

Integrated Child Development Services
National Rural Health Mission



Photograph of Mother & Child

Family Identification
 Mother's Name _____ Age _____
 Father's Name _____
 Address _____
 Mother's Education: illiterate/primary/middle/high school/graduate

Pregnancy Record
 Mother's ID No. _____
 Date of the last menstrual period _____ / ____ / ____
 Expected date of delivery _____ / ____ / ____
 No. of pregnancies/ previous live births _____ / ____
 Last delivery conducted at: Institution Home
 Current delivery: Institution Home
 JSY Registration No. _____
 JSY payment Amount _____ Date _____ / ____ / ____

Birth Record
 Child's Name _____
 Date of Birth _____ / ____ / ____ Birth Weight _____ kgs _____ gms
 Girl Boy Birth Registration No: _____

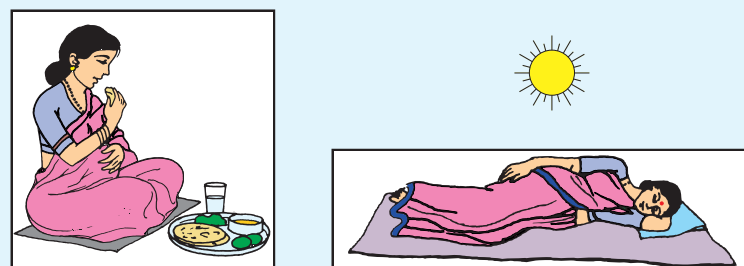
Institutional Identification
 AWW _____ AWC/Block _____
 ASHA _____ ANM _____
 SHC / Clinic _____
 PHC / Town _____ Hospital / FRU _____
 Contact Nos. ANM _____ Hospital _____
 Transport Arrangement _____

AWC Reg. No. _____ Date _____ Sub-centre Reg. No. _____ Date _____
 Referral _____

Regular checkup is essential during pregnancy

Months	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Registration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BP, Blood & Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T.T. Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron Tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Care During Pregnancy



- Consume a variety of foods
- Consume more food – around 1/4th times extra than the normal diet
- Consume SNP from the AWC regularly
- Take at least two hours of rest during the day. In addition to 8 hours of rest at night.
- Use only adequately iodised salt

Ensure nutrition counselling at every ANC

ANTENATAL CARE

OBSTETRIC COMPLICATION IN PREVIOUS PREGNANCY (Please tick (✓) the relevant history)

- A. APH B. Eclampsia C. PIH
 D. Anaemia E. Obstructed labor F. PPH
 G. LSCS H. Congenital anomaly in baby I. Others

PAST HISTORY (Please tick (✓) the box of the appropriate response(s))

- A. Tuberculosis B. Hypertension C. Heart Disease
 D. Diabetes E. Asthma F. Others

EXAMINATION

General Condition	Heart	Lungs	Breasts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ANTENATAL VISITS

	1	2	3	4
Date				
Any complaints				
POG (Weeks)				
Weight (Kg)				
Pulse rate				
Blood pressure				
Pallor				
Oedema				
Jaundice				

ABDOMINAL EXAMINATION

Fundal height				
Weeks/cm				
Lie/Presentation				
Fetal movements	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent
Fetal heart rate per minute				
P/V if done				

ESSENTIAL INVESTIGATIONS

Hemoglobin			
Urine albumin			
Urine sugar			
Signature of ANM			

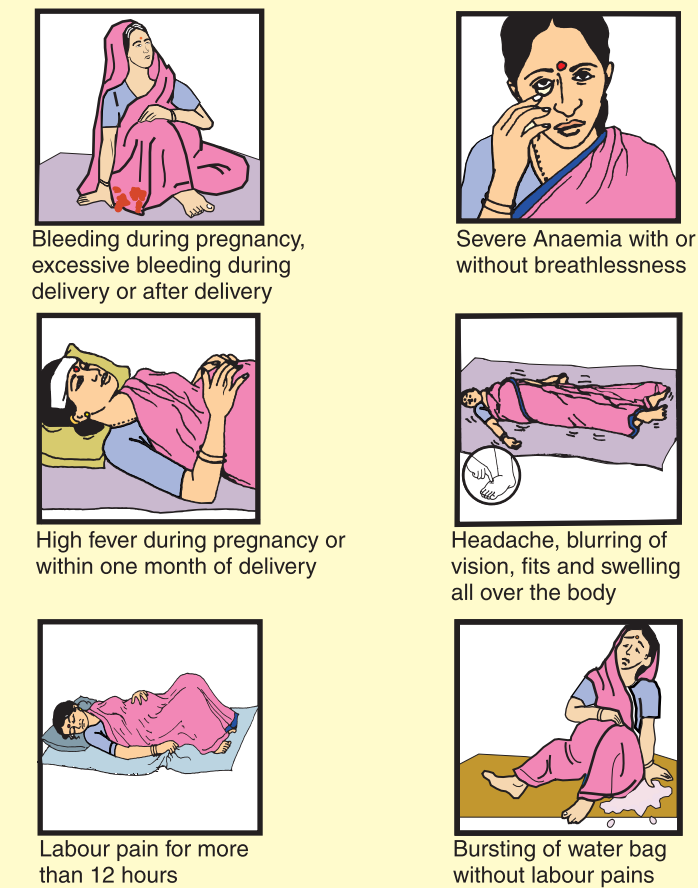
Blood Group & Rh Typing. _____ Date _____ / ____ / ____

OPTIONAL INVESTIGATIONS

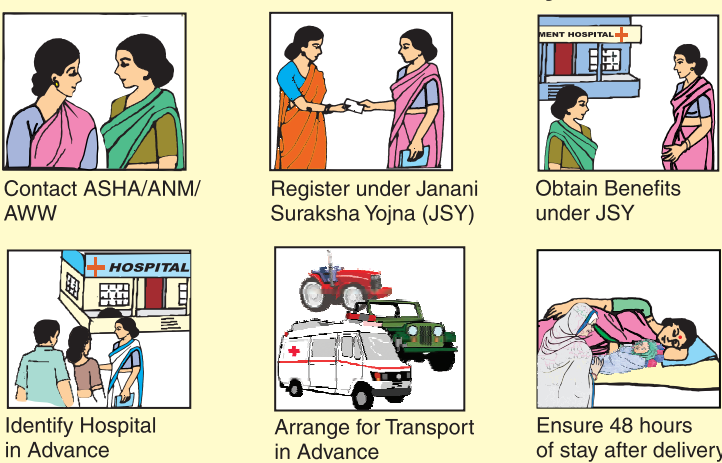
- Urine pregnancy test. _____ Date _____ / ____ / ____
- Hbs Ag. _____ Date _____ / ____ / ____
- Blood sugar. _____ Date _____ / ____ / ____

Participate in monthly fixed village Mother Child Health & Nutrition Day

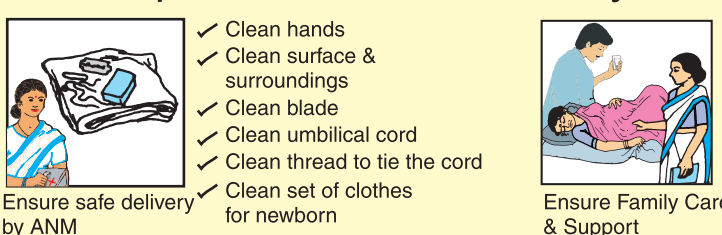
If you or anyone in your family sees any of these danger signs, take the pregnant woman to the hospital immediately



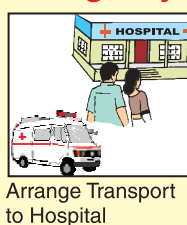
Ensure Institutional Delivery



Preparation in case of Home Delivery



Emergency



Arrange Transport to Hospital

After Delivery



Initiated Breastfeeding within 1 Hour of Birth
 Yes No

Family Planning Counselling



Family Planning Counselling

Ensure early and exclusive breastfeeding 0-6 months

POST NATAL CARE

Date of delivery _____ Place of delivery _____ Type of Delivery _____
 _____ N. _____ Instr. _____ CS _____
 Term/Preterm _____ If at institution period of stay post delivery _____
 Complications, if any (Specify) _____
 Sex of baby M F *Weight of baby _____ kg. _____ gms
 Cried immediately after birth Y N
 Initiated exclusive breast feeding within 1 hour of birth Y N
 * (Three extra visits if birth weight < 2.5kg)

POST PARTUM CARE

	1 st Day	3 rd Day	7 th Day	6 th Week
Any complaints				
Pallor				
Pulse rate				
Blood pressure				
Temperature				
Breasts Soft/engorged				
Nipples Cracked/normal				
Uterus Tenderness Present/absent				
Bleeding P/V Excessive/normal				
Lochia Healthy/foul smelling				
Episiotomy/Tear Healthy/infected				
Family planning Counselling				
Any other complications and referral				

CARE OF BABY

	1 st Day	3 rd Day	7 th Day	6 th Week
Urine passed				
Stool passed				
Diarrhea				
Vomiting				
Convulsions				
Activity (good /lethargic)				
Sucking (good/ poor)				
Breathing (fast/difficult)				
Chest drawing Present/absent				
Temperature				
Jaundice				
Condition of umbilical stump				
Skin pustules Present/absent				
Any other complications				

NEWBORN CARE

- Keep the child warm
- Start breastfeeding within 1 hour after birth.
- For the first 6 months, feed the baby only mother's milk
- Do not bathe the child for the first 48 hours
- Keep the cord dry
- Keep the child away from people who are sick
- Weigh your child at birth
- Give special care if child weighs less than 2.5 kg. at birth

DANGER SIGNS – SEE HEALTH WORKER

- Weak sucking or refuses to breastfeed
- Baby unable to cry/difficult breathing
- Yellow palms and soles
- Fever or cold to touch
- Blood in stools
- Convulsions
- Lethargic or unconscious

Details of Immunisation

Birth to 3 Years

Birth	Birth	Birth	
B.C.G.	OPV-0*	Hepatitis B-0*	* For Institutional Delivery
1½ months	2½ months	3½ months	
OPV-1	OPV-2	OPV-3	
1½ months	2½ months	3½ months	9 months
DPT-1	DPT-2	DPT-3	Measles
1½ months	2½ months	3½ months	9 months
Hepatitis B-1	Hepatitis B-2	Hepatitis B-3	Vitamin A

16 to 24 months

16-24 months	16 months	24 months
DPT Booster	Polio Booster	Vitamin A
30 months	36 months	
Vitamin A	Vitamin A	

Remember

- Give Iron & Folic Acid syrup to children over 6 months as prescribed
- Deworm children over 1 year biannually as prescribed

Feeding, playing and communicating with children helps them grow and develop well

0 to 6 months

Feeding

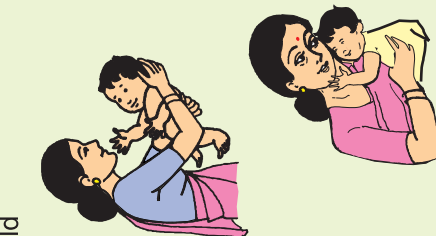


- Start breastfeeding immediately after birth – within 1 hour
- Exclusively breastfeed for 6 months. Do not give any other food or drinks and not even water
- Breastfeed as many times as the child wants
- Breastfeed day and night

0 to 3 months

What you can do

Smile at your child, look into child's eyes and talk to your child

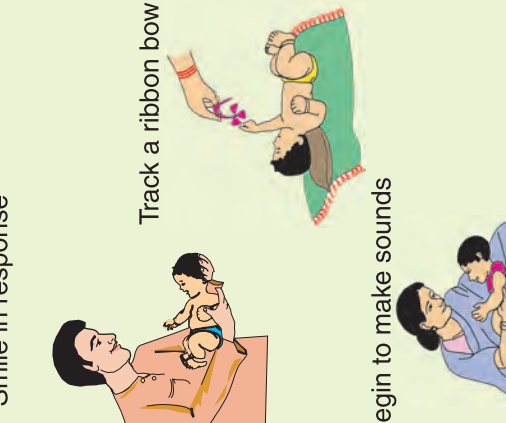


Provide visual for the child to see, hear, feel and move

3 to 6 months

What children can do

Around 3 months, most children can smile in response



Track a ribbon bow
 Begin to make sounds

3 to 6 months

What you can do

Have large colourful objects for your child to see and to reach for



Talk to & respond to your child. Get a conversation going with sounds or gestures

3 to 6 months

What children can do

Around 6 months, most children can hold head steady when held upright



Reach out for objects