre-referral stabilization of newborns and children with danger signs by ANM/CHO:

- Continue breastfeeding
- Provide skin-to-skin thermal care
- Give pre-referral dose of oral amoxycillin and IM gentamicin to children presenting with general danger signs, severe pneumonia, severe febrile disease and SAM with medical complications
- For severe dehydration rehydrate with ORS till the time referral is possible
- For acute diarrhoea and severe acute malnutrition, give zinc supplements for 14 days- Give 10 mg (1/2 tab of 20 mg tablet) to infants aged 2-<6 months; Give 20mg (1 tab of 20 mg tablet) to children 6-59 months
- Tepid sponging for fever
- Give Paracetamol for High Fever (≥ 38.5 C/101.3 F)- Give a single dose of paracetamol in the clinic; Give 3 additional doses of paracetamol for use at home every 6 hours until high fever or ear pain is gone

Sick child to be supported with pre-referral stabilization before referral

4.4 Home-Based Kangaroo Mother Care (KMC)

Low birth weight and small newborns discharged from SNCUs, MNCUs, or NBSUs require continued Kangaroo Mother Care (KMC) at home for **a minimum of 8 hours per day** to support survival, growth, and development. During scheduled SSBSK home visits, ASHA shall:

- Counsel caregivers on the importance of **prolonged skin-to-skin contact** and demonstrate correct **KMC positioning**.
- Promote **exclusive breastfeeding and encourage active family involvement** in KMC practice.
- **Monitor daily duration of KMC**, adequacy of feeding, weight gain, and thermal protection.
- Remain **vigilant for danger signs**; poor feeding, lethargy, hypothermia, or breathing difficulty and promote timely referral when indicated.
- Mobilize families to attend VHSNDs or support group sessions for reinforcement of KMC and exclusive breastfeeding practices.

Kangaroo Mother Care for LBW children

4.5 Referral of 'At-risk' newborns

'At-risk' newborns do not require immediate referral to a health facility unless danger signs are present. Referral decisions shall be taken jointly by ASHA, ANM, and CHO in consultation with the parents. Prior to facility referral, CHO shall undertake a comprehensive assessment and refer to the appropriate facility only if the condition warrants expert or specialist opinion.

ASHAs and ANMs shall be clearly informed about designated referral facilities for sick or 'At-risk' newborns and young children. Each district and block shall prepare and maintain an updated list of:

- Functional Newborn Stabilization Units (NBSUs) and Special Newborn Care Units (SNCUs).
- District Early Intervention Centres (DEICs) and paediatric units.
- Health facilities empanelled under Ayushman Bharat, where available in proximity.

This facility list shall be shared with CHOs at Ayushman Arogya Mandirs (AAMs) and made available to all ASHAs and ANMs in their respective areas. The list of newborns discharged from neonatal units shall also be maintained and made accessible for community-based follow-up.

During monthly review meetings and trainings, the referral facility list shall be disseminated to all frontline workers along with key logistical details; including distance and estimated travel time from each village and the National Ambulance Service call centre number to facilitate timely and appropriate referrals.

ASHA would facilitate that all SNCU/NBSU -discharged newborns for follow-up visits at the facility by trained doctors to prevent future complications. In addition, all 'At-risk' newborns would receive mandatory facility follow ups within 8 days for care and support.

Remember

1. 'At-risk' new-borns would not be misunderstood as "Newborns with danger signs."
2. The term 'At-risk' newborn refers to those newborns who require closer observation and follow-up because of biological vulnerability and are more prone to develop danger signs. These newborns require more support through additional home visits, parent counselling and growth monitoring to promote overall growth and development.
3. Newborns with danger signs present with acute symptoms like those mentioned in the box (and also in the MCP card) and require urgent referral and treatment at an appropriate health facility. It is important to note that any newborn or young child can develop danger signs as a result of childhood illness, including those identified to be 'At-risk'.

4.6 Facility follow-up linkages for discharged newborns and children

For Newborn discharged after hospitalisation

All SNCU discharged newborns would be scheduled for follow-up visits at the facility on the **8th day, 1 month, 3 months, 6 months, and 12 months of age** for growth monitoring, developmental assessment, feeding review, immunization check, and early complication detection. Hearing and vision screening as per guidelines is performed, enabling early detection of hearing and vision impairments, timely referral, follow-up, and parental counselling to prevent developmental delays.

If the newborn cannot be taken to the SNCU at the district level, the ASHA would counsel and facilitate the family to have the infant examined at the nearest available health facility. A list of all SNCU/NBSU-discharged newborns ("SNCU/NBSU graduates") would be shared with both ANM & CHO, MO I/C of PHC and the block RBSK-MHT team to support service convergence & follow up of these SNCU/NBSU graduates at the District Early Intervention Centre (DEIC) under RBSK programme. These follow-up requirements will be reinforced during ASHA training sessions.

For Child discharged after hospitalisation

Children discharged from the Nutrition Rehabilitation Centre (NRC), District Early Intervention Centre (DEIC), or those who were earlier treated in the Special Newborn Care Unit (SNCU) or identified with defects at birth or developmental delays require special attention and close follow ups. These children are at higher risk of growth faltering, malnutrition (SAM & MAM), and repeated infections and developmental delays.

In addition to the regular SSBSK home visits by ASHA, these children must attend facility-based follow-up visits as advised at the time of discharge. ASHA would counsel caregivers on the importance of these follow-up visits, maintain and remind caregivers of the schedule, and help them reach the facility. ASHA training packages will include & emphasise the importance of these facility follow-ups.

4.7 Protocols for management of 'At-risk' newborns and children

Figure 4.2: Protocol for management of 'At-risk' newborn

'At-risk' Newborn
(Low birth weight / preterm, Not-breastfeeding, SNCU discharged, Congenital malformations, Low weight for Age)

Assess for any illness

If signs of serious illness/danger signs*

YES

- Inform ANM/CHO/MO
- Counsel family about need of immediate referral
- Linkages with Comprehensive Lactation Management Centres (CLMC) are established to facilitate availability of safe, pasteurized Donor Human Milk for feeding of sick, preterm and low birth weight babies admitted in Neonatal Intensive Care Units and Special Newborn Care Units
- Arrange transport for referral of mother –infant dyad to a nearest health facility.
- Treat to prevent low blood sugar.
- Advise the mother to continue KMC & BF during transport to health facility.

NO

Check temperature, count respiratory rate, heart rate & for any blue/yellow coloration

DISCHARGED

If newborn weighs <2500 gms	• Promote, counsel & demonstrate KMC to mother/ care giver (Skin to skin contact for ≥8 hours/day or as much as possible) to keep baby • When not in KMC position: Advise 2-layer clothing with head and feet covered, and protect from direct airflow, Demonstrate baby wrapping to family members • If further referral needed due to a danger sign, refer mother & baby dyad to nearest health facility & advice mother to continue KMC and breastfeeding during transport
Assess and support Breastfeeding	• Promote correct attachment & positioning of baby • Counsel mother to feed 10-12 times in a day & night (in every 2 hours) • Counsel to wake the newborn if not fed in last 3 hours by gentle stimulation • Counsel to feed fully from one breast before switching to other
If newborn on Expressed breast milk, check if newborn is being fed with katori and paladai (advise not to use bottle)	
For SNCU discharged	Check and encourage continuation of KMC as many hours as possible per day; advise to continue prescribed care, medications & continue breast feeding Encourage follow up visits to SNCU as per schedule given in discharge ticket
Assess and support mother's health & nutrition	• Counsel mother to take 3 main meals and 1-2 nutritious snacks daily to support breast feeding • Refer if mother has any complications like fever, cough >2 weeks. • Counsel mother for continued intake of IFA, Calcium and medicines if any prescribed • In vulnerable households, assess mother's nutritional support and link to available government schemes
Counsel for hand hygiene practices, timely immunization, nurturing care (parenting tips) & promptly seeking help in case of any of danger signs	
Assess family situation & support	• Counsel family members (Grandmother, Husband) about importance of family support for mother to practice exclusive breastfeeding, and for her emotional wellbeing of mother
Child is not gaining weight	• Follow up every week till child has weight gain on two consecutive visits. • If no weight gains despite support– ANM/CHO would help mother in feeding in cross-cradle position. If that is also not effective –refer to a health facility • If no weight gains despite help by ANM/CHO –refer to SNCU/health facility for the management

Figure 4.3: Protocol for management of 'At-risk' Child

'At-risk' Child
Low Weight for Age, Recurrent illness, Development Delay or NRC discharge

Assess for any illness

If signs of serious illness/danger signs*

YES

- Refer to CHO/ MO
- Counsel family about need of immediate referral
- Arrange transport for referral of mother –infant dyad to a nearest health facility
- Treat to prevent low blood sugar.
- Advise the mother how to keep the infant warm on the way to the hospital.
- Refer URGENTLY to hospital

NO

Check temperature & count respiratory rate

DISCHARGED

Assess Breastfeeding	• correct attachment positioning wherever needed, • counsel mother to feed 8-10 times in a day & night, on demand (whenever child feeding cues are there) and • feed fully from one breast before switching to other • look for any other condition that hinder breastfeeding
If newborn on EBM	check if mother able to express enough milk, & newborn being fed with katori and spoon If newborn on top feed (and cannot receive breastmilk)- advise non diluted milk, encourage feeding with katori and spoon (no bottle use)
Check for conditions interfering with feeding (eg; cleft lip/palate)	
Assess mother's health & Nutrition-	• Counsel mother to take 3 main meals & 1-2 snacks with good food diversity. • Refer if mother has any serious illness like fever, cough >2 weeks. • Counsel for timely intake of IFA, Calcium and medicines if any prescribed
Assess family situation & provide support:	• Counsel family members (Grandmother, Husband) about importance of family support for practicing exclusive breastfeeding • Counsel for hand hygiene, timely immunization, development supportive practices (sensory stimulation) & seeking help in case of any of danger signs
Child is not gaining weight/ NRC discharge	• Follow up weekly till there is documented weight gain on two consecutive visits. • If no weight gains despite help– refer to SNCU/health facility for the management • Counsel on follow up at NRC in cases of NRC discharged child.
In cases of recurrent illness.	• Counsel on need for further investigations and referral to higher health facility in cases of recurrent illness.
Developmental delay	• Counsel on referral to higher health facility for further assessment by pediatrician. • Counsel on follow up at NRC in cases of NRC discharged child.

4.8 Role of Ayushman Arogya Mandir (AAM) in newborn & child health

AAM serve as the primary contact points for newborn and child healthcare, ensuring early screening, timely intervention, and continuity of care. The key responsibilities of AAM in newborn and child health include:

- Providing essential newborn care if AAM-SHC is a delivery point, including immediate drying, delayed cord clamping, skin-to-skin contact, early initiation of breastfeeding, and administration of Vitamin K.
- Ensuring immunization services as per the National Immunization Schedule.
- Promoting exclusive breastfeeding and counselling on Infant and Young Child Feeding (IYCF) practices.
- Outpatient management of sick young infants and children for all illnesses as per IMNCI protocol including assessment, classification, and management.
- Provision of follow-up care of children discharged from higher health facilities
- Screening, early management, timely referral and follow-up care for nutritional disorders including childhood undernutrition deficiencies, overweight and obesity related problems in children.
- Use and validate records of children in the Mother and Child Protection (MCP) card with focus on growth monitoring.
- Conducting health promotion and preventive interventions such as deworming, Vitamin A supplementation, and Anemia Mukt Bharat (AMB) initiatives.
- Home visits by ASHAs and ANMs in the catchment area. Support ASHA/Multi-Purpose Worker (MPW) maintain line list of all newborns (delivered at home and institution both), infants, children especially those vulnerable newborns – NBSU/SNCU/NRC discharged, children identified with any of the 4Ds under RBSK, children with early growth faltering etc.

Ayushman Arogya Mandir (AAM)

- Check that the records of newborn and children, are maintained in reporting formats, integrated Reproductive and Child Health (RCH) register/JANANI Portal and updated regularly.
- Support ASHA, ASHA Facilitators and MPW for maintaining functional items as per guidelines and proper use of SSBSK kit during each home visit. Check that the child health related medicines, consumables, reagents, and logistics are in adequate stock at the AAM-SHC.
- Capacity building of ASHAs and ANM during team meeting at AAM-SHC/PHC
- Conducting monthly meetings with MPW and ASHAs at the AAM-SHC for assessing progress on mother and child health related outcomes, identifying and addressing gaps in services and records, discussing common barriers as well as good practices.
- Facilitate multi-sectoral convergence for community level action on health promotion and prevention with support of ASHA, MPW, AWW, VHSNC, Panchayat/tribal groups and VHSND sessions. Organise health camps/special health education drives/health promotion campaigns/activities.

Figure 4.4: Linkages of 'At-risk' child with Comprehensive primary health care

Active Identification of 'At-risk' Child during home visits

- **Responsibilities:** By ASHA
- **When:** During scheduled home visits
- **What to do:**
  - Screen child for risk factors
  - Mark as 'At-risk' in the MCP Card and Home Visit card and develop a line list
  - Keep providing the routine home visits and more focused nurturing care counselling
  - Fill a **Referral Slip** using the standard format (tick boxes + remarks).
  - Inform caregiver to visit AAM on next VHSND or well-baby session day.

Referral & Facilitation to Primary Health Facilities

- **Responsibilities:** ASHA (with CHO/ANM support)
- **When:** Immediate and prompt
- **What to do:**
  - Accompany the caregiver and child to the nearest AAM during VHSND or designated OPD
  - If not possible, tele-call to CHO and prioritise the visit.
  - Check that the referral slip and MCP card are carried during the visit.

Assess & Manage at Facilities

- **Responsibilities:** CHO,MO at AAM or PHC
- **What to do:**
  - Check reason for referral
  - Re assess weight, length/height, immunization status, and milestone chart in MCP Card.
  - Assess, diagnose and classify risk (e.g., SAM/MAM, developmentally delayed, birth defect etc.) and vitals.
  - Connect them to provide treatment/counselling or **refer further to RBSK- MHT/ NRC/DEIC** as needed. Fill the **Back-Referral Note** and hand over to caregiver/ASHA.

Document & share Feedback

- **Responsibilities:** CHO → ASHA + PHC team
- **What to do:**
  - Update child's records in **CPHC portal and support reporting in HMIS**
  - Share action taken and follow-up instructions with ASHA.
  - Encourage ANM updates the MCP Card and Sub-Centre Register.

Promote follow up at home

- **Responsibilities:** ASHA (with ANM /CHO supervision)
- **When:** As per home visit schedule or earlier if specified by CHO/MOIC in the treatment card
- **What to do:**
  - Reinforce advice given (feeding, care practices, treatment compliance).
  - Monitor response to treatment or referrals.
  - Inform immediately to ANM/CHO, if condition worsens or referral is not completed
  - Maintain child's follow-up schedule and report during sector meetings.

4.9 Financial provision under SSBSK programme

A) ASHA Incentives:

ASHA will be entitled for financial incentives to conduct scheduled home visits for all newborns & young children up to 3 years of age under SSBSK programme.

Additional incentives will be provisioned for identification and follow up of 'At-risk' newborn and young children during home visits

ASHA will also receive entitled incentives for identification and timely referral of high-risk postnatal mother, ensuring healthy outcome for both mother and baby after completion of post-natal period.

B) Financial Incentives for family:

Family of 'At-risk' newborns will receive financial incentives to support facility follow-up visit within 8 days of life/ day of discharge from health facility [Health Facility type: CHC-FRU, SDH & DH having facility of Paediatric & Newborn care services].

Arna prasan ceremony- significant for complementary feeding

4.10 Framework to identify the high-risk post-natal mother

The high-risk mother identified during post-natal period may be a pre-identified high-risk pregnancy (HRP during antenatal period) or may develop complications for the first time during post-natal period.

Pre-identified HRP:

Post-natal mothers who were already identified and managed as HRP during their ANC/PMSMA/e-PMSMA visit

- If post-natal mother was already identified as high-risk pregnancy during her e-PMSMA visit, the concerned ASHA will make home visits as per the SSBSK schedule and shall be entitled for the incentives per HRP for healthy outcome of both mother and newborn at 45th day of delivery, under extended PMSMA scheme.

HRP identified in post-natal period:

Post-natal mothers who were normal throughout their ANC (antenatal care) period but were identified as high-risk during home visits by ASHA.

- If post-natal mother was normal throughout her ANC period but was later screened positive for any of the danger signs during HBNC visits by ASHA, she will be referred to the nearest healthcare facility/PMSMA session for diagnosis and further management.
- Such identified woman shall be referred for management and follow-ups by MO/OBGY at the PMSMA session days till complete management Post natal high-risk women is entitled to use transport and in-facility services under JSSK.
- Subsequent to confirmation and management of the high-risk condition by the Medical Officer/OBGY specialist, and on achieving a healthy outcome for both mother and the baby, the concerned ASHA will be incentivized per high-risk post-natal mother, after 45th day of delivery.

The high-risk conditions to look for in a postnatal mother:

1. Fever
2. Severe anemia (Excessive bleeding (changing pad 5 or more/ day), presence of giddiness, paleness, weakness)
3. Urinary Tract Infection (High fever >102°F, burning urination)
4. Vaginal Infection (Foul smelling white discharge, fever >100°F)
5. Abdominal pain
6. Neurological symptoms (Blurred vision / Convulsion/ Speaking Abnormally)
7. Oedema of face, hands and legs
8. Difficulty in breathing
9. Jaundice
10. Incontinence of stool and urine

Steps to be followed during referral of a high-risk postnatal mother

Any high-risk condition in postpartum period warrants immediate attention and referral. After the identification, referral process includes – Documentation, Communication, Preliminary Management, Transport and Follow Up of high-risk mother during PNC visits. ASHA would arrange free referral transport under JSSK in consultation with ANM/CHO.

In case of emergency, a prior information would be shared with referral centre/concerned nodal officer by the ANM.

ASHA/ANM would accompany the postnatal mother in case of emergency and would Encourage that all ANC and delivery records are carried by the postnatal mother while being referred.

Follow up, after the referral by CHO/ANM and ASHA, needs to be supported.

Mother's counselling on nutrition in post-natal word and in paediatric ward

05 Chapter SSBSK Programme in Urban Settings

5.1 Urban Health: A Focused Approach

Urban vulnerable communities, particularly in slums and informal settlements, face significant health challenges due to inadequate healthcare access, poor sanitation, and overcrowding, with women and children being disproportionately affected. SSBSK programme is crucial in delivering essential postpartum and child health services to these groups.

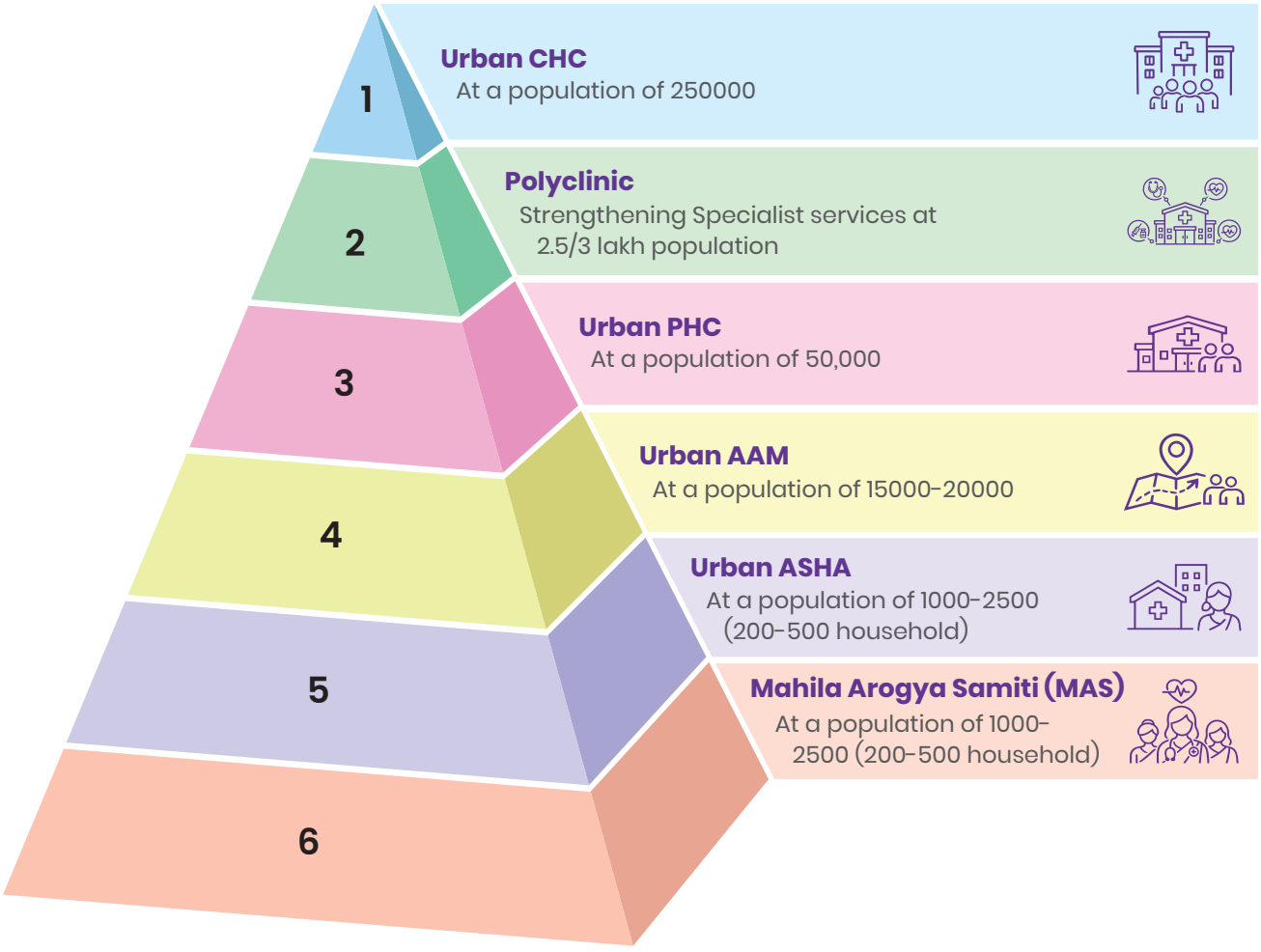
Mobile health interventions, digital tracking of high-risk newborns, community support networks, and strengthened linkages with urban health services, involving ASHAs, Mahila Arogya Samitis, in coordination with other departments will help in effective implementation of the programme in urban contexts to strengthen comprehensive care.

Every new life deserves the best start

5.2 Background

The National Urban Health Mission (NUHM) is a flagship initiative of the Ministry of Health and Family Welfare (MoHFW) to improve urban health outcomes through inter-sectoral convergence. It mandates focus on reaching out to urban communities and vulnerable sections with ASHAs through community processes like Mahila Arogya Samitis, health melas, and Urban Health & Nutrition Days (UHNDs) devised with a multi sectoral approach to play a critical role in prevention and health promotion.

Figure 5.1: Urban Health Care System and the Coverage



As per ASHA update 22-23, close to 0.8 Lakh ASHAs are in urban areas which is approximately one ASHA serves more than 2000 population.

Nearly 71% of all urban ASHAs are trained in 4 rounds of module 6&7, 75% are trained in NCD whereas only 50% are trained in HBYC. The states &UT have constituted 85% of MAS and 67% of JAS against target.

Trained and skilled ASHA during home visit

Urban Primary Health Centres (U-PHCs) act as the first point of referral for cases identified by ASHA during home visits/through ANM during routine immunization (RI) session/ at Urban Ayushman Arogya Mandir (UAAM). Urban Ayushman Arogya Mandir (U-AAM) is the first point of primary contact at the community level to provide comprehensive primary healthcare closer to the community. Use of teleconsultation services such as e-Sanjeevani, supports timely diagnosis, management, and referral decisions enhancing continuity and quality of care.

Role of Poly-Clinic: Polyclinics in urban settings will function as the primary specialist referral points under SSBSK, providing specialised paediatric and obstetric-gynaecology services, essential diagnostics, and follow-up care for newborns and young children. They act as referral hubs for mapped UPHCs/UAAMs, ensuring timely specialist consultation, follow-up care, and continuity of services for 'At-risk' newborns and young children through structured referral pathways.

Urban vulnerable communities, particularly those residing in slums and informal settlements, face multiple health challenges due to inadequate access to healthcare facilities, poor sanitation, and high population density. under the National Urban Health Mission (NUHM), home-based care is an important strategy to facilitate that essential maternal, newborn, and child healthcare services reach this vulnerable population.

Following are the considerations during implementation of home-based care of children under NUHM

1. In urban settings, there is **AAM-UPHC** (for **population of 50,000**), **AAM-USHC** (for **population of 15,000- 20,000**), **Polyclinic** (for **population: 2.5 – 3 lakhs**) and **UCHC** (for **population 2.5 lakh**)
2. An ASHA covers a **population ranging from 1000-2500** in urban areas
3. In areas where there is no dedicated ASHA Facilitator, the **Public Health Manager/ ANM** shall play the role of ASHA Facilitator
4. **Each ANM** is expected to provide services for a **population of 10,000** (or 2000 households). She will have 4-5 urban ASHAs under her supervision, each responsible for a population of 1000-2500 (200-500 households)
5. ANM will work closely as part of a **team**, which will include the **MO, staff nurse and other functionaries** at the UPHC, the Urban ASHAs she supervises and the AWWs in her catchment area.
6. In areas where there is no dedicated ASHA, the Public Health Manager needs to coordinate with the housing societies/areas with no resident welfare association (RWA)/societies by involving ANMs and other health workers so that no areas are left out.

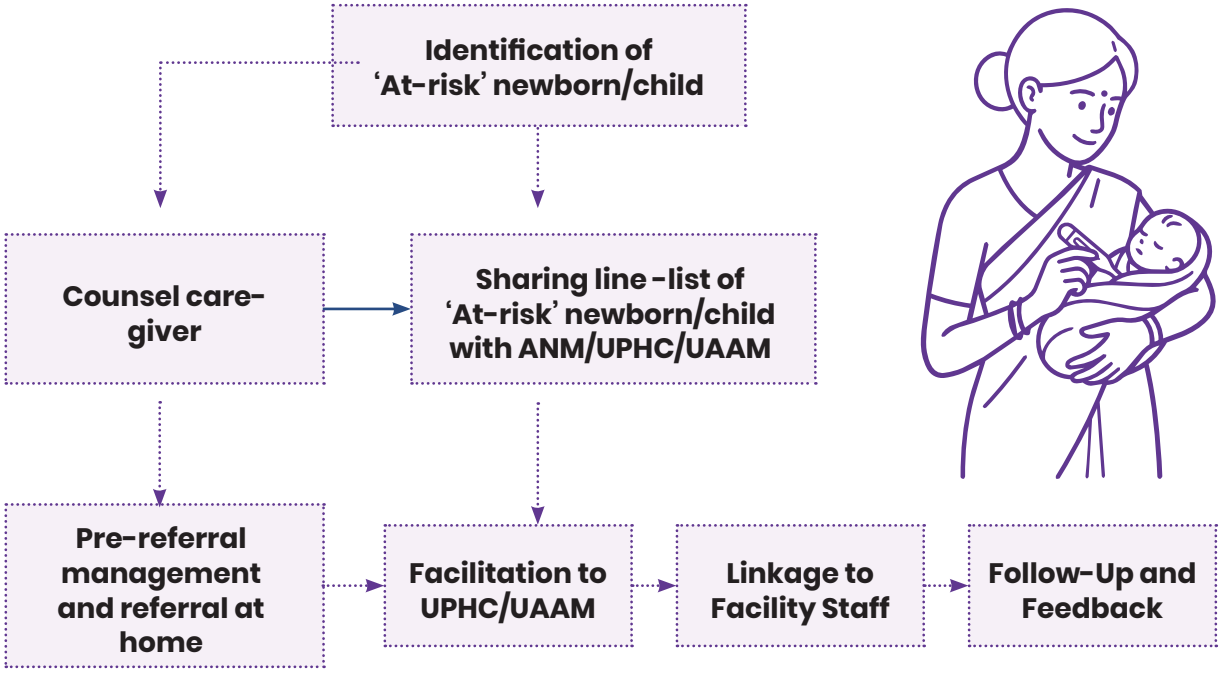
Mapping vulnerable pockets by Urban ASHAs

In her defined geographical area, lists and regularly updates the details of all households using Urban Health Index Register (UHIR) and in Slum Health Index Register identifies vulnerable families, 'At-risk' infants and others like malnutrition, incomplete immunization, untreated illnesses, or lack of parental support.

Structured Referral linkages to UPHC and Urban AAM: ASHAs with support from outreach (ANMs) and facility teams (Medical Officers and staff nurses) with ongoing training, closely collaborate between community and facility. Effective referral will also require standardized tools and discussion in review meetings at the UPHCs.

The scheduled home visits remain the same for both rural and urban settings under the SSBSK guidelines.

Figure 5.2: Steps in the Referral Pathway at community level during SSBSK visit



Identification of 'At-risk' newborn or young child/postnatal mother with danger signs during routine SSBSK visits

Sharing line list of 'At-risk' newborn and young child and registered postnatal mother with ANM and MO of UAAM.

Counselling of caregivers on care seeking, entitlements under schemes, home care in illness including nutrition, hygiene, and disease prevention.

Pre referral management and referral: Provide referral note and communication to the referred facility about the case if referral is from UPHC/UAAM.

Facilitation: ASHAs may accompany/arrange for the child & caregiver to reach the UPHC/UAAM, especially for those in vulnerable settings or the ones with danger signs.

Linkage to facility staff: on arrival, the ASHA connects the client with relevant staff.

Follow-up and feedback: After referral, ASHAs follows up with the family to support care seeking and to monitor compliance with the prescribed care.

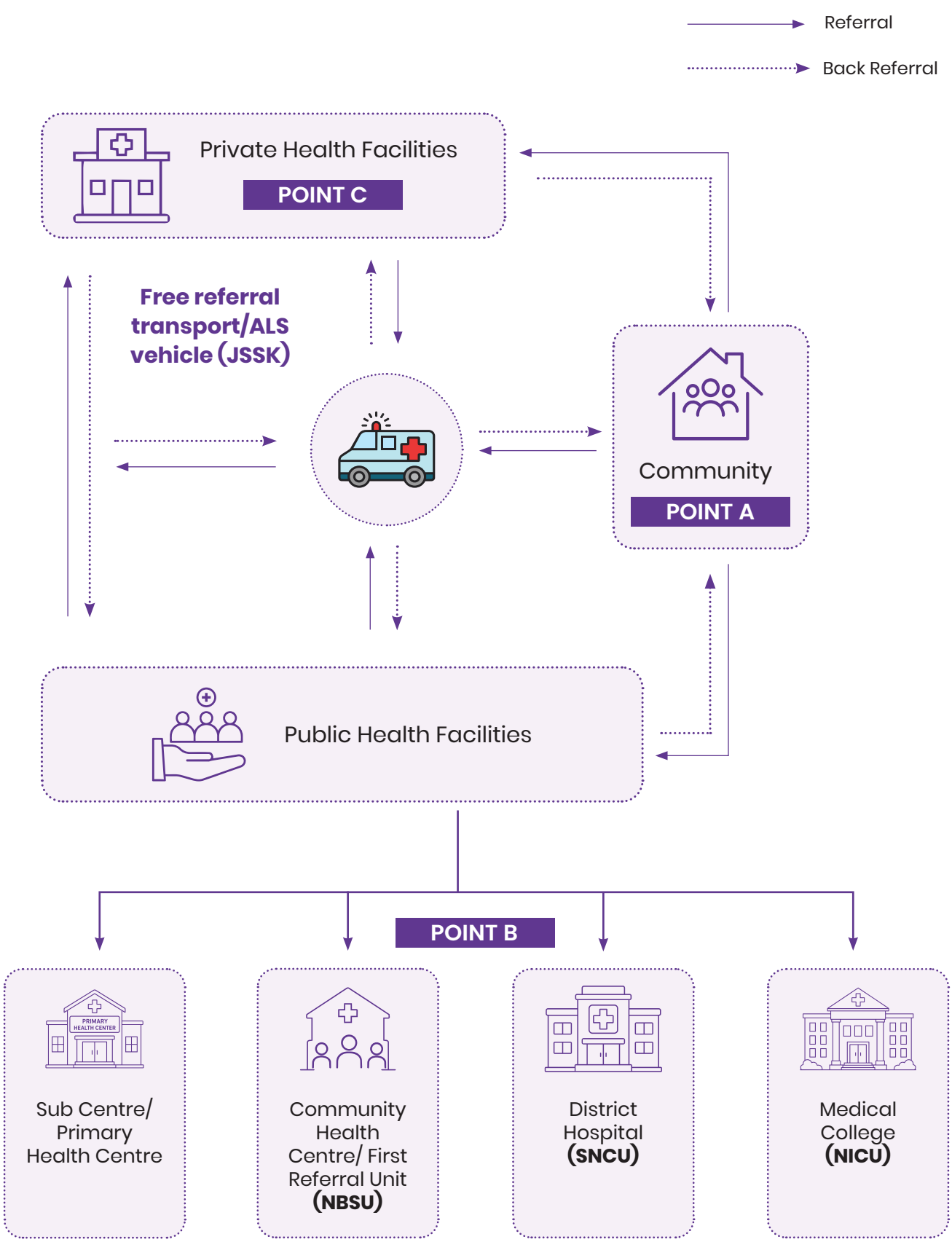
Key activities for referral pathways for facility care in urban PHCs/ AAM/Urban CHC/Polyclinics/Medical college/District hospital with functional NBSU/SNCU

Establish functional mapping of facilities of Urban PHCs/AAMs as the first level of care and Urban CHCs/Polyclinics/Medical college/District Hospitals as first referral units which are appropriately equipped. This mapping is dynamic, adapting with changes over time.

- Implement structured referral process such as:
  - Standardized referral documentation formats, referral registers to track referrals and outcomes at the facility to be provided.
  - Pre-referral communication between ASHAs, ANMs, and staff at facilities-polyclinics and DHs to facilitate
  - Availability for timely transport of referred newborn/ postnatal mother accompanied by ASHAs /family members when possible
  - Functional follow-up and back referral by communicating discharge plans to PHC/ AAM teams and ASHAs and ANMs
- Involve both Jan Arogya & Rogi Kalyan Samitis in supporting referral pathways by, facilitating transport to create a seamless continuum from community to facility care in urban areas.

Timely care and treatment is essential for every child in stress

Figure 5.3: Proposed Referral Pathway for Newborn Babies



5.3 Community platform Support

Mahila Arogya Samiti (MAS)

MAS plays a role in referring by building community-level support, communicates with the family during referral for care seeking, regarding available services and coordinating with providers to facilitate access to care at the urban PHC or AAM and, if needed, accompany them to appropriate health facilities.

Additional Support Functions

- Immediate reporting of any maternal/ child death/disease outbreak to the ASHA/ ANM or PHC medical officer to support community surveillance.
- Monitors the quality and equity of service delivery in the area by identifying service gaps.

Role of Jan Arogya Samitis (JAS) and Rogi Kalyan Samitis (RKS)

Screening, management, and follow-up of 'At-risk' newborn by facilitating coordination between health facility, Urban ASHAs, and ANMs by ensuring scheduled visits and promoting linkages with programmes like ***Rashtriya Bal Swasthya Karyakram*** (RBSK) and special newborn care units (SNCUs) by following activities:

Overseeing the early identification of danger signs and timely referrals at the facility, line-listing and documentation of 'At-risk' newborns

Facilitating that health facilities are equipped to support referrals and emergency care for newborn.

Mobilizing the community and generating participation and awareness to support the mothers and families for the newborn care practices and care of the 'At-risk' newborns.

Reviewing service delivery, referrals, and outreach activities in periodic meetings to monitor performance and identify any gaps in newborn care and follow-up.

Utilizing untied funds provided through RKS to address locally context relevant issues affecting newborn care, such as arranging transportation for referral or purchasing necessary equipment and supplies for newborn care.

RWA (Resident Welfare Association)

In urban and peri-urban areas, ASHA engages RWAs to promote awareness on newborn care, immunization, and risk signs, while ensuring support for follow-up visits to 'At-risk' children. RWAs help strengthen community accountability, facilitate health outreach events (such as Shishu Shivir), and improve coordination between families and the nearest AAM/urban health facility.

Figure 5.4: Monthly review meetings at UPHC and UAAM level

Serve as critical platforms to assess the implementation of referral protocols, completeness of follow-up care, resource needs, and capacity-building of ASHAs and facility staff to improve newborn health outcomes in urban areas. The areas to look into at UPHC level:

Supportive supervision at Urban PHC and Urban AAM: Joint visits of ASHA with ANM.

MO UPHC to **check data accuracy in beneficiary registers** (UHIR) and digital tracking tools both of GOI & State (i.e JANANI and e-kavach).

Review home visits data for coverage, referrals, and outcomes specifically for 'At-risk' newborns & babies

Share progress and challenges related to Samagra Shishu Bal Swasthya Karyakram (SSBSK) like supply availability, training needs, community acceptance, gaps in referral system and addressing delays or dropouts in care

Review of incentive payments and motivation of ASHAs in providing SSBSK services.

Build **coordination and communication between UPHC and ASHAs** and look into challenges faced by ASHAs

Counsel specially on breastfeeding support, KMC, early identification of danger signs, and referral for complications.

Review meetings at AAM-UPHC/AAM-UHSC level

Case discussions, **'At-risk' newborn referral, treatment and follow-up** including logistic and supply issues if any

Promote tele care through **e-Sanjeevani**

Orientation on **newborn care services, monitoring of growth & development, nutrition and immunization.**

Strengthening **linkages with secondary/ tertiary care facilities** for appropriate care.

Program review is important for better implementation

06 Chapter Institutional Mechanism

6.1 Overview of Institutional Mechanism

A structured institutional mechanism is required for building capacity, ensuring effective implementation, monitoring, and providing supportive supervision of ASHAs. Strengthening support structures at the state, district, block, sub-block and AAM levels, and establishing strategic Civil Society partnerships, is important for sustaining and expanding the SSBSK programme.

AAM serving in the remote border areas

6.2 Institutional Structure at Different Levels

I. National Level

National Programme Team (NHM, MoHFW, NHSRC)

The Child Health Division MoHFW, in coordination with Maternal Health & Nutrition Division of MoHFW along with NHSRC, will provide strategic direction, technical support, and policy guidance for the Samagra Shishu Bal Swasthya Karyakram (SSBSK) programme. Their responsibilities will include facilitating capacity building through National-level training and cascade training support, and ensuring robust monitoring and evaluation mechanisms to track programme performance and outcomes and undertaking periodic field visits to review and strengthen programme implementation.

Technical Advisory Group

The Technical Advisory Group (TAG) constituted to support Child Health division, MoHFW will provide guidance and support for implementation, mentoring & monitoring of SSBSK programme.

II. State Level

State Mentoring Group for ASHA and Community Processes

The group is composed of experts and practitioners from community health, academia, medical colleges, Child Health Nodal officer, Civil Societies, and urban health specialists. They provide strategic guidance for the effective implementation of SSBSK, ensuring a collaborative and comprehensive approach to improving maternal and child health outcomes.

State Management Team (Housed within SPMU)

The Nodal Officer of Child Health and Maternal Health programme in coordination with State ASHA and Community process team is responsible for planning, implementation and supervision of Samagra Shishu Bal Swasthya Karyakram (SSBSK) programme including ASHA training. Their role is to facilitate the efficient implementation and monitoring of services and promoting effective community health practices under SSBSK.

State ASHA and Community Processes Resource Centre

Provide technical support data management, monitoring & supportive supervision and capacity-building efforts for ASHAs under SSBSK Programme.

The State Training Team

Consists of dedicated state level ASHA master-trainers who are responsible for Samagra Shishu Bal Swasthya Karyakram (SSBSK) training of ASHAs.

State Institutes of Health and Family Welfare (SIHFW) and State Health Systems Resource Centers (SHSRC)

Play a key role in providing these trainers, and they can also be leveraged to conduct state-level Training of Trainers (TOT) programmes. This collaborative approach strengthens a structured and comprehensive training system for ASHAs across the state.

III. District Level

District Coordination Committee for ASHA and Community Processes

Operates under the District Health Society and is led by the Chief Medical & Health Officer (CM&HO) and District Child Health Nodal Officer supported by District Community process nodal officer. It includes members from the District Mentoring Group, programme officers, district training sites, and the District Planning and Monitoring Committee. The committee is responsible for overseeing the implementation of Samagra Shishu Bal Swasthya Karyakram (SSBSK) and monitoring ASHA performance to promote effective service delivery.

The District ASHA and Community Processes Team

consists of the District Community Mobilizer, District Data Assistant, and all Block Community Mobilizers.

The District Training Team

Includes District/ASHA Master Trainers who are responsible for facilitating SSBSK training at the district level. Together, these teams facilitate the smooth implementation of community processes and the effective delivery of training programmes.

IV. Block Level

The Block ASHA and Community Processes Team is led by the Block Medical Officer (BMO)/Nodal Officer and includes the Block Community Mobilizer/Block Community Programme Manager, along with all ASHA Facilitators and Child Health Nodal Officer. This team is responsible for supervising ASHAs in the delivery of services, ensuring quality implementation at the block level.

V. Sub-Block Level

One ASHA Facilitator supervises a cluster of 15-20 ASHAs, with a reduced number of 10 in challenging terrains such as hilly or tribal areas. ASHAs are considered the primary healthcare team for AAM-SHC and PHC. In non-high focus states and Union Territories, a second ANM at the SHC may assist ASHAs in their roles.

VI. Urban Level

Urban Committee for ASHAs and Community Processes Team

A dedicated team for Urban settings, consists of:

- Urban Medical & Health Officer
- Urban Public Health Manager/Urban Health Coordinator
- Urban Community Mobilizer (Urban ASHA)
- Accounts Executive or Data Assistant

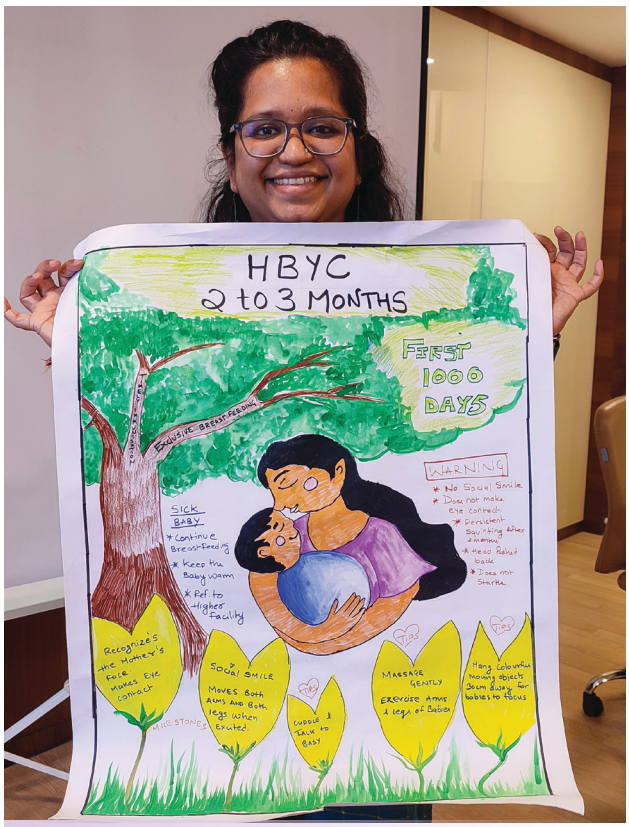
ASHAs in urban settings to receive support from ANMs and Urban ASHA Facilitators where available.

Role of Civil Societies in Community Processes for SSBSK

The City/District Health Society would collaborate with Civil Societies with proven expertise in community health processes to enhance the effectiveness of ASHAs. These Civil Societies can be assigned specific zones for training and mentoring ASHAs, ensuring that their interventions contribute to implementation of SSBSK.

Contribution from Medical Colleges, Academia and Researchers

Technical oversight and support for high quality training, monitoring, evaluation and learning, and implementation research would be crucial for the mid-course correction and success of the multidimensional and intersectoral approach being pursued by the SSBSK. Accordingly, the States can identify and empanel the support of experts from medical colleges, academic and research institutions.



Transforming knowledge into action— ToT participant from HBNC & HBYC training

6.3 Institutional support from different levels

	State Level	District and Block Level
 **Capacity Building**	• Development of SSBSK training plan • State-level master trainers conduct Training of Trainers (ToTs).	• Training sessions for ASHA master trainers and ASHA Facilitators on key domains • Periodic refresher training sessions to update skills and knowledge in identified gaps areas.
 **Monitoring and Supervision**	• Use of digital platforms for digital tracking of ASHA visits and service delivery. • Performance review meetings at state level meetings. • Supportive supervision visits by State teams.	• Monthly ASHA performance assessment by ASHA Facilitators with reporting connectivity to VHSNC, JAS, Block/district/state nodal officers. • Community-based feedback mechanisms for service quality improvement in JAS.
 **Incentives and Support for ASHAs**		• Incentives for SSBSK visits • Provision of SSBSK kits and job aids for ASHAs. • Recognition mechanisms for high-performing ASHAs

6.4 Capacity Building

The success of SSBSK depends on the capacity of frontline health workers, including ASHAs, ANMs, AWW, CHOs, MOs, Urban health consultant and ASHA Facilitators/ Sangini/ Supervisors. This training strategy aims to strengthen their skills and knowledge for providing effective home-based care for children up to 3 years of age, ensuring improved survival, growth, and development.

Objectives

1. Reinforce and enhance the knowledge and skills of ASHAs, AFs, ANMs, AWWs in home-based care components under SSBSK
2. Provide hands-on practice and role clarity among ASHAs, ANMs, CHOs, ASHA Facilitators/ Sangini/ Supervisors and AWWs for effective implementation.
3. facilitate skill retention through periodic refresher trainings.
4. Build synergy between various cadres to promote a holistic approach for SSBSK under RMNCAH+N interventions

Types of Training (A part of Integrated Training Package)

An integrated integrated training package for ASHAs, ANMs and CHOs has now been developed, ensuring a holistic care model which includes home-based care for newborns, young child and post-natal care for mothers. This integration enables that frontline health workers to receive comprehensive training on home-based care as a part of their overall responsibilities, equipping them with essential skills to provide seamless maternal and child health services.

A comprehensive training module covering key components of SSBSK	Target audience: ASHAs, ANMs, CHOs and ASHA Facilitators	AWW shall be part of the training for limited topics	Duration: 3 days (including theoretical and skill-based sessions).	Mode: Residential and non-residential training sessions, depending upon the feasibility and distance from ASHA's base location

Key Topics

1. 
Importance of home visits and revised schedule

2. 
Care of newborn and breastfeeding

3. 
Nurturing care for Early Childhood Development (ECD) with focus on responsive caregiving, age-appropriate play and communication.

4. 
Identification of 'At-risk' newborns and young children and extended support

5. 
Identification of danger signs and appropriate referral

6. 
Communication and counselling techniques

7. 
Optimal infant and young child feeding

8. 
Use of MCP cards for growth monitoring, identifying growth faltering and early action.

9. 
Prevention and management of common childhood illnesses (diarrhoea, pneumonia, malnutrition).

10. 

Demonstrate preparation/ administration of ORS and IFA

11. 
Infection prevention and handwashing techniques

12. 
Orientation on Shaishav App and digital recording and reporting formats

13. 
Integration of digital tools and job aids for effective counselling

Refresher Training for ASHAs, ANMs, and ASHA Facilitators

Periodic refresher training to reinforce knowledge and skills	Target audience: ASHAs, ASHA Facilitators, ANMs and CHO	Duration: 3 days
Mode: On-site, hands-on training with simulation-based learning (case studies, role play, videos, skill stations etc.)	Module used- Refresher Module	Target audience- Already trained ASHAs and AFs in SSBSK; ANMs and CHOs

Key Topics

1. All the topics will be covered in main training, however the refresher shall be more discussion-based, focusing on practical solution to the challenges faced during visits, case studies, role plays etc.
2. Review of HBCC components and updates
3. Practical demonstrations on newborn care and childhood interventions
4. Addressing barriers to behaviour change in communities
5. Use of Shaishav App and digital MCH card for tracking growth and development of children
6. Strengthening inter-sectoral coordination and referral mechanisms

Training Methodology

The training will follow a participatory, hands-on approach to support effective learning and skill-building among participants for implementation of SSBSK. A combination of interactive classroom training, practical demonstrations, field exposure, and filed based demonstrative learning will be employed. The methodology will also focus on peer learning, role-plays, case discussions, and the use of digital job aids to reinforce key concepts and best practices.

Classroom Training	Interactive sessions with facilitators using presentations, discussions, and case studies
Practical Demonstrations	Hands-on practice on skills require such as measuring temperature and weight, wrapping a newborn, Kangaroo Mother Care in low-birth-weight babies, recording vitals, assessment of 'At risk children', identification of sick newborn, referral protocols, ORS preparation, counselling and messaging for caregivers and mothers etc.
Field Practicum	Supervised home visits to reinforce skills in real settings. data collection and reporting and demonstration of HNBCC
Simulation-Based Learning	Role-plays and case scenarios for critical thinking, decision making and skill enhancement
Job Aids and IEC Materials	Optimal use of MCP cards, pictorial counselling aids, and audiovisuals (for danger signs in mother and newborn, and age-appropriate play and communication activities)

Training Cascade Model

National-Level Training of Trainers (ToT)	Will be conducted by MoHFW in collaboration with NHSRC at National level mobilizing the National pool of trainers
State-Level Training	Master trainers trained at the National level will conduct state-level ToTs focusing on the new content added to the programme and to the training modules
District-Level Training	State trainers will train district master trainers and district/ block health officials (DCPM/DCM or BCPM/BCM)
Block-Level Training	District trainers will train ASHAs, ANMs, AFs at the block level
Sector Meetings	Trained ANMs and ASHA Facilitators will conduct training sessions for ASHAs during regular monthly sector or PHC review meetings, based on gaps identified through field monitoring and supportive supervision. These sessions will be conducted in coordination with the MoIC-PHC. Additionally, some technical topics can be covered by the MoIC during these meetings. ANMs and ASHA Facilitators would coordinate with the MoIC to plan and facilitate these sessions effectively

Training Monitoring and Evaluation

- A schedule of training shall be planned in advance.
- SASHAKT portal/application shall be used for planning and monitoring all trainings
- The training plan shall be uploaded by the training in charge on the SASHAKT portal
- ASHAs will have the opportunity to volunteer for any training by registering on the SASHAKT portal. However, such registration will have to be authorized by the Training in charge before the ASHA reports for the scheduled training.
- Pre and post-training assessments to measure knowledge and skill enhancement.
- On-the-job mentoring and supportive supervision for skill reinforcement.
- Periodic refresher training every six months.
- Feedback mechanisms for continuous quality improvement
- State ASHA resource centre or District ASHA resource centre will monitor randomly at least 20% of the trainings of ASHA in a year for quality purposes
- In addition to the monitoring, State and district ASHA resource centres will also undertake 5% post training evaluations periodically

Supply Chain and Resource Availability

To facilitate effective implementation, timely availability of key supplies is essential:

- MCP cards for reiterating the information given in the MCP card and its practical use during home visits.
- Equipments and supplies required for the conducting skill stations- flexible doll, digital thermometer, weighing machine, cotton ball soaked in spirit (alcohol), blanket, clean cotton cloth, sari-blouse, gown or shawl/ Kangaroo care bag/ baby bag etc.
- ORS, IFA syrup, and other essential commodities.
- IEC materials, flipbooks, and digital counselling aids.
- Adequate training venues and logistics support.

Pilot testing of refresher training module on home based care

6.5 Supportive Supervision

The supportive supervision mechanism under the SSBSK programme has been developed to promote effective, timely, and quality delivery of newborn and child health services. Supportive supervision emphasizes continuous mentoring, problem-solving, skills reinforcement, and a team-based approach among frontline health workers (FLWs) for improved service delivery and outcomes.

Objectives of Supportive Supervision

The supportive supervision mechanism aims to achieve the following objectives:

1. Strengthen quality and coverage of SSBSK services through mentoring and performance monitoring of ASHAs and other FLWs
2. Enables timely identification, follow-up, and referral of "At-risk" newborns and sick young children
3. Promote family-centred newborn and maternal care practices through effective counselling and community engagement
4. Foster a problem-solving, team-based culture among FLWs by creating safe spaces for experience sharing and feedback
5. Enhance data quality and encourage its use for decision-making and programme improvement at all levels

Supportive supervision by ASHA Facilitator and ANM during the home visit to newborn

Supervisory Cadres and Roles

Supportive supervision under SSBSK will be carried out at multiple levels by designated cadres. Each cadre has defined roles, responsibilities, and supervisory frequencies, ensuring structured and continuous mentoring:

1

ASHA Facilitator/ASHA Supervisor

2

Auxiliary Nurse Midwife (ANM)

3

Community Health Officer (CHO)

4

Medical Officer (MO/ MoIC)

5

Urban health consultant (UHC)

6

Anganwadi Supervisor

Supportive Supervision Roles and Responsibilities by Cadre for SSBSK

The following table outlines the roles and responsibilities of each cadre in ensuring structured and supportive supervision at multiple levels under the SSBSK programme. The objective is to transition from an ASHA-centric approach to a more institutionalized, team-based system of newborn and child care, with clearly defined supervisory and accountability mechanisms across all cadre:

Table 6.1 : Summary of roles & responsibilities of supervisory Cadre under SSBSK

ASHA Facilitator/ ASHA Supervisor 	❯ Supervise 15–20 ASHAs and conducts at least one supervisory visit per ASHA per month. ❯ Mentor ASHAs during home visits, reinforcing skills on newborn care, counselling, and danger sign identification. ASHA would share the findings with concerned ANM and CHO and use these findings in sector/cluster meeting. ❯ Provide on-the-job mentoring on weighing, temperature recording, ORS/IFA administration, and maternal mental health screening. ❯ Review ASHA registers, home visit forms, and logistics, ensuring completeness and accuracy. ❯ Conduct joint supervisory visits to all 'At-risk' newborns and young children annually. ❯ Identify training gaps and recommends refresher sessions.

Auxiliary Nurse Midwife (ANM) 	• Supervise approximately five ASHAs within her assigned area (AAM-SHC). • Conduct at least one joint home visit per month with the ASHA Facilitator. • Review forms filled by ASHAs and provides timely, constructive feedback. • Joint home visits with ASHA & CHO/MO (in urban areas) to monitor follow-up of 'At-risk' newborns (Day 3, Day 7) and 'At-risk' children (during 3rd & 6th month) ensuring early detection of 'At-risk' conditions/complications and organise referral (if required). • Utilize VHSNDs to review performance and assess mobilization of postnatal mothers. • Enable correct entry of incentive claims and facilitates digital reporting.
Community Health Officer (CHO) 	**Facility-Based Newborn and Child Care** • Facilitate availability of appropriate equipment and provide essential newborn care at AAM-SHC delivery points • Conduct routine assessments for danger signs in newborns and infants and strengthen early intervention • Administer first-line treatment and stabilization for sick newborns prior to referral • Monitor growth assessments, immunization, and nutrition supplementation **Referral and Linkages** • Coordinate timely referrals of sick or 'At-risk' newborns and children to appropriate higher-level facilities, ensuring pre-referral stabilization including administration of necessary antibiotics and fluids • Maintain communication with MO I/C and higher referral units for efficient case management • Support tele-consultation through e-Sanjeevani for complex cases requiring specialist advice **Community-Based Care and Joint Home Visits** • **Conduct joint home visits with ASHA and ANM for 'At-risk' newborns (Day 3 and Day 7) and 'At-risk' young children (3rd and 6th month) to facilitate timely follow-up, early detection, and referral** • Validate ASHA messaging on breastfeeding, KMC, complementary feeding, and developmental milestones • Review growth charts and promote early stimulation and play-based counselling during visits

	Supervision, Capacity Building, and Data Management • Conduct monthly review and mentoring sessions with ANMs and ASHAs; discuss field observations from ANM and ASHA Facilitators to build ASHA capacity • Supervise screening and referral of sick newborns and children as per IMNCI protocols • Support quality counselling and service delivery during home and facility visits • Record newborn and child health indicators in the JANANI portal • Participate in VHSND/UHSND sessions for regular tracking of maternal and child health indicators • Coordinate with MO I/C for technical support and logistics management
Medical Officer (MO / MoIC) 	• Lead block-level technical review meetings with CHOs and ANMs; synthesise field observations from CHO, Anganwadi Supervisors, and ASHA Facilitators through the Block Community Mobiliser for corrective action • Supervise newborn care services at AAM-SHCs under the PHC and monitor implementation of the SSBSK programme • Conduct joint home visits with ANM and CHO under urban health settings for 'At-risk' newborns (Day 3 and Day 7) and 'At-risk' young children (3rd and 6th month) to promote early detection, management, and referral • Manage referrals for high-risk newborns and sick children to appropriate higher facilities, including SNCUs, NBSUs, and NRCs for SAM with medical complications • Review data quality, drug supply chains, SSBSK kit utilization, and availability of essential medicines and equipment at AAM • Provide on-the-job training and mentorship to CHOs, ASHAs, ANMs, and MPWs during sector and PHC review meetings • Facilitate convergence with ICDS and POSHAN Abhiyaan for growth monitoring and malnutrition management • Lead maternal and child death reviews for corrective action

Urban Health Consultants 	● Provide technical support to the City Health Society for effective SSBSK implementation as per NUHM norms. ● Strengthen referral linkages between ASHAs, UPHCs, Polyclinics, and tertiary facilities for 'At-risk' newborns and young children. ● Coordinate and support capacity-building and mentoring of Urban ASHAs and ANMs on SSBSK components. ● Monitor SSBSK performance using NUHM indicators and support gap-closure at UPHC and ward levels. ● Facilitate convergence with AWWs, MAS, Civil Societies, and ULBs to improve community outreach and service uptake.
Anganwadi Supervisor 	● Provide supportive supervision to AWWs in collaboration with NHM supervisors. ● Support convergence between AWWs and ASHAs for SSBSK service delivery. ● Monitor growth monitoring records and preschool activities at Anganwadi Centres. ● Participate in joint training and review meetings to strengthen coordination.

Platforms for Structured Supervision

Supervision activities are conducted through structured and platforms as below:

Joint Supportive Supervision Calendar: defining frequency and cadre-specific coverage for joint field visits. A structured PHC wise supervision plan will be developed by the block community mobiliser, to facilitate joint field visits by ANMs, ASHA Facilitators, and Anganwadi Supervisors ensuring fair and balanced distribution of field responsibilities among supervisors.

1. **Monthly Sector/Cluster and PHC Review Meetings:** for case discussions, data reviews, and mentoring.
2. **Digital Communication Channels (e.g., Social media groups like WhatsApp):** for real-time coordination, problem-solving, and referral follow-up. This platform will facilitate real-time communication to address daily field-level challenges under the supervision of the Mo/IC.

Monitoring, Feedback, and Capacity Building

Regular monitoring and feedback mechanisms are integral to the supportive supervision framework. Supervisory findings must be documented through standard checklists, discussed during monthly review meetings, and used to plan refresher trainings. Data validation and feedback loops would be maintained through digital dashboards at PHC, block, and district levels.

6.6 Institutional Mechanisms under Urban Settings

The State Programme Management Unit (SPMU), State Health System Resource Centres (SHSRC) and the State Institutes of Health and Family Welfare (SIHFW) will continue to play similar roles for the State as do their National counterparts for the Centre.

Urban Local Bodies (ULBs) such as Municipal Corporations (dedicated funds for public health and related activities), Municipalities, Municipal Councils, Nagar Palika, Notified Area Committee, Cantonment Boards, and similar entities would make an augmented representation at district level. Additional healthcare funds at all Urban Local Bodies will enhance Institutional infrastructures to address urban health needs, thereby promoting effective governance mechanisms.

Programme Management Units (PMUs) of NUHM at all level will work in collaboration, coordination and integration with the programme divisions and municipal corporations will implement the National programmes in the urban areas, health systems strengthening components such as infrastructure, human resources for health, quality, essential supply chain and equipment etc.

Urban AAM plays a critical role in urban maternal and child health care

Fathers are equally responsible for child's good health and nurturing care

07 Chapter Monitoring & Reporting

7.1 Monitoring of the programme

The progress of implementation of the SSBSK programme will be closely monitored by the MoHFW on a quarterly basis. State child health and community process nodal officers are to provide details of the status of ASHA training and equipment related to SSBSK along with details of the SSBSK visits and referrals made by ASHAs and the total expenditure on HBNC by the state.

The following are the key indicators for SSBSK programme:

A. Coverage & Reach

1 **% Newborns completed scheduled SSBSK home Visits (within 42 days)**

Numerator: *Number of newborns received scheduled SSBSK visit*
Denominator: *Number of live newborns*

2 **% of newborn identified as 'At-risk' against visited under SSBSK**

Numerator: *Number of newborns identified as 'At-risk'*
Denominator: *Number of newborns visited*

3 **% Young child received due scheduled of home visits under SSBSK (6 weeks to 36 months)**

Numerator: *Young-children 6 weeks to 36 months received SSBSK visits*
Denominator: *Number of young-child due for scheduled home visits (6 weeks to 36 months)*

4 **% of young child identified as 'At-risk' against visited due schedule under SSBSK**

Numerator: *Number of young children 6 weeks to 36 months identified as 'At-risk'*
Denominator: *Number of young-child (6 weeks to 36 months)due for scheduled home visits*

B. Service Delivery Quality

1 **% of 'At-risk' newborn received joint visits conducted by ANM & CHO as per SSBSK schedule (on 3rd & 7th Day)**

Numerator: *Number of 'At-risk' newborns received joint visits by ANM-CHO*
Denominator: *Number of At-risk newborns*

2 **% of 'At-risk' young children (6 weeks to 36 months) received joint visits by ANM & CHO as per SSBSK schedule (during 3rd & 6th month)**

Numerator: *Number of 'At-risk' young children (6 weeks to 36 months) received joint visits by ANM-CHO*
Denominator: *Number of At-risk young children(6 weeks to 36 months)*

3 **% of 'At-risk' newborn identified with danger signs**

Numerator: *Number of 'At-risk' newborns identified with danger signs*
Denominator: *Number of 'At-risk' newborns identified*

4 **% of 'At-risk' newborn referred to higher facility against identified with danger signs**

Numerator: *Number of 'At-risk' newborns with danger signs referred to higher facility*
Denominator: *Number of 'At-risk' newborns identified with danger signs*

5 **% of 'At-risk' newborn with danger signs got successfully discharged after treatment**

Numerator: *Number of 'At-risk' newborns successfully discharged after treatment*
Denominator: *Number of 'At-risk' newborns identified with danger signs*

6 **% 'At-risk' newborn received facility follow up post discharge (after treatment)**

Numerator: *Number of 'At-risk' newborns followed up at facility after discharge*
Denominator: *Number of 'At-risk' referred*

7 **% of 'At-risk' young children (6 weeks to 36 months) identified with danger signs**

Numerator: *Number of 'At-risk' children identified with danger signs*
Denominator: *Number of 'At-risk' children (6 weeks to 36 months)*

8 **% of 'At-risk' young children (6 weeks to 36 months) with danger signs referred to higher facility**

Numerator: *Number of 'At-risk' children referred to higher facility*
Denominator: *Number of 'At-risk' children identified with danger signs*

9 **% of 'At-risk' children with danger signs got successfully discharged after treatment**

Numerator: *Number of 'At-risk' children successfully discharged after treatment*
Denominator: *Number of 'At-risk' children identified with danger signs*

C. Post-natal mother, Nutrition & ECD

10 **% Children identified with growth faltering as per MCP card (stunting/wasting/ underweight i.e. SAM & MAM)**

Numerator: *Number of children identified with SAM/MAM/Growth faltering*
Denominator: *Number of children screened for growth faltering (6 weeks to 36 months)*

11 **% children identified with achieving delayed milestones**

Numerator: *Number of children fall under achieving delayed milestone*
Denominator: *Number of children screened for age-appropriate development milestone (6 weeks to 36 months)*

D. Effect of climate on Newborn & Children

12 **% caregivers of children (0–5 years) counselled by frontline workers on heat-related illness prevention during summer season**

Numerator: *Number of caregivers of children (0–5 years) who report receiving counselling from ASHA, ANM, AWW, or any health worker on protecting their child from heat-related illness during the summer season*
Denominator: *Total number of caregivers of children (0–5 years) contacted during the reference period*

13 **% caregivers of children (0–5 years) counselled by frontline workers on protecting their child from air pollution-related illness**

Numerator: *Number of caregivers of children (0–5 years) who report receiving counselling from ASHA, ANM, AWW, or any health worker on protecting their child from air pollution-related illness during the reference period*
Denominator: *Total number of caregivers of children (0–5 years) contacted during the reference period*

Dashboard Indicators for SSBSK

Newborn (Birth to 6 weeks)

1. Total number of live births in ASHA catchment area
2. Total number of At-Risk newborns identified
3. Total number of At-Risk newborns referred to higher facility
4. Total number of 'At-risk' newborn got scheduled joint visit by ANM & CHO (on 3rd & 7th day)
5. Total 'At-risk' newborn got successfully discharged from facility after treatment
6. Number of mothers (family) received wage loss compensation against newborn admission in facility

Young Child (6 weeks to 36 months)

7. Total number of 'At-risk' children identified
8. Total number of 'At-risk' children got scheduled joint visit by ANM & CHO (during 3rd & 6th month)
9. Total number of 'At-risk' children referred to higher facility
10. Total 'At-risk' children got successfully discharged from facility after treatment
11. Total number of children identified with key milestone delay/ warning sign

Others

12. Total number of postnatal mothers referred to higher facility on identification of danger signs
13. Caregivers counselled on heat-related illness prevention (children 0–5 years)
14. Caregivers counselled on air pollution-related illness prevention (children 0–5 years)

7.2 Components of the programme monitoring

Effective monitoring is central to ensuring quality implementation of the SSBSK programme, which integrates home-based newborn and child care from birth up to 36 months of age. Monitoring will be conducted at multiple levels—community, facility, block, district, state, and National—to promote accountability, performance review, and data-driven decision-making.

1. Child-wise Tracking and Digital Data Management

- Each newborn and young child will be registered under SSBSK with an ABHA ID, enabling longitudinal tracking from birth to 36 months and its linkages with POSHAN Tracker.
- All home visits conducted by ASHA will be documented in the SSBSK Home-Visit Card and entered into the digital tracking module integrated with the JANANI portal.
- The data system will capture details of: visit schedule adherence, risk categorization,referrals, counselling provided, and follow-up outcomes.
- States already maintaining digital HBNC/HBYC modules will transition to a unified SSBSK linked with HMIS for monitoring.

2. Step-wise Monitoring Process

1 **ASHA Level**

- ASHA will complete the home-visit in Shaishav App during every household visit for newborn or young child (0–36 months).
- The App will capture individual child and visit based information like date, risk status, counselling provided, danger-sign detection, and referral details.

2 **ASHA Facilitator / ANM Level**

- The ASHA Facilitator/ANM will verify during the monthly ASHA meeting after reviewing the number and quality of visits.
- Based on verified performance, a signed token/slip will be issued to the ASHA and submitted to the PHC staff (clerk/accountant) for incentive processing.
- Joint visits of 'At-risk' newborns & children by ANM & CHO/MO will be reviewed by block MO

3 **Primary Health Centre (PHC) / AAM Level:**

- Payments to ASHAs will be made by the PHC clerk/accountant after review and approval by the MO/CHO-AAM, based on validated reports and supervisory feedback.
- The CHO, along with the PHC Medical Officer, will facilitate robust reporting in the JANANI portal and HMIS portals, review monthly progress, and participate in VHSND/UHSND sessions for data validation and feedback.

4 **Block Level**

- The Block Programme Manager and Data Entry Operator will compile monthly data from all sub-centres.
- Block review meetings by block nodal officers – child health and community process will be held to analyse coverage indicators, referral completion, and performance of ASHAs and ANMs.
- Supervisory observations and feedback from ASHA Facilitators will be presented for corrective action.

5 **District Level**

- The District Nodal Officer (Child Health) in support from the District officer for community process will monitor implementation through monthly supervisors' meetings and field visits.
- The Chief Medical Officer (CMO) in support of District Nodal Officers Child Health and Community Process will review block-wise performance during district review meetings, focusing on process and output indicators (home-visit coverage, 'At-risk' tracking, and referrals).

6 **State Level**

- The State Nodal Officer (Child Health/ Community Process) will review programme performance through district presentations on a quarterly basis.
- The State Mission Director will review progress during the state-level CMO meetings, focusing on quality, data consistency, and corrective measures.

7 **National Level**

- The Child Health Division, MoHFW, supported by the National Health Systems Resource Centre (NHSRC), will monitor the implementation and effectiveness of SSBSK across states through quarterly data reviews and virtual review meetings.

3. Review and Feedback Mechanism

- Monthly AAM-level meetings will review data on home visits, 'At-risk' identification, referral follow-up, data completeness and supervisory observations from the AAM catchment area.
- Block and district reviews will focus on trend analysis, data completeness, and corrective actions for low-performing areas.
- State and National dashboards will generate reports on key process, output, and outcome indicators.

4. Performance Evaluation and Incentive Mechanism

- The team-based incentive system of MoHFW will be used for evaluation of ASHA, ANM, and AWW performance under SSBSK.
- Incentives will be linked to:
  - Completion of scheduled home visits,
  - Accurate documentation,
  - Timely referral of 'At-risk' cases, and
  - Achievement of child health, nutrition, and developmental milestones.

5. Continuous Quality Improvement Improvement Through Periodic Monitoring & Review

- Periodic monitoring through regular field visits, data analysis, and feedback at all levels will identify training gaps and performance issues.
- Findings will guide refresher training, supportive supervision, and problem-solving.
- Periodic review of data trends will inform programme planning, policy revision, and system strengthening so that every newborn and child under SSBSK receives quality, continuous, and risk-based care.

ASHA distributes ORS and Zinc at home for children

08 Chapter Digitisation of Services under the Programme

Decision Support System (DSS) Application

SSBSK delivers continuous, home-based care for every newborn and child from birth to 36 months through scheduled home visits by the ASHA, supported by the ANM, CHO and MO. To make this care timely, complete and accountable, the programme uses a Decision Support System (DSS) tracking tool. The application is built directly on the standard SSBSK home-visit formats (Form 1 to Form 6, given in annexures) and converts each recorded observation into prompt options, classifications and actions at the point of care.

The application is a mobile-based, offline-enabled digital tool, operated by ASHAs and ANMs/CHOs, for recording and tracking all newborns and young children during home visits and joint visits.

On doing entry of RCH/ABHA-ID or details of the child/mother, the demographic details and immunization status are auto-populated through integrated with JANANI portal.

At every visit the worker records observations against the standard checklist; the application interprets and guides the next step; assessment, counselling, referral or follow-up.

Design Principle: From Format to Decision Support

The SSBSK home-visit formats define the schedule of care by specifying what providers would assess, observe, and counsel during each contact with the mother, newborn, and child. The DSS application digitizes these formats and applies embedded care protocols, guiding providers on appropriate actions such as counselling, follow-up visits, continued care, or referral. This facilitates timely, complete, and consistent service delivery, early identification and follow-up of 'At-risk' children, prompt referral for danger signs, and targeted counselling to address identified gaps. The application works in the offline mode and data is backed up on the cloud once network is available.

Figure 8.1: Key features of the "Shaishav App"

Features of the Application

The application carries the following features, each derived from the SSBSK home-visit formats:

Feature	Description
Classification into 'At-risk' newborn and children	• Based on the observations, the DSS app classifies children into 'At-risk' newborns or 'At-risk' children • It opens up additional contact points and joint visits for the 'At-risk' case • It generates the list of 'At-risk' cases to share with ANwM, CHO and MO
Scheduling of home visits	• The app plans, schedules and tracks SSBSK visits and follow-up visits • It sends reminders for due and missed visits
Symptoms and danger signs	• The app presents the danger-sign checklist for the newborn, child and mother and opens up related educational videos • On any danger sign, it prompts an immediate referral • It indicates the place of referral based on facility mapping
Counsel-ling points on emerging gaps	• Based on the gaps that emerge during the visit, the app prompts the relevant counselling points • It guides the caregiver on feeding, caregiving, home safety and ma-ternal well-being focusing on mental health concerns
Joint visits and collaboration	• The app facilitates joint visits with ANM/CHO • It tracks collaboration and promotes continuity of care
Geo-enabled supervision	• The app records geo-tagged visits and activity • It supports supportive supervision in real time
Digital case management	• The app maintains child and family profiles and history in one place • It records 'At-risk' conditions, referrals and follow-ups against each case
Vulnerability assessment & New age issues in Child	• The app records the household vulnerability profile and prioritised follow-up • Captures new age issues and related counselling for children on; ▶ Screen time ▶ Effect of digital exposure on children ▶ Family involvement ▶ Effect of heat related illness and indoor air pollution
IEC & Education-al videos	• The app provides counselling videos at the point of care • Videos cover breastfeeding, KMC, wrapping, breast feeding hand washing, complementary feeding, ECD
Dashboard for Decision making & monitoring	• The app provides dashboards and reports • It gives quick insights for data-driven decisions and timely action • The app tracks ASHA/ANM/CHO performance and service coverage • It monitors key indicators for effective implementation

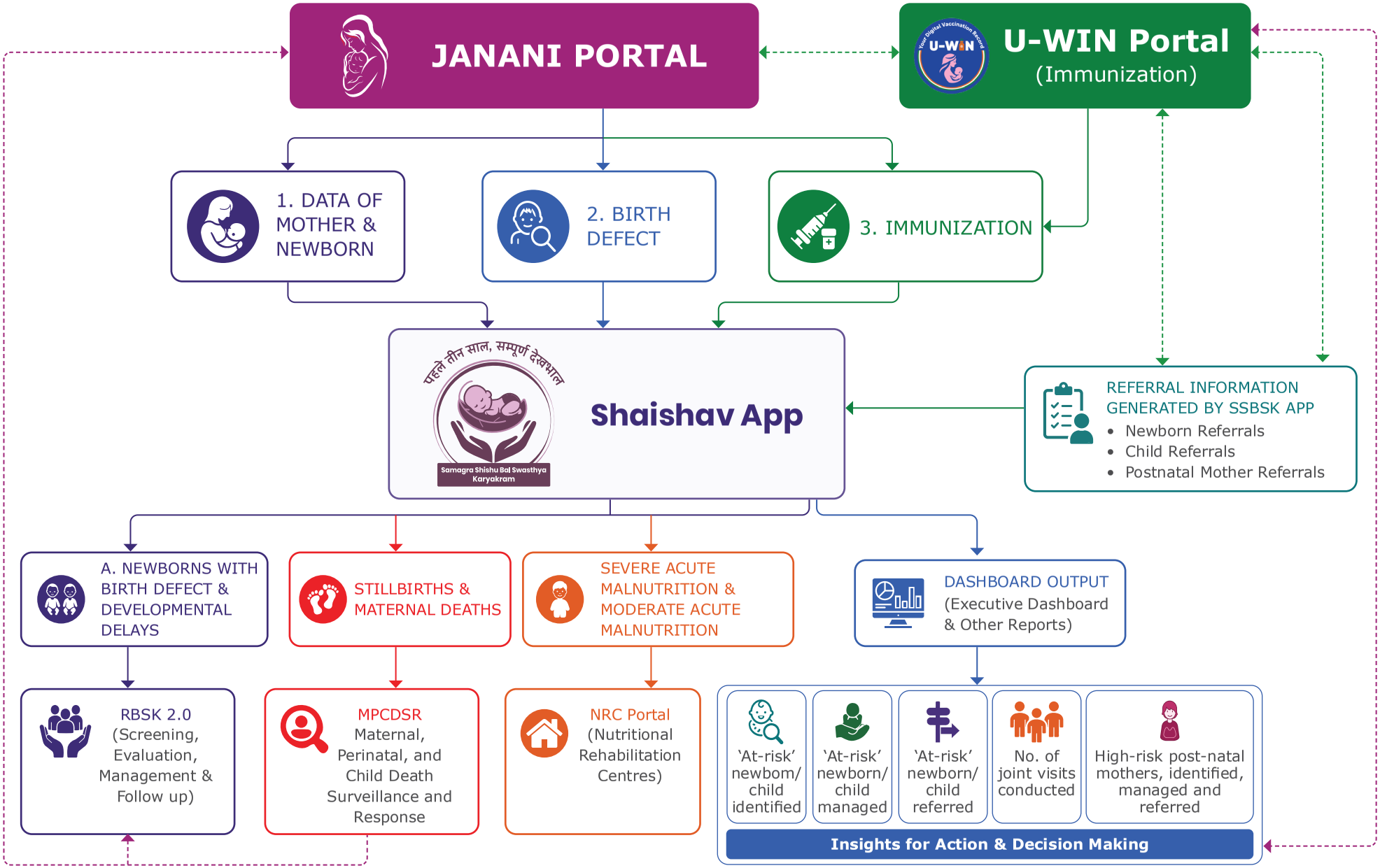
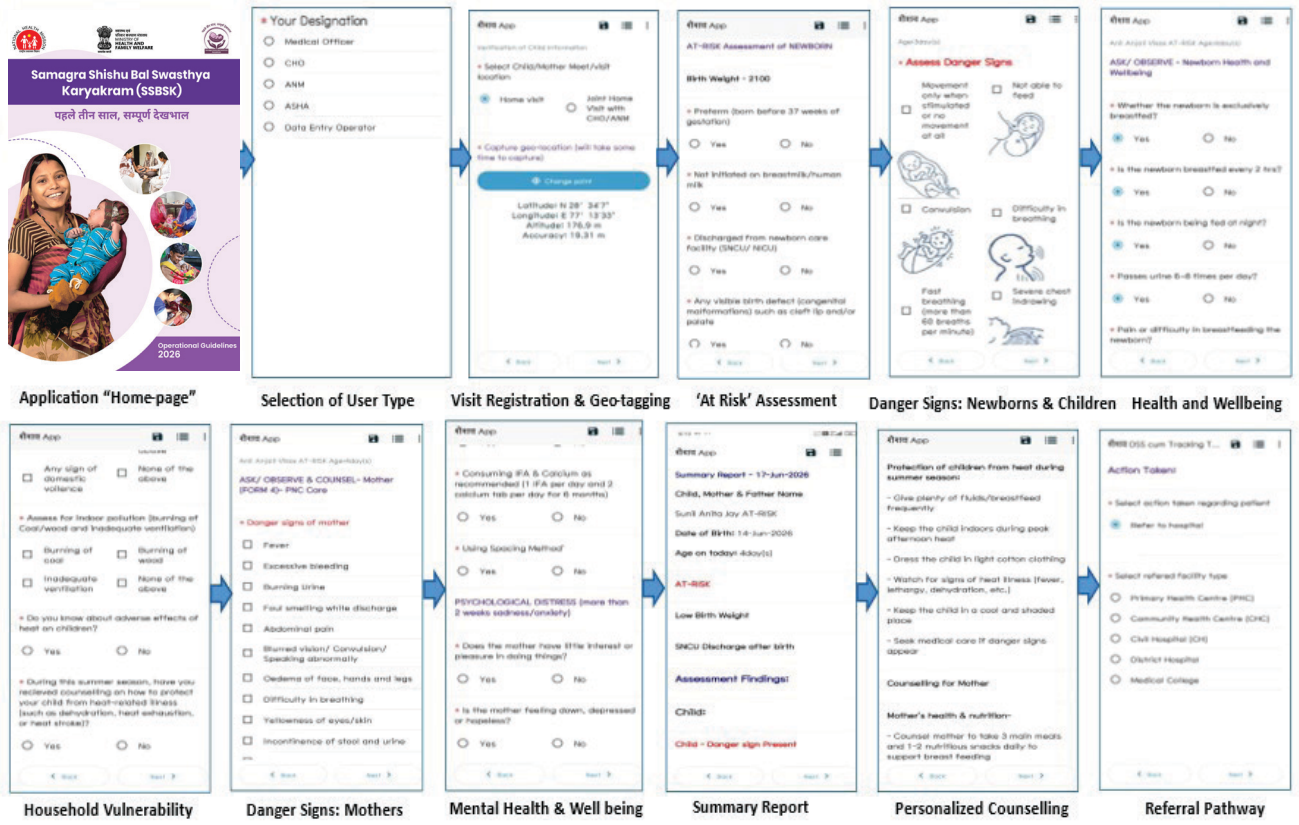
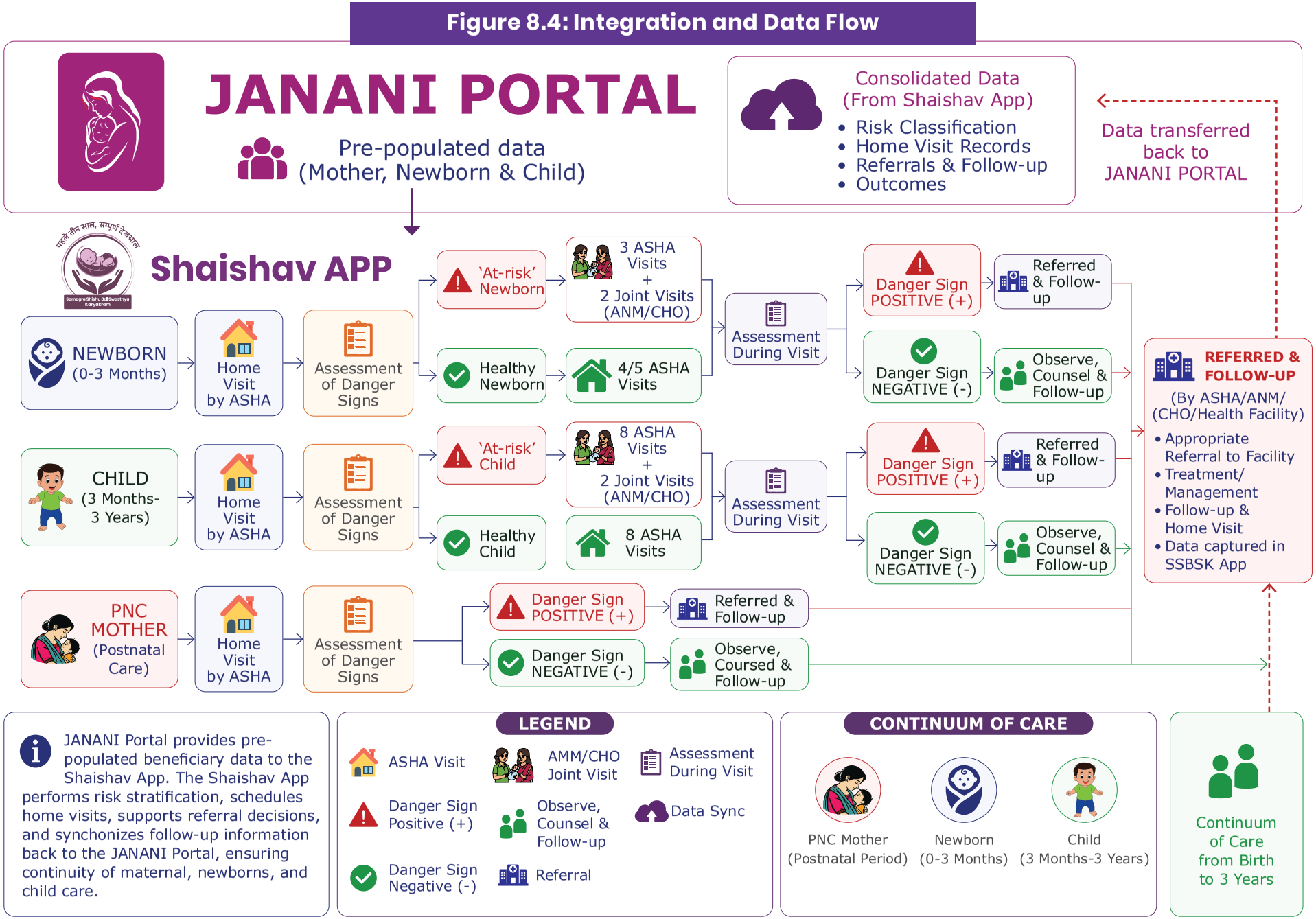

JANANI PORTAL
U-WIN Portal
(Immunization)
1. DATA OF MOTHER & NEWBORN
2. BIRTH DEFECT
3. IMMUNIZATION
पहले तीन साल, सम्पूर्ण देखभाल
Samagra Shishu Bal Swasthya Karyakram
Shaishav App
REFERRAL INFORMATION GENERATED BY SSBSK APP
• Newborn Referrals
• Child Referrals
• Postnatal Mother Referrals
A. NEWBORNS WITH BIRTH DEFECT & DEVELOPMENTAL DELAYS
STILLBIRTHS & MATERNAL DEATHS
SEVERE ACUTE MALNUTRITION & MODERATE ACUTE MALNUTRITION
DASHBOARD OUTPUT
(Executive Dashboard & Other Reports)
RBSK 2.0
(Screening, Evaluation, Management & Follow up)
MPCDSR
Maternal, Perinatal, and Child Death Surveillance and Response
NRC Portal
(Nutritional Rehabilitation Centres)
'At-risk' newborn/ child identified
'At-risk' newborn/ child managed
'At-risk' newborn/ child referred
No. of joint visits conducted
High-risk post-natal mothers, identified, managed and referred
Insights for Action & Decision Making

Figure 8.3: Snapshot of Shaishav App



ASHA using Shaishav App for data recording under JANANI Portal

Figure 8.4: Integration and Data Flow



Annexures

Annexure 1: Summary of actions to be performed by ASHA for managing postnatal mothers, 'At-risk' & healthy newborns and children

For All Newborns (Birth to 6 weeks) and Postnatal Mothers

1. Prepare and share line-list of newborns with ANM.
2. Use ASHA home visit checklist to cover the key questions, follows the steps of examination and counsel the mother & family.
3. Provide immediate newborn care in case of home & transit delivery.
4. Counsel and support family for keeping the newborn warm.
5. Teach mother appropriate breastfeeding technique/ breastmilk expression and feeding by cup and paladai if required. If the newborn has cleft lip/palate use dropper instead.
6. Guide mothers and caregivers on responsive feeding—encouraging feeding in response to hunger and satiety cues, maintaining eye contact, and making breastfeeding a positive, interactive experience.
7. Demonstrate early play and communication activities - talking, singing softly, smiling, and gentle touch during care routines to promote bonding and brain development.
8. Teach and counsel mother for nurturing care (parenting tips in MCP Card)
9. Monitor weight gain.
10. Be watchful and refer for the postpartum complications in the mother.
11. Counsel family to watch for danger signs in mother and newborn and seek immediate care.
12. Counsel on immunization for new born and importance for the consumption of IFA and calcium by mother.
13. Focus on mother's health, nutrition and mental wellbeing, family support & link to government nutrition and social schemes.
14. Assess mother's mental wellbeing at every visit; screen for postpartum mental health concerns using PHQ-2/ CBAC tools, provide first-line empathetic counselling, and refer to TeleMANAS or AAM if needed
15. Counsel on healthy spacing options and supply commodities.
16. Reinforce hand hygiene practices, safe environment
17. Plan joint visit with ANM for additional support if needed.

For 'At-risk' Newborn

1

At every visit: assess and record weight, temperature, and respiratory rate.

2

Look & assess the danger signs, when present provide first level care & refer the newborn to an appropriate health facility. Keep continuing KMC during transport. If the family is unable to go to the health facility, facilitate ANM visits the newborn urgently at home.

3

Hypothermic newborns to be kept warm in-home setting — provide skin-to-skin care, provide 2-layer clothing, keep head and feet covered, not to expose baby to direct airflow.

4

For LBW & pre-term infants: Demonstrate and reinforce home based KMC, encourage ≥8 hours/day or as much as possible.

5

For SNCU discharged infants: advise to continue prescribed care, medications & continue breast feeding Encourage follow up visits to SNCU as per schedule given in discharge ticket.

6

Counsel & guide mother to breast-feed baby in every 2 hours or demand feeding depending on the hunger cues if possible and advice to note frequency/number of times urine passed (at least 6-8 times in a day). Support for addressing any breastfeeding problems / issues

7

If breast feeding is not possible, teach the mother to express breast milk & feed the newborn using cup & paladai, If the newborn has cleft lip or palate use paladai instead.

8

Guide mothers and caregivers on responsive feeding—encouraging feeding in response to hunger and satiety cues, maintaining eye contact, and making breastfeeding a positive, interactive experience.

9

Demonstrate early play and communication activities - talking, singing softly, smiling, and gentle touch during care routines to promote bonding and brain development.

10

Monitor weight gain and red flags for delayed milestones.

11

Focused counselling and reinforcement for nurturing care (parenting tips – MCP Card) and for supporting maternal emotional wellbeing

12

Plan additional home visits or tele-counselling for close monitoring and follow-up as needed based on risk category.

For All Young Children (6 weeks to 36 months)

1. Prepare and update line-list of young children.
2. Use SSBSK home visit checklist (in Shaishav App) to cover key questions, follow steps of examination, and counsel the mother.
3. Monitor weight and plot on growth chart in MCP Card at every visit; counsel family on growth progress.
4. Counsel mother on age-appropriate initiation of complementary feeding at six months focusing on food consistency, frequency, quantity, and dietary diversity.
5. Reinforce continued breastfeeding alongside complementary feeding up to 2 years and beyond.
6. Counsel and support mother on maternal nutrition; diet diversity, IFA and calcium supplementation during lactation.
7. Assess immunisation status at every visit and counsel family on due vaccines; link to VHSND and UIP sessions.
8. Demonstrate age-appropriate play, stimulation, and communication activities; talking, reading, singing, and interactive play to promote brain development.
9. Counsel caregivers on nurturing care; responsive caregiving, safety and security at home, and limiting screen exposure, particularly during mealtimes.
10. Engage fathers, grandparents, and other family members in caregiving and play routines.
11. Counsel on WASH practices; handwashing, safe drinking water, and sanitation to prevent diarrhoea and infections.
12. Screen for common childhood illnesses; ARI, diarrhoea, fever; provide first-level care and refer if needed.
13. Assess developmental milestones as per MCP Card and counsel family on age-appropriate development.
14. Focus on mother's post-natal complications, mental wellbeing, family support, and linkage to government nutrition and social schemes.
15. Plan joint visit with ANM or AWW for additional support if needed.
16. Assess mother's emotional wellbeing at every visit; screen for postnatal depression using PHQ-2/CBAC tools, provide first-line empathetic counselling, and refer to Tele-MANAS or AAM if needed.

For 'At-risk' Young Children (6 weeks to 36 months)

1. At every visit: assess and record weight, temperature, and any illness signs; update 'At-risk' line-list accordingly.

2. Assess and classify nutritional status; identify Moderate Acute Malnutrition (MAM), Severe Acute Malnutrition (SAM), or underweight.

3. For SAM children with medical complications: refer to Nutrition Rehabilitation Centre (NRC); follow up on NRC discharge and encourage that prescribed diet and medications are continued at home.

4. For MAM and moderately underweight children: provide intensified counselling on complementary feeding, dietary diversity, and caloric adequacy; link to ICDS for Take Home Ration (THR) and supplementary nutrition.

5. Monitor weight gain at every visit; if weight faltering is observed, increase visit frequency and plan joint visit with ANM and AWW.

6. Assess developmental milestones at every visit using MCP Card; identify and document any delay; refer to RBSK Mobile Health Team or DEIC for further evaluation.

7. For children with recurrent illness: maintain illness history, promote timely referral, and follow up post-discharge with focused counselling on care and nutrition.

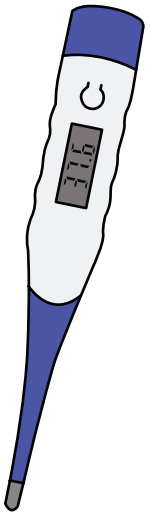
8. Provide intensified counselling on age-appropriate play and stimulation; emphasise the role of family engagement in supporting developmental catch-up.

9. Counsel caregivers on limiting screen exposure and promoting face-to-face interaction, storytelling, and play with household items.

Annexures-2: SSBSK Kit

The contents of ASHA kit are:

1. Digital Thermometer



Purpose: A digital thermometer is used to measure body temperature accurately in infants and young children, enabling early detection of fever or hypothermia.

How to use:

- Check that the thermometer has a measurement range of 32–42°C (89.6–109.4°F).
- It would have an easy-to-read LCD display with a buzzer signal function to indicate completion of measurement.
- Place the thermometer orally, in the axilla, or rectally as appropriate.
- The device would take 60–90 seconds to measure temperature and must be calibratable for accuracy.
- The accuracy should be ±1°C (±2°F).

2. Torch

Purpose: The torch is used to examine the infant's eyes, ears, and mouth. It also helps in identifying persistent squint or absence of eye contact by 2 months of age.

How to use:

Gently direct the torchlight (not too bright and not very close) towards the infant's eyes to observe eye contact and check for squint. Use it to illuminate the ears and mouth to detect any visible abnormalities or infections.

3. Digital Watch

Purpose: A digital watch is used to accurately record and monitor the date and time while conducting assessments and documenting milestones. It helps provide precise measurement of age-specific observations and referral timelines.

How to use:

- Use a standard digital watch that displays hours, minutes, and seconds, along with the date.
- The dial would be illuminated for use in low-light settings.
- Standard numerals (not Roman) would be used for clarity.
- Battery life would be at least one year, and the battery would be easily replaceable and readily available.

4. ASHA kunji

Purpose: ASHA Kunji is a set of structured counselling cards designed to support ASHA in delivering standardized, age-appropriate messages to caregivers during home visits. It helps strengthen caregiver knowledge on newborn care, feeding practices, immunization, growth monitoring, danger signs, early stimulation, and responsive caregiving under HBYC. It enables uniform communication and improves counselling quality.

How to use:

During each home visit, ASHA selects the relevant counselling card based on the child's age and identified needs. She shows the pictorial side to the caregiver and explains the key messages using simple language. ASHA would encourage discussion, clarify doubts, demonstrate practices where needed (e.g., positioning for breastfeeding, play activities), and involve fathers or other family members. The cards would be used as a guide so that no key message is missed during the visit

ASHA would also use the cards to reinforce messages during follow-up visits and for counselling families of 'At-risk' children who require closer monitoring.

5. Neonatal weighing scale- Tubular spring type with sling

Purpose: The neonatal weighing scale is used to accurately measure the weight of newborns, which is critical for identifying low birth weight and monitoring growth. Correct weight recording is essential, as even a difference of 100 grams may affect classification and management.

How to use:

- Use a hanging tubular handheld type scale with a durable plastic tubular body.
- The scale would measure weights from 0 up to at least 5000 grams.
- The measurement panel must be clear, easy to read, and color-coded:
  - **Green:** >2500 g
  - **Yellow:** 2000–2500 g
  - **Red:** <2000 g
- Graduation would be in 100 g intervals with a zero-adjustment facility.
- Check for a corrosion-protected load hook and a suspension ring/hook at the top for holding, with a lower hook for attaching the newborn holding sling.
- The sling would be soft, durable, and secure for safe placement of the newborn.

Note: While tubular spring-type scales are widely used, a digital weighing scale is strongly encouraged as it minimizes errors in recording, provides higher accuracy, and supports better monitoring and management of newborns.

Sling of the weighing scale: would be made of parachute cloth, cloth and stitching of the sling would be smooth and soft for the newborn, size would be big enough to hold an newborn of maximum weight of 5 kg (approx. length-74 cm and breadth-54 cm), sling would have two loops, one at each end which can be hanged in the hook of spring scale.

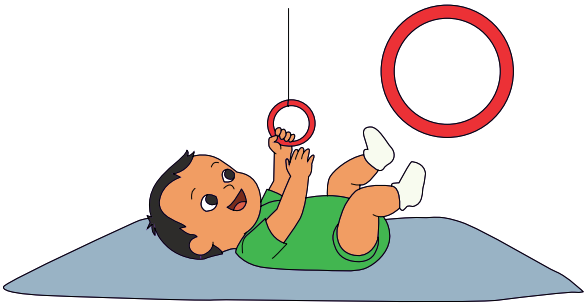
6. Red ring with red string

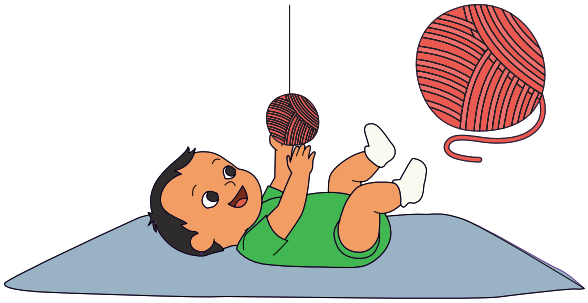
Purpose: This simple tool is used to assess visual development milestones in young infants, including visual fixation, eye contact, tracking, reaching, and hand-eye coordination. It also helps to identify conditions like squint if present.

How to use:

The red ring would be tied with a thread/string and dangled in front of the newborn's eyes at a distance of approximately 30 cm.

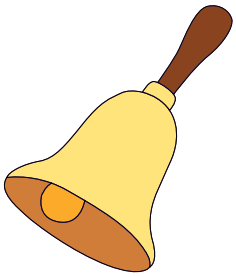
- By **2 months**: Observe visual fixation or eye contact. A squint (if present) can also be noticed.
- By **4 months**: Assess whether the infant tracks the moving object with both eyes.
- By **4–6 months**: Observe if the infant reaches for the object, indicating hand-eye coordination.
- If the infant does not achieve these milestones by 6 months, referral is required.





7. Handbell

Purpose: This simple household handbell is used to test response to sound in young infant (Observe behavioral responses as the head turns towards the bell).

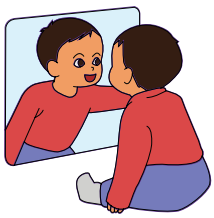


How to use:

Bell is held at a distance of at least 30 cm away from ear and out of sight of newborn and would be rung and the response of the child would be noted.

8. Plastic Mirror

Purpose: The plastic mirror is used to observe the infant's social interaction, curiosity, and early speech development milestones. It helps in assessing whether the child recognizes self-image and begins to babble simple sounds.



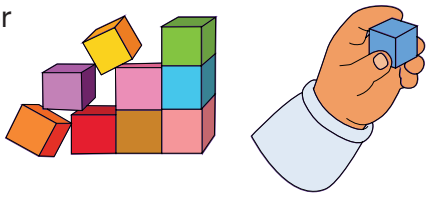
How to use:

Hold the mirror in front of the infant.

- By **4–6 months**: Most infants enjoy looking at themselves in the mirror.
- By **9 months**: The child would look into the mirror and start producing simple syllables such as pa-pa-pa, ma-ma, ba-ba-ba.
- If the infant does not respond to the mirror or does not start babbling by 9 months, referral is required.

9. One-inch Cube

Purpose: The cube is used to assess the infant's fine motor development, particularly grasping skills, which are important for hand function and coordination.



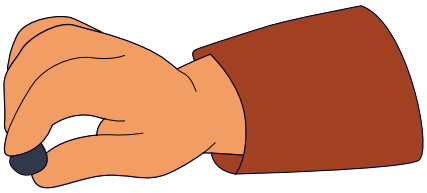
How to use:

Offer the cube to the infant and observe the grasp.

- By **7–9 months**: The child would be able to grasp the cube using all fingers.
- If grasp is not achieved by 6 months, referral is required.

10. Raisins or Kishmish

Purpose: Raisins are used to assess fine motor development, specifically the pincer grasp, which is a key milestone in early childhood development.



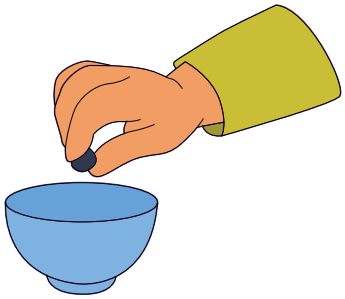
How to use:

Place a few raisins in front of the child.

- By **9–12 months**: The child would be able to pick up the raisins using the thumb and index finger (pincer grasp).
- If the child cannot pick small objects with finger and thumb by 12 months, referral is required.

11. Plastic Container or Bowl

Purpose: The container is used to assess the child's ability to perform coordinated actions and problem-solving skills, such as placing small objects inside a container.

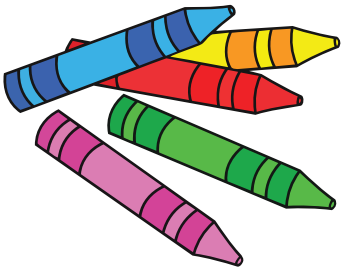


How to use:

Give the child a small plastic container or bowl along with small objects (like pebbles or blocks) and observe.

- By **18 months**: The child would be able to put small objects into the container. If not observed by 18 months, referral is required.

12. Crayons with Note Book



Purpose: Crayons and a notebook are used to assess early fine motor development, creativity, and the ability to use tools for self-expression.

How to use:

Provide the child with crayons and a notebook.

- By **18 months**: The child would be able to scribble spontaneously on paper.
- If the child does not scribble by 24 months, referral is required.

13. Toy Car or any colorful toy and cloth Or Red Ball with a plastic Katori

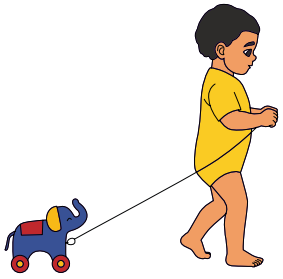
Purpose: This tool is used to assess the child's cognitive development, memory, and object permanence skills (understanding that objects continue to exist even when hidden).

How to use:

Show the toy (car, colorful toy, or red ball) to the child and partially or fully hide it under a cloth or inside a plastic katori while the child is watching.

- By 7–9 months: The child would begin to look for toys that are hidden in front of them.
- By 12 months: The child would be able to search for a toy that is partially hidden after watching you hide it.
- If the child does not attempt to search for half-hidden toys by 12 months, referral is required.

14. Pulling Toy



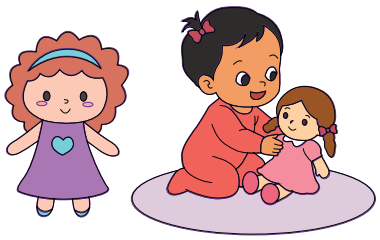
Purpose: The pulling toy is used to assess gross motor development, particularly steady walking and coordination while managing an object.

How to use:

Provide the child with a small toy attached to a string and encourage them to pull it while walking. By 24 months: The child would be able to walk steadily while pulling the toy.

If the child is unable to walk steadily with the toy by 24 months, referral is required.

15. Doll (Material - Made of non-toxic plastic and good quality cloth)



Purpose: A doll is used to assess the child's pretend play (symbolic play), social-emotional development, imagination, and early language skills. It helps determine whether the child can imitate caregiving actions and engage in role-play appropriate for age (2-3 years).

How to use:

Place the doll in front of the child and observe spontaneous interaction. If needed, gently prompt the child by saying, "Feed the baby," "Make the baby sleep," or "Show how you take care of the baby." Observe whether the child imitates caregiving actions, talks to the doll, or engages in pretend play.

Annexures-3: Shaishav App Reporting Format

Section 1: For ASHA during home visits

General Form (Autofill when we enter the ABHA ID) (FORM 1)

Healthcare provider details

Mobile number .....

ASHA Name .....

District ..... Block ..... Facility ..... (Reference: HFR list) Village .....

Basic Details of child

ABHA ID ..... (to be filled by ASHA and the following details autofill)

Bal ABHA ..... (Auto generated from JANANI app)

Mother's Name ..... Father's Name ..... Mobile Number .....

Address ..... Village ..... Block ..... District ..... State .....

MCP Card available with mother ☐ Yes ☐ No

Name of Child ..... (OPEN FOR EDITING)

Stillbirth (Yes/No) (If stillbirth, then update/connect with MPCDSR Portal) Sex ☐ Male ☐ Female

Date of Birth ..... (calendar) Time of birth: ..... Age: (auto calculate) Birth weight (in gms)

Place of Delivery: ☐ Home ☐ Institution Type of Delivery: ☐ Normal ☐ C-section

Date of Discharge of newborn from institution: .....

Date of Discharge of mother from institution: .....

- Was the newborn discharged from SNCU? (Yes/No)
- Did the infant cry immediately after birth? (Yes/No) (In case of home delivery, refer to health facility if delayed cry)
- First feed to the baby after birth (Breastmilk/ Others) (Drop down Menu)
- When was the breastfeeding started?: <1 HR, 1-4 HRS, 4 TO 24 HRS, > 24 HRS (Drop down menu)
- **Immunization detail to be filled in every visit (AUTOFILL FROM U-WIN PORTAL) (If not/ partially immunized then prompt)**
- **Check the line listing if the newborn is at 'At-risk' (Yes/No)**

ASK/ OBSERVE/ COUNSEL	D1	D3	D 5	D7	D 10	D 14	D 21	D28	D42
Is the newborn/child available? (Yes/No) (If Yes, proceed with Form 2B. If No, then choose the cause from the drop-down menu: 1. Not alive 2. Admitted in health care facility 3. Visiting relatives out of town 4. Family migrated)									
If the newborn/child is not alive, then note the Date____, time___ and place of death___ (If Dead/ Not Alive, MPCDSR portal update)									
Is the mother alive? (Yes/No) (if not alive, then note the Date----------, time --------- and place of death-------, Update MPCDSR portal)									
"AT RISK" NEWBORN - ASK/ OBSERVE - (FORM 2B) **(Multiple selection options) (If Yes, Inform ANM/CHO/MO)**									
Birth weight is less than 2500 gms									
Preterm (born before 37 weeks of gestation)									
Whether breastmilk/human milk initiated Yes/No									
Discharged from newborn care facility (SNCU/ NICU)									
Any visible birth defect (congenital malformations) such as cleft lip and/ or palate etc. (prompt: Inform RBSK Team)									
Whether the newborn regained the birth weight by Day 14 of life (Joint visit by ANM/ CHO: Day 3 & 7)									
Whether the newborn gained weight in two consecutive visits after 14 days of life (If yes, Refer to higher centre in consultation with ANM/ CHO)									
If the newborn was referred to SNCU/ NBSU/ Facility: Yes/No 1. Newborn still admitted in SNCU/ NBSU/ Facility during the visit: Yes/No 2. Newborn discharged after successful treatment from the SNCU/ NBSU/Facility: Yes/No									
If the Newborn is 'At-risk'- Home visits will be conducted by ASHA on Day-1/discharge,3,5,7,10,14,21,28 and 42 (At-risk format to open)									
For Age 0 to 2 months – Reporting Format for Newborn (FORM 3, for all newborns), If the child is healthy - Home visits will be conducted by ASHA on Day-3,7,14, and 42									
Temperature: Measure and record (°F)									
Danger signs of newborn (Multiple option selection) (If Any "YES", Referral Pop Up- PLACE of referral- For Assessment refer to CHO/MO Stabilization at CHC/PHC and treatment at DH) (link to facility mapping)									
Danger signs observed • Movement only when stimulated or no movement at all • Not able to feed • Convulsion • Difficulty in breathing • Fast breathing (more than 60 breaths per minute) • Severe chest indrawing • Yellowness in palm and feet • Blood in stool • Axillary temperature 37.5° C or above (feels hot to touch) • Axillary temperature less than 35.5° C (feels cold to touch)									

If Danger sign was present, was the newborn referred to health facility/ SNCU/NBSU: Yes/No 1. Newborn still admitted in health facility/ SNCU/NBSU during the visit: Yes/No 2. Newborn discharged after successful treatment from the health facility/ SNCU/NBSU: Yes/No									
Whether joint home visits to 'At-risk' newborn conducted on 3 and 7 days of life? (Yes/No)									
ASK/ OBSERVE - Newborn Health and Wellbeing									
Weight- Record (in grams)									
Whether the newborn is exclusively breastfed? Yes/ No									
If exclusively breastfed, Is the newborn feeding adequately:									
1. Is the newborn breastfed every 2 hrs? Yes/No									
2. Is the newborn being fed at night? Yes/No									
3. Passes urine 6-8 times/ day? Yes/ No									
4. Is there any weight gain? Yes/ No									
If not exclusively breastfed, then Choose the correct option & COUNSEL on Exclusive Breastfeeding:									
1. Was the feed "Mixed i.e breastfeed and top feed"?: Yes/ No									
2. Was the feed "Totally top feed"?: Yes/ No									
Pain or difficulty in breastfeeding the newborn Yes/ No **(If "YES", refer to health facility in consultation with ANM/ CHO)**									
Breast engorgement/ cracked nipple Yes/ No **(If "YES", refer to health facility in consultation with ANM/ CHO)**									
LBW / Preterm receiving KMC: Yes/ No									
Check for skin pustules: Yes/ No **(If "YES", refer to health facility in consultation with ANM/ CHO)**									
Check for yellowness/ discharge from eyes: Yes/ No **(If "YES", refer to health facility in consultation with ANM/ CHO)**									
Check for pus or bleeding from umbilicus: Yes/ No **(If "YES", refer to health facility in consultation with ANM/ CHO)**									
Household profile of Newborn (one time only, registration)									
• Assess whether the family is vulnerable or not (such as migrants/ disabled child/ far reached areas/ daily wager/ single parent/ substance abuse- smoking, alcoholism, tobacco etc.) (Multiple choice selection) • Observe sign of domestic violence (Yes/ No) • Assess for indoor pollution (burning of coal/wood, inadequate ventilation) (Multiple choice selection) • Do you know about adverse effects of heat on newborns? (Yes/ No) • During this summer season, have you received counselling on how to protect your newborns from heat-related illness (dehydration, heat exhaustion, or heat stroke)? (Yes/ No)									

Counselling to mother/ caregiver for newborn (SHOW VIDEOS)									
1. **Counsel on-** Responsive caregiving, Feeding cues / signs of hunger, Danger signs in newborn, Managing breast engorgement or cracked nipple, Compliance with treatment and follow up visit schedule when applicable (Prompt for counselling) 2. **Counselling for protection of children from heat during summer season** • Give plenty of breastfeed frequently • Keep the child indoors during peak afternoon heat • Dress the child in light cotton clothing • Watch for signs of heat illness (fever, lethargy, dehydration, etc.) • Keep the child in a cool and shaded place									
Demonstrate and Counsel- Support in breastfeeding, Hand Washing, KMC, Newborn wrapping (Prompt for counselling)									
ASK/ OBSERVE & COUNSEL- Mother (FORM 4)- PNC Care (To discuss)									
Temperature: Measure and record (oF)									
Danger signs of mother (Multiple option selection) (If any "YES", Referral Pop Up- PLACE of referral)									
• **Fever** • **Severe anemia** (Excessive bleeding (changing pad 5 or more/ day), presence of giddiness, paleness, weakness) • **Urinary Tract Infection** (High fever >102°F, burning urination) • **Vaginal Infection** (Foul smelling white discharge, fever >100°F) • **Abdominal pain** • **Neurological symptoms** (Blurred vision / Convulsion/ Speaking Abnormally) • **Oedema of face, hands and legs** • **Difficulty in breathing** • **Jaundice** • **Incontinence of stool and urine**									
ASK/ EXAMINE- Mother Health and Wellbeing									
Adequate diet (3 meals + 2 snacks/day) Yes/ No									
Whether Mother/ Family members are washing hand as per the Hand washing technique Yes/ No									
IFA & Calcium consumed (1 IFA per day and 2 calcium Tab daily for 6 months) Yes/ No									
Spacing Method (Yes/ No, If not used, counsel)									
Psychological distress (>2 weeks sadness/anxiety) (If any of the two questions are answered as "Yes", then prompt for referral to CHO/MO)									
1. Does the mother have little interest or pleasure in doing things?									
2. Is the mother feeling down, depressed or hopeless?									
Counselling to mother/ family for mother									
Counsel on- Danger signs in mother, Adequate nutrition in postpartum mother, Spacing Method, Mental health (Prompt for counselling)									

ASHA Signature ANM Signature CHO/MO Signature

ASK/ OBSERVE & COUNSEL	M-3	M-6	M-9	M-12	M-18	M-24	M-30	M-36
At 2 months to 36 months: ASK/ OBSERVE – 'At-risk' Young Child (FORM 5)								
Record weight of the child (in kg)								
Record length/height (in cm) as per MCP card, at AWC/ VHSND/ RI session/ on fixed day (growth chart auto plotting)								
OBSERVE/ ASK for 'At-risk'- (Multiple choice selection) (If yes, Inform ANM/CHO/MO)								
• Moderately Underweight (weight-for-age: below -2SD to -3SD (YELLOW) OR MAM (weight-for- length/ height: equal or below -2SD to -3SD) (YELLOW) • Severely Underweight (weight-for-age: below -3SD) (RED) OR SAM (weight-for- length /height: below -3SD) (RED) • NRC Discharge • Recurrent illness (minimum two episodes in a time frame up to one year requiring hospitalization/ doctor consultation) • Delay in achieving the development milestone as per MCP Card Underweight/ Severe underweight (Pop up, Counsel & Refer to NRC if Yes)								
If the child was referred to NRC/ Paediatric Unit: Yes/No 1. Child still admitted in NRC/ Paediatric Unit during the visit Yes/No] 2. Child discharged after successful treatment from the NRC/ Paediatric Unit? Yes/No								
For Age 2 months to 36 months – Reporting Format (FORM 6)								
Record Temperature (°F)								
Ask and Observe danger signs- (Multiple option selection) (If "YES", Referral Pop Up- PLACE of referral- For refer to AAM/CHC/PHC/DH)								
• Not able to feed/drink • Vomits everything often • Lethargy/ unconsciousness • Convulsions/convulsing now • Difficulty in breathing • Fast breathing (2 mon. to 12 mon: more than 50 breaths per minute; 12 mon to 5 years: more than 40 breath per minute) • Severe chest in-drawing • Fever (more than 37.5° C or 99.5° F) more than 7 days and no doctor consultation taken • Diarrhoea more than 14 days (Signs of dehydration like sunken eyes and skin pinch goes back slowly • Blood in stools								
If Danger sign was present and the child was referred to health facility: Yes/No 1. Child still admitted in health facility during the visit Yes/No 2. Child discharged after successful treatment from the health facility Yes/No								

Whether joint home visits to 'At-risk' child conducted at 3rd and 6th month of life? (Yes/No)								
ASK/ OBSERVE - Young Child Health and Wellbeing								
Breastfeeding continued (Yes/ No)								
Note the details of complementary feed (YES/ NO) 1. 3rd Month visit: Breast feeding continued 2. 6th Month visit: 2-3 tablespoons of food at a time, 2-3 times each day 3. 9th Month visit: ½ cup/katori serving at a time, 2-3 times each day with 1-2 healthy snacks between the meals 4. 12th Month visit: ½ cup/katori serving at a time, 3-4 times each day 5. 18th Month to 36th Month visit: One small chapati OR 4 teaspoons or 1/4of a small katori (150 ml) of rice serving at a time, 3 times a day with 1-2 healthy snacks between meals, one glass (150 ml) milk twice a day								
If any visible birth defect or developmental delay present, linked with RBSK-MHT/DEIC/DH(Paediatrician) (Yes/ No)								
In case of any visible birth defect, receiving treatment and under follow up (Yes/ No)								
Deworming received (only for child above 1 yr) (Yes/ No)								
Vitamin A received (check and counsel at 9 months and twice a year following first dose up to 5 years age) (Yes/ No)								
IFA syrup given (check and counsel) (Counsel for 1ml bi-weekly for under 5 children) (Yes/ No)								
ORS available at home (Yes/ No)								

Ask/Observe & Counsel on Early Childhood Development including Safety & Security of Child								

• Does father and other family members spend time with child: Yes/No, If yes, (drop down)
  ▸ Playing
  ▸ Interactions
  ▸ Storytelling
  ▸ Singing
• Does your child see the TV/ Mobile : Yes/No, If Yes, counsel for avoiding screen time
• Do you and your family are aware about the objects which can be harmful for the child: Yes/No (Like water storage, fire, sharp objects, smoke, toxic substances, poison, dip pit, open electric wire, vehicles, child abuse etc.), if no, Prompt for
counselling
• How do you know that child is hungry? Options:
  ▸ Child cry
  ▸ Ask for food
  ▸ Gives cues
Counsel family for encouraging child for self-feeding and self-learning. Also to give prompt respond to child's need like: play, crying, feeding, health issues, safety								

Household profile for young child (if new registration)								
• Assess whether the family is vulnerable or not (such as migrants/ disabled child/ far reached areas/ daily wager/ single parent/ substance abuse- smoking, alcoholism, tobacco) (Multiple choice selection) • Observe sign of domestic violence (Yes/ No) • Assess for indoor pollution (burning of coal/wood and inadequate ventilation) (Multiple choice selection) • Do you know about adverse effects of heat on children? (Yes/ No) • During this summer season, have you received counselling on how to protect your child from heat-related illness (such as dehydration, heat exhaustion, or heat stroke)? (Yes/ No)								
Counsel the mother/ caregiver for the young child and mother (SHOW VIDEOS)								
1) Hand washing, exclusive breastfeeding till 6 months, complementary feeding along with breastfeeding till 2 years, diet diversity, responsive feeding, positive parenting, responsive caregiving, Danger signs, Preparation of ORS and Zinc supplementation in case of diarrhoea, healthy spacing choices as per MCP card, ECD and Safety & security (Prompt for counselling) **2) Counselling for protection of children from heat during summer season** • Give plenty of fluids/breastfeed frequently • Keep the child indoors during peak afternoon heat • Dress the child in light cotton clothing • Watch for signs of heat illness (fever, lethargy, dehydration, etc.) • Keep the child in a cool and shaded place • Seek medical care if danger signs appear								

ASHA Signature ANM Signature CHO/MO Signature

Section 2: For CHO/ANM during joint home visits

Part 1:'At-risk' Newborn

(Joint visits with ASHA on Day 3 and 7 for 'At-risk' newborns at Home. In case of urban areas, MO from Urban AAM would conduct joint visit with ANM)

FORM 1: General Form (Autofill when enter the ABHA ID)

Basic Details of child

ABHA ID..... (to be filled by ASHA and the following details autofill)

Mother's Name..... Father's Name.....

Mobile Number..... Mother's AADHAR Card number.....

Address..... Village..... Block.....

District..... State.....

ASHA Name..... MCP Card available with mother ☐ Yes ☐ No

Name of Child ..... (OPEN FOR EDITING)

Sex of the child: ☐ Male ☐ Female Age: (auto calculate from DOB)

Date of Visit (Autofill)_____

Is the newborn/child available? (Yes/No) (If Yes, proceed with Form 2).
If No, then choose the cause from the drop-down menu:

1. **Not alive**
2. **Admitted in health care facility**
3. **Visiting relatives out of town**
4. **Family migrated)**

FORM 2: Assessment of 'At-risk' newborn

Check the line listing if the newborn is at 'At-risk' (Yes/No) (Flagged as 'At-risk' post ASHA's visit)

- Birth weight is less than 2500 gms **(Yes/No)**
- Preterm (born before 37 weeks of gestation) **(Yes/No)**
- Not initiated on breastmilk/human milk **(Yes/No)**
- Discharged from newborn care facility (SNCU/ NICU) **(Yes/No)**
- Any visible birth defect (congenital malformations) such as cleft lip and/or palate (prompt: Inform RBSK Team) **(Yes/No)**
- Not regained birth weight by Day 14 of life **(Not Applicable)**
- Not gaining weight in two consecutive visits after 14 days of life **(Not Applicable)**

FORM 3: Management of sick newborn (0–2 months of age) by CHO/ANM

1. Identify problems

A. General Information

	ASK and LOOK **What are the child's problems?** If not reported, then ask the following leading questions and look for the danger signs. **If YES**, sign present ☐Tick ☐	**Any DANGER SIGN or other problem to refer?**	**SICK but NOT a Danger Sign?**
☐	Lethargic or unconscious?	☐ Movement only well simulated or no movement at all	
☐	Infant breastfed? Specify number of times breastfed in 24 hours:.....		
☐	Difficulty in feeding?	☐ Not able to feed at all	
☐	Convulsions?	☐ Convulsions	
☐	**Count breaths for 1 minute:** _____ breaths per minute (bpm) Fast breathing: 60 bpm or more	☐ Fast breathing	
☐	Chest indrawing?	☐ Severe Chest indrawing	
☐	Jaundice present? When did jaundice first appear (if present)? ☐ Less than 24 hours of birth ☐ More than 24 hours of birth	☐ Jaundice in infant aged less than 24 hours ☐ Yellow palms and soles	☐ Jaundice in infant aged more than 24 hours ☐ Palms and soles not yellow
☐	If diarrhea present? If yes, blood in stools?	☐ Signs of dehydration ☐ Blood in stools	☐ Diarrhea present, but no signs of dehydration
☐	Restless and irritable?	☐ Restless and irritable	
☐	Pinch skin of abdomen. Does the skin go back slowly?	☐ Skin pinch goes back slowly	
☐	Sunken eyes?	☐ Sunken eyes	
☐	Axillary temperature ☐ 37.5 °C/ 99.5 °F (or feels hot to touch) ☐ 35.5 °C/ 95.5 °F (or feels cold to touch)	☐ 37.5 °C/ 95.5 °F (or feels cold to touch) ☐ 35.5 °C/ 95.5 °F (or feels cold to touch)	
☐	Skin pustules		☐ Skin pustules
☐	Umbilicus- red or draining pus?		☐ Umbilicus red or draining pus
☐	Any other problem that needs referral (for example, problem in breast feeding, oral thrush)	☐ Other problem to refer:	

2. Decide: Refer to health facility or treat infant at home (tick decision)

Refer or treat infant (tick treatments given and other actions) (tick treatments given and other actions)

☐ **If ANY Danger Sign or other problem, refer to health facility**		☐ **If NO Danger Sign, treat at home and advise caregiver**	
If any danger sign, **REFER URGENTLY to health facility:** **ASSIST REFERRAL to health facility:** ☐ Explain why infant needs to go to health facility. ☐ Advise to keep child warm, if child is NOT hot with fever. ☐ Advise mother to continue breastfeeding and suggest mother to go with the infant		If no danger sign, **TREAT at home and ADVISE on home care:**	
☐ If **PSBI** **(Possible Serious Bacterial Infection)** **(Not feeding well or Convulsions or Chest indrawing or Fast breathing or Fever or Hypothermia or Lethargic infant)**	☐ Give first dose of oral amoxycillin and intramuscular gentamicin. ☐ Continue breastfeeding if able to feed ☐ Advise the mother how to keep the young infant warm on the way to the hospital	☐ **If Local bacterial Infection present**	☐ Give oral amoxycillin for 5 days ☐ Teach the mother how to treat local infections at home ☐ Advise the mother to give home care to the young infant ☐ Advise the mother when to visit health facility immediately ☐ Follow up after 2 days by ANM/ CHO
☐ **If Jaundice in infant aged less than 24 hours with yellow palms and soles**	☐ Continue breastfeeding ☐ Advise the mother how to keep the young infant warm on the way to the hospital	☐ **If Jaundice in infant aged more than 24 hours and palms and soles are not yellow**	☐ Advise the mother to give home care to the young infant ☐ Advise the mother to visit health facility immediately if the infant's palm or soles appear yellow ☐ Follow up after 2 days
☐ **If Severe and Some Dehydration (lethargic/ restless and irritable, sunken eyes and skin pinch goes back very slowly/slowly)**	☐ Give first dose of oral amoxycillin and intramuscular gentamicin. ☐ Refer URGENTLY to hospital with the mother giving frequent sips of ORS on the way to infant. ☐ Advise mother to continue breastfeeding. ☐ Advise mother how to keep the young infant warm on the way to the hospital.	☐ **If No dehydration**	☐ Give fluids and breastfeeds to treat diarrhoea at home (Plan A) ☐ Advise mother when to visit health facility immediately ☐ Follow up after 2 days if no improvement

☐ **If very low weight (wt less than 1800 gm in infants less than 7 days) (Note: For newborns delivered at home)**	☐ Continue breastfeeding if able to feed ☐ Warm the young infant by skin to skin contact if temperature < 36.5 C (or feels cold to touch) while arranging referral. ☐ Advise mother how to keep the young infant warm on the way to hospital	☐ **If Feeding Problem And/ Or Low Weight**	☐ Counsel and support for breastfeeding ☐ If not well attached or not suckling effectively, teach correct positioning and attachment. ☐ If breastfeeding less than 8 times in 24 hours, advise to increase frequency of breastfeeding. ☐ If not breastfeeding at all ☐ refer for breastfeeding counseling ☐ advise mother about giving locally appropriate animal milk and teach the mother to feed with a cup and spoon ☐ If oral thrush, teach the mother to manage thrush at home. ☐ Teach the mother how to keep the young infant warm at home and advise to increase frequency of breastfeeding ☐ If breast or nipple problem, teach the mother to treat them. ☐ Advise mother to give home care to the young infant. ☐ Advise mother when to visit health facility immediately. ☐ Follow-up any feeding problem or thrush after 2 days. ☐ Follow-up low weight for age after 14 days.

FORM 4: Assessment of Early Childhood Development including Safety & Security of Newborn

- Whether the family members are careful regarding the safety and security of the newborn, (heaters, indoor smoke, insects etc) (Yes/ No) (If No, Prompt for counselling)
- Whether the family members promptly respond to the needs of the newborn (crying, feeding, health issues, safety)? (Yes/ No) (If No, Prompt for counselling)

FORM 5: Assessment of Danger Signs in Post-Partum Mother (If any "YES", Referral Pop Up- PLACE of referral, If all "NO", move to FORM 6)

- **Fever (Yes/No)**
- **Severe anemia** (Excessive bleeding (changing pad 5 or more/ day), presence of giddiness, paleness, weakness) **(Yes/No)**
- Urinary Tract Infection (High fever >102°F, burning urination) **(Yes/No)**
- Vaginal Infection (Foul smelling white discharge, fever >100°F) **(Yes/No)**
- Abdominal pain **(Yes/No)**
- Neurological symptoms (Blurred vision / Convulsion/ Speaking Abnormally) **(Yes/No)**
- Oedema of face, hands and legs **(Yes/No)**
- Difficulty in breathing **(Yes/No)**
- Jaundice **(Yes/No)**
- Incontinence of stool and urine **(Yes/No)**

FORM 6: Psychological distress in post-partum mother (>2 weeks sadness/anxiety) (If any "YES", Referral to MO, Pop Up- PLACE of referral)

1. Does the mother have little interest or pleasure in doing things?
2. Is the mother feeling down, depressed or hopeless?

- **Note: Advise ASHA for counselling, follow up and referral in consultation with ANM/ CHO**

Part 2: 'At-risk' Child

(For Joint visits with ASHA at 3rd and 6th month for 'At-risk' children at Home. In case of urban areas, MO from Urban AAM would conduct joint visit with ANM)

FORM 1: General Form (Autofill when enter the ABHA ID)

Basic Details

ABHA ID..... (to be filled by ANM/CHO and the following details autofill)

Mother's Name..... Father's Name.....

Mobile Number..... Mother's AADHAR Card number.....

Address..... Village..... Block.....

District..... State.....

ASHA Name..... MCP Card available with mother ☐ Yes ☐ No

Name of Child ..... (OPEN FOR EDITING)

Sex of the child: ☐ Male ☐ Female Age: (auto calculate from DOB)

Date of Visit (Autofill)_____

Is the newborn/child available? (Yes/No) (If Yes, proceed with Form 2).
If No, then choose the cause from the drop-down menu:

1. **Not alive**
2. **Admitted in health care facility**
3. **Visiting relatives out of town**
4. **Family migrated)**

Was the child previously flagged as 'At-risk' newborn?

FORM 2: Management of sick young child (2-36 months of age) by CHO/ANM

1. Identify problems

ASK and LOOK		Any DANGER SIGN or other problem to refer?	SICK but NOT a Danger Sign?
ASK: What are the child's problems? **YES**, sign present ☐ Tick ☐			
☐	Difficulty drinking or feeding? IF YES, ☐ not able to drink or feed anything?	☐ Not able to drink or feed anything	
☐	Vomiting? If yes, ☐ vomits everything?	☐ Vomits everything	
☐	Diarrhoea (loose stools)? IF YES, for how long? ____days.	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	Convulsions?	☐ Convulsions	
☐	Cough? If yes, for how long? __ days	☐ Cough for 21 days or more	
☐	Fever (reported or now)? If yes, started ____ days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	Any other problem I cannot treat (for example, injury, burn) If any OTHER PROBLEMS, refer.	☐ Other problem to refer	
LOOK:			
☐	Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	Axillary temperature above 37.5 °C/ 99.5 °F (or feels hot to touch)		☐ Above 37.5 °C/ 95.5 °F (or feels cold to touch)
☐	Chest indrawing? (FOR ALL CHILDREN)	☐ Severe Chest indrawing	
☐	**IF COUGH, count breaths in 1 minute:** _____breaths per minute (bpm) Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	Sunken eyes?	☐ Sunken eyes	
☐	Drinks water eagerly, thirsty?		☐ Drinks eagerly, thirsty
☐	Pinch skin of abdomen. Does the skin go back slowly?	☐ Skin pinch goes back slowly	
☐	Restless and irritable?		☐ Restless and irritable
☐	WFL <-3 SD score (red color on MCP card)	☐ Red color on MCP card	
☐	Swelling of both feet?	☐ Swelling of both feet	
☐	Severe palmar pallor?	☐ Severe palmar pallor?	

2. Decide: Refer or treat child (tick decision)

Refer or treat child (tick treatments given and other actions)

☐ **If ANY Danger Sign or other problem, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

If any danger sign,

REFER URGENTLY to health facility:

ASSIST REFERRAL to health facility:

☐ Explain why child needs to go to health facility.

☐ FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:

If no danger sign,

TREAT at home and ADVISE on home care:

☐ **If Severe Pneumonia or Very Severe Disease** (lethargy or unconsciousness, persistent vomiting or severe chest indrawing)	☐ Give pre-referral dose of oral amoxycillin &IM gentamicin	☐ **If Fast breathing**	☐ Give amoxycillin for 5 days. ☐ Advise home care for cough and cold. ☐ Follow-up after 2 days.
☐ **If Diarrhea with severe dehydration** (lethargic or unconscious, sunken eyes, skin pinch goes back slowly)	☐ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way. ☐ Advise the mother to continue breastfeeding.	☐ **If Diarrhea with some or no dehydration (restless and irritable, drinks eagerly)**	☐ **Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. ☐ **Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but at least ½ cup ORS solution after each loose stool. ☐ **Give zinc supplement.** Give 1 dose daily for 14 days: ☐ Age 2 months up to 6 months—1/2 tablet (total 5 tabs) ☐ Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ **If Fever present (area non-endemic for malaria)**	☐ Give first dose of oral amoxycillin and IM gentamicin ☐ Treat the child to prevent low blood sugar by giving milk or sugar water ☐ Give one dose of paracetamol for high fever (temp. 38.5 C/101.3 F or above)	☐ **If Fever (malaria risk)**	☐ Give oral antimalarial ACT. ☐ Age up to 12 months—AS ½ SP ¼ ☐ Age 12 months up to 5 years—AS SP and Primaquine 1 tablet D-1 D2 and D3 1 tablet AS only ☐ Age 5 yrs up to9 yrs— AS SP and Primaquine 2, 1.5 and 2 tablets on D-1 D2 and D3 1 tablet 1 tablet AS only ☐ **Advise caregiver on use of a bednet (ITN).** ☐ **Follow-up after 2 days if fever persists** ☐ **If fever is present every day for more than 7 days, refer for assessment**

☐ **If Severe Acute Malnutrition** (WFL <–3 SD score: red color on MCP card)	☐ Give first dose of oral amoxycillin and IM gentamicin ☐ Treat the child to prevent low blood sugar by giving milk or sugar water ☐ Keep the child warm on the way to hospital.	☐ **If No Acute Malnutrition**	☐ If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding ☐ If feeding problem, follow-up in 5 days.
☐ **If Severe Palmar Pallor**	☐ Refer URGENTLY to hospital to assess the causes and treat accordingly	☐ **If No Palmar Pallor**	☐ Give prophylactic iron folic acid if child 6 months or older.
☐ **For any sick child who can drink, advise to give fluids and continue feeding.** ☐ **Advise to keep child warm, if child is NOT hot with fever.** ☐ **Write a referral note.** ☐ **Arrange transportation, and help solve other difficulties in referral.** ☐ **FOLLOW UP child on return at least once a week until child is well.**		☐ **For ALL children treated at home, advise on home care**	☐ **Advise caregiver to give more fluids and continue feeding.** ☐ **Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool ☐ **Follow up child in 3 days** (schedule appointment in item 6 below).

4. **If any OTHER PROBLEM or condition you cannot manage, refer child to health facility, write referral note.** (If diarrhoea, give ORS. Do not give antibiotic or antimalarial.)
   Describe problem: _____

5. **Counsel for complementary feeding and discuss age-appropriate feeding**

FORM 3: Assessment of 'At-risk' child

Weight of the child (in kg): _____
Length/height of the child (in cm):_____

Examine for 'At-risk' child (If any "YES", move to FORM 4)

- Moderately Underweight (weight-for-age: below -2SD to -3SD (YELLOW) OR MAM (weight-for-length/ height: equal or below -2SD to -3SD) (YELLOW) **(Yes/No)**
- Severely Underweight (weight-for-age: below -3SD) (RED) OR SAM (weight-for- length /height: below -3SD) (RED) **(Yes/No)**
- NRC Discharge (Yes/No)
- Recurrent illness (minimum two episodes in a time frame up to one year requiring hospitalization/ doctor consultation) **(Yes/No)**
- Delay in achieving the development milestone as per MCP Card **(Yes/No)**

FORM 4: Assessment of Early Childhood Development including Safety & Security of Child

- Does father and other family members spend time with child: Yes/No, If yes, (ask below mentioned-Yes/No)
  - Playing
  - Interactions
  - Storytelling
  - Singing
- Does your child see the TV/ Mobile : Yes/No, If Yes, counsel for avoiding screen time
- Do you and your family are aware about the objects which can be harmful for the child: Yes/No (Like *water storage, fire, sharp objects, smoke, toxic substances, poison, dip pit, open electric wire, vehicles, child abuse etc.*), if no, Prompt for counselling
- How do you know that child is hungry? Options (multiple choice):
  - Child cry
  - Ask for food
  - Gives cues

Counsel family for encouraging child for self-feeding and self-learning. Also to give prompt respond to child's need like: play, crying, feeding, health issues, safety

Section 3: For ANM during Well Baby Session at VHSND

- *ANM would triage the sick newborns and children during VHSND (by asking mothers if the child is unwell or if the child appears to be sick on general appearance) and attend to them first*
- *ANM would also give priority to 'At-risk' newborn and children*

FORM 1: General Form (Autofill when enter the ABHA ID)

Basic Details of child

ABHA ID..... (to be filled by ASHA and the following details autofill)

Mother's Name..... Father's Name..... Mobile Number.....

Address..... Village..... Block.....

District..... State.....

ASHA Name..... MCP Card available with mother ☐ Yes ☐ No

Name of Child ..... (OPEN FOR EDITING)

Sex of the child: ☐ Male ☐ Female Age: (auto calculate)

FORM 2: Promotion of newborn and childcare services & Counselling

- **Date of Visit** *(Autofill)*_____
- **Check the line listing if the newborn/ child is at 'At-risk'** *(Yes/No) (If "Yes", counsel as per the 'At-risk' condition and inform about danger signs)*
- **If the newborn or child has a danger sign, measure the following:**

☐ Axillary temperarure (in °F): _____

☐ Respiratory Rate (count breaths/ min): _____

I. Growth and Development

- **Record weight (for newborn in gms/ for child in kgs): _____**
- **Record length/ height of the newborn or child (in cms): _____**
- **Weight and length/height in the MCP card plotted (Yes/No)**
- **Growth curve (in green/ yellow/ red zone) reviewed with parent/s and action explained** (Yes/No)

II. Newborn & Child Feeding

- **Baby is on Breastfeeding (Yes/No) _____**
- **Is there any difficulties faced by mother while breastfeeding the baby? (Yes/No) _____** *(If Yes, counsel the mother regarding appropriate breastfeeding methods)*
- **Is the child on age-appropriate complimentary feeding? (Yes/No) _____** *(Counsel the mother regarding Quantity, frequency and diversity of the foods in complimentary feeding)*

III. Developmental Milestone

- **Check if ASHA has shown parents the MCP card regarding age-appropriate developmental milestone i.e. 'What most babies do as per age'** (Yes/No)
- **Warning signs checked as per MCP card** (Yes/No)
  (If yes, counsel on the referral and further assessment by MO/ pediatrician)

IV. Early Childhood Development (ECD)

- **Parent counselled on Early Childhood Development (ECD) including responsive caregiving** (Yes/No)
- **Mother informed about safety & security at home and surrounding environment** (Yes/No)

Counselling Checklist

Counselling for 'At-risk' newborn & children
☐ Inform about danger signs in newborns and children
☐ Follow up in SNCU discharged
☐ Referral and follow up in newborns with birth defects
☐ Follow up at NRC in malnourished children
☐ Referral and further assessment in children with recurrent illness/ delayed development milestones

Counselling if danger signs present in newborns & children
☐ Explain why newborn/ child needs to go to health facility.
☐ Advise to keep child warm during referral transport
☐ *Advise mother to continue breastfeeding (if the child is able to feed). For any sick child who can drink, advise to give fluids and continue feeding.*
☐ If signs of dehydration (like sunken eyes and skin pinch goes back slowly), refer URGENTLY to hospital with the mother giving frequent sips of ORS on the way.
☐ In children in fever, give one dose of paracetamol for high fever (temp. 38.5 C/101.3 F or above)
☐ Write a referral note
☐ Arrange transportation and inform higher facility.

Counselling on Malnutrition

- [ ] Explain the growth chart and how to monitor the growth curve
- [ ] Promote exclusive breastfeeding till 6 months and continue till 2 years
- [ ] Age-appropriate complementary feeding advice
- [ ] Micronutrient supplementation after 6 months of age
- [ ] Children with SAM: Explain the need for NRC visit and admission
- [ ] For NRC discharged -emphasize the need for follow up
- [ ] Health education on hygiene & immunization

Group Counselling on Early Childhood Development (ECD)

- [ ] Educate on age-appropriate stimulation
- [ ] Encourage nurturing care, responsive caregiving, positive parenting & responsive feeding
- [ ] How to check achievement of age-appropriate milestones
- [ ] Safety & security of the child

Section 4: For CHO/MO checklist during AAM-Shishu Shivir

<table>
<tr><td colspan="6">A. General Information</td></tr>
<tr><td colspan="2">ABHA ID (mother):</td><td colspan="4">Baal ABHA ID:</td></tr>
<tr><td>Date & time of visit:</td><td>District/Block:</td><td>Name of Centre</td><td colspan="3">AAM NIN:</td></tr>
<tr><td>Name of CHO/ MO & Contact no:</td><td>Name of Mother:</td><td>Name of Father:</td><td colspan="3">Contact no.</td></tr>
<tr><td>Name of Child:</td><td>Date of Birth
_____
*Age of Child (in days and months)</td><td>Gender:
☐ Male
☐ Female</td><td>Place of Delivery:
☐Home
☐ Institution</td><td colspan="2">Type of Delivery:
☐ Normal
☐ C-section</td></tr>
<tr><td colspan="6">Immunization detail</td></tr>
<tr><td colspan="6">B. ASK/ EXAMINE- ‘At-risk’ Newborn (0-2 months) (Write “Yes” for all that apply)</td></tr>
<tr><td colspan="3">Birth weight is less than 2.5kg</td><td colspan="3">Discharged from SNCU/newborn care facility</td></tr>
<tr><td colspan="3">Preterm (born before 37 weeks of gestation)</td><td colspan="3">Not regained birth weight by Day 14 of life</td></tr>
<tr><td colspan="3">Not initiated on breastmilk/human milk</td><td colspan="3">Not gaining weight in two consecutive visits after 14 days of life (on 14th day)</td></tr>
<tr><td colspan="6">Any visible birth defect (congenital malformations) such as cleft lip and/or palate</td></tr>
<tr><td colspan="6">C. Danger Signs of newborn (0-2 months) (If any sign present, manage as per IMNCI protocol)</td></tr>
<tr><td colspan="3">Temperature (in oC):</td><td colspan="3">Breath count: breaths/min</td></tr>
<tr><td colspan="3">Movement only when stimulated or no movement at all</td><td colspan="3">Severe chest indrawing</td></tr>
<tr><td colspan="3">Not able to feed</td><td colspan="3">Yellowness in palm and feet</td></tr>
<tr><td colspan="3">Convulsion</td><td colspan="3">Blood in stool</td></tr>
<tr><td colspan="3">Difficulty in breathing</td><td colspan="3">Axillary temperature 37.5° C or above (feels hot to touch)</td></tr>
<tr><td colspan="3">Fast breathing (more than 60 breaths per minute)</td><td colspan="3">Axillary temperature less than 35.5° C (feels cold to touch)</td></tr>
<tr><td colspan="6">D. General Examination of newborn (0-2months) (Write “Yes” for all that apply)</td></tr>
<tr><td colspan="3">Jaundice</td><td colspan="3">Skin pustules</td></tr>
<tr><td colspan="3">Umbilical discharge</td><td colspan="3">Passes Urine 6-8 times/day (in newborn)</td></tr>
<tr><td colspan="6">E. ASK/ EXAMINE – ‘At-Risk’ Child (2-59 months) (Write “Yes” for all that apply)</td></tr>
<tr><td colspan="3" rowspan="2">Moderately Underweight (YELLOW) (indicates weight-for-age: below -2SD to -3SD
OR MAM (YELLOW) (weight-for- length/ height: equal or below -2SD to -3SD)</td><td colspan="3">NRC Discharge</td></tr>
<tr><td colspan="3">Recurrent illness (minimum two episodes in a time frame up to one year requiring hospitalization/ doctor consultation)</td></tr>
<tr><td colspan="3">Severely Underweight (RED) (indicates weight-for-age: below -3SD)
OR SAM (RED) (weight-for- length / height: below -3SD)
(Note: If “Yes”, then refer to NRC for further follow up)</td><td colspan="3">Delay in achieving the development milestone as per MCP Card</td></tr>
</table>

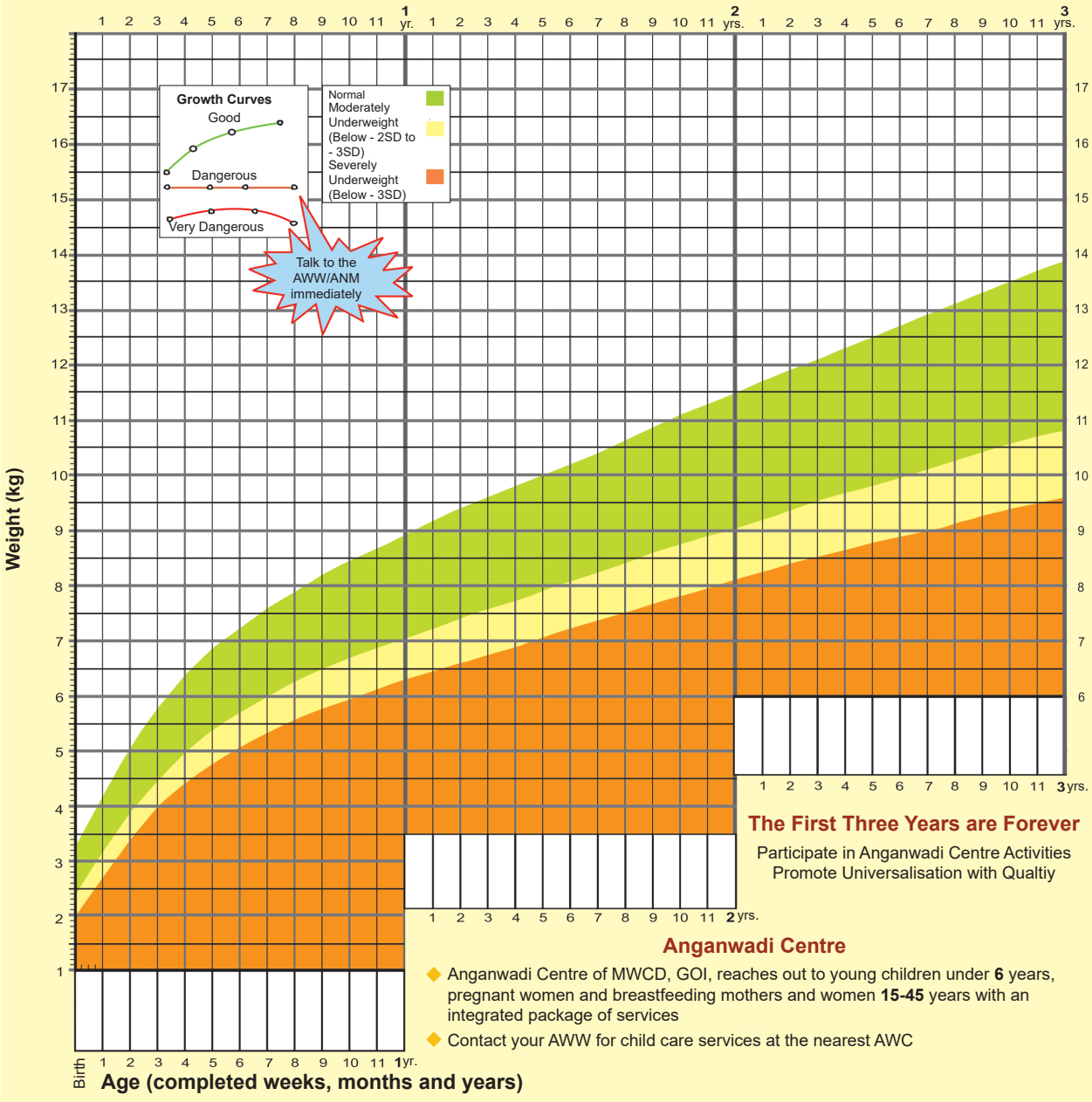
If child 2 months- 5 years			
Danger Signs of Child (2 -59 months) (Write "Yes" for all that apply, manage as per IMNCI protocol)			
Temperature (in °C):	Breath count: breaths/min		
Not able to feed/drink	Fast breathing (2 months to 12 months: more than 50 breaths per minute; 12 months to 5 years: more than 40 breath per minute)		
Vomits everything often	Severe chest in-drawing		
Lethargy/ unconsciousness	Fever (more than 37.5° C or 99.5° F) more than 7 days and no doctor consultation taken		
Convulsions/convulsing now	Diarrhoea more than 14 days (Signs of dehydration like sunken eyes and skin pinch goes back slowly)		
Difficulty in breathing	Blood in stools		
Anthropometric Measurements (Confirm growth chart plotting in MCP card)			
Weight (in kg): **Weight for age (tick appropriate column)**	Normal (GREEN)	Below -2SD to -3SD (YELLOW)	Below -3SD (RED)
Weight for length/ height classification Refer Annexure to categorize	Normal	<-2SD	<-3SD
Head Circumference (in cm): Refer Annexure to categorize	Normal	Microcephaly <-2SD	Macrocephaly > + 2SD
Does the child have any 4D's (Defects/ Deficiency/ Diseases/ Developmental delay)? (Yes/No) (Note: In case of birth defects or developmental delay, refer to RBSK Team for further assessment and management)			
F. Ask/Observe & Counsel on Early Childhood Development including Safety & Security of Child			
Does father and other family members spend time with child: (Yes/No), If yes, • Playing (Yes/No) • Interactions (Yes/No) • Storytelling (Yes/No) • Singing (Yes/No) If no, Prompt for counselling	Do you and your family are aware about the objects which can be harmful for the child: Yes/No (Like water storage, fire, sharp objects, smoke, toxic substances, poison, dip pit, open electric wire, vehicles, child abuse etc.), if no, Prompt for counselling		
Does your child see the TV/ Mobile: Yes/No, If Yes, counsel for avoiding screen time	How do you know that child is hungry? (Select correct option) • Child cry • Ask for food • Gives cues		
Counsel family for encouraging child for self-feeding and self-learning. Also to give prompt respond to child's need like: play, crying, feeding, health issues, safety			

ANNEXURE 4: Use of growth charts for girls and boys

ANNEXURE -4.1 Growth chart for GIRLS (Weight-for-age - Birth to 3 years)

GIRL: Weight-for-age - Birth to 3 years

(As per WHO Child Growth Standards)



The First Three Years are Forever

Participate in Anganwadi Centre Activities
Promote Universalisation with Qualtiy

Anganwadi Centre

- Anganwadi Centre of MWCD, GOI, reaches out to young children under **6** years, pregnant women and breastfeeding mothers and women **15-45** years with an integrated package of services
- Contact your AWW for child care services at the nearest AWC

Services at Anganwadi Centre

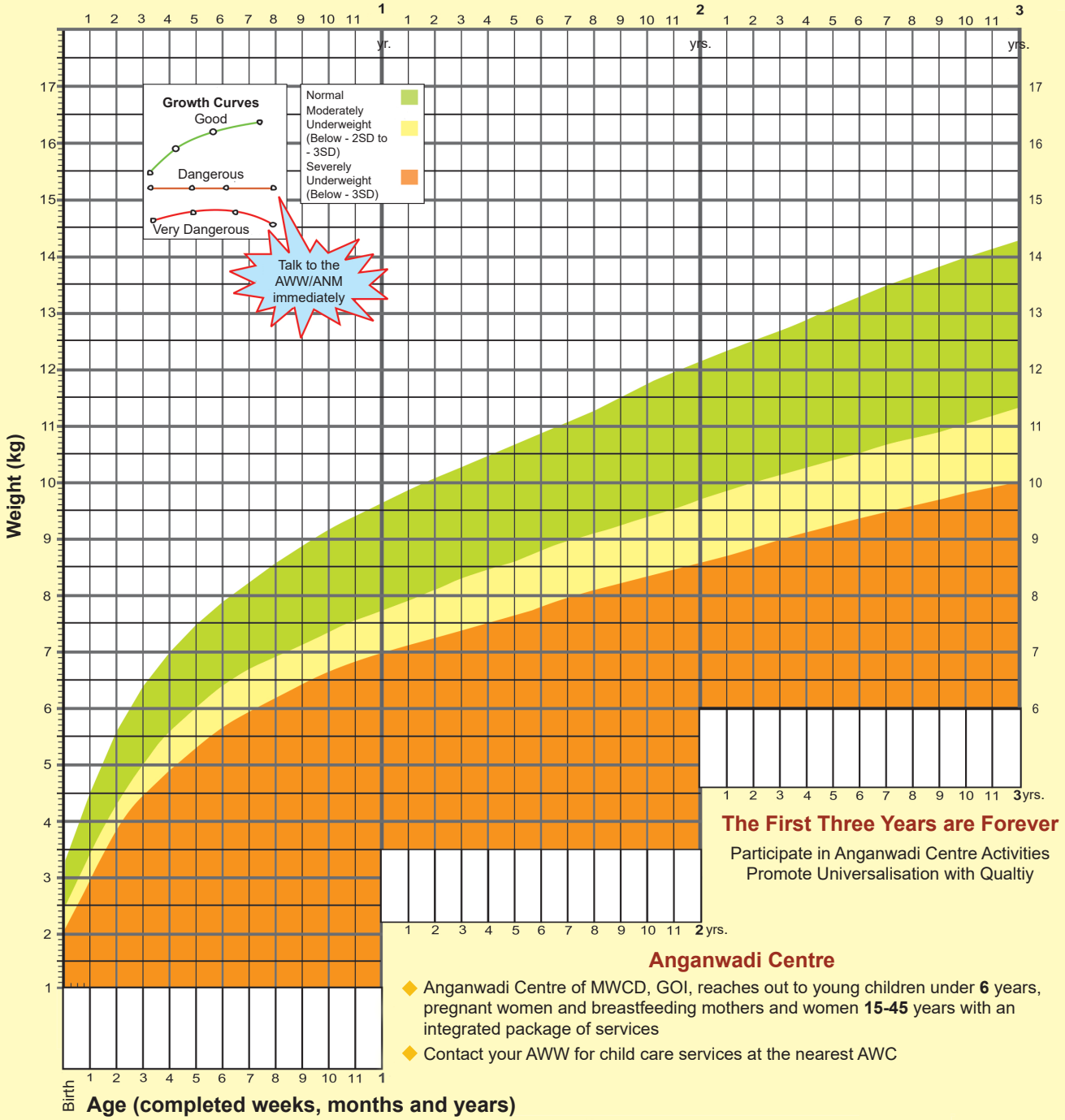
- Supplementary nutritional support, growth monitoring and promotion
- Nutrition and health education
- Immunization
- Health check-up
- Referral services
- Early childhood care and preschool education

Ensure equal care for the girl child

ANNEXURE -4.2 Growth chart for Boys (Weight-for-age - Birth to 3 years)

BOY: Weight-for-age - Birth to 3 years

(As per WHO Child Growth Standards)



The First Three Years are Forever

Participate in Anganwadi Centre Activities
Promote Universalisation with Qualtiy

Anganwadi Centre

- Anganwadi Centre of MWCD, GOI, reaches out to young children under **6** years, pregnant women and breastfeeding mothers and women **15-45** years with an integrated package of services
- Contact your AWW for child care services at the nearest AWC

Services at Anganwadi Centre

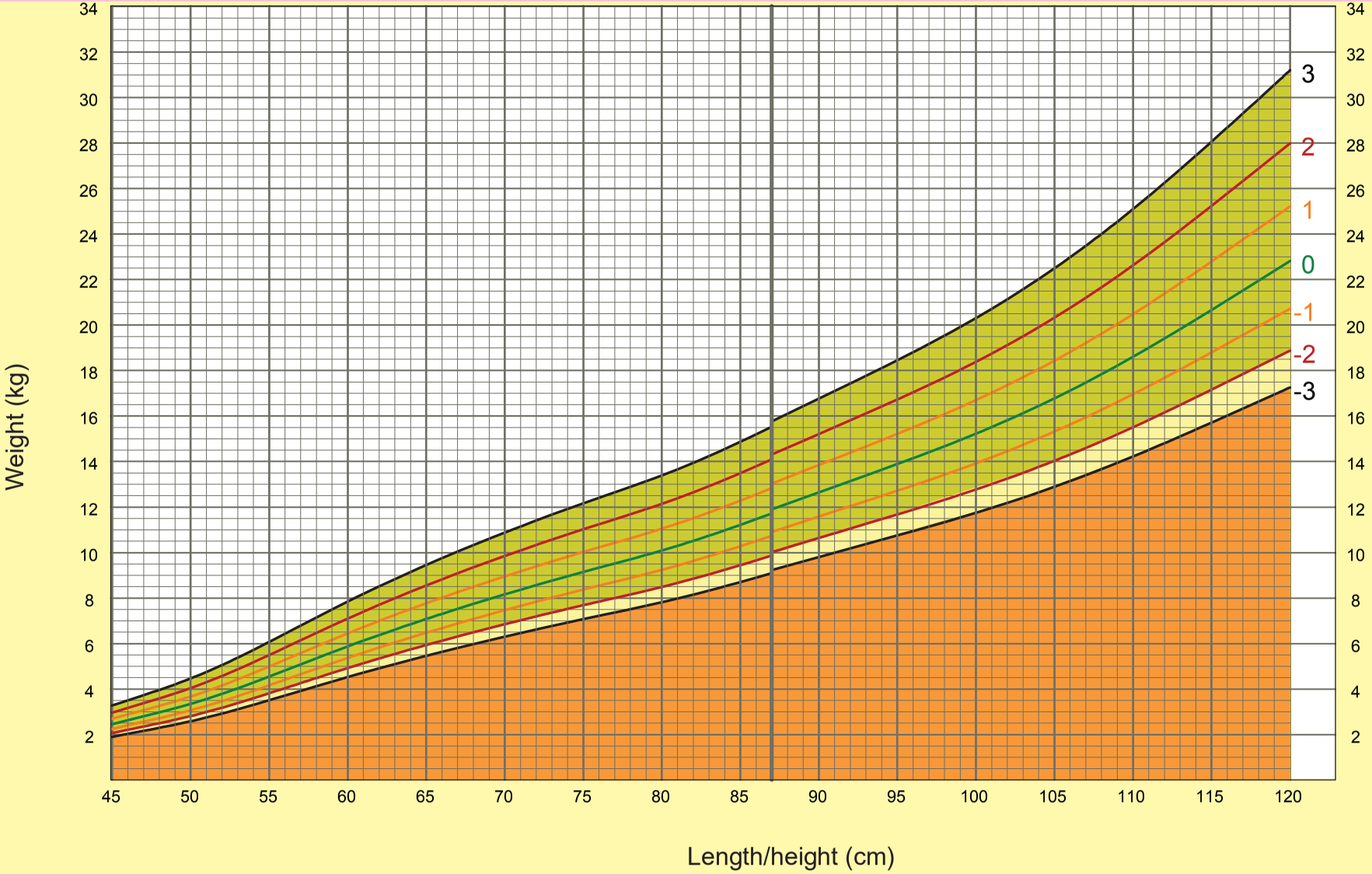
- Supplementary nutritional support, growth monitoring and promotion
- Nutrition and health education
- Immunization
- Health check-up
- Referral services
- Early childhood care and preschool education

Have your child weighed at the AWC every month

ANNEXURE -4.3 Growth chart for Girls (Weight-for-length/height)

Weight-for-length/height Girls

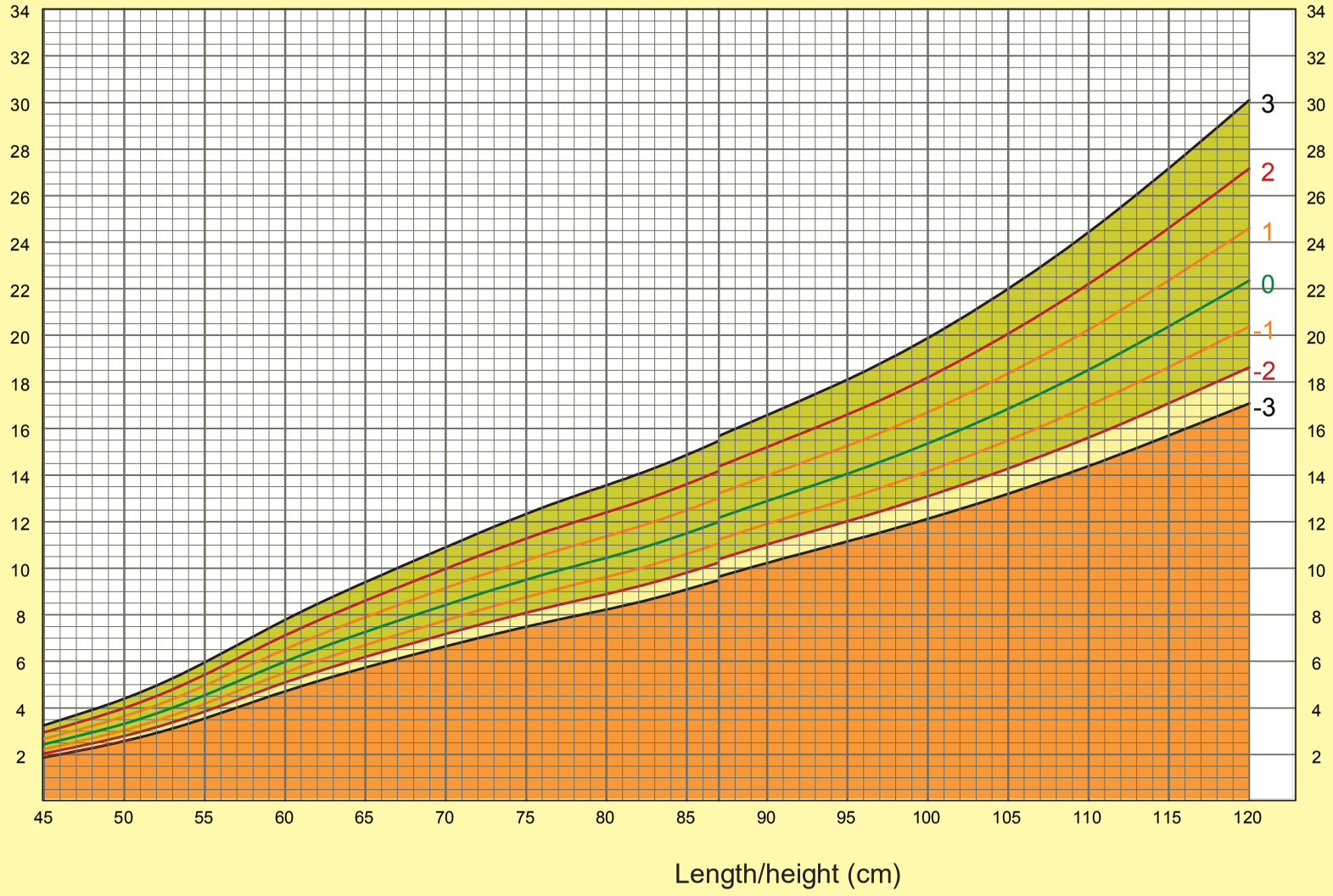
(As per WHO Child Growth Standards)



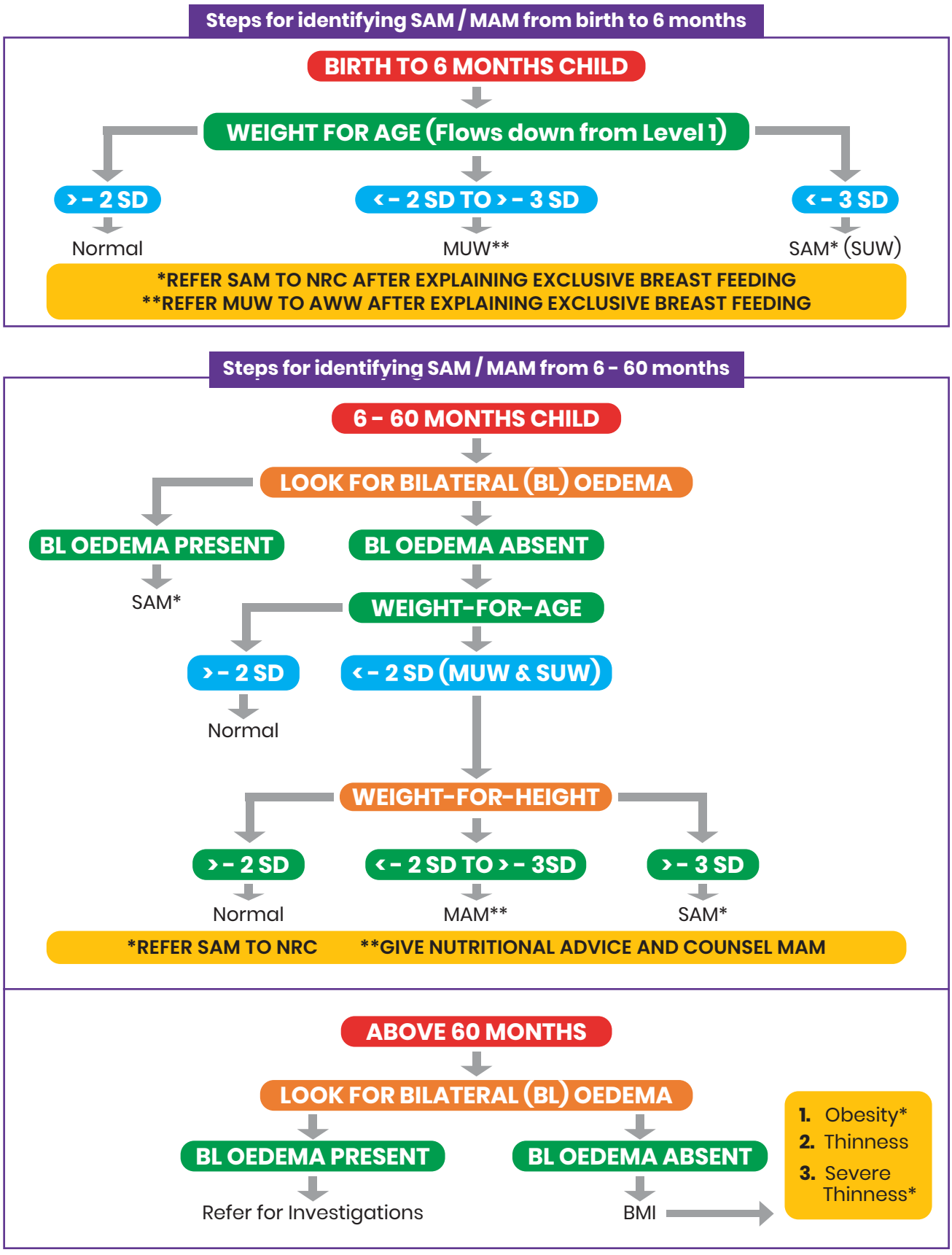
ANNEXURE – 4.4 Growth chart for BOYS (Weight-for-length/height)

Weight-for-length/height Boy

(As per WHO Child Growth Standards)



Annexures-4.5: Step for identifying SAM/MAM newborn and children



Annexure 5: Use of Weight-for-age & Weight-for-length chart (z-scores)

Annexure 5.1 Weight-for age for girls and boys

To determine weight-for-age and identify severely underweight and moderately underweight.

GIRLS							Year	Month	BOYS						
-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD	Month		-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
2	2.4	2.8	3.2	3.7	4.2	4.8	0:0	0	2.1	2.5	2.9	3.3	3.9	4.4	5
2.7	3.2	3.6	4.2	4.8	5.5	6.2	0:1	1	2.9	3.4	3.9	4.5	5.1	5.8	6.6
3.4	3.9	4.5	5.1	5.8	6.6	7.5	0:2	2	3.8	4.3	4.9	5.6	6.3	7.1	8
4	4.5	5.2	5.8	6.6	7.5	8.5	0:3	3	4.4	5	5.7	6.4	7.2	8	9
4.4	5	5.7	6.4	7.3	8.2	9.3	0:4	4	4.9	5.6	6.2	7	7.8	8.7	9.7
4.8	5.4	6.1	6.9	7.8	8.8	10	0:5	5	5.3	6	6.7	7.5	8.4	9.3	10.4
5.1	5.7	6.5	7.3	8.2	9.3	10.6	0:6	6	5.7	6.4	7.1	7.9	8.8	9.8	10.9
5.3	6	6.8	7.6	8.6	9.8	11.1	0:7	7	5.9	6.7	7.4	8.3	9.2	10.3	11.4
5.6	6.3	7	7.9	9	10.2	11.6	0:8	8	6.2	6.9	7.7	8.6	9.6	10.7	11.9
5.8	6.5	7.3	8.2	9.3	10.5	12	0:9	9	6.4	7.1	8	8.9	9.9	11	12.3
5.9	6.7	7.5	8.5	9.6	10.9	12.4	0:10	10	6.6	7.4	8.2	9.2	10.2	11.4	12.7
6.1	6.9	7.7	8.7	9.9	11.2	12.8	0:11	11	6.8	7.6	8.4	9.4	10.5	11.7	13
6.3	7	7.9	8.9	10.1	11.5	13.1	1:0	12	6.9	7.7	8.6	9.6	10.8	12	13.3
6.4	7.2	8.1	9.2	10.4	11.8	13.5	1:1	13	7.1	7.9	8.8	9.9	11	12.3	13.7
6.6	7.4	8.3	9.4	10.6	12.1	13.8	1:2	14	7.2	8.1	9	10.1	11.3	12.6	14
6.7	7.6	8.5	9.6	10.9	12.4	14.1	1:3	15	7.4	8.3	9.2	10.3	11.5	12.8	14.3
6.9	7.7	8.7	9.8	11.1	12.6	14.5	1:4	16	7.5	8.4	9.4	10.5	11.7	13.1	14.6
7	7.9	8.9	10	11.4	12.9	14.8	1:5	17	7.7	8.6	9.6	10.7	12	13.4	14.9
7.2	8.1	9.1	10.2	11.6	13.2	15.1	1:6	18	7.8	8.8	9.8	10.9	12.2	13.7	15.3
7.3	8.2	9.2	10.4	11.8	13.5	15.4	1:7	19	8	8.9	10	11.1	12.5	13.9	15.6
7.5	8.4	9.4	10.6	12.1	13.7	15.7	1:8	20	8.1	9.1	10.1	11.3	12.7	14.2	15.9
7.6	8.6	9.6	10.9	12.3	14	16	1:9	21	8.2	9.2	10.3	11.5	12.9	14.5	16.2
7.8	8.7	9.8	11.1	12.5	14.3	16.4	1:10	22	8.4	9.4	10.5	11.8	13.2	14.7	16.5
7.9	8.9	10	11.3	12.8	14.6	16.7	1:11	23	8.5	9.5	10.7	12	13.4	15	16.8
8.1	9	10.2	11.5	13	14.8	17	2:0	24	8.6	9.7	10.8	12.2	13.6	15.3	17.1
8.2	9.2	10.3	11.7	13.3	15.1	17.3	2:1	25	8.8	9.8	11	12.4	13.9	15.5	17.5
8.4	9.4	10.5	11.9	13.5	15.4	17.7	2:2	26	8.9	10	11.2	12.5	14.1	15.8	17.8
8.5	9.5	10.7	12.1	13.7	15.7	18	2:3	27	9	10.1	11.3	12.7	14.3	16.1	18.1
8.6	9.7	10.9	12.3	14	16	18.3	2:4	28	9.1	10.2	11.5	12.9	14.5	16.3	18.4
8.8	9.8	11.1	12.5	14.2	16.2	18.7	2:5	29	9.2	10.4	11.7	13.1	14.8	16.6	18.7
8.9	10	11.2	12.7	14.4	16.5	19	2:6	30	9.4	10.5	11.8	13.3	15	16.9	19
9	10.1	11.4	12.9	14.7	16.8	19.3	2:7	31	9.5	10.7	12	13.5	15.2	17.1	19.3
9.1	10.3	11.6	13.1	14.9	17.1	19.6	2:8	32	9.6	10.8	12.1	13.7	15.4	17.4	19.6
9.3	10.4	11.7	13.3	15.1	17.3	20	2:9	33	9.7	10.9	12.3	13.8	15.6	17.6	19.9
9.4	10.5	11.9	13.5	15.4	17.6	20.3	2:10	34	9.8	11	12.4	14	15.8	17.8	20.2
9.5	10.7	12	13.7	15.6	17.9	20.6	2:11	35	9.9	11.2	12.6	14.2	16	18.1	20.4
9.6	10.8	12.2	13.9	15.8	18.1	20.9	3:0	36	10	11.3	12.7	14.3	16.2	18.3	20.7
9.7	10.9	12.4	14	16	18.4	21.3	3:1	37	10.1	11.4	12.9	14.5	16.4	18.6	21
9.8	11.1	12.5	14.2	16.3	18.7	21.6	3:2	38	10.2	11.5	13	14.7	16.6	18.8	21.3

GIRLS							Year	Month	BOYS						
-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD	Month		-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
9.9	11.2	12.7	14.4	16.5	19	22	3:3	**39**	10.3	11.6	13.1	14.8	16.8	19	21.6
10.1	11.3	12.8	14.6	16.7	19.2	22.3	3:4	**40**	10.4	11.8	13.3	15	17	19.3	21.9
10.2	11.5	13	14.8	16.9	19.5	22.7	3:5	**41**	10.5	11.9	13.4	15.2	17.2	19.5	22.1
10.3	11.6	13.1	15	17.2	19.8	23	3:6	**42**	10.6	12	13.6	15.3	17.4	19.7	22.4
10.4	11.7	13.3	15.2	17.4	20.1	23.4	3:7	**43**	10.7	12.1	13.7	15.5	17.6	20	22.7
10.5	11.8	13.4	15.3	17.6	20.4	23.7	3:8	**44**	10.8	12.2	13.8	15.7	17.8	20.2	23
10.6	12	13.6	15.5	17.8	20.7	24.1	3:9	**45**	10.9	12.4	14	15.8	18	20.5	23.3
10.7	12.1	13.7	15.7	18.1	20.9	24.5	3:10	**46**	11	12.5	14.1	16	18.2	20.7	23.6
10.8	12.2	13.9	15.9	18.3	21.2	24.8	3:11	**47**	11.1	12.6	14.3	16.2	18.4	20.9	23.9
10.9	12.3	14	16.1	18.5	21.5	25.2	4:0	**48**	11.2	12.7	14.4	16.3	18.6	21.2	24.2
11	12.4	14.2	16.3	18.8	21.8	25.5	4:1	**49**	11.3	12.8	14.5	16.5	18.8	21.4	24.5
11.1	12.6	14.3	16.4	19	22.1	25.9	4:2	**50**	11.4	12.9	14.7	16.7	19	21.7	24.8
11.2	12.7	14.5	16.6	19.2	22.4	26.3	4:3	**51**	11.5	13.1	14.8	16.8	19.2	21.9	25.1
11.3	12.8	14.6	16.8	19.4	22.6	26.6	4:4	**52**	11.6	13.2	15	17	19.4	22.2	25.4
11.4	12.9	14.8	17	19.7	22.9	27	4:5	**53**	11.7	13.3	15.1	17.2	19.6	22.4	25.7
11.5	13	14.9	17.2	19.9	23.2	27.4	4:6	**54**	11.8	13.4	15.2	17.3	19.8	22.7	26
11.6	13.2	15.1	17.3	20.1	23.5	27.7	4:7	**55**	11.9	13.5	15.4	17.5	20	22.9	26.3
11.7	13.3	15.2	17.5	20.3	23.8	28.1	4:8	**56**	12	13.6	15.5	17.7	20.2	23.2	26.6
11.8	13.4	15.3	17.7	20.6	24.1	28.5	4:9	**57**	12.1	13.7	15.6	17.8	20.4	23.4	26.9
11.9	13.5	15.5	17.9	20.8	24.4	28.8	4:10	**58**	12.2	13.8	15.8	18	20.6	23.7	27.2
12	13.6	15.6	18	21	24.6	29.2	4:11	**59**	12.3	14	15.9	18.2	20.8	23.9	27.6
12.1	13.7	15.8	18.2	21.2	24.9	29.5	5:0	**60**	12.4	14.1	16	18.3	21	24.2	27.9
12.4	14	15.9	18.3	21.2	24.8	29.5	5:1	**61**	12.7	14.4	16.3	18.5	21.1	24.2	27.8
12.5	14.1	16	18.4	21.4	25.1	29.8	5:2	**62**	12.8	14.5	16.4	18.7	21.3	24.4	28.1
12.6	14.2	16.2	18.6	21.6	25.4	30.2	5:3	**63**	13	14.6	16.6	18.9	21.5	24.7	28.4
12.7	14.3	16.3	18.8	21.8	25.6	30.5	5:4	**64**	13.1	14.8	16.7	19	21.7	24.9	28.8
12.8	14.4	16.5	19	22	25.9	30.9	5:5	**65**	13.2	14.9	16.9	19.2	22	25.2	29.1
12.9	14.6	16.6	19.1	22.2	26.2	31.3	5:6	**66**	13.3	15	17	19.4	22.2	25.5	29.4
13	14.7	16.8	19.3	22.5	26.5	31.6	5:7	**67**	13.4	15.2	17.2	19.6	22.4	25.7	29.8
13.1	14.8	16.9	19.5	22.7	26.7	32	5:8	**68**	13.6	15.3	17.4	19.8	22.6	26	30.1
13.2	14.9	17	19.6	22.9	27	32.3	5:9	**69**	13.7	15.4	17.5	19.9	22.8	26.3	30.4
13.3	15	17.2	19.8	23.1	27.3	32.7	5:10	**70**	13.8	15.6	17.7	20.1	23.1	26.6	30.8
13.4	15.2	17.3	20	23.3	27.6	33.1	5:11	**71**	13.9	15.7	17.8	20.3	23.3	26.8	31.2
13.5	15.3	17.5	20.2	23.5	27.8	33.4	6:0	**72**	14.1	15.9	18	20.5	23.5	27.1	31.5
13.6	15.4	17.6	20.3	23.8	28.1	33.8	6:1	**73**	14.2	16	18.2	20.7	23.7	27.4	31.9
13.7	15.5	17.8	20.5	24	28.4	34.2	6:2	**74**	14.3	16.2	18.3	20.9	24	27.7	32.2
13.8	15.6	17.9	20.7	24.2	28.7	34.6	6:3	**75**	14.5	16.3	18.5	21.1	24.2	28	32.6
13.9	15.8	18	20.9	24.4	29	35	6:4	**76**	14.6	16.5	18.7	21.3	24.4	28.3	33
14	15.9	18.2	21	24.6	29.3	35.4	6:5	**77**	14.7	16.6	18.8	21.5	24.7	28.6	33.3
14.1	16	18.3	21.2	24.9	29.6	35.8	6:6	**78**	14.9	16.8	19	21.7	24.9	28.9	33.7
14.2	16.1	18.5	21.4	25.1	29.9	36.2	6:7	**79**	15	16.9	19.2	21.9	25.2	29.2	34.1
14.3	16.3	18.6	21.6	25.3	30.2	36.6	6:8	**80**	15.1	17.1	19.3	22.1	25.4	29.5	34.5
14.4	16.4	18.8	21.8	25.6	30.5	37	6:9	**81**	15.3	17.2	19.5	22.3	25.6	29.8	34.9
14.5	16.5	18.9	22	25.8	30.8	37.4	6:10	**82**	15.4	17.4	19.7	22.5	25.9	30.1	35.3
14.6	16.6	19.1	22.2	26.1	31.1	37.8	6:11	**83**	15.5	17.5	19.9	22.7	26.1	30.4	35.7

as per WHO standards

Annexure 5.2 Weight-for-length girls (Birth to 2 years)

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
45.0	1.9	2.1	2.3	2.5	2.7	3.0	3.3
45.5	2.0	2.1	2.3	2.5	2.8	3.1	3.4
46.0	2.0	2.2	2.4	2.6	2.9	3.2	3.5
46.5	2.1	2.3	2.5	2.7	3.0	3.3	3.6
47.0	2.2	2.4	2.6	2.8	3.1	3.4	3.7
47.5	2.2	2.4	2.6	2.9	3.2	3.5	3.8
48.0	2.3	2.5	2.7	3.0	3.3	3.6	4.0
48.5	2.4	2.6	2.8	3.1	3.4	3.7	4.1
49.0	2.4	2.6	2.9	3.2	3.5	3.8	4.2
49.5	2.5	2.7	3.0	3.3	3.6	3.9	4.3
50.0	2.6	2.8	3.1	3.4	3.7	4.0	4.5
50.5	2.7	2.9	3.2	3.5	3.8	4.2	4.6
51.0	2.8	3.0	3.3	3.6	3.9	4.3	4.8
51.5	2.8	3.1	3.4	3.7	4.0	4.4	4.9
52.0	2.9	3.2	3.5	3.8	4.2	4.6	5.1
52.5	3.0	3.3	3.6	3.9	4.3	4.7	5.2
53.0	3.1	3.4	3.7	4.0	4.4	4.9	5.4
53.5	3.2	3.5	3.8	4.2	4.6	5.0	5.5
54.0	3.3	3.6	3.9	4.3	4.7	5.2	5.7
54.5	3.4	3.7	4.0	4.4	4.8	5.3	5.9
55.0	3.5	3.8	4.2	4.5	5.0	5.5	6.1
55.5	3.6	3.9	4.3	4.7	5.1	5.7	6.3
56.0	3.7	4.0	4.4	4.8	5.3	5.8	6.4
56.5	3.8	4.1	4.5	5.0	5.4	6.0	6.6
57.0	3.9	4.3	4.6	5.1	5.6	6.1	6.8
57.5	4.0	4.4	4.8	5.2	5.7	6.3	7.0
58.0	4.1	4.5	4.9	5.4	5.9	6.5	7.1
58.5	4.2	4.6	5.0	5.5	6.0	6.6	7.3
59.0	4.3	4.7	5.1	5.6	6.2	6.8	7.5
59.5	4.4	4.8	5.3	5.7	6.3	6.9	7.7

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
60.0	4.5	4.9	5.4	5.9	6.4	7.1	7.8
60.5	4.6	5.0	5.5	6.0	6.6	7.3	8.0
61.0	4.7	5.1	5.6	6.1	6.7	7.4	8.2
61.5	4.8	5.2	5.7	6.3	6.9	7.6	8.4
62.0	4.9	5.3	5.8	6.4	7.0	7.7	8.5
62.5	5.0	5.4	5.9	6.5	7.1	7.8	8.7
63.0	5.1	5.5	6.0	6.6	7.3	8.0	8.8
63.5	5.2	5.6	6.2	6.7	7.4	8.1	9.0
64.0	5.3	5.7	6.3	6.9	7.5	8.3	9.1
64.5	5.4	5.8	6.4	7.0	7.6	8.4	9.3
65.0	5.5	5.9	6.5	7.1	7.8	8.6	9.5
65.5	5.5	6.0	6.6	7.2	7.9	8.7	9.6
66.0	5.6	6.1	6.7	7.3	8.0	8.8	9.8
66.5	5.7	6.2	6.8	7.4	8.1	9.0	9.9
67.0	5.8	6.3	6.9	7.5	8.3	9.1	10.0
67.5	5.9	6.4	7.0	7.6	8.4	9.2	10.2
68.0	6.0	6.5	7.1	7.7	8.5	9.4	10.3
68.5	6.1	6.6	7.2	7.9	8.6	9.5	10.5
69.0	6.1	6.7	7.3	8.0	8.7	9.6	10.6
69.5	6.2	6.8	7.4	8.1	8.8	9.7	10.7
70.0	6.3	6.9	7.5	8.2	9.0	9.9	10.9
70.5	6.4	6.9	7.6	8.3	9.1	10.0	11.0
71.0	6.5	7.0	7.7	8.4	9.2	10.1	11.1
71.5	6.5	7.1	7.7	8.5	9.3	10.2	11.3
72.0	6.6	7.2	7.8	8.6	9.4	10.3	11.4
72.5	6.7	7.3	7.9	8.7	9.5	10.5	11.5
73.0	6.8	7.4	8.0	8.8	9.6	10.6	11.7
73.5	6.9	7.4	8.1	8.9	9.7	10.7	11.8
74.0	6.9	7.5	8.2	9.0	9.8	10.8	11.9
74.5	7.0	7.6	8.3	9.1	9.9	10.9	12.0
75.0	7.1	7.7	8.4	9.1	10.0	11.0	12.2

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
75.5	7.1	7.8	8.5	9.2	10.1	11.1	12.3
76.0	7.2	7.8	8.5	9.3	10.2	11.2	12.4
76.5	7.3	7.9	8.6	9.4	10.3	11.4	12.5
77.0	7.4	8.0	8.7	9.5	10.4	11.5	12.6
77.5	7.4	8.1	8.8	9.6	10.5	11.6	12.8
78.0	7.5	8.2	8.9	9.7	10.6	11.7	12.9
78.5	7.6	8.2	9.0	9.8	10.7	11.8	13.0
79.0	7.7	8.3	9.1	9.9	10.8	11.9	13.1
79.5	7.7	8.4	9.1	10.0	10.9	12.0	13.3
80.0	7.8	8.5	9.2	10.1	11.0	12.1	13.4
80.5	7.9	8.6	9.3	10.2	11.2	12.3	13.5
81.0	8.0	8.7	9.4	10.3	11.3	12.4	13.7
81.5	8.1	8.8	9.5	10.4	11.4	12.5	13.8
82.0	8.1	8.8	9.6	10.5	11.5	12.6	13.9
82.5	8.2	8.9	9.7	10.6	11.6	12.8	14.1
83.0	8.3	9.0	9.8	10.7	11.8	12.9	14.2
83.5	8.4	9.1	9.9	10.9	11.9	13.1	14.4
84.0	8.5	9.2	10.1	11.0	12.0	13.2	14.5
84.5	8.6	9.3	10.2	11.1	12.1	13.3	14.7
85.0	8.7	9.4	10.3	11.2	12.3	13.5	14.9
85.5	8.8	9.5	10.4	11.3	12.4	13.6	15.0
86.0	8.9	9.7	10.5	11.5	12.6	13.8	15.2
86.5	9.0	9.8	10.6	11.6	12.7	13.9	15.4
87.0	9.1	9.9	10.7	11.7	12.8	14.1	15.5
87.5	9.2	10.0	10.9	11.8	13.0	14.2	15.7
88.0	9.3	10.1	11.0	12.0	13.1	14.4	15.9
88.5	9.4	10.2	11.1	12.1	13.2	14.5	16.0
89.0	9.5	10.3	11.2	12.2	13.4	14.7	16.2
89.5	9.6	10.4	11.3	12.3	13.5	14.8	16.4
90.0	9.7	10.5	11.4	12.5	13.7	15.0	16.5
90.5	9.8	10.6	11.5	12.6	13.8	15.1	16.7

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
91.0	9.9	10.7	11.7	12.7	13.9	15.3	16.9
91.5	10.0	10.8	11.8	12.8	14.1	15.5	17.0
92.0	10.1	10.9	11.9	13.0	14.2	15.6	17.2
92.5	10.1	11.0	12.0	13.1	14.3	15.8	17.4
93.0	10.2	11.1	12.1	13.2	14.5	15.9	17.5
93.5	10.3	11.2	12.2	13.3	14.6	16.1	17.7
94.0	10.4	11.3	12.3	13.5	14.7	16.2	17.9
94.5	10.5	11.4	12.4	13.6	14.9	16.4	18.0
95.0	10.6	11.5	12.6	13.7	15.0	16.5	18.2
95.5	10.7	11.6	12.7	13.8	15.2	16.7	18.4
96.0	10.8	11.7	12.8	14.0	15.3	16.8	18.6
96.5	10.9	11.8	12.9	14.1	15.4	17.0	18.7
97.0	11.0	12.0	13.0	14.2	15.6	17.1	18.9
97.5	11.1	12.1	13.1	14.4	15.7	17.3	19.1
98.0	11.2	12.2	13.3	14.5	15.9	17.5	19.3
98.5	11.3	12.3	13.4	14.6	16.0	17.6	19.5
99.0	11.4	12.4	13.5	14.8	16.2	17.8	19.6
99.5	11.5	12.5	13.6	14.9	16.3	18.0	19.8
100.0	11.6	12.6	13.7	15.0	16.5	18.1	20.0
100.5	11.7	12.7	13.9	15.2	16.6	18.3	20.2
101.0	11.8	12.8	14.0	15.3	16.8	18.5	20.4
101.5	11.9	13.0	14.1	15.5	17.0	18.7	20.6
102.0	12.0	13.1	14.3	15.6	17.1	18.9	20.8
102.5	12.1	13.2	14.4	15.8	17.3	19.0	21.0
103.0	12.3	13.3	14.5	15.9	17.5	19.2	21.3
103.5	12.4	13.5	14.7	16.1	17.6	19.4	21.5
104.0	12.5	13.6	14.8	16.2	17.8	19.6	21.7
104.5	12.6	13.7	15.0	16.4	18.0	19.8	21.9
105.0	12.7	13.8	15.1	16.5	18.2	20.0	22.2
105.5	12.8	14.0	15.3	16.7	18.4	20.2	22.4
106.0	13.0	14.1	15.4	16.9	18.5	20.5	22.6

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
106.5	13.1	14.3	15.6	17.1	18.7	20.7	22.9
107.0	13.2	14.4	15.7	17.2	18.9	20.9	23.1
107.5	13.3	14.5	15.9	17.4	19.1	21.1	23.4
108.0	13.5	14.7	16.0	17.6	19.3	21.3	23.6
108.5	13.6	14.8	16.2	17.8	19.5	21.6	23.9
109.0	13.7	15.0	16.4	18.0	19.7	21.8	24.2
109.5	13.9	15.1	16.5	18.1	20.0	22.0	24.4
110.0	14.0	15.3	16.7	18.3	20.2	22.3	24.7

WHO Child Growth Standards

Annexure 5.3 Weight-for-length boys (Birth to 2 years)

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
45.0	1.9	2.0	2.2	2.4	2.7	3.0	3.3
45.5	1.9	2.1	2.3	2.5	2.8	3.1	3.4
46.0	2.0	2.2	2.4	2.6	2.9	3.1	3.5
46.5	2.1	2.3	2.5	2.7	3.0	3.2	3.6
47.0	2.1	2.3	2.5	2.8	3.0	3.3	3.7
47.5	2.2	2.4	2.6	2.9	3.1	3.4	3.8
48.0	2.3	2.5	2.7	2.9	3.2	3.6	3.9
48.5	2.3	2.6	2.8	3.0	3.3	3.7	4.0
49.0	2.4	2.6	2.9	3.1	3.4	3.8	4.2
49.5	2.5	2.7	3.0	3.2	3.5	3.9	4.3
50.0	2.6	2.8	3.0	3.3	3.6	4.0	4.4
50.5	2.7	2.9	3.1	3.4	3.8	4.1	4.5
51.0	2.7	3.0	3.2	3.5	3.9	4.2	4.7
51.5	2.8	3.1	3.3	3.6	4.0	4.4	4.8
52.0	2.9	3.2	3.5	3.8	4.1	4.5	5.0
52.5	3.0	3.3	3.6	3.9	4.2	4.6	5.1
53.0	3.1	3.4	3.7	4.0	4.4	4.8	5.3
53.5	3.2	3.5	3.8	4.1	4.5	4.9	5.4
54.0	3.3	3.6	3.9	4.3	4.7	5.1	5.6
54.5	3.4	3.7	4.0	4.4	4.8	5.3	5.8
55.0	3.6	3.8	4.2	4.5	5.0	5.4	6.0
55.5	3.7	4.0	4.3	4.7	5.1	5.6	6.1
56.0	3.8	4.1	4.4	4.8	5.3	5.8	6.3
56.5	3.9	4.2	4.6	5.0	5.4	5.9	6.5
57.0	4.0	4.3	4.7	5.1	5.6	6.1	6.7
57.5	4.1	4.5	4.9	5.3	5.7	6.3	6.9
58.0	4.3	4.6	5.0	5.4	5.9	6.4	7.1
58.5	4.4	4.7	5.1	5.6	6.1	6.6	7.2
59.0	4.5	4.8	5.3	5.7	6.2	6.8	7.4
59.5	4.6	5.0	5.4	5.9	6.4	7.0	7.6

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
60.0	4.7	5.1	5.5	6.0	6.5	7.1	7.8
60.5	4.8	5.2	5.6	6.1	6.7	7.3	8.0
61.0	4.9	5.3	5.8	6.3	6.8	7.4	8.1
61.5	5.0	5.4	5.9	6.4	7.0	7.6	8.3
62.0	5.1	5.6	6.0	6.5	7.1	7.7	8.5
62.5	5.2	5.7	6.1	6.7	7.2	7.9	8.6
63.0	5.3	5.8	6.2	6.8	7.4	8.0	8.8
63.5	5.4	5.9	6.4	6.9	7.5	8.2	8.9
64.0	5.5	6.0	6.5	7.0	7.6	8.3	9.1
64.5	5.6	6.1	6.6	7.1	7.8	8.5	9.3
65.0	5.7	6.2	6.7	7.3	7.9	8.6	9.4
65.5	5.8	6.3	6.8	7.4	8.0	8.7	9.6
66.0	5.9	6.4	6.9	7.5	8.2	8.9	9.7
66.5	6.0	6.5	7.0	7.6	8.3	9.0	9.9
67.0	6.1	6.6	7.1	7.7	8.4	9.2	10.0
67.5	6.2	6.7	7.2	7.9	8.5	9.3	10.2
68.0	6.3	6.8	7.3	8.0	8.7	9.4	10.3
68.5	6.4	6.9	7.5	8.1	8.8	9.6	10.5
69.0	6.5	7.0	7.6	8.2	8.9	9.7	10.6
69.5	6.6	7.1	7.7	8.3	9.0	9.8	10.8
70.0	6.6	7.2	7.8	8.4	9.2	10.0	10.9
70.5	6.7	7.3	7.9	8.5	9.3	10.1	11.1
71.0	6.8	7.4	8.0	8.6	9.4	10.2	11.2
71.5	6.9	7.5	8.1	8.8	9.5	10.4	11.3
72.0	7.0	7.6	8.2	8.9	9.6	10.5	11.5
72.5	7.1	7.6	8.3	9.0	9.8	10.6	11.6
73.0	7.2	7.7	8.4	9.1	9.9	10.8	11.8
73.5	7.2	7.8	8.5	9.2	10.0	10.9	11.9
74.0	7.3	7.9	8.6	9.3	10.1	11.0	12.1
74.5	7.4	8.0	8.7	9.4	10.2	11.2	12.2
75.0	7.5	8.1	8.8	9.5	10.3	11.3	12.3

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
75.5	7.6	8.2	8.8	9.6	10.4	11.4	12.5
76.0	7.6	8.3	8.9	9.7	10.6	11.5	12.6
76.5	7.7	8.3	9.0	9.8	10.7	11.6	12.7
77.0	7.8	8.4	9.1	9.9	10.8	11.7	12.8
77.5	7.9	8.5	9.2	10.0	10.9	11.9	13.0
78.0	7.9	8.6	9.3	10.1	11.0	12.0	13.1
78.5	8.0	8.7	9.4	10.2	11.1	12.1	13.2
79.0	8.1	8.7	9.5	10.3	11.2	12.2	13.3
79.5	8.2	8.8	9.5	10.4	11.3	12.3	13.4
80.0	8.2	8.9	9.6	10.4	11.4	12.4	13.6
80.5	8.3	9.0	9.7	10.5	11.5	12.5	13.7
81.0	8.4	9.1	9.8	10.6	11.6	12.6	13.8
81.5	8.5	9.1	9.9	10.7	11.7	12.7	13.9
82.0	8.5	9.2	10.0	10.8	11.8	12.8	14.0
82.5	8.6	9.3	10.1	10.9	11.9	13.0	14.2
83.0	8.7	9.4	10.2	11.0	12.0	13.1	14.3
83.5	8.8	9.5	10.3	11.2	12.1	13.2	14.4
84.0	8.9	9.6	10.4	11.3	12.2	13.3	14.6
84.5	9.0	9.7	10.5	11.4	12.4	13.5	14.7
85.0	9.1	9.8	10.6	11.5	12.5	13.6	14.9
85.5	9.2	9.9	10.7	11.6	12.6	13.7	15.0
86.0	9.3	10.0	10.8	11.7	12.8	13.9	15.2
86.5	9.4	10.1	11.0	11.9	12.9	14.0	15.3
87.0	9.5	10.2	11.1	12.0	13.0	14.2	15.5
87.5	9.6	10.4	11.2	12.1	13.2	14.3	15.6
88.0	9.7	10.5	11.3	12.2	13.3	14.5	15.8
88.5	9.8	10.6	11.4	12.4	13.4	14.6	15.9
89.0	9.9	10.7	11.5	12.5	13.5	14.7	16.1
89.5	10.0	10.8	11.6	12.6	13.7	14.9	16.2
90.0	10.1	10.9	11.8	12.7	13.8	15.0	16.4
90.5	10.2	11.0	11.9	12.8	13.9	15.1	16.5

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
91.0	10.3	11.1	12.0	13.0	14.1	15.3	16.7
91.5	10.4	11.2	12.1	13.1	14.2	15.4	16.8
92.0	10.5	11.3	12.2	13.2	14.3	15.6	17.0
92.5	10.6	11.4	12.3	13.3	14.4	15.7	17.1
93.0	10.7	11.5	12.4	13.4	14.6	15.8	17.3
93.5	10.7	11.6	12.5	13.5	14.7	16.0	17.4
94.0	10.8	11.7	12.6	13.7	14.8	16.1	17.6
94.5	10.9	11.8	12.7	13.8	14.9	16.3	17.7
95.0	11.0	11.9	12.8	13.9	15.1	16.4	17.9
95.5	11.1	12.0	12.9	14.0	15.2	16.5	18.0
96.0	11.2	12.1	13.1	14.1	15.3	16.7	18.2
96.5	11.3	12.2	13.2	14.3	15.5	16.8	18.4
97.0	11.4	12.3	13.3	14.4	15.6	17.0	18.5
97.5	11.5	12.4	13.4	14.5	15.7	17.1	18.7
98.0	11.6	12.5	13.5	14.6	15.9	17.3	18.9
98.5	11.7	12.6	13.6	14.8	16.0	17.5	19.1
99.0	11.8	12.7	13.7	14.9	16.2	17.6	19.2
99.5	11.9	12.8	13.9	15.0	16.3	17.8	19.4
100.0	12.0	12.9	14.0	15.2	16.5	18.0	19.6
100.5	12.1	13.0	14.1	15.3	16.6	18.1	19.8
101.0	12.2	13.2	14.2	15.4	16.8	18.3	20.0
101.5	12.3	13.3	14.4	15.6	16.9	18.5	20.2
102.0	12.4	13.4	14.5	15.7	17.1	18.7	20.4
102.5	12.5	13.5	14.6	15.9	17.3	18.8	20.6
103.0	12.6	13.6	14.8	16.0	17.4	19.0	20.8
103.5	12.7	13.7	14.9	16.2	17.6	19.2	21.0
104.0	12.8	13.9	15.0	16.3	17.8	19.4	21.2
104.5	12.9	14.0	15.2	16.5	17.9	19.6	21.5
105.0	13.0	14.1	15.3	16.6	18.1	19.8	21.7
105.5	13.2	14.2	15.4	16.8	18.3	20.0	21.9
106.0	13.3	14.4	15.6	16.9	18.5	20.2	22.1

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
106.5	13.4	14.5	15.7	17.1	18.6	20.4	22.4
107.0	13.5	14.6	15.9	17.3	18.8	20.6	22.6
107.5	13.6	14.7	16.0	17.4	19.0	20.8	22.8
108.0	13.7	14.9	16.2	17.6	19.2	21.0	23.1
108.5	13.8	15.0	16.3	17.8	19.4	21.2	23.3
109.0	14.0	15.1	16.5	17.9	19.6	21.4	23.6
109.5	14.1	15.3	16.6	18.1	19.8	21.7	23.8
110.0	14.2	15.4	16.8	18.3	20.0	21.9	24.1

WHO Child Growth Standards

Annexure 5.4 Weight-for-height girls (2 - 5 years)

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
65.0	5.6	6.1	6.6	7.2	7.9	8.7	9.7
65.5	5.7	6.2	6.7	7.4	8.1	8.9	9.8
66.0	5.8	6.3	6.8	7.5	8.2	9.0	10.0
66.5	5.8	6.4	6.9	7.6	8.3	9.1	10.1
67.0	5.9	6.4	7.0	7.7	8.4	9.3	10.2
67.5	6.0	6.5	7.1	7.8	8.5	9.4	10.4
68.0	6.1	6.6	7.2	7.9	8.7	9.5	10.5
68.5	6.2	6.7	7.3	8.0	8.8	9.7	10.7
69.0	6.3	6.8	7.4	8.1	8.9	9.8	10.8
69.5	6.3	6.9	7.5	8.2	9.0	9.9	10.9
70.0	6.4	7.0	7.6	8.3	9.1	10.0	11.1
70.5	6.5	7.1	7.7	8.4	9.2	10.1	11.2
71.0	6.6	7.1	7.8	8.5	9.3	10.3	11.3
71.5	6.7	7.2	7.9	8.6	9.4	10.4	11.5
72.0	6.7	7.3	8.0	8.7	9.5	10.5	11.6
72.5	6.8	7.4	8.1	8.8	9.7	10.6	11.7
73.0	6.9	7.5	8.1	8.9	9.8	10.7	11.8
73.5	7.0	7.6	8.2	9.0	9.9	10.8	12.0
74.0	7.0	7.6	8.3	9.1	10.0	11.0	12.1
74.5	7.1	7.7	8.4	9.2	10.1	11.1	12.2
75.0	7.2	7.8	8.5	9.3	10.2	11.2	12.3
75.5	7.2	7.9	8.6	9.4	10.3	11.3	12.5
76.0	7.3	8.0	8.7	9.5	10.4	11.4	12.6
76.5	7.4	8.0	8.7	9.6	10.5	11.5	12.7
77.0	7.5	8.1	8.8	9.6	10.6	11.6	12.8
77.5	7.5	8.2	8.9	9.7	10.7	11.7	12.9
78.0	7.6	8.3	9.0	9.8	10.8	11.8	13.1
78.5	7.7	8.4	9.1	9.9	10.9	12.0	13.2
79.0	7.8	8.4	9.2	10.0	11.0	12.1	13.3
79.5	7.8	8.5	9.3	10.1	11.1	12.2	13.4

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
80.0	7.9	8.6	9.4	10.2	11.2	12.3	13.6
80.5	8.0	8.7	9.5	10.3	11.3	12.4	13.7
81.0	8.1	8.8	9.6	10.4	11.4	12.6	13.9
81.5	8.2	8.9	9.7	10.6	11.6	12.7	14.0
82.0	8.3	9.0	9.8	10.7	11.7	12.8	14.1
82.5	8.4	9.1	9.9	10.8	11.8	13.0	14.3
83.0	8.5	9.2	10.0	10.9	11.9	13.1	14.5
83.5	8.5	9.3	10.1	11.0	12.1	13.3	14.6
84.0	8.6	9.4	10.2	11.1	12.2	13.4	14.8
84.5	8.7	9.5	10.3	11.3	12.3	13.5	14.9
85.0	8.8	9.6	10.4	11.4	12.5	13.7	15.1
85.5	8.9	9.7	10.6	11.5	12.6	13.8	15.3
86.0	9.0	9.8	10.7	11.6	12.7	14.0	15.4
86.5	9.1	9.9	10.8	11.8	12.9	14.2	15.6
87.0	9.2	10.0	10.9	11.9	13.0	14.3	15.8
87.5	9.3	10.1	11.0	12.0	13.2	14.5	15.9
88.0	9.4	10.2	11.1	12.1	13.3	14.6	16.1
88.5	9.5	10.3	11.2	12.3	13.4	14.8	16.3
89.0	9.6	10.4	11.4	12.4	13.6	14.9	16.4
89.5	9.7	10.5	11.5	12.5	13.7	15.1	16.6
90.0	9.8	10.6	11.6	12.6	13.8	15.2	16.8
90.5	9.9	10.7	11.7	12.8	14.0	15.4	16.9
91.0	10.0	10.9	11.8	12.9	14.1	15.5	17.1
91.5	10.1	11.0	11.9	13.0	14.3	15.7	17.3
92.0	10.2	11.1	12.0	13.1	14.4	15.8	17.4
92.5	10.3	11.2	12.1	13.3	14.5	16.0	17.6
93.0	10.4	11.3	12.3	13.4	14.7	16.1	17.8
93.5	10.5	11.4	12.4	13.5	14.8	16.3	17.9
94.0	10.6	11.5	12.5	13.6	14.9	16.4	18.1
94.5	10.7	11.6	12.6	13.8	15.1	16.6	18.3
95.0	10.8	11.7	12.7	13.9	15.2	16.7	18.5

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
95.5	10.8	11.8	12.8	14.0	15.4	16.9	18.6
96.0	10.9	11.9	12.9	14.1	15.5	17.0	18.8
96.5	11.0	12.0	13.1	14.3	15.6	17.2	19.0
97.0	11.1	12.1	13.2	14.4	15.8	17.4	19.2
97.5	11.2	12.2	13.3	14.5	15.9	17.5	19.3
98.0	11.3	12.3	13.4	14.7	16.1	17.7	19.5
98.5	11.4	12.4	13.5	14.8	16.2	17.9	19.7
99.0	11.5	12.5	13.7	14.9	16.4	18.0	19.9
99.5	11.6	12.7	13.8	15.1	16.5	18.2	20.1
100.0	11.7	12.8	13.9	15.2	16.7	18.4	20.3
100.5	11.9	12.9	14.1	15.4	16.9	18.6	20.5
101.0	12.0	13.0	14.2	15.5	17.0	18.7	20.7
101.5	12.1	13.1	14.3	15.7	17.2	18.9	20.9
102.0	12.2	13.3	14.5	15.8	17.4	19.1	21.1
102.5	12.3	13.4	14.6	16.0	17.5	19.3	21.4
103.0	12.4	13.5	14.7	16.1	17.7	19.5	21.6
103.5	12.5	13.6	14.9	16.3	17.9	19.7	21.8
104.0	12.6	13.8	15.0	16.4	18.1	19.9	22.0
104.5	12.8	13.9	15.2	16.6	18.2	20.1	22.3
105.0	12.9	14.0	15.3	16.8	18.4	20.3	22.5
105.5	13.0	14.2	15.5	16.9	18.6	20.5	22.7
106.0	13.1	14.3	15.6	17.1	18.8	20.8	23.0
106.5	13.3	14.5	15.8	17.3	19.0	21.0	23.2
107.0	13.4	14.6	15.9	17.5	19.2	21.2	23.5
107.5	13.5	14.7	16.1	17.7	19.4	21.4	23.7
108.0	13.7	14.9	16.3	17.8	19.6	21.7	24.0
108.5	13.8	15.0	16.4	18.0	19.8	21.9	24.3
109.0	13.9	15.2	16.6	18.2	20.0	22.1	24.5
109.5	14.1	15.4	16.8	18.4	20.3	22.4	24.8
110.0	14.2	15.5	17.0	18.6	20.5	22.6	25.1
110.5	14.4	15.7	17.1	18.8	20.7	22.9	25.4

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
111.0	14.5	15.8	17.3	19.0	20.9	23.1	25.7
111.5	14.7	16.0	17.5	19.2	21.2	23.4	26.0
112.0	14.8	16.2	17.7	19.4	21.4	23.6	26.2
112.5	15.0	16.3	17.9	19.6	21.6	23.9	26.5
113.0	15.1	16.5	18.0	19.8	21.8	24.2	26.8
113.5	15.3	16.7	18.2	20.0	22.1	24.4	27.1
114.0	15.4	16.8	18.4	20.2	22.3	24.7	27.4
114.5	15.6	17.0	18.6	20.5	22.6	25.0	27.8
115.0	15.7	17.2	18.8	20.7	22.8	25.2	28.1
115.5	15.9	17.3	19.0	20.9	23.0	25.5	28.4
116.0	16.0	17.5	19.2	21.1	23.3	25.8	28.7
116.5	16.2	17.7	19.4	21.3	23.5	26.1	29.0
117.0	16.3	17.8	19.6	21.5	23.8	26.3	29.3
117.5	16.5	18.0	19.8	21.7	24.0	26.6	29.6
118.0	16.6	18.2	19.9	22.0	24.2	26.9	29.9
118.5	16.8	18.4	20.1	22.2	24.5	27.2	30.3
119.0	16.9	18.5	20.3	22.4	24.7	27.4	30.6
119.5	17.1	18.7	20.5	22.6	25.0	27.7	30.9
120.0	17.3	18.9	20.7	22.8	25.2	28.0	31.2

WHO Child Growth Standards

Annexure 5.5 Weight-for-height for Boys (2-5 years)

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
65.0	5.9	6.3	6.9	7.4	8.1	8.8	9.6
65.5	6.0	6.4	7.0	7.6	8.2	8.9	9.8
66.0	6.1	6.5	7.1	7.7	8.3	9.1	9.9
66.5	6.1	6.6	7.2	7.8	8.5	9.2	10.1
67.0	6.2	6.7	7.3	7.9	8.6	9.4	10.2
67.5	6.3	6.8	7.4	8.0	8.7	9.5	10.4
68.0	6.4	6.9	7.5	8.1	8.8	9.6	10.5
68.5	6.5	7.0	7.6	8.2	9.0	9.8	10.7
69.0	6.6	7.1	7.7	8.4	9.1	9.9	10.8
69.5	6.7	7.2	7.8	8.5	9.2	10.0	11.0
70.0	6.8	7.3	7.9	8.6	9.3	10.2	11.1
70.5	6.9	7.4	8.0	8.7	9.5	10.3	11.3
71.0	6.9	7.5	8.1	8.8	9.6	10.4	11.4
71.5	7.0	7.6	8.2	8.9	9.7	10.6	11.6
72.0	7.1	7.7	8.3	9.0	9.8	10.7	11.7
72.5	7.2	7.8	8.4	9.1	9.9	10.8	11.8
73.0	7.3	7.9	8.5	9.2	10.0	11.0	12.0
73.5	7.4	7.9	8.6	9.3	10.2	11.1	12.1
74.0	7.4	8.0	8.7	9.4	10.3	11.2	12.2
74.5	7.5	8.1	8.8	9.5	10.4	11.3	12.4
75.0	7.6	8.2	8.9	9.6	10.5	11.4	12.5
75.5	7.7	8.3	9.0	9.7	10.6	11.6	12.6
76.0	7.7	8.4	9.1	9.8	10.7	11.7	12.8
76.5	7.8	8.5	9.2	9.9	10.8	11.8	12.9
77.0	7.9	8.5	9.2	10.0	10.9	11.9	13.0
77.5	8.0	8.6	9.3	10.1	11.0	12.0	13.1
78.0	8.0	8.7	9.4	10.2	11.1	12.1	13.3
78.5	8.1	8.8	9.5	10.3	11.2	12.2	13.4
79.0	8.2	8.8	9.6	10.4	11.3	12.3	13.5
79.5	8.3	8.9	9.7	10.5	11.4	12.4	13.6

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
65.0	5.9	6.3	6.9	7.4	8.1	8.8	9.6
65.5	6.0	6.4	7.0	7.6	8.2	8.9	9.8
66.0	6.1	6.5	7.1	7.7	8.3	9.1	9.9
66.5	6.1	6.6	7.2	7.8	8.5	9.2	10.1
67.0	6.2	6.7	7.3	7.9	8.6	9.4	10.2
67.5	6.3	6.8	7.4	8.0	8.7	9.5	10.4
68.0	6.4	6.9	7.5	8.1	8.8	9.6	10.5
68.5	6.5	7.0	7.6	8.2	9.0	9.8	10.7
69.0	6.6	7.1	7.7	8.4	9.1	9.9	10.8
69.5	6.7	7.2	7.8	8.5	9.2	10.0	11.0
70.0	6.8	7.3	7.9	8.6	9.3	10.2	11.1
70.5	6.9	7.4	8.0	8.7	9.5	10.3	11.3
71.0	6.9	7.5	8.1	8.8	9.6	10.4	11.4
71.5	7.0	7.6	8.2	8.9	9.7	10.6	11.6
72.0	7.1	7.7	8.3	9.0	9.8	10.7	11.7
72.5	7.2	7.8	8.4	9.1	9.9	10.8	11.8
73.0	7.3	7.9	8.5	9.2	10.0	11.0	12.0
73.5	7.4	7.9	8.6	9.3	10.2	11.1	12.1
74.0	7.4	8.0	8.7	9.4	10.3	11.2	12.2
74.5	7.5	8.1	8.8	9.5	10.4	11.3	12.4
75.0	7.6	8.2	8.9	9.6	10.5	11.4	12.5
75.5	7.7	8.3	9.0	9.7	10.6	11.6	12.6
76.0	7.7	8.4	9.1	9.8	10.7	11.7	12.8
76.5	7.8	8.5	9.2	9.9	10.8	11.8	12.9
77.0	7.9	8.5	9.2	10.0	10.9	11.9	13.0
77.5	8.0	8.6	9.3	10.1	11.0	12.0	13.1
78.0	8.0	8.7	9.4	10.2	11.1	12.1	13.3
78.5	8.1	8.8	9.5	10.3	11.2	12.2	13.4
79.0	8.2	8.8	9.6	10.4	11.3	12.3	13.5
79.5	8.3	8.9	9.7	10.5	11.4	12.4	13.6

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
80.0	8.3	9.0	9.7	10.6	11.5	12.6	13.7
80.5	8.4	9.1	9.8	10.7	11.6	12.7	13.8
81.0	8.5	9.2	9.9	10.8	11.7	12.8	14.0
81.5	8.6	9.3	10.0	10.9	11.8	12.9	14.1
82.0	8.7	9.3	10.1	11.0	11.9	13.0	14.2
82.5	8.7	9.4	10.2	11.1	12.1	13.1	14.4
83.0	8.8	9.5	10.3	11.2	12.2	13.3	14.5
83.5	8.9	9.6	10.4	11.3	12.3	13.4	14.6
84.0	9.0	9.7	10.5	11.4	12.4	13.5	14.8
84.5	9.1	9.9	10.7	11.5	12.5	13.7	14.9
85.0	9.2	10.0	10.8	11.7	12.7	13.8	15.1
85.5	9.3	10.1	10.9	11.8	12.8	13.9	15.2
86.0	9.4	10.2	11.0	11.9	12.9	14.1	15.4
86.5	9.5	10.3	11.1	12.0	13.1	14.2	15.5
87.0	9.6	10.4	11.2	12.2	13.2	14.4	15.7
87.5	9.7	10.5	11.3	12.3	13.3	14.5	15.8
88.0	9.8	10.6	11.5	12.4	13.5	14.7	16.0
88.5	9.9	10.7	11.6	12.5	13.6	14.8	16.1
89.0	10.0	10.8	11.7	12.6	13.7	14.9	16.3
89.5	10.1	10.9	11.8	12.8	13.9	15.1	16.4
90.0	10.2	11.0	11.9	12.9	14.0	15.2	16.6
90.5	10.3	11.1	12.0	13.0	14.1	15.3	16.7
91.0	10.4	11.2	12.1	13.1	14.2	15.5	16.9
91.5	10.5	11.3	12.2	13.2	14.4	15.6	17.0
92.0	10.6	11.4	12.3	13.4	14.5	15.8	17.2
92.5	10.7	11.5	12.4	13.5	14.6	15.9	17.3
93.0	10.8	11.6	12.6	13.6	14.7	16.0	17.5
93.5	10.9	11.7	12.7	13.7	14.9	16.2	17.6
94.0	11.0	11.8	12.8	13.8	15.0	16.3	17.8
94.5	11.1	11.9	12.9	13.9	15.1	16.5	17.9
95.0	11.1	12.0	13.0	14.1	15.3	16.6	18.1

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
95.5	11.2	12.1	13.1	14.2	15.4	16.7	18.3
96.0	11.3	12.2	13.2	14.3	15.5	16.9	18.4
96.5	11.4	12.3	13.3	14.4	15.7	17.0	18.6
97.0	11.5	12.4	13.4	14.6	15.8	17.2	18.8
97.5	11.6	12.5	13.6	14.7	15.9	17.4	18.9
98.0	11.7	12.6	13.7	14.8	16.1	17.5	19.1
98.5	11.8	12.8	13.8	14.9	16.2	17.7	19.3
99.0	11.9	12.9	13.9	15.1	16.4	17.9	19.5
99.5	12.0	13.0	14.0	15.2	16.5	18.0	19.7
100.0	12.1	13.1	14.2	15.4	16.7	18.2	19.9
100.5	12.2	13.2	14.3	15.5	16.9	18.4	20.1
101.0	12.3	13.3	14.4	15.6	17.0	18.5	20.3
101.5	12.4	13.4	14.5	15.8	17.2	18.7	20.5
102.0	12.5	13.6	14.7	15.9	17.3	18.9	20.7
102.5	12.6	13.7	14.8	16.1	17.5	19.1	20.9
103.0	12.8	13.8	14.9	16.2	17.7	19.3	21.1
103.5	12.9	13.9	15.1	16.4	17.8	19.5	21.3
104.0	13.0	14.0	15.2	16.5	18.0	19.7	21.6
104.5	13.1	14.2	15.4	16.7	18.2	19.9	21.8
105.0	13.2	14.3	15.5	16.8	18.4	20.1	22.0
105.5	13.3	14.4	15.6	17.0	18.5	20.3	22.2
106.0	13.4	14.5	15.8	17.2	18.7	20.5	22.5
106.5	13.5	14.7	15.9	17.3	18.9	20.7	22.7
107.0	13.7	14.8	16.1	17.5	19.1	20.9	22.9
107.5	13.8	14.9	16.2	17.7	19.3	21.1	23.2
108.0	13.9	15.1	16.4	17.8	19.5	21.3	23.4
108.5	14.0	15.2	16.5	18.0	19.7	21.5	23.7
109.0	14.1	15.3	16.7	18.2	19.8	21.8	23.9
109.5	14.3	15.5	16.8	18.3	20.0	22.0	24.2
110.0	14.4	15.6	17.0	18.5	20.2	22.2	24.4
110.5	14.5	15.8	17.1	18.7	20.4	22.4	24.7

cm	-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
111.0	14.6	15.9	17.3	18.9	20.7	22.7	25.0
111.5	14.8	16.0	17.5	19.1	20.9	22.9	25.2
112.0	14.9	16.2	17.6	19.2	21.1	23.1	25.5
112.5	15.0	16.3	17.8	19.4	21.3	23.4	25.8
113.0	15.2	16.5	18.0	19.6	21.5	23.6	26.0
113.5	15.3	16.6	18.1	19.8	21.7	23.9	26.3
114.0	15.4	16.8	18.3	20.0	21.9	24.1	26.6
114.5	15.6	16.9	18.5	20.2	22.1	24.4	26.9
115.0	15.7	17.1	18.6	20.4	22.4	24.6	27.2
115.5	15.8	17.2	18.8	20.6	22.6	24.9	27.5
116.0	16.0	17.4	19.0	20.8	22.8	25.1	27.8
116.5	16.1	17.5	19.2	21.0	23.0	25.4	28.0
117.0	16.2	17.7	19.3	21.2	23.3	25.6	28.3
117.5	16.4	17.9	19.5	21.4	23.5	25.9	28.6
118.0	16.5	18.0	19.7	21.6	23.7	26.1	28.9
118.5	16.7	18.2	19.9	21.8	23.9	26.4	29.2
119.0	16.8	18.3	20.0	22.0	24.1	26.6	29.5
119.5	16.9	18.5	20.2	22.2	24.4	26.9	29.8
120.0	17.1	18.6	20.4	22.4	24.6	27.2	30.1

WHO Child Growth Standards

Annexure 6: Head circumference reference charts

HEAD CIRCUMFERENCE-FOR-AGE BOYS BIRTH TO 3 YEARS (Z-SCORES)						HEAD CIRCUMFERENCE-FOR-AGE GIRLS BIRTH TO 3 YEARS (Z-SCORES)					
Month	-3 SD	-2 SD	Median	2 SD	3 SD	-3 SD	-2 SD	Median	2 SD	3 SD	Month
0	30.7	31.9	34.5	37.0	38.3	30.3	31.5	33.9	36.2	37.4	0
1	33.8	34.9	37.3	39.6	40.8	33.0	34.2	36.5	38.9	40.1	1
2	35.6	36.8	39.1	41.5	42.6	34.6	35.8	38.3	40.7	41.9	2
3	37	38.1	40.5	42.9	44.1	35.8	37.1	39.5	42.0	43.3	3
4	38	39.2	41.6	44.0	45.2	36.8	38.1	40.6	43.1	44.4	4
5	38.9	40.1	42.6	45.0	46.2	37.6	38.9	41.5	44.0	45.3	5
6	39.7	40.9	43.3	45.8	47.0	38.3	39.6	42.2	44.8	46.1	6
7	40.3	41.5	44	46.4	47.7	38.9	40.2	42.8	45.5	46.8	7
8	40.8	42.0	44.5	47.0	48.3	39.4	40.7	43.4	46.0	47.4	8
9	41.2	42.5	45	47.5	48.8	39.8	41.2	43.8	46.5	47.8	9
10	41.6	42.9	45.4	47.9	49.2	40.2	41.5	44.2	46.9	48.3	10
11	41.9	43.2	45.8	48.3	49.6	40.5	41.9	44.6	47.3	48.6	11
12	42.2	43.5	46.1	48.6	49.9	40.8	42.2	44.9	47.6	49.0	12
13	42.5	43.8	46.3	48.9	50.2	41.1	42.4	45.2	47.9	49.3	13
14	42.7	44	46.6	49.2	50.5	41.3	42.7	45.4	48.2	49.5	14
15	42.9	44.2	46.8	49.4	50.7	41.5	42.9	45.7	48.4	49.8	15
16	43.1	44.4	47.0	49.6	51.0	41.7	43.1	45.9	48.6	50.0	16
17	43.2	44.6	47.2	49.8	51.2	41.9	43.3	46.1	48.8	50.2	17
18	43.4	44.7	47.4	50.0	51.4	42.1	43.5	46.2	49.0	50.4	18
19	43.5	44.9	47.5	50.2	51.5	42.3	43.6	46.4	49.2	50.6	19
20	43.7	45.0	47.7	50.4	51.7	42.4	43.8	46.6	49.4	50.7	20
21	43.8	45.2	47.8	50.5	51.9	42.6	44.0	46.7	49.5	50.9	21
22	43.9	45.3	48.0	50.7	52.0	42.7	44.1	46.9	49.7	51.1	22
23	44.1	45.4	48.1	50.8	52.2	42.9	44.3	47.0	49.8	51.2	23
24	44.2	45.5	48.3	51.0	52.3	43.0	44.4	47.2	50.0	51.4	24
25	44.3	45.6	48.4	51.1	52.5	43.1	44.5	47.3	50.1	51.5	25
26	44.4	45.8	48.5	51.2	52.6	43.3	44.7	47.5	50.3	51.7	26
27	44.5	45.9	48.6	51.4	52.7	43.4	44.8	47.6	50.4	51.8	27
28	44.6	46.0	48.7	51.5	52.9	43.5	44.9	47.7	50.5	51.9	28
29	44.7	46.1	48.8	51.6	53.0	43.6	45.0	47.8	50.6	52.0	29
30	44.8	46.1	48.9	51.7	53.1	43.7	45.1	47.9	50.7	52.2	30
31	44.8	46.2	49.0	51.8	53.2	43.8	45.2	48.0	50.9	52.3	31
32	44.9	46.3	49.1	51.9	53.3	43.9	45.3	48.1	51.0	52.4	32
33	45	46.4	49.2	52.0	53.4	44	45.4	48.2	51.1	52.5	33
34	45.1	46.5	49.3	52.1	53.5	44.1	45.5	48.3	51.2	52.6	34
35	45.1	46.6	49.4	52.2	53.6	44.2	45.6	48.4	51.2	52.7	35
36	45.2	46.6	49.5	52.3	53.7	44.3	45.7	48.5	51.3	52.7	36

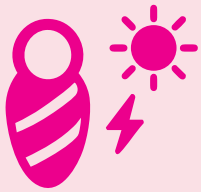
2007 WHO Reference

HEAD CIRCUMFERENCE-FOR-AGE BOYS BIRTH TO 3 YEARS (Z-SCORES)						HEAD CIRCUMFERENCE-FOR-AGE GIRLS BIRTH TO 3 YEARS (Z-SCORES)					
Month	-3 SD	-2 SD	Median	2 SD	3 SD	-3 SD	-2 SD	Median	2 SD	3 SD	Month
37	45.3	46.7	49.5	52.4	38.3	30.3	31.5	33.9	36.2	37.4	37
38	45.3	46.8	49.6	52.5	40.8	33.0	34.2	36.5	38.9	40.1	38
39	45.4	46.8	49.7	52.5	42.6	34.6	35.8	38.3	40.7	41.9	39
40	45.4	46.9	49.7	52.6	44.1	35.8	37.1	39.5	42.0	43.3	40
41	45.5	46.9	49.8	52.7	45.2	36.8	38.1	40.6	43.1	44.4	41
42	45.5	47.0	49.9	52.8	46.2	37.6	38.9	41.5	44.0	45.3	42
43	45.6	47.0	49.9	52.8	47.0	38.3	39.6	42.2	44.8	46.1	43
44	45.6	47.1	50.0	52.9	47.7	38.9	40.2	42.8	45.5	46.8	44
45	45.7	47.1	50.1	53.0	48.3	39.4	40.7	43.4	46.0	47.4	45
46	45.7	47.2	50.1	53.0	48.8	39.8	41.2	43.8	46.5	47.8	46
47	45.8	47.2	50.2	53.1	49.2	40.2	41.5	44.2	46.9	48.3	47
48	45.8	47.3	50.2	53.1	49.6	40.5	41.9	44.6	47.3	48.6	48
49	45.9	47.3	50.3	53.2	49.9	40.8	42.2	44.9	47.6	49.0	49
50	45.9	47.4	50.3	53.2	50.2	41.1	42.4	45.2	47.9	49.3	50
51	45.9	47.4	50.4	53.3	50.5	41.3	42.7	45.4	48.2	49.5	51
52	46.0	47.5	50.4	53.4	50.7	41.5	42.9	45.7	48.4	49.8	52
53	46.0	47.5	50.4	53.4	51.0	41.7	43.1	45.9	48.6	50.0	53
54	46.1	47.5	50.5	53.5	51.2	41.9	43.3	46.1	48.8	50.2	54
55	46.1	47.6	50.5	53.5	51.4	42.1	43.5	46.2	49.0	50.4	55
56	46.1	47.6	50.6	53.5	51.5	42.3	43.6	46.4	49.2	50.6	56
57	46.2	47.6	50.6	53.6	51.7	42.4	43.8	46.6	49.4	50.7	57
58	46.2	47.7	50.7	53.6	51.9	42.6	44.0	46.7	49.5	50.9	58
59	46.2	47.7	50.7	53.7	52.0	42.7	44.1	46.9	49.7	51.1	59
60	46.3	47.7	50.7	53.7	52.2	42.9	44.3	47.0	49.8	51.2	60

Annexure 7: Care of Newborns and Children during High Temperatures with Changing Climate

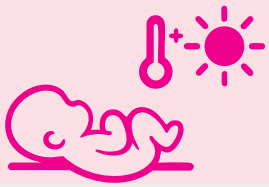
For Babies

How hot weather can affect babies.



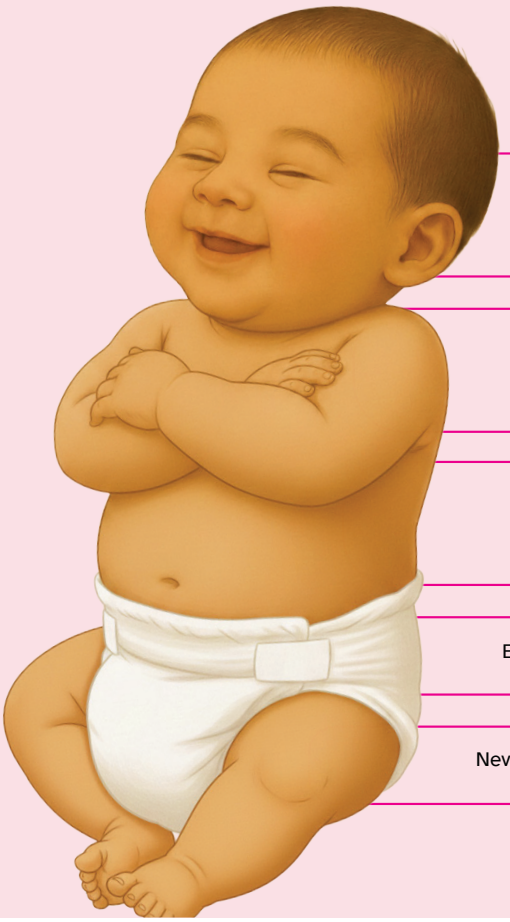
During first three months of pregnancy even a day of exposure to high temperature/heatwave can affect baby's development.

Hot weather at any stage of pregnancy can increase the chances of baby being born with a defect, born too early (preterm birth), death of the baby inside the uterus at full term (stillbirth) or born too small (low birth weight).



Newborn babies are very sensitive to heat. Their bodies cannot control their body temperature well especially in hot and humid conditions with atmospheric temperature above 31°C.

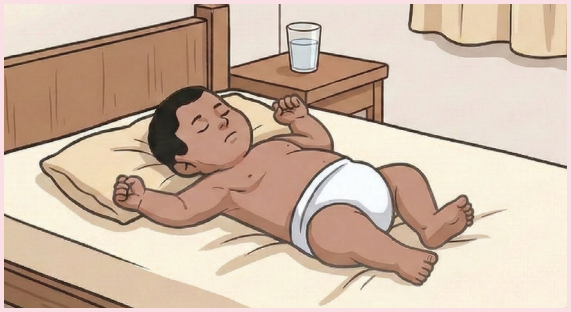
What can you do during hot weather/heatwave for babies?



- Keep the room cool and well-ventilated to ensure baby's axillary temperature remains normal (between 36.5°C-37.5°C / 97.7°F to 99.5°F) and not unusually warm.
- Avoid baby's exposure to the direct high heat, direct sunlight indoors and outdoors.
- Ensure hydration: continue breastfeeding frequently, avoid trying new food options during high heat unless advised.
- Ensure baby passes urine at least 6 to 8 times per day.
- Never leave the baby in a closed vehicle or under direct sunlight.

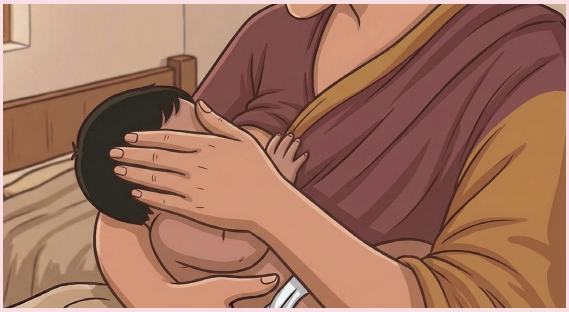
Simple, sustainable cooling measures

Dress light



Dress your baby in light clothing and use layers to adjust to the temperature.

Plenty of fluids



Offer an extra breastfeed or bottle for babies under 6 months. Babies may also require shorter feeds but more often.

Shade

Keep your baby in the shade and avoid direct sunlight by closing curtains or windows where sunlight enters the room.

Use a fan

Use a fan to help circulate cool air. If using an air conditioner, don't let it get too cold.

Identify early signs of heat stress in babies	**Identify serious signs of heat impact in babies, seek immediate medical care (Call 108/102)**
Heat rashes (especially in diaper area, neck, armpits)	Refusal to feed
Mild irritability or more crying than usual	Excessive irritability
Warm to touch, mild increase in temperature	Sunken eyes and/or soft spot-on forehead
Irritability during feeding	Dry mouth and absence of tear/sunken eyes
Less urine or fewer wet diapers	Repeated vomiting or diarrhea
Flushed cheeks or sweating	Decreased urine output/ No wet diaper for 6+ hours
Mild vomiting once or twice	Lethargy, floppy limbs, difficulty in waking up,not responding normally, seizures
Excessive sleeping	Fast breathing or racing heart
If not resolved, contact ASHA, ANM, your doctor or visit nearest health care facility.	Skin feels hot and dry or hot and clammy
	Bleeding from any part of the body

Annexure 8: Glimpses from SSBSK journey

SSBSK TAG Chaired by as AS & MD, NHM

SSBSK TAG Consultation Meeting

SSBSK TAG Members During the Consultation Meeting

TAG Sub-group Consultation for SSBSK Reporting and Recording Tools

TAG Sub-group Consultation for SSBSK IEC/BCC Strategies

Pilot testing of refresher training module on home base child care

Skill Training in TOT of HBNC & HBYC, Odisha

Reaching the Unreached Newborn in Remote Area, Gujarat

Home Visit to Newborn in Urban, Jammu & Kashmir

ECD and Play for Young Children by ASHA & Supervisor, Kerala

Community Interaction on Health Service Delivery, Himachal Pradesh

Monitoring and Boosting ASHAs, ANM, CHO in the Border Area, Assam

Complementary Feeding to Young Child, Madhya Pradesh

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