NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

HANDBOOK FOR ASHA
ON HOME BASED CARE FOR YOUNG CHILD

ADDITIONAL HOME VISITS TO ADDRESS THE YOUNG CHILD

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ABOUT THIS BOOK

The Handbook for ASHAs on Home Based Care for Young Child covers topics related to Nutrition, Health, Early Childhood Development and Water Sanitation and Hygiene (WASH). The sections on Nutrition, Health and WASH formed a part of previous training of ASHAs. Thus, training in this handbook will serve as refresher for these topics, will build on existing knowledge of ASHAs and help her develop new skills related to Early Childhood Development.

As part of Home Based Newborn Care, ASHAs are already undertaking six or seven home visits on 3rd, 7th, 14th, 21st, 28th, and 42nd days of birth for the newborn (for home deliveries, an extra visit on day of birth). This handbook will support ASHAs in undertaking activities for the additional visits for the child during the 3rd, 6th, 9th, 12th and 15th months of age to provide the Home Based Care for the Young Child.

The handbook is intended as a reading material for the ASHA and is therefore to be given to each ASHA during the training. The content of this handbook will be covered in five days training.

ACKNOWLEDGEMENTS

The Handbook for ASHA on Home Based Care for Young Child has been developed by the National Health Systems Resource Centre (NHSRC) and Child Health Division of Ministry of Health and Family Welfare in technical consultation with experts from JHPIEGO-NIPI and UNICEF. The sections of the handbook also incorporate content from the resource material of the Home Based New Born Care + (NIPI), Integrated Management of Newborn and Childhood Illnesses (IMNCI), Intensified Diarrhoea Control Fortnight, Anemia Mukt Bharat, Mother's Absolute Affection (MAA) Programme, revised Maternal and Child Protection (MCP) Card and material related to growth monitoring developed by Ministry of Women and Child Development and National Institute of Public Cooperation and Child Development (NIPCCD).

LIST OF ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
ACT-AL	Artemisinin-based Combination Therapy-Artemether- Lumefantrine
ACT-SP	Artemisinin-based Combination Therapy (Artesunate+Sulfadoxine- Pyrimethamine)
AIDS	Acquired Immunodeficiency Syndrome
AEFI	Adverse Effects Following Immunization
AF	ASHA Facilitator
AS	Artesunate
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
COC	Combined Oral Contraceptive Pill
CQ	Chloroquine
ECD	Early Childhood Development
EBM	Expressed Breast Milk
FP-LMIS	Family Planning Logistics Management Information System
FSSAI	Food Safety and Standards Authority of India
HBNC	Home Based Newborn Care
HBYC	Home Based Care for Young Child
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
I-NIPI	Intensified- National Iron Plus Initiative
ITN	Insecticide-Treated Net
IUCD	Intra-Uterine Contraceptive Device
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LTMA	Learning Tool for Milestone Assessment
MAS	Mahila Arogya Samiti
MDM	Mid-Day Meal
MCP	Mother and Child Protection

LIST OF ABBREVIATIONS

MCTS	Mother and Child Tracking System
MI	Mission Indradhanush
MPW	Multi-Purpose Worker
NBSU	Newborn Stabilization Unit
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Salt
PHC	Primary Health Centre
Pf	Plasmodium falciparum
PAIUCD	Post-Abortion Intra-Uterine Contraceptive Device
PPIUCD	Post-Partum Intra-Uterine Contraceptive Device
POP	Progestin Only Pill
POSHAN Abhiyaan	PM's Overarching Scheme for Holistic Nourishment Abhiyaan
PQ	Primaquine
Pv	Plasmodium vivax
RDT	Rapid Diagnostic Test
RI	Routine Immunization
SAM	Severe Acute Malnutrition
SBM	Swachh Bharat Mission
SC	Sub-Centre
SHG	Self-Help Group
SNCU	Special Newborn Care Unit
SP	Sulphadoxine-Pyrimethamine
THR	Take Home Ration
UHND	Urban Health Nutrition Day
UPHC	Urban Primary Health Centre
VISHWAS	Village based Initiative to Synergise Health, Water and Sanitation
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

CONTENTS

SECTION 1

INTRODUCTION AND RATIONALE OF HOME BASED CARE FOR YOUNG CHILD PROGRAMME

1.1 BACKGROUND

The implementation of the National Health Mission (NHM), has helped India in reducing maternal and child deaths, and greatly improved access of women and children to health care services. In your own communities, you would have seen an increase in children getting immunized, in pregnant women getting antenatal care, in using health care facilities for deliveries, in the use of family planning by couples, and generally making more use of health care facilities. A large part of this success can be attributed to your work as an ASHA. However, many healthcare challenges persist, and they need our attention.

One example of this continuing challenge is malnutrition among young children. You know from your training that child malnutrition is an important cause of deaths in under-five children. Children who are undernourished have increased risk to infections, frequent episodes of illness and take longer to recover. Malnutrition also affects their physical growth and mental development. There are many programmes to address this problem, but the burden of malnutrition in children continues to remain high in our country.

It is observed that-

- About half of the children under 6 months of age are exclusively breastfed.
- About 4 children out of 10 children under 3 years are breastfed within one hour of birth.
- 1 child out of 10 breastfeeding children aged 6-23 months receive an adequate diet (adequate diet means-feeding several times a day as per the age recommendation and giving a diverse variety of foods to meet the requirement for optimal growth and development).
- More than half the children between 6-59 months of age are anaemic (haemoglobin level less than 11.0g/dl).

Underweight Children

About 4 children out of 10 children under five years of age are underweight (have low weight for their age).

Wasted Children

About 2 children out of 10 children under five years of age are wasted (have low weight for their length/height).

Stunted Children

About 4 children out of 10 children under five years of age are stunted (have low height for their age).

Source: *National Family Health Survey (NFHS-4)*

Early childhood is the most rapid period of development in human life and ensuring care of the mother and the child from the point of conception to the first few years of life lays the basis for healthy mental, emotional and physical growth of children.

A healthy childhood is not achieved by providing adequate nutrition and health care alone. Children need an environment with parents/caregivers giving them love, affection and appreciation. It is important for parents/caregivers to spend time playing and communicating with children for social, mental and emotional development, which ultimately leads to healthy and happy children, leading to a productive society. Such development helps the child to improve learning capacity, perform better in school and form strong social bonds.

1.2 INTRODUCTION AND RATIONALE FOR HOME BASED CARE FOR YOUNG CHILD (HBYC) PROGRAMME

There are many tasks that you as an ASHA are already undertaking to address the health and nutrition needs of newborns, infants and children up to the age of five years. You are undertaking 6/7 home visits to provide Home Based Newborn Care (HBNC) up to 42 days after the birth. In case of low birth weight (LBW) babies, Special Newborn Care Unit (SNCU)/Newborn Stabilization Unit (NBSU) and Nutrition Rehabilitation Centre (NRC) discharged babies, day of discharge is counted as day 1 of home visit schedule and the six remaining home visits are completed as per HBNC visit schedule i.e. 3rd, 7th, 14th, 21st, 28th and 42nd day from the day of discharge. The HBNC visits enabled continuity of care and ensured survival of the new born.

The first six weeks of life is a time of vulnerability for the child and your role in undertaking frequent home visits during this period to provide Home Based Newborn Care is vital. However, the period after the first 42 days to the first few years of life is also important. After this period your visits and child's contact with the health systems is limited to immunization, in case of illness or for management of malnutrition.

FIRST VISIT*	3rd DAY
SECOND VISIT	7th DAY
THIRD VISIT	14th DAY
FOURTH VISIT	21st DAY
FIFTH VISIT	28th DAY
SIXTH VISIT	42nd DAY

**For home deliveries, you conduct an extra visit on day of birth*

It has also been observed that around 3 months of age and beyond, problems such as discontinuation of breastfeeding, delay in initiation or incomplete complementary feeding beyond six months, poor care seeking for sickness, etc. arise. In addition, poor hygiene and sanitation and poor child rearing practices in the home during this period may also lead to sub-optimal physical growth and

development of the child. Through structured home visits, these issues can be identified early and appropriate actions can be taken, thus reducing the adverse impact of these factors.

To provide support for nutrition and early childhood development, the Home Based Care for Young Child (HBYC) has been launched as part of the National Health Mission and POSHAN Abhiyaan of the Ministry of Women and Child Development.

The goals of POSHAN Abhiyaan are to:

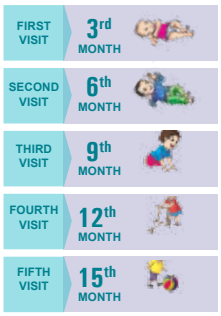
- Prevent and reduce stunting and undernutrition amongst children in the age group of 0-6 years by 2% per year, respectively; and
- Reduce the prevalence of anaemia in children (6-59 months) by 3% per year.
- Reduce low birth weight by 2% per year.

1.3 OBJECTIVES OF HBYC

The objectives of HBYC are to:

- Reduce child deaths and illnesses;
- Improve nutritional status of young children; and
- Ensure proper growth and early childhood development of young children.

As part of HBYC initiative, you will undertake **five additional** home visits after the 42nd day, in addition to the 6/7 visits for HBNC. You will visit the child on completion of **3 months, 6 months, 9 months, 12 months and 15 months.** In addition, the quarterly home visits schedule for low birth weight babies, SNCU and NRC discharged children that you are already making will be included into this HBYC schedule.



Home visits will allow you to identify problems early and support families in taking the appropriate action, whether through improved home care practices or through visiting health facilities. The additional home visits will increase contacts with the child and parents/caregivers during the first fifteen months of life, providing opportunities for the following:

- Promote exclusive breastfeeding for the first 6 months of life.
- Emphasize timely, adequate and appropriate complementary feeding for children on completion of six months and beyond.
- Build the capacity of mothers/caregivers through counselling and support to identify and manage problems related to nutrition and health in their child.

- Allow for early identification of delay in growth and development of children by using the MCP card.
- Enable prevention and management of common childhood illnesses.
- Ensure prompt referral of sick children to health facilities for management of complications.
- Follow-up for compliance to medication and care of sick children discharged from health facilities.

The HBYC programme will target **all** children (girls and boys) between 3 months up to 15 months of age. However, you have to give special attention to the healthcare and follow-up needs of low birth weight children, sick children, malnourished children and children discharged from SNCU/ NBSU and NRC.

Using past training experience, ensure that girl children receive equal care and attention as given to boys. Therefore, counselling of parents/caregivers during home visits to avoid discrimination on account of gender should be given due priority.

1.4 CONVERGENCE BETWEEN ASHA, ANGANWADI WORKER AND AUXILIARY NURSE MIDWIFE/MULTI-PURPOSE WORKER

You have been working in close coordination with the Anganwadi Worker (AWW) and the Auxiliary Nurse Midwife (ANM) or Multi-Purpose Worker (MPW-Female) of your area for preventive and promotive health needs of young children. Such team- work is essential for monitoring the health, growth and development of children.

Under HBYC, you will continue to work as a team with AWW and ANM/MPW to undertake the wider range of actions to improve the nutritional status, growth and early childhood development of young children. Details of roles and responsibilities are provided in the next section.

Figure 1: Existing contacts with children and families by ASHA and proposed additional visits under HBYC

Before HBYC

There are no Home visits by ASHA for the child after 42nd day*

HBNC

6/7 Home visits by ASHA up to 42nd day of birth

***Only Health centre contacts-** Immunization contacts at health centres at 1.5 month, 2.5 months, 3.5 months, 9 months and 15-18 months, in case of illness or management of malnutrition.

After HBYC

HBNC

6/7 Home visits by ASHA

Additional Home Visits by ASHA on completion of **3rd, 6th, 9th, 12th & 15th** months to ensure early childhood growth and development.

SECTION 2

ROLES AND RESPONSIBILITIES OF THE ASHA IN HOME BASED CARE FOR YOUNG CHILD

2.1 ROLES AND RESPONSIBILITIES OF ASHA IN HOME BASED CARE

2.1.1 Your role as an ASHA under HBYC programme is linked to each of the four components- Nutrition, Health including family planning for the couple, Early Childhood Development and Water, Sanitation and Hygiene (WASH). These are explained in detail in sections 4-7 of this handbook.

HBYC does not mean that the focus on the newborn is reduced. The 6/7 visits you make as part of HBNC will continue, and you will undertake the following activities, which you have already been undertaking. You will also continue to fill the HBNC form (Mother-Newborn Home Visit Card) as you have been trained to do. Just to recapitulate, few of the activities under HBNC are listed below:

1. Counsel mothers and families on key messages on newborn care such as infant and young child feeding, assessment of malnutrition, keeping the newborn warm, promotion of hand- washing, etc.
2. Provide skin, cord and eye care of the child.
3. Assess if the child is high risk, pre-term or low birth weight, and take action accordingly.
4. Support the mother in sustaining breast feeding through teaching the mother proper positioning and attachment, diagnosing and counselling in case there are problems with breastfeeding.

5. Teach the mother to express breastmilk and feed baby using cup and spoon in case of pre-mature newborn in order to sustain breastfeeding.
6. Advocate the family regarding the need for the mother to get adequate rest and nutrition which helps the mother in recovering from child-birth and in breastfeeding.
7. Monitor newborn's weight and temperature.
8. Look for any signs of sickness and arrange for prompt referral to appropriate facility in case you find danger signs in newborn.
9. Discourage unhealthy practices such as early bathing, bottle feeding, etc.

2.1.2 The activities for HBYC are based on the revised Mother and Child Protection (MCP) card. The MCP card forms the basis for you to plan interventions, both for yourself and as support to AWW/ANM (MPW). The MCP card will work as a reference material to help you complete all the activities. In the training, you will be taught how to use the revised MCP card and undertake age-appropriate actions as listed in the card (Refer page-8 in the MCP card). The ASHA Facilitator (AF) and ANM/MPW will provide support and supervise you in effectively carrying out the activities under HBYC.

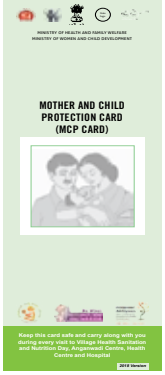


Table 1: Key tasks at various ages of the child that will be performed by ASHA and AWW

Home Visits	ASHA	AWW*
At 3rd Month	• Support exclusive breastfeeding • Ensure recording/plotting of growth chart- weight-for-age and weight-for- length/height by AWW; identify growth faltering • Check immunization status • Counsel for the following- a. Exclusive breast feeding (birth to 6 months) b. Hand- washing practices c. Family planning d. Parenting-ensuring appropriate play and communication • If the child is sick, has development delay or danger signs, provide counselling, first contact care and refer if required.	• Weigh infants monthly • Record weight of the child and plotting on growth chart (weight-for-age) • Record length/height of the child and plotting on growth chart (weight-for-length/height) • Identify underweight and wasting in children and take appropriate action • Counsel regarding growth monitoring • Counsel mothers for exclusive breast feeding from birth to 6 months of age • Distribute 'Take Home Ration' to lactating mothers and counsel for nutrition • Check for developmental delays
At 6th, 9th, 12th and 15th Months	All above activities **PLUS-** • Ensure that age-appropriate complementary food is given on completion of 6 months • Ensure measles vaccine and Vitamin A dose is given as per schedule • Counsel for age-appropriate complementary feeding on completion of 6 months • Provide Oral Rehydration Salt (ORS) packet at home; demonstrate how to prepare ORS and give to the child when required • Provide IFA syrup at home • Teach mother/caregiver regarding IFA syrup administration; ensure that IFA syrup is given to the child by the mother/caregiver on a bi-weekly basis • Provide first contact care and referral for illness	All above activities **PLUS-** • Distribute 'Take Home Ration' and provide nutrition-specific counselling to mothers/caregivers for their children • Provide supplementary food from Anganwadi Centre (AWC) • Counsel regarding age-appropriate complementary feeding on completion of 6 months of age • Counsel for deworming of children above 1 year of age

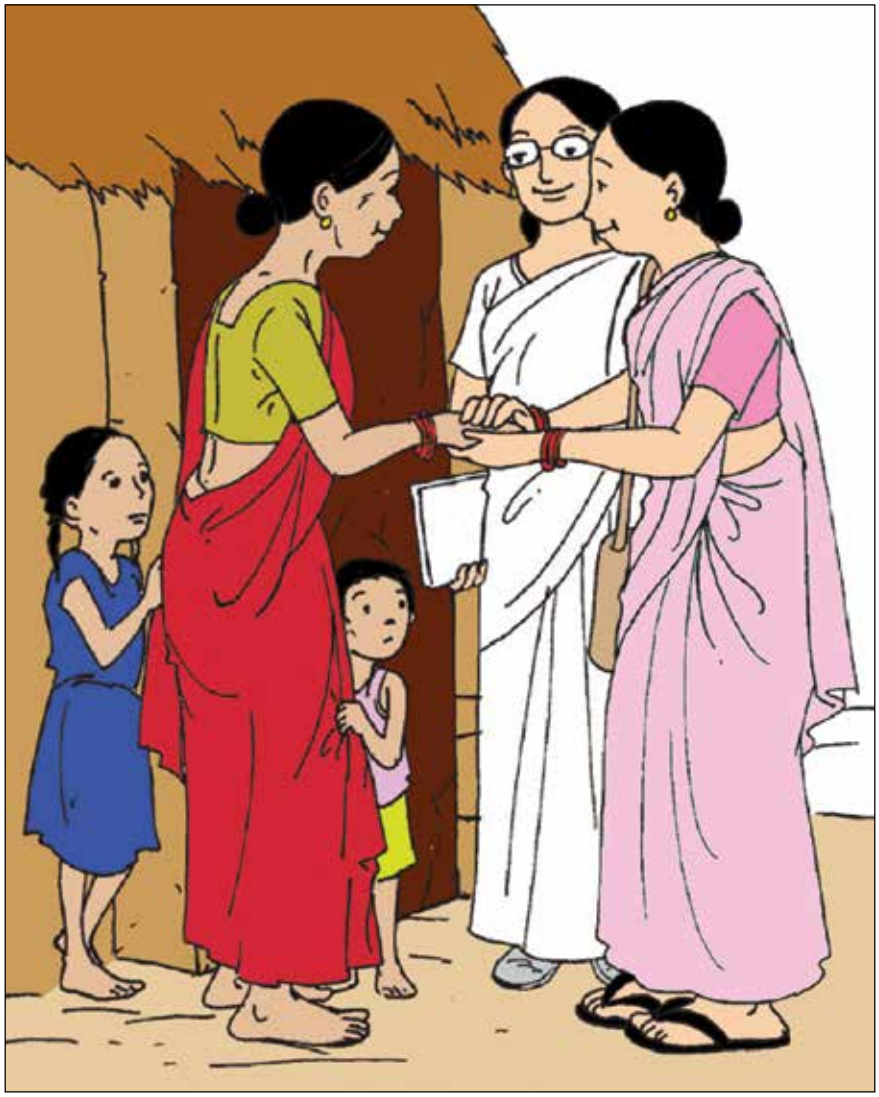
AWW: Adapted from Operational Guidelines on HBYC, 2018.*

In addition to the tasks described in Table-1, you will also be trained on the components of HBYC namely Nutrition, Health including family planning for the couple, Early Childhood Development and activities related to Water, Sanitation and Hygiene (WASH).

NUTRITION HEALTH EARLY CHILDHOOD DEVELOPMENT WASH

2.2 ROLE OF ASHA FACILITATOR AND ANM/MPW

As for other activities, you will continue to be monitored by the ASHA Facilitator and ANM/MPW. Their responsibility is to mentor, support, help you to solve problems, and accompany you on your periodic home visits.



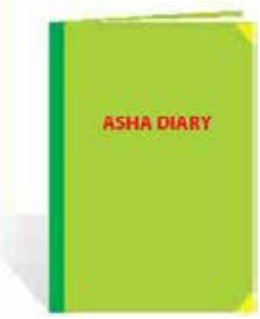
SECTION 3

PLANNING FOR HOME VISITS

3.1 PLANNING FOR HOME VISITS

Quarterly home visits under HBYC will need to be carefully planned as this intervention covers children in various age groups.

To plan your visits, you need to have the following:



1. **ASHA diary/register-** To help you list all young children between 3 months-15 months of age in your area. Among these, you will require to prepare an updated list of children who have registered in Anganwadi Centre (AWC) and are due for immunization.

2. **HBYC card-** HBYC card will be used to record details of activities undertaken by you for receiving incentives for five additional home visits for each young child (Annexure-1). The HBYC card will be provided to you by your state for recording details of activities for each child. You will tick mark (√) and write yes/no (as specified) against the activities conducted in two forms- HBYC card and in the MCP card (page-8) of the mother/ caregiver. HBYC card will be the basis for your payment. The MCP card will be retained by the mother/ caregiver.

3. **Job-Aid-** Job-Aid will be provided to you to conduct the home visits more effectively. This will help you in recalling the key messages to be given to the mother/caregiver during each HBYC visit.

4. **MCP card-** You will be provided a copy of new MCP card during your training and you will be required to use the MCP card as a reference material during your HBYC visits.

5. **Medicines dosage and dispensing schedule** for sick child management is provided in Annexure-2.

6. **ASHA Kit-** You will continue to use (medicines and HBNC kit) that has been earlier provided to you for HBNC.

7. **Items required for screening in Early Childhood Development-** In Annexure 3, there is a list of commonly available items that are

given for teaching the mother/caregivers to conduct age-specific milestone assessments for the child. These items will be locally available in your area (e.g. handbell, torch, red plastic bangle, plastic mirror, etc.) and can be collected while planning your HBYC visits to demonstrate use of these items to the mother/caregivers. Some of these items may also be easily available from the nearest AWC.

3.2 ESTIMATING THE NUMBER OF CHILDREN TO BE COVERED BY AN ASHA

An estimate of the number of children that you would need to cover in your home visits- In a population of 1000, you will generally have 30 newborns per year. This means 2-3 newborns (30/12 months) will be added every month in your coverage area.

Estimate of children under an ASHA

Remember- It is not necessary that each ASHA will have exactly 1000 population under her. There is a variation in the population covered under ASHA across the states.

Before undertaking each visit, it will be useful to recall principles of communication to be followed during home visits that have been taught to you in earlier trainings.

- Greet appropriately and ask how the family is.
- Explain why you are visiting and that you are there to help.
- Be friendly and respectful.
- Speak with a gentle voice.
- Use simple words in local language and advise appropriately.
- Listen carefully-Encourage the mother/caregiver and family members to speak.
- Listen patiently to what the mother/caregiver and family members speak.
- Empathize with the family if there are any problems.
- Praise what the mother/caregiver/family member is doing correctly and build up their self-confidence.
- Do not be judgmental.
- Ask the right questions. Ask open- ended questions (where you can get responses from the mother/caregivers).
- Check if the family members or mother have any questions.
- Thank the family after the visit and inform them when you will return.

3.3 ADDITIONAL FINANCIAL INCENTIVES FOR ASHA

Table 2 provides the details regarding the additional financial incentives that you will receive under the programme.

Table 2: Additional financial incentives under the HBYC programme

Amount (Rs.)	Outcome
• Rs. 50 per visit (incentive of INR Rs. 250/- for five additional home visits for each young child) • In case of more than one child like twins/triplets, the amount of incentive will be provided per child	• Number of home-visits conducted • HBYC card filled* • Age-appropriate activities recorded in the MCP card (page 8)

**You will fill the HBYC card (given as Annexure-1) after completion of specified activities listed for 3 months, 6 months, 9 months, 12 months and 15 months visits and get them validated by your supervisor- ASHA Facilitator or the ANM/MPW. Your supervisor will verify the activities completed for enabling you to earn Rs 50 incentive/visit (Rs. 250/- for five additional home visits). Finally, the HBYC card will be submitted to your supervisor on completion of activities for each child. A counter foil of HBYC card (given in Annexure-1) will be retained by you as reference copy.*

In addition, as mentioned earlier in this section, you will also tick mark (√) and write yes/no (as specified) against the activities conducted for each child in the MCP card of the mother/caregiver. You may provide your signature and write the date of completion of home visit for the particular month in the MCP card. This MCP card will be returned to the mother/caregiver.

3.4 VERIFICATION BY ASHA FACILITATOR OR ANM/MPW

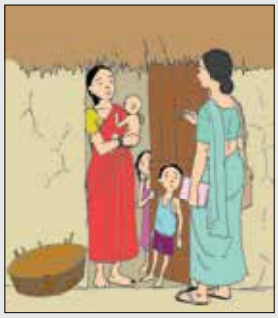
The payment will be given after verification by either the ASHA Facilitator or ANM/MPW that age-appropriate activities is completed and recorded as tick mark (√) in the MCP card. They will match the HBYC card filled by the ASHA with the MCP card of the mother. The existing mechanism of payment to ASHAs will be followed to ensure timely payment. ANM/MPW will also visit 10% children of her service area as joint household visits with ASHAs.

3.5 ADDRESSING SOCIAL VULNERABILITY FOR HBYC

You have learnt about 'vulnerable or marginalised' population in your community in the module on 'Reaching the Unreached' and why is it important to ensure that they receive healthcare services.

Vulnerable or marginalised population are those groups of people or families in our communities who belong to any of the categories listed below-

- Families belonging to a particular caste, ethnic, or religious group who are a minority in the community and who are not seen as equals by others. They could belong to scheduled castes, scheduled tribes and minority communities.
- Women headed households: Where the husband works outside the village, where women are separated or deserted by their husbands, or the husband is dead, where women have alcoholic husbands, or husbands who are differently abled and women bear the sole responsibility for earning a livelihood and taking care of the family.



- Families living in distant hamlets/tolas, whose houses lie between villages on hilltops or in the fields, or in areas which are cut off during the rainy season.

- Families living in slum/slum like locations, homeless people living on roadsides, under bridges, flyovers, along railway tracks, in night shelters, homeless recovery shelters, beggars' home, leprosy homes, etc.
- Families with differently abled children, unaccompanied children, elderly people or families where there is no adult support. Families having members living with HIV and AIDS, Tuberculosis, Leprosy, etc.
- Migrant families, either those who migrate into the village community, or those who stay outside the village for livelihood such as to urban areas- cities, towns, etc. and return periodically.

- Families engaged in unorganised/informal work and hazardous occupation- construction, brick and lime kiln workers, head loaders, sex workers, ragpickers, street children, etc.
- Families of those who work as daily wage labourers or are seasonal workers, who have no employment and are destitute.
- Displaced populations usually in the case of any sudden impact disaster, such as an earthquake or a flood-like situation, threat or conflict, etc.

In addition to these social categories, two classes of children are particularly vulnerable.

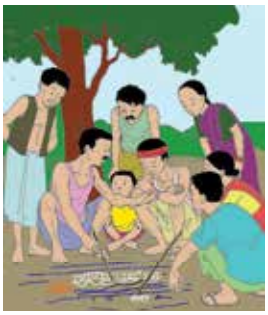
1. Girl children- Across the country, we note that boys are given preference over girls whether in feeding or health care-seeking for any illness. Girl children are therefore particularly vulnerable and you must ensure that your visits to homes with girl children also highlights the importance of equal non-discriminatory behaviour in addition to other support that you provide.

2. Sick children- Low birth weight children, malnourished children, children discharged from SNCU/NRC, children sick due to any childhood illnesses, children with feeding disorders, etc. have compromised growth, are prone to repeated infections and therefore need particular attention.

You have already learnt regarding **'The EIGHT-FOLD Path',** for identifying the vulnerable and marginalised population and your role in each of the steps listed.

As the ASHA and a member of the community you know the families who fall in the category of being vulnerable and marginalised. Your prime focus should be on children belonging to such families who are the most vulnerable and likely to be unreached.

1. Mapping



You have already mapped children under five years of age within your population. Ensure that a list of all those families which fall in the categories of being vulnerable and marginalised (as discussed above) having children from 3 months to 15 months of age is prepared and updated on a routine basis.

2. Prioritizing

Under HBYC, you are required to make quarterly home visits to all children between 3 months to 15 months of age. However, due to specific constraints, children belonging to vulnerable and marginalised households may get missed. You need to make extra efforts to ensure that children from such families are not missed. Once you have mapped all children eligible for HBYC in your population, you will particularly focus on vulnerable and marginalised-families having girl child, where children have not registered at the Anganwadi centre, families that do not visit the Village Health Nutrition Day (VHND)/Urban Health Nutrition Day (UHND) sessions, where a previous child death has occurred, where children are malnourished, where children have not been identified or admitted for nutritional rehabilitation due to lack of prompt access to healthcare services, children discharged from SNCU or NRC, families where children fall ill frequently or live in unhygienic conditions, etc.

3. Communicating

You should inform the families about why these services are needed, where they are available, and what their health entitlements are. The job-aid and MCP card which will be used as reference material can help ensure that you do not miss any important message for the child during the scheduled home-visits.

4. Understanding

Often people have a reason or a problem for why they are not able to use health services. Do not assume that their attitudes are bad. You may have to explore options for changing the way existing services are being provided. You will have to discuss these concerns with your supervisors and bring to their notice. For instance, in some cases, the ANM/MPW will need to make a home visit to provide immunization to the child, or the Anganwadi worker will have to deliver the Take Home Ration (THR) to the household for the child or to record weight and length/height of the child to monitor growth. You may have to accompany these mothers/ caregivers during VHND/UHND sessions or healthcare facilities if required, etc.

5. Counselling

Listen to people's problems, build a relationship of trust, and work with them to find solutions. You could accompany them to the VHND/UHND or the health facility so that they feel comfortable and confident about accessing them on their own in the future.

6. Persisting

Changing behaviours is not very easy to do, especially among poor and marginalized families, who may not perceive the immediate gains of your home visits or for whom there are other important priorities. It needs repeated visits and counselling so that these visits are beneficial for proper growth and development of their children. Keep in mind that once the families overcome their reluctance to adopt preventive and promotive health behaviours and begin to access health services, your need for frequent visits will reduce.

7. Coordinating

It is quite likely that there still remain families, who despite your persistent efforts will not access services. You can ask members of the Village Health Sanitation and Nutrition Committee (VHSNC), Mahila Arogya Samiti (MAS), Self- Help Group (SHG) or request your ASHA Facilitator or the ANM/MPW, who may be in a position to influence these families, to accompany you on a home visit.

8. Mobilizing

Getting people together gives people the confidence to change. Organization provides strength. Building solidarity creates confidence. Leadership provides inspiration and optimism to break out of age-old inertia. So, organize community meetings, join together to sing songs, take out a rally, and celebrate survival. Mobilization is the most important tool of all.

SECTION 4

NUTRITION

4.1 Exclusive Breastfeeding

4.2 Complementary Feeding

4.3 Iron and Folic Acid Supplementation

4.1 EXCLUSIVE BREASTFEEDING

In our country, only about half of the children under 6 months of age are being exclusively breastfed. In ASHA Module 6 and 7, you have already been trained on key concepts of breastfeeding. The training helped you to counsel mothers and clear their misconceptions related to breastfeeding.

This section will further reinforce some of these important concepts to counsel families (mothers and caregivers) during your HBYC visits.

4.1.1 WHAT IS EXCLUSIVE BREASTFEEDING?

Exclusive breastfeeding means feeding the child **ONLY** breast milk for the first 6 months (180 days). Breast milk provides all nutrients and contains sufficient water to meet the requirements of the child up to six months of age; the infants who are exclusively breastfed do not require anything else.

4.1.2 ELICITING INFORMATION ABOUT EXCLUSIVE BREASTFEEDING DURING HOME VISITS

- Greet the woman in a kind and friendly way while using the mother's/caregiver's and child's name.
- Ask her to tell you about herself and her child in her own way, starting with the things that she feels are important.

- To know more about breastfeeding practices, you can ask questions like:
  - What do you feed the child?
  - If child is breastfed, ask how many times in the whole day, the child is breastfed?
  - Is the child given anything other than breast milk (other milk, water, etc.)?
- Listen but be careful not to sound critical. Try not to repeat questions. Some mothers/caregivers tell you these things spontaneously. Others will give you information when you empathize and show that you understand how they feel. Some mothers/caregivers take longer.
- Encourage the mother/caregivers to contact you, or the AWW or the ANM/MPW of their area in case of problems related to breastfeeding.

4.1.3 IMPORTANT MESSAGES FOR BREASTFEEDING

You may refer to page 10 of MCP card, available with the family for counselling the mother and caregivers on breastfeeding.

You should reinforce the following key messages to promote breastfeeding amongst the mother/ caregivers:

- Early initiation of breastfeeding immediately after birth or definitely within 1 hour of birth provides 'colostrum' (mother's first milk) to the newborn that helps in fighting diseases. *Colostrum- the first thick yellowish milk is essential for the newborn's nutrition and protection against infections and diseases*. This also encourages flow of breastmilk, keeps the newborn warm and promotes bonding between the mother and the newborn.

- You may remind the parents that breastmilk helps in better growth of the brain, ensures proper development and improves intelligence, protects against dangerous illnesses, protects against obesity, hypertension (blood pressure), diabetes mellitus, etc. during adulthood.

- Mother should breastfeed as often as the child wants in day and night. Frequent feeding helps mothers to produce more breastmilk.
- Mother should continue breastfeeding even during diarrhoea or any other illnesses to help the child to get optimal nutrition and recover from the illness faster.

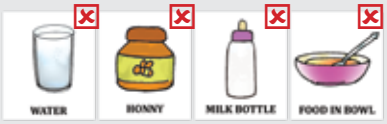
- Breast feeding mother should eat extra and drink plenty of fluids to provide adequate milk for the child during this time.
- Mother should pay attention to/observe early signs of hunger in the child like restlessness, opening mouth and turning head from side to side, putting tongue in and out and sucking on fingers or fists. Crying is a late sign of hunger. Mother should smile, talk and look into child's eyes while breastfeeding, encouraging the child to communicate (but not rock the child while breastfeeding).

Counsel and reassure the mother in busting the myth that she does not have enough milk for the growing child. Almost all mothers produce enough breast milk for one or even two children up to 6 months of age. Usually, even when a mother thinks that she does not have enough breast milk, her child is in fact getting all that she/he needs. Build her confidence and support her to breastfeed by increasing the number of times she feeds the child. She should also be advised to take adequate rest.

Support the mother in recovering from childbirth and advocate to the family members the importance of adequate rest and nutrition for the mother. Also, encourage the family to support the mother by sharing her workload so that she can successfully breastfeed her child.

Mothers also resume work during this time. You can counsel them to feed the child before going and after coming back. Also suggest these mothers to express milk for the day which can be given to the child by other caregivers.

Discourage the mother/family from:



- Giving top feeds (other than breast milk like animal milk, powdered milk, etc.) during the first six months.
- Giving additional food or fluid, herbal water, honey, glucose water, ghutti water, plain water, animal or powdered milk, etc. during the first six months.

- Using bottles and teats (a plastic nipple used on top of the bottle) for feeding the child as they are harmful and are likely to carry infections.

4.1.4 ENSURING BREASTFEEDING OF LOW BIRTH WEIGHT (LBW) AND SICK INFANTS

You know that infants with less than 2.5 kg body weight (or birth weight less than 2500 grams) are low birth weight infants. LBW infants, sick infants and malnourished children have higher risk of early growth retardation, infectious disease, developmental delay and death during infancy and childhood. Such children are usually treated in facilities like SNCUs, NBSUs and NRC as they need specialised healthcare by trained service providers.

You need to explain that low birth weight, sick and malnourished infants may have feeding difficulties initially because they are weak or sick, get tired easily and thus their intake is poor. They may also have additional problems like difficulty in swallowing, vomiting, or abdominal distension.

During your home visits to families having sick children, LBW infants and malnourished children, explain the mother/caregiver that these children have higher nutritional needs than normal children. Explain the mothers/caregivers to:

- Breastfeed several times a day, every two-three hours, even during the night.
- Stroke on sides of the lips and the upper part of the chin to wake up a sleeping child for feeding.
- Feed expressed breast milk (EBM) using a cup, katori, paladai and spoon in case they are unable to feed directly from the breast.

- Put to breast to allow them to lick the nipple and try to suckle. Once the child is able to suckle, child should be put to the breast as often as possible to stimulate milk production.
- Use Kangaroo Mother Care (KMC) to prevent hypothermia; KMC provides skin-to-skin contact, warmth and closeness to the mother's breast. Fathers can also practice Kangaroo Care.

Remember

- To counsel that all children- both girls and boys from birth to 6 months need to be breastfed on demand, both day and night-at least 8 to 12 times in 24 hours.
- To use your skills learnt during your training in ASHA Module-6 and 7, to correct the position for breastfeeding, address common breastfeeding problems and common reasons for decreased/stopping breastfeeding, teaching expressing milk by hand and feeding the expressed milk.
- To reassure the family members and seek their support for the mother in providing additional care to low birth weight baby.
- To advise mother regarding storage of Expressed Breast Milk (EBM):
  - Can be kept in a covered container at room temperature for up to 6 hours.
  - Milk not fed to the infant within 6 hours of expressing should be discarded.
  - Can be stored in the main compartment of a regular refrigerator (2°C to 8°C) for 24 hours.

During your home visits, ensure that the mother continues to breastfeed exclusively for 6 months.

4.2 COMPLEMENTARY FEEDING

4.2.1 COMPLEMENTARY FEEDING- WHY START COMPLEMENTARY FEEDING ON COMPLETION OF SIX MONTHS OF AGE AND CONTINUE BREASTFEEDING?

Children should be introduced to semi-solid, soft foods (complementary feeding) on completion of six months of age because:

- Breast milk alone is not sufficient to meet the growing needs of the child.
- 6 months to 24 months is a period of rapid growth and development in the young child and demands extra nutrition.

Breastfeeding should be continued:

- For a minimum of 2 years or beyond because it is an important source of nutrition, provides energy and protection from illness.
- It protects infants from infection, who are particularly vulnerable during the transition period when complementary feeding begins.

Breastfeeding

+

Complementary feeding

4.2.2 REQUIREMENTS OF COMPLEMENTARY FOODS

1. Timely

Introduced at completion of six months when requirement for energy and nutrients exceeds that provided by breastmilk alone.

2. Adequate

Should provide sufficient nutrients to meet the growing needs of the child- energy, protein, vitamins and minerals from different food groups like cereals such as wheat, wheat flour (atta/maida), rice, rice flakes (chirwa), maize/ corn, barley, semolina (suji), vermicelli (sevian), puffed rice (murmura), etc. and millets like bajra, ragi, jowar, etc. and pulses (daals) and legumes such as channa daal, besan, moong daal, arhar daal/tur daal, white/black/green chana, lobia, etc; vegetables (including green leafy vegetables and other coloured vegetables) and fruits; milk and milk products like milk, curd, cottage cheese (paneer), etc., animal products/non-vegetarian foods (meat, liver, fish, poultry, eggs (well-cooked), etc.); and ghee/butter/cooking oil and sugar/jaggery (gur) and nuts. Roasted, crushed and powdered/mashed groundnuts can be added to the food (only if the child is not allergic).

3. Properly Fed

Active feeding method to encourage the child to eat more without forced feeding. Children have small stomach therefore should be fed more frequently. Feed children from a separate cup/katori/plate at recommended frequency (Table 3).

4. Safe

Food should be hygienically prepared and stored. Mothers/caregivers should wash their hands with soap and water before preparing food and feeding the child. Also wash the child's hands.

Disadvantages of adding foods too soon i.e. before completion of 6 months of age	Disadvantages of adding foods too late i.e. later than completion of 6 months of age
• Decrease the intake or output of breast milk resulting in a low nutrient diet • Increase risk of illness especially diarrhoea	• Growth and development slows down or stops- physical and brain growth faltering* • Risk of deficiencies and infectious diseases

**Growth faltering means the child does not grow in an age appropriate manner in terms of weight and length/height.*

Table 3: Five important things to remember about Complementary Feeding

Consistency	Quantity	Frequency	Density	Variety
• Depends on age of the child and readiness to chew and swallow. • Initially include soft and mashed foods. • Move gradually to foods with appropriate thick consistency. • Give Daal (& not Daal ka Paani) • Feed prepared should not be too thin and too thick. Test: stays on a spoon when the spoon is tilted (see figure given below)	• Increase with the age of the child. • Encourage for better intake but not force child to eat more. • At one-year, child should receive half the mother's nutrition.	• Increase with the age of the child. • Number of feeds will increase gradually with increase in age of the child.	• Add a spoon of some edible oils or fats/ ghee/butter; sugar/ jaggery (gur) to each feed, to make the feed rich in energy.	• Add fruits and vegetables- The rule is that the greener it is, or the more red and yellow is the feed, the more is the protective quality. • Meat, egg (well-cooked), poultry, fish, etc. are liked by children and are also very nutritive and protective.

Figure 2: Different consistencies of Complementary Food

4.2.3 ASSESSING INFORMATION ABOUT COMPLEMENTARY FEEDING FROM THE MOTHER/CAREGIVER

- **Start by asking if the mother/caregiver is breastfeeding the child?**
  - How many times in a day- both day and night?
  - Is the child breast fed at night? If yes, how many times is the child fed at night.
- **Does the child take any other food or fluids?**
  - What foods or fluids?
  - How many times per day?
  - Are the foods thick or thin?
  - What do you use to feed the child?

- How large are the servings (cup/katori, teaspoon, tablespoon)?
- Does the child receive separate serving from the family members?
- Who feeds the child and how?
- What feeding difficulties does mother/caregiver experience, if any?

- **Ask if the child's feeding has changed during the illness?**
  - If yes, how?

The mother's/caregiver's answers to these questions will give you an idea whether the child is receiving adequate amount of nutrition from breastfeeding and complementary feeding. You should counsel for continuation of breastfeeding during the home visits, support them in maintaining age-appropriate feeding pattern by counselling on what should be avoided and teach right quantities for complementary feeds. It is also important to inform them about feeding during illness and recovery phase and regarding specific nutritional needs of malnourished children.

4.2.4 IMPORTANT MESSAGES FOR MOTHERS AND CAREGIVERS ON COMPLEMENTARY FEEDING

- Combination of pulses (daals) and legumes with cereals and millets should be given. Example- daal with rice or cracked wheat porridge (dalia) with daal, chappati/roti soaked in daal, bajra khichri with daal, etc. Feed should be prepared from locally available pulses and cereals/ millets.
- Oil/ghee/butter, sugar/jaggery (gur), roasted crushed and powdered/ mashed groundnut (if the child is not allergic) etc. can be added to the feed for making it rich, tasty and easy to swallow. Do not add spices to the food of the child.
- Locally available, fresh and seasonal fruits and vegetables should be given to the child. Washed, cooked and mashed fruits and vegetables can be added to the feed.

- Cereals/millets and pulses that are soaked, sprouted, dry roasted and powdered for cooking can be given to the child as they are easily digested.
- Animal products/non-vegetarian foods (meat, liver, fish, poultry, eggs (well-cooked), etc.), wherever culturally acceptable, can be started as early and given as often possible to the child.
- Plan for one to two healthy snacks in between the main meals. Snacks are like small meals which are given in between main meals. These must **NOT** be a replacement of meals. Mashed fruits like banana, papaya, mango, cheeku and other soft fruits; boiled and mashed potatoes, mashed vegetables, well-cooked eggs, curd, panjeeri, laddoo, halwa, upma, idli, poha with crushed/mashed groundnuts (do not add groundnuts if child is allergic), etc. are some of the examples of food items to be given as snack to the child.

- Introduce only one food at a time, variety can be increased by adding new foods one by one.
- Show interest, smile or play games to encourage children to eat enough food.
- Continue complementary feeding during illness and increase the amount during the recovery period.
- Feed the child in a separate cup/katori/plate as it will help mother/caregivers to understand the quantity of food eaten by the child.
- If the child dislikes a particular food, remove it from the diet for some time and give again at a later stage.

- Complementary foods should be prepared hygienically. Mothers/ caregivers must wash their hands before preparing and before feeding the child. The child's hands should be washed also. Clean utensils should be used to prepare the feed of the child.
- Girls and boys have the same nutrition requirement to grow and develop. So they both should be given the same amount and similar kind of food.

4.2.5 INFORMING MOTHERS AND CAREGIVERS WHAT SHOULD BE AVOIDED IN COMPLEMENTARY FEEDING

It is also important to explain mothers/caregivers to **avoid**:

- Ready-made or processed food available in the market such as toffees, sweets, chips, chocolates, biscuits, namkeens; drinks such as tea, coffee, cola drinks, cold drinks, fruit juices, sharbats, etc.
- Showing personal dislikes for any food item otherwise child will not learn to eat all types of foods.
- Food which can pose choking hazard such as whole nuts, grapes, raw carrot pieces, etc. initially. These should be given only at a later stage when the chewing and swallowing ability has been fully developed.

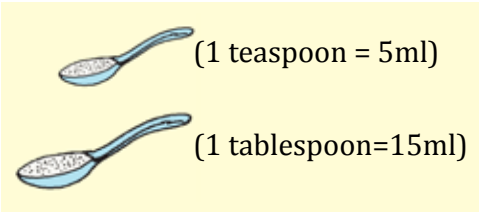
4.2.6 SOME USEFUL HOUSEHOLD MEASUREMENTS FOR PREPARING FEEDS FOR THE CHILD

Age-appropriate feeding recommendations on complementary feeding at completion of 6 months to 12 months and beyond is given the MCP card, page number 11. Refer to this, while counselling mothers/caregivers regarding complementary feeding.

The quantity mentioned may be difficult for a family to measure correctly. The size of cup/katori, serving spoon/karchi, teaspoon and tablespoon can vary in size and shape. Thus, it is important to explain the mother and caregiver about the quantity by showing common household utensils that are used in the family for serving food.

Household measurements of commonly used household utensils:

- 1 full cup/katori*= 250 ml (the volume may vary)
- 1 serving spoon/karchi= 100 ml (the volume can vary)
- 1 teaspoon- 5 ml
- 1 tablespoon- 15 ml



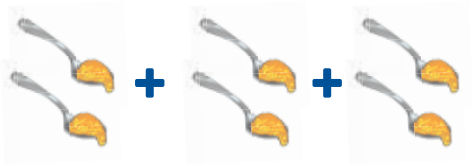
With the child's bowl, it can be easy to demonstrate how much is 1/2 (half), 3/4th, and a full cup/katori as shown in the figure given below.

Figure 3: Common household measurement of a cup/katori

1/2 (half) cup/katori | *3/4th cup/katori* | *1 full cup/katori (250ml)**

Complementary Feeding- Quantity and Frequency for the Child

- Breastfeed as often as the child wants and continue breastfeeding if the child is sick.



At 6 months - On completion of 6 months, start feeding 2-3 tablespoons at each meal of soft, well-mashed foods, 2-3 times each day.

From 6 months upto 9 months-2-3 tablespoons to be gradually increased to half (1/2) cup/katori at each meal of mashed food, 2-3 times each day and 1-2 snacks.

From 9 months upto 12 months-Atleast half (1/2) cup/katori at each meal of finely chopped or mashed food and foods that the baby can pick up with her/his fingers, 3-4 times each day and 1-2 snacks.

From 12 months upto 2 years- Introduce family foods, chopped or mashed, give ¾ to 1 full cup/katori at each meal, 3-4 times each day and 1-2 snacks.

For 2 years and older children, give a variety of family foods to the child, at least 1 full cup/katori (250ml) at each meal, 3-4 meals each day with 1-2 nutritious snacks between meals.

4.2.7 FEEDING THE CHILD RESPONSIVELY

Mothers/caregivers should recognize the signs of hunger and respond as soon as possible. Responsive feeding means gently encouraging—not forcing—the child to eat.

Counsel the mothers/caregivers to:

1. Be patient in feeding the child and encourage them to eat. Do not force the child to eat.
2. Try different food combinations, tastes and methods to encourage feeding if children refuse many foods.
3. Play games to help the child to eat enough food and to encourage the child to try new foods.
4. Minimize any disturbances - during meals, if the child loses interest easily.
5. Smile and talk to children during feeding, with eye to eye contact as feeding times are periods of learning and affection.
6. Do not express anger at children who refuse to eat. These actions usually result in children eating less.

4.2.8 FEEDING OF SICK AND MALNOURISHED CHILD

Timely initiation of complementary feeding along with responsive feeding are also important for sick and malnourished children. The messages given above on complementary feeding are also useful for these children. During this time, the child may not want to eat much, but children need small frequent meals and more fluids, including breastmilk and other liquids to recover more quickly during illness. Children who are breastfeeding, need to be breastfed more often and for longer time. After an illness, children should be given more food and more often than usual for at least 2 weeks to help recover from the weight lost during illness.

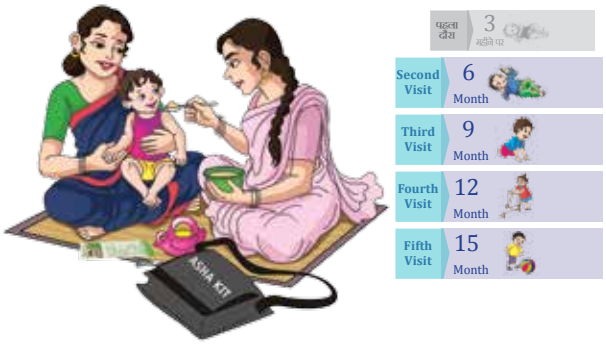
4.2.9 ROLE OF ASHA IN PROMOTING BREASTFEEDING AND COMPLEMENTARY FEEDING

You may use the MCP card, Page 8, to ensure that activities related to breastfeeding and complementary feeding are undertaken during the home visits. Also, with reference to MCP card, pages- 10 and 11,

messages related to early and exclusive breastfeeding and age- appropriate complementary feeding, respectively can be explained to the mother/caregiver. During each home visit from 3 months up to 15 months, you will:

- Encourage the mother/caregiver to exclusively breastfeed the child from birth to 6 months and provide complementary feeding on completion of 6 months of age, to girl and boy children alike.
- Ensure support from family members- husband, mother and father in-law, etc. for the mother to provide her sufficient rest and adequate nutrition to breastfeed her child. Family support is required to feed the child responsively.

- Provide counselling to mother/caregivers on importance of early and exclusive breastfeeding and timely introduction of age-appropriate complementary feeding to the child. Ensure that families having children- low birth weight, malnourished, sick, those discharged from SNCU/NBSU/NRC, etc. are counselled and following your advice.
- Undertake joint visits with ASHA Facilitator or ANM/MPW to a household where you are unable to convince the family for exclusive breastfeeding/complementary feeding.
- Educate regarding the importance of regular hand-washing before and after preparing food, before feeding the child and after using the toilet.
- Mobilise the lactating mothers and their children for registration at the nearby Anganwadi centre to receive 'Take Home Ration' (THR) for themselves and their children beyond 6 months of age.



- Refer mothers with problems in breastfeeding and those children who are unable to take breastfeed or complementary feed to ANM at Sub-Centre (SC) or trained medical specialist at nearest health facility for appropriate care. Follow-up with them closely to ensure child is provided appropriate care and is growing well.

As an ASHA, you can mobilise support from VHSNC/MAS, VHNDs/UHNDs, self-help group meetings, mother's group meetings, support groups, etc. for promotion and counselling activities related to breastfeeding and complementary feeding. These groups can also help you in overcoming the harmful traditional practices and beliefs related to young child feeding and nutrition prevalent amongst mothers-in- law, fathers- in-law, husband and other family members.

On completion of 6 months of age, counsel mother/caregiver to ensure that all children are being given healthy food in adequate amount through responsive feeding and continued frequent on demand breastfeeding for at least 2 years.

4.3. IRON AND FOLIC ACID SUPPLEMENTATION

In ASHA Module- 6, you have been trained in management of anaemia among women. In this section, you will learn that anaemia is also a common problem among children in India.

4.3.1 WHAT IS ANAEMIA?

Anaemia is a condition when there is low haemoglobin level in the body resulting in less ability to carry oxygen to all parts of the body.

Anaemia in children occurs when the haemoglobin level in the body is less than 11 g/dl.

Anaemia in children causes poor learning ability, low concentration, tiredness, poor school performance and poor coordination of language. The child is unable to reach his/her full potential both physically and mentally.

Table 4: Haemoglobin levels to diagnose anaemia (g/dl)

Age group	Anaemia		
	Mild	**Moderate**	**Severe**
Children 6–59 months of age	10–10.9	7–9.9	<7

Source: World Health Organization (WHO)-Nutritional Anemia: Tools for Effective Prevention and Control, 2017.

4.3.2 CAUSES OF NUTRITIONAL ANAEMIA IN CHILDREN

Breastmilk is sufficient to meet the iron requirement of a breastfed child until 6 months of age. Iron from breast milk is more easily available to the young child. The onset of anaemia in young children is generally after 6 months of age and increases from 6–8 months till the child is 1 year old. The common causes of nutritional anaemia are:

- Low iron stores at birth due to anaemia in mother.
- Non-exclusive breastfeeding up to 6 months of age.
- Too early introduction of inappropriate complementary food i.e. before completion of 6 months of age (resulting in diminished breast milk intake, insufficient iron intake, and heightened risk of intestinal infections).
- Late introduction of appropriate (iron-rich) complementary foods i.e. later than completion of 6 months of age.
- Insufficient quantity of iron and iron enhancers in diet (foods rich in Vitamin C) and low availability of dietary iron (especially from vegetarian diet).
- Iron loss due to parasite load (e.g. malaria, intestinal worms).
- Poor environmental sanitation, unsafe drinking water and inadequate personal hygiene leading to frequent illnesses.

To overcome this problem, government has launched Anemia Mukt Bharat campaign recently to promote Iron and Folic Acid (IFA) supplementation for prevention of anaemia in all children 6-59 months of age. The dose and regime of IFA supplementation and deworming under the programme is explained in this chapter.

Table 5: Dose and regime for Iron Folic Acid supplementation for prevention of anaemia*

Age group	Dose and regime
Children 6-59 months of age*	Biweekly, 1 ml Iron and Folic Acid syrup Each ml of Iron and Folic Acid syrup containing 20 mg elemental Iron + 100 mcg of Folic Acid Bottle (50ml) to have an 'auto-dispenser' and information leaflet as per Ministry of Health and Family Welfare guidelines in the mono-carton

IFA SUPPLEMENT

Source: Operational Guidelines for Programme Managers. Anemia Mukt Bharat-Intensified National Iron Plus Initiative (I-NIPI), Ministry of Health and Family Welfare, Government of India, 2018.

IFA syrup should **NOT be given in children suffering from acute illness (fever, diarrhoea, pneumonia, etc.). Mother/caregiver should be advised to continue subsequent doses of IFA supplementation as soon as the child recovers from these illnesses. It is also not to be provided in children suffering from thalassemia major and in those with history of repeated blood transfusion. The IFA supplementation in severely acute malnourished (SAM) children, should be continued as per management protocol for SAM management provided by NRC or Primary Health Centre (PHC/UPHC) Medical Officer.*

4.3.3 DEWORMING

Children and adolescents: To address the problem of transmission of worms from soil, the government has been implementing the National Deworming Day programme. The programme undertakes biannual mass deworming (albendazole tablet) campaign for children and adolescents in the age groups between 1 and 19 years on designated dates – 10 February and 10 August every year.


ALBENDAZOLE

Table 6: Dose and regime for deworming

Age group	Dose and regime	Appropriate Administration
Less than 12 months of age	Not to be given	Not to be given
Children 12-24 months of age	Biannual dose of 400 mg albendazole (½ tablet)	Appropriate administration of tablets to children between the ages of 1 and 3 years is important. The tablet should be broken and crushed between two spoons, then safe water added to help administer the medicine.
Children 24-59 months of age	Biannual dose of 400 mg albendazole (1 tablet)	

Source: Operational Guidelines for Programme Managers. Anemia Mukt Bharat-Intensified National Iron Plus Initiative (I-NIPI), Ministry of Health and Family Welfare, Government of India, 2018.

4.3.4 DOSE, REGIME AND ADMINISTRATION OF IFA SUPPLEMENTATION AND BIANNUAL DEWORMING OF CHILDREN

- IFA syrup will be provided bi-weekly and you will teach mothers/caregivers to provide the biweekly IFA dose to their children.

- You will be provided 50 ml IFA syrup bottle (with auto-dispenser) from PHC/Sub-centre; 2 bottles/ child/year (in first year of child, one 50 ml bottle will be required). You will write the date of giving the IFA syrup bottle to the mother/caregiver in the compliance card as given on page 27 in the MCP card.
- The IFA syrup bottles have an auto-dispenser so that only 1 ml of syrup will be dispensed at a time (having the required dosage for children).
- You can provide the 50 ml IFA syrup bottle (with auto-dispenser) to mothers/caregivers during home visits or utilize the platform of VHND/UHND or other dedicated rounds such as Vitamin A round, etc.
- Albendazole tablets will be provided to children for biannual deworming, with dose as given in the table above (once in 6 months) during the National Deworming Day (10th February and 10th August every year). Under this strategy, under-five children, out-of school children and adolescents are provided deworming tablet at Anganwadi centres by AWWs, whereas school-going children and adolescents are provided the deworming treatment through school platform. The date of administration of albendazole to the child will be entered by ANM/MPW as given on Page 27 in the MCP card.

Fortified Foods

FORTIFIED FOODS

Food fortification refers to the addition of micronutrients (vitamins and minerals required in small amounts for development) in a food so as to improve the nutritional quality of food at very reasonable cost and to provide public health benefit with minimal risk to health. Fortified food is a food which has undergone the process of fortification as per regulations. The Government of India has mandated the use of fortified salt, wheat flour and oil in foods served under Integrated Child Development Services (ICDS) and Mid-day Meal (MDM) schemes to address micronutrient deficiencies. In addition, all health facility-based programmes where food is being provided are mandated to provide fortified wheat, rice (with iron, folic acid and vitamin B12), and double fortified salt (with iodine and iron), and oil (with vitamin A and D) as per standards for fortification of staple foods (salt, wheat, rice, milk and oil) prescribed and notified by the Food Safety and Standards Authority of India (FSSAI, 2016).

4.3.5 ROLE OF ASHA IN IMPLEMENTATION OF IFA SUPPLEMENTATION AND BIANNUAL DEWORMING FOR CHILDREN

- Enumerate all the eligible children aged 6 to 59 months of age and prepare a line-listing. Refer to Page 27 of MCP card for information regarding biweekly iron folic acid supplementation and biannual deworming for children (Compliance Card).
- Provide IFA syrup (1 ml) biweekly for the first week during your home visits.

- Demonstrate to the mothers/caregivers to provide IFA syrup through the auto- dispenser bottle. Follow these steps for giving IFA syrup:
  a. Child must be held in the mother's/caregiver's lap.
  b. Encourage the child to open the mouth.
  c. If the child does not open the mouth, press the cheeks gently together for the mouth to open.
  d. Shake the IFA syrup bottle well before use. Explain the mother/caregiver that the entire dose of IFA syrup should be administered into the child's mouth and watch the child swallow the entire dose.
  e. Explain the mother/caregiver that child should be administered IFA syrup only on fixed days on a biweekly basis (preferably Wednesday and Saturday).
  f. IFA should be given at least one hour after consumption of food (breastfed/ given semi-solid food/solid food).

  g. Mark a tick (√) in the compliance card as given on page 27 in the MCP card after giving the dose for the month-wise bi-weekly IFA syrup supplementation.
- Undertake fortnightly home visits from the second week onwards up to the month end (the remaining 6 doses for the month), and encourage the mothers/caregivers to administer IFA syrup to their child themselves in your presence. This would help in confidence building of the mothers/caregivers in providing IFA syrup to her child.
- Explain the mother/caregiver to record compliance by marking a tick (√) in the compliance card as given on page 27 in the MCP card, in the month-wise bi-weekly IFA syrup supplementation section after giving every dose of iron folic acid syrup. After a month, the mothers/caregivers would acquire the required skills and confidence in providing IFA syrup to their child twice a week and marking the same in the compliance card.
- Regularly motivate the families who refuse to provide IFA syrup and albendazole tablets to their children. Undertake joint visits with ASHA Facilitator or ANM/MPW to difficult households where you are unable to convince the family for biweekly IFA supplementation and biannual deworming for children.
- During the home visits, counsel the mothers and caregivers about:
  - Free availability of IFA syrup and deworming tablets at public health facilities and Anganwadi Centres.
  - Benefit of IFA syrup for their child, improving iron and folate content of the diets and the importance of sanitation and hygienic practices in order to prevent anaemia and worm infestation in the child.

- Importance of providing the IFA supplementation and biannual deworming in children; its positive impact on physical and mental development of the child e.g. improvement in well-being, attentiveness in studies and intelligence, etc.
- Minor side effects associated with IFA administration such as black discolouration of stools.
- Preservation of IFA bottle – in a cool and dark place, away from reach of children, keeping the lid of the bottle tightly closed each time after administration, etc.
- Immediately contacting the ANM/MPW in case of any problem after consumption of iron folic acid syrup by the child.
- Informing them to contact either you or the ANM/MPW for a new IFA syrup bottle if the bottle finishes.

- Monitor that the mother/caregiver has given IFA syrup to the child (by looking at the tick (√) in the MCP card on page 27).
- Encourage the mother/caregivers to include iron-rich and folic acid-rich foods in the diet of the child-dark green leafy vegetables like mustard leaves (sarson saag), drumstick, turnip leaves, fenugreek (methi), bathua, mint (pudina), amaranth (chaulai), spinach (palak), spring onion, colocasia (arbi) leaves, etc. ; ragi, whole wheat flour, pumpkin, raw banana (plantain banana), pulses (daals), legumes (rajmah, lobia, soyabean, black chickpeas (kala chana), jaggery (gur), fresh peas, fresh beans, nuts, dry dates, raisins, sesame (til) seeds, animal foods/ non-vegetarian sources like meat, liver, poultry, egg, fish, etc.
- Advice to include foods containing Vitamin C like cauliflower, cabbage, tomato, watermelon, guava, orange, lemon, gooseberry (amla), sweet lime (mosambi), etc. and animal foods- meat, poultry, fish, liver, egg, etc., fermented and sprouted foods (grains and pulses), etc. as these increase the absorption of iron. Iron and folic acid fortified foods can also be included in the diet wherever available.

Provide mother/caregiver with the IFA syrup bottle and during your home visits ensure children receive biweekly IFA supplementation. Mobilise the families having children aged 12-59 months of age for biannual deworming with albendazole tablets.

SECTION 5

HEALTH

5.1 Family Planning

5.2 Full Immunization for Children

5.3 Growth Monitoring

5.4 Management of Sick Child During Home Visits

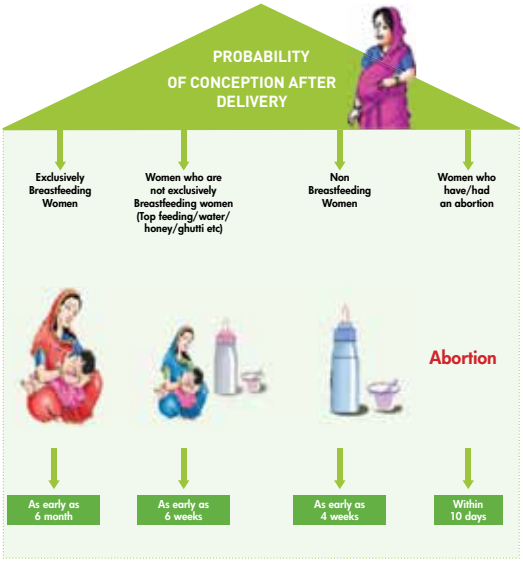
5.1 FAMILY PLANNING

You have been trained regarding Family Planning- couples (women and men) needs for family planning and types of family planning methods and information on each method's side-effects in detail in ASHA Module-7. This section is intended to serve as a refresher, and builds on your existing knowledge.

Under HBNC visits, you have been maintaining and updating the list of eligible couples, lactating mothers, children below 5 years of age in your community in the health register, counselling the mother after delivery regarding the need of contraceptive services, reinforcing the concept of healthy timing and spacing of births, enabling them to make an informed choice, and ensuring access to contraceptive services.

There are chances of conception after delivery amongst:

- Exclusively breastfeeding women as early as 6 months
- Women who are not exclusively breastfeeding women- giving top feeding/water/honey/ghutti, etc. as early as 6 weeks
- Non-breastfeeding women as early as 4 weeks and
- Women who have/had an abortion within 10 days



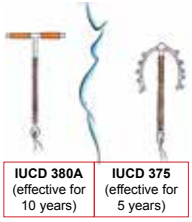
You are aware of the different methods available for family planning. Some of these are a part of your kit which should be replenished from nearest health facility/ANM/MPW periodically after placing indent through Family Planning-Logistics Management Information System (FP-LMIS) software in form of an SMS from your registered mobile number detailing the commodity code and quantity required. You may refer to MCP card, page 26 to show the couple the different choices of contraceptive methods offered under the Family Planning Programme.

5.1.1 CONTRACEPTIVE METHODS AVAILABLE IN FAMILY PLANNING PROGRAMME

1. Spacing methods- Injectable contraceptive MPA (Antara programme); Oral Contraceptive Pills (OCPs) including Combined Oral Contraceptive Pills (COCs) (Mala-N), non-hormonal Centchroman pills (Chhaya), Progestin Only Pills (POPs); Condoms (Nirodh) and Intra-Uterine Contraceptive Device (IUCD 380 A and 375).


Injectable MPA (Antara Programme)


Progestin only pill




Combined Oral Contraceptive Pills (Mala-N)


Centchroman (Chhaya)

Condom

Remember

Of all the contraceptive methods available, COCs (Mala- N) should **NOT** be taken by women who are breastfeeding till six months after delivery as it affects the quantity and quality of breastmilk. Centchroman pills (Chhaya) and POPs can be started anytime after delivery once woman is comfortable. Injectable MPA (Antara Programme) can be taken by women after 6 weeks of delivery and IUCD can be inserted immediately or within 48 hours of vaginal delivery (and immediately after Caesarean section). Thereafter, IUCD can be inserted beyond 6 weeks of delivery. IUCD can also be inserted within 12 days of completion of abortion. All other spacing contraceptives can be started immediately or within 7 days of completion of abortion.

2. Permanent Methods (Limiting Methods)- Female sterilization and Male sterilization. Remember that female sterilization can also be adopted immediately or within 7 days of delivery/ completion of abortion (called as post-partum/ post-abortion sterilization) whereas male sterilization can be adopted anytime.

Female Sterilization Male Sterilization

3. Emergency Contraceptive Pill (Ezy pill)- This is not a regular method of contraception. It must be consumed within 72 hours (the earlier, the better) in cases of unplanned/ unprotected/ forced intercourse or accidental breaking/ slipping of the condom.

You are being incentivized for ensuring spacing of 3 years after the birth of 1st child and in case the couple opts for permanent limiting method after 2 children. Additionally, you are incentivized for counselling and escorting the client for Postpartum IUCD (PPIUCD)/Post Abortion IUCD (PAIUCD) insertion.

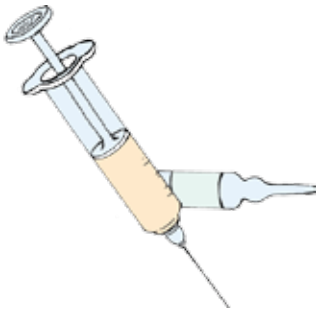
5.1.2 DURING YOUR HOME VISITS, YOU WILL COUNSEL THE COUPLES ON FAMILY PLANNING

- Explain the risk of unprotected sex and high chances of conceiving. Mention that return of fertility is uncertain and women can conceive even before their menses/periods return.
- Counsel couples to maintain spacing of 3 years between two children for the health of both mother and child.
- Counsel the couple on available basket of contraceptive choices under the National Family Planning Program for spacing and limiting births.
- Counsel couples for adoption of appropriate family planning methods in post-partum/ post abortion period.
- Deliver contraceptives like Nirodh (condoms), Mala-N, Chhaya and Ezy pills at the doorstep of beneficiaries.
- Inform the couples about availability of all contraceptives services free of cost in the public health facilities.
- Escort the woman to health facility if she chooses to adopt PPIUCD/PAIUCD services or sterilization services.

- Inform the couple to contact you or other healthcare providers to seek information regarding available methods and help them choose a method that is most suitable to them.

During your home visits, counsel the couple on the importance of family planning and maintaining healthy timing and spacing of birth, also inform them regarding the availability of wide range of contraceptive methods and help them make suitable choices of these methods.

5.2 FULL IMMUNIZATION FOR CHILDREN



Immunization, has been covered in detail as part of your training in ASHA Module- 7. You are actively involved in Mission Indradhanush (MI) for improving the immunization coverage of your area. This section will provide an update on new vaccines introduced as part of the National Immunization Schedule and will be a recapitulation of your roles in improving uptake of immunization services as part of your household visits.

5.2.1 NATIONAL IMMUNIZATION SCHEDULE

Page 36 of the MCP card provides detail of National Immunization Schedule for children at birth to 9 months of age and page 37 of the MCP card provides details for children from 16-24 months to 16 years of age.

ANM/MPW will fill the details- date of vaccination and also write the next vaccination date in the MCP card and will return the card to the mother. You may refer to the MCP card, page 36 to check the immunization status of the child during the household visits from 3rd month to 15 months of age and use the Immunization Essentials as given on page number 38, to understand the updated immunization schedule of vaccination from birth to $1^{1}/_{2}$ years of age.

VACCINATION NAME	BIRTH	$1^{1}/_{2}$ months	$2^{1}/_{2}$ months	$3^{1}/_{2}$ months	9 months	$1^{1}/_{2}$ years
BCG prevents tuberculosis	✓					
Hepatitis B prevents liver disease	✓					
OPV prevents polio	✓	✓	✓	✓		✓
IPV prevents polio		✓		✓		
Penta prevents whooping cough, diptheria, tetanus, Hep B and Hib infections		✓	✓	✓		
PCV prevents pneumonia		✓		✓	✓	
Rota prevents diarrhoea		✓	✓	✓		
MR prevents measles, rubella					✓	✓
Japanese encephalitis prevents brain fever					✓	✓
DPT prevents whooping cough, diptheria and tetanus						✓

5.2.2 POSSIBLE REASONS FOR LOW IMMUNIZATION COVERAGE

To address the gaps in improving population coverage it is important to understand the possible reasons for low immunization coverage. From your experience you will know that some of these possible reasons are-

- **Lack of awareness of benefits of routine immunization-** Families/caregivers are unaware regarding the benefits of Routine Immunization (RI).
- **Failure to organize immunization camps-** At planned outreach site (anganwadi centre during monthly VHND/UHND), Sub-centre (SC) or Primary Health Centre (PHC)/Urban Primary Health Centre (UPHC) sites due to shortage of frontline staff.

- **Lack of information-** The healthcare providers have not informed the families/caregivers about what vaccines are due, when they are due and why they are needed.
- **Drop-outs-** Children who receive one or more vaccination, but do not return for subsequent doses. Often families migrate for livelihood and children belonging to these families miss out on vaccination.
- **Unreached population-** There are usually the vulnerable or marginalised populations *(the categories belonging to such families has been taught in social vulnerability section)* who do not know about immunization or face socio-economic barriers to utilize health services.
- **Geographic barrier-** People living too far away from a health centre or outreach site are unable to travel long distances and face challenges in completing a full immunization schedule for children.
- **Resistant population-** Families do not believe in immunization services, even though a health centre is within reach, as there is fear of side effects, etc.
- **Missed opportunities-** Seen in case of children who visit the health centre for some other reason but are not screened for immunization by health workers.
- **Cultural or religious reasons-** There is refusal of vaccination due to myths, rumors and misconceptions prevalent in few sections of the society.
- **Gender barrier-** Sometimes women are not allowed to attend sessions by their family members. Also, if it is a girl child, family members may not give importance to her vaccination.
- **Financial barrier-** Sometimes families do not attend immunization sessions because of wage loss, etc.
- **Fear of Adverse Effects Following Immunization (AEFI)-** Fear of AEFI is also a major cause of refusal of vaccines.

5.2.3 ROLE OF ASHA IN IMPROVING IMMUNIZATION COVERAGE

- Continue to enumerate all households in your service area and make a list of children up to two years eligible for different vaccines. Update this list regularly to ensure inclusion of new families having children below 15 months of age.
- Check the immunization status of the child from the MCP card- whether child has received age-appropriate vaccines during the home visits.
- Praise and encourage the family for ensuring their child's immunization if all necessary vaccines have been given. Identify family constraints/ reasons for missed immunization and support or counsel to address the same.

- Inform when and where the family can take the child for the next vaccination, for a missed vaccine, or if a vaccine is due soon.

- Pay special attention to include children from families who are vulnerable or marginalised, sick, LBW and malnourished infants. Joint visits may be undertaken with ASHA Facilitators and ANMs/ MPW to mobilize these children for immunization.
- Ensure effective mobilization of children for immunization sessions during VHND/UHND session or at the health facilities. This can be achieved by-

  - Escorting the mother/caregiver and child to the session/ health centre for immunization, if required. This may be required for families living in remote areas or those having sick children, malnourished children, girl child, etc.
  - VHSNC/MAS members playing an important role to motivate resistant families for immunization. Initiate community level action to enable positioning of ANM/MPW and AWW in sub-centres/ AWCs in hamlets or urban slums/basti which do have these frontline functionaries.

A Routine Immunization Counterfoil, as given on Page 39 and 40 in the MCP card, enlists the date of vaccination from birth to 16 years of age, which is to be kept with the ANM/MPW to maintain the child's record.

Address common concerns related to immunization

You need to counsel mothers and caregivers that-

- A mild illness is usually not a reason to reschedule vaccinations
- The child may still be vaccinated even if he or she has:
  - A low-grade fever (less than 100 degrees)
  - A cold, runny nose or cough
  - Ear infection
  - Mild diarrhoea
- ANM/MPW or the Medical Officer at PHC or UPHC can determine if the child can be vaccinated in case of mild illness.
- After a vaccination, the child may cry a little, but that usually settles soon with a feed or some comfort provided by the family member.
- Common, minor side-effects such as a slight fever, pain, swelling or redness at the site of the injection and irritability are normal and usually resolve without any serious consequences. Extra fluids, rest and paracetamol medicine when necessary helps the child recover soon from the effects of immunization. However, if other reactions or changes in the child's body are noted, it is a matter of concern, and the child must be referred immediately to the health facility.

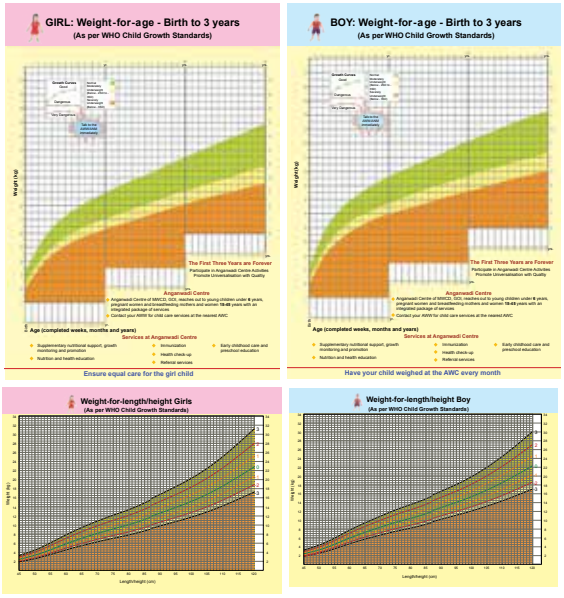
During each visit, check the immunization status of the child in the MCP card to ensure that child is up to date as per the immunization schedule.

5.3 GROWTH MONITORING

Weight and length/height are the commonly used growth measurements in children. Length is recorded for children less than 2 years of age and height for children above 2 years of age. Growth is measured in terms of changes in weight with respect to age, length or height of children. Growth monitoring helps in visualising change in weight over a period of time with respect to age, length/height of the child and helps to identify if the child is growing adequately or not. Recording of child's weight should be done once every month up to age of 3 years and at least once in 3 months, thereafter. Length is to be recorded once in three months from birth to 2 years of age and height once in 6 months (2 years to 5 years of age). There are separate growth charts for girls and boys, as they have different weights and lengths/heights beginning at birth and grow to different sizes according to age. These are available in the MCP card.

These changes are useful in giving advice to the mother about the growing pattern of the child. This process is called 'GROWTH MONITORING'. You are already familiar with growth monitoring from your training in ASHA Module 7.

Optimal growth and development of the child can be ensured only with adequate food, absence of illness and a caring, nurturing and social environment. Maximum growth happens in the first two years of life. A healthy child approximately doubles the birth weight at 5th month and is three times the birth weight by the first birthday. By the end of second year, the weight is 4 times the birth weight. We must understand that weight gain is not the only way to assess a child's growth. Increase in length or height of the child is also included in the growth pattern of the child. However, changes in child's length are slower than the weight. At the time of birth, the baby's length is around 50 cm. Expected gain in length in the first year after birth is 25 cms and in the second year is 12 cms, contributing to a total increase of 37 cms length/height in the first two years of life.



The AWW uses the growth chart for monitoring growth for every child, separately available for girls and boys. Every child in the village, should be weighed and her/his weight be plotted on the growth chart according to the age of the child. In addition, the length/height of the child will also be recorded in the growth chart given for weight-for-length/height. The AWW will be responsible for recording weight and length/height of the child during VHNDs/UHNDs, or the ANM/MPW can also record the weight and length/height of the child in the SC or during outreach sessions.

As part of your HBYC visits, you need to ensure that the weight and length/height of the child is recorded by the AWW and details are made available to the mother/caregiver by the AWW either

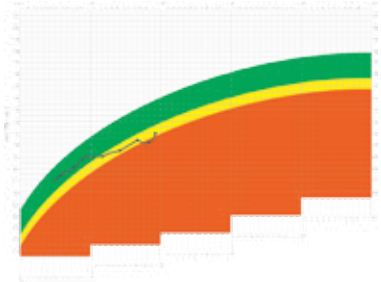
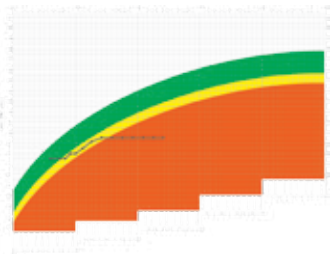
in MCP card or other mechanism as specified by your district or State. If the weight and/or length/height of the child is not recorded, you will mobilise and accompany the mother/caregiver to the nearest Anganwadi Centre (AWC) or SC for recording the weight and length/height of the child for ensuring growth monitoring.

5.3.1 WHAT IS GROWTH FALTERING?

Growth faltering is the slowing or stopping of growth. It is a sign that something is wrong with the child and immediate action must be taken to restore growth. Monitoring or measuring growth regularly is important to see whether the child is growing properly.

By joining the weight dots on the growth chart, the curve (called growth curve) on the growth chart can be understood. The direction of the growth curve indicates the progress of the child and is helpful in providing appropriate counselling and initiating necessary actions such as referral etc. for malnourished children.

Table 7 – Interpretation of growth curve

Good - Upward curve	Dangerous- Flat curve	Very Dangerous- Downward curve
The curve is moving upwards. Indicates adequate weight gain for the age of the child. The child is growing well and is healthy. 	The curve is flat, but has not gone down to another colour band. Indicates that the child is not gaining weight and is not growing adequately. This is called stagnation. The child needs extra attention of the mother. Also, the cause needs to be investigated. Talk to AWW/ ANM (MPW) immediately. Such children should be taken to a 24X7 PHC/UPHC or higher facility for a medical consultation. 	The curve is moving down, into another colour band. Indicates loss of weight. Talk to AWW/ANM (MPW) immediately. Child may be severely underweight and she/he needs urgent specialised medical care and immediate referral. 
Praise, and assess feeding to reinforce the good practices of the mother/caregiver.	Review feeding, praise what she is doing well and identify feeding problems, if any and give appropriate feeding advice for bringing about change. Check for any episode of illness. Take corrective action. Follow-up for compliance.	Follow- up after 5 days to ensure compliance.

You have already learnt in ASHA Module- 7, on how to check for nutritional oedema of both feet. To check for oedema (swelling due to fluid retention), grasp the foot so that it rests in your hand with your thumb on top of the foot. Press your thumb gently for a few seconds on the upper surface of each foot. The child has oedema if a pit (dent) remains in the foot when you lift your thumb. This is one of the ways to detect children with severe malnutrition in the community. Such children will require prompt hospitalisation in a centre which manages such children. This is often the District Hospital.

5.3.2 ROLE OF ASHA IN PROMOTING GROWTH MONITORING-PREVENTIVE AND PROMOTIVE COMMUNITY LEVEL CARE

- Explain the family members regarding the importance of weighing and measuring length/height of the child regularly.
- Discuss the trend of growth of the child with the mother/caregiver during each of the home visits by looking at the MCP card or as communicated by the AWW. Provide counselling depending on the direction of the growth curve in the MCP card or as specified by the AWW.
- Prioritise and list children who are underweight, wasted, low birth weight, not gained weight for 2 months, are not growing well or who are "at risk" of undernutrition due to frequent illnesses like fever, diarrhoea and acute respiratory infection; children with inadequate or insufficient dietary intake, mother with illness or those living in unhygienic conditions, etc., should also be weighed frequently for taking corrective and timely action.
- Ensure early registration of all children soon after birth to 15 months of age at the nearest AWC to avail the child care services like supplementary nutritional support, growth monitoring and promotion, immunization, early child care, health check-up, referral services, etc.
- Ensure that children from 6 months of age to 15 months are provided Take Home Ration (THR) at the AWC.
- Counsel the mother/caregiver regarding promotion of exclusive breastfeeding for the first six months of a child's life, age-appropriate complementary feeding practices for all children aged 6–24 months, importance of hand-washing, using clean drinking water and its storage, safe sanitation and hygiene practices, age-specific immunization, appropriate play and communication with the child, etc. for proper growth and development.
- Pay extra attention to malnourished children, sick children, low birth weight children, etc. and refer to the health facility for further management in case of growth faltering. Follow-up with mother/caregiver to ensure adherence to treatment plan suggested by health facilities for these children.
- Use platforms like VHSNC/MAS, VHND/UHND, camps, mother support groups, self-help groups, community meetings, etc. to disseminate the importance of growth monitoring and finding suitable measures for rehabilitation and management of the malnourished children.
- Explore the option of using untied funds of VHSNC/MAS to meet the special care needs of malnourished children if required.

During each visit, ensure that weight and length/height of the child is recorded by the AWW and details are made available for understanding the growth pattern of each child.

5.4 MANAGEMENT OF SICK CHILD DURING HOME VISITS

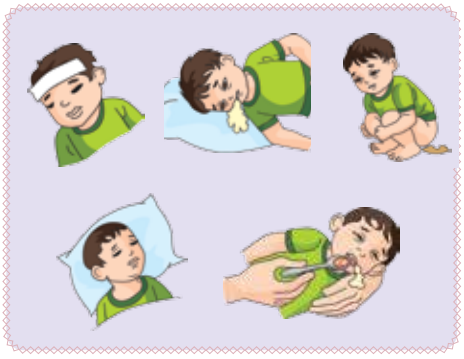
You have already learnt management of a sick child during your trainings in ASHA Module-7. This section will support in refreshing your knowledge and skills in management of young children who are suffering from common childhood illnesses such as Fever, Acute Respiratory Infections (ARIs) and Diarrhoea. You must assess the child for sickness during all the household visits under HBYC.

5.4.1 INITIAL ASSESSMENT FOR DANGER SIGNS

1. **Identify problem-** If not reported by the mother/caregiver, ask whether the child is sick during all your home visits.

2. **Assess all children with an illness for the presence of general danger signs:**

   - Not able to drink or breastfeed
   - Vomits everything
   - Has convulsions (fits)
   - Is lethargic or unconscious



   Recall that these general danger signs indicate serious illness. These can occur in many illnesses. Some danger signs may occur without any relationship to the type of illness. For example-fever, diarrhoea, pneumonia, meningitis or malaria can all produce lethargy or unconsciousness.

3. **Refer immediately, a child with any of the above danger signs.** In addition to these general danger signs, there may be other signs like fast breathing, chest indrawing, stiff neck, etc. in other diseases that require immediate referral.

Delay in availing healthcare services especially in case of sick girl child is a common practice seen in families. Families need to be especially counselled to avoid delay in providing treatment to the sick girl child to prevent worsening of the condition. Ensure that you also pay extra attention to children from vulnerable/ marginalized households, low birth weight children, malnourished children, SNCU/NBSU/NRC discharged children, etc. as they are weak and are more prone to falling ill through repeated infections.

You along with the ANM/MPW at community level will work together to protect, prevent and treat children below 15 months of age from common childhood illnesses discussed in this section.

5.4.2 MANAGING FEVER

You know that fever is a very common problem in young children. A child (2 months-5 years) has fever if the axillary temperature is 37.5 degree Celsius or above (99.5 degree Fahrenheit). A child with fever may have malaria or another disease such as simple cough or cold or other viral infection. Follow these steps if you come across a child suffering from fever during your home visits.

1. **Measure the temperature of the child** by placing the thermometer in the armpit of the sick child for 2 minutes if you find a child who appears to be sick or is warm.

2. **Refer urgently** to the nearest health facility **if the fever has been present every day for more than seven days or if there are any general danger signs or stiffness of neck.**
3. **Classify and provide appropriate management of fever as follows:**

Table 8 – Classification for appropriate management for fever in a child

Signs/Symptoms	Status	Action to be taken
Any general danger sign or stiff neck General Danger Signs: • Not able to drink or breastfeed or, • Vomits everything or • Has convulsions/fits or • Is lethargic or unconscious	Very severe febrile disease	• Give first dose of Cotrimoxazole. • Give first dose of antimalarial after making a smear. • Give one dose of Paracetamol to bring the high fever down (Temperature 38.5 degree Celsius or 101.3 degree Fahrenheit or above). • Refer **URGENTLY** to hospital.
Fever (by history or feels hot) in a malarial endemic area	Malaria-Rapid Diagnostic Test (RDT) positive	• Give first dose of anti-malarial, after making a blood smear. • Give one dose of paracetamol for high fever (Temperature 38.5 degree Celsius or 101.3 degree Fahrenheit or above) • Advise extra fluids*, continue feeding and advise about general danger signs. • Advise caregivers on use of insecticide-treated nets (ITNs). • Follow up in two days if fever persists. • If fever is present every day for more than seven days, refer the child.

Source: ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

Advise the mother/caregiver to-

- Feed the child during illness.
- Give extra fluids* -
  - Increase breast feeding.
  - Offer the child extra to drink (home fluids)- rice-pulse based drink, vegetable soup, green coconut water, milk, lemon drink, plain clean water, yoghurt drink, etc. (if child is above 6 months of age).

5.4.3 MANAGING ACUTE RESPIRATORY INFECTION (ARI)

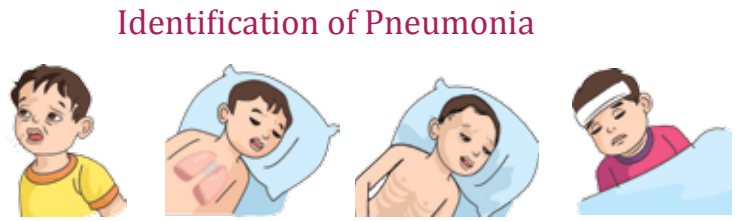
You may also come across children with cough and cold and/or difficulty in breathing during your household visits. These children are said to be suffering from Acute Respiratory Infection (ARI)**.**

Pneumonia, one of the most common ARI in children, is caused by certain germs, such as bacteria or viruses and affects the lungs. It can spread in a number of ways. The viruses and bacteria that are commonly found in a child's nose or throat, can infect the lungs if they are inhaled. They may also spread via air-borne droplets from a cough or sneeze. In addition, pneumonia may spread through blood, especially during and shortly after birth.

The MCP card, on page 9 provides details of identification of pneumonia and breath counts to identify pneumonia. Counsel mother/caregiver on identification of pneumonia using the MCP card during your home visits.

5.4.4 IDENTIFICATION OF PNEUMONIA

1. Coughing gets worse
2. Fast breathing
3. Chest indrawing
4. Fever



It can be identified by breath counts. Count the breaths in one minute to assess difficulty in breathing based on what you have learnt in earlier trainings.

Decide whether the child has normal breathing or fast breathing.

If the child's age is	The child has fast breathing if you count
Less than 2 months	**60 breaths** per minute or more
2 months to 12 months/1 year	**50 breaths** per minute or more
12 months/1 year to 5 years	**40 breaths** per minute or more

Note: The child who is exactly 12 months old (1 year) has fast breathing if you count 40 breaths per minute or more.

Classify and provide appropriate management of ARI as follows if you come across a child suffering from ARI during your home visit.

Table 9 – Classification for appropriate management for childhood pneumonia

Signs/Symptoms	Status	Action to be taken
Presence of any general danger sign – • Not able to drink or breastfeed or • Persistent vomiting or • Convulsions/fits, • Lethargic or unconscious **or** Chest indrawing	Severe Pneumonia or Very Severe Disease	• Give first dose of Cotrimoxazole. • Refer **URGENTLY** to hospital.
Fast breathing	Pneumonia	• Give Cotrimoxazole for 5 days. • Follow-up in 2 days. • If improving, advise home care** and tablets to continue. • If no improvement, refer to a hospital.
No signs of pneumonia or very severe disease	No pneumonia: cough or cold	• Advise home care for cough or cold**. • If coughing for more than 30 days, refer for further assessment to a hospital.

Source: ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

Advise home care for cough or cold**

Advise the mother/caregiver to-

- Feed the child during illness.
- Give increased fluids: Increase breast feeding. Offer the child extra to drink (home fluids) like- rice-pulse based drink, vegetable soup, green coconut water, milk, lemon drink, plain clean water, yoghurt drink, etc. (if child is above 6 months of age).
- Soothe the throat, with a safe remedy (age 6 months or more).

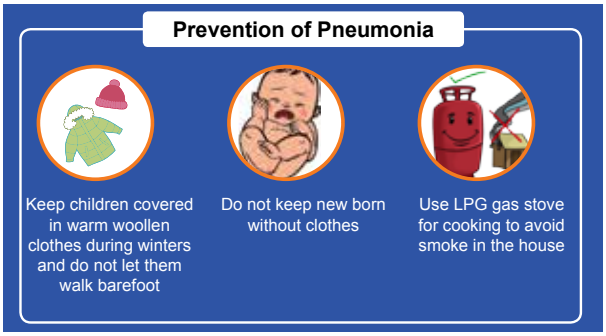
Safe remedies to recommend:

- Continue breastfeeding.
- Honey, tulsi, ginger, herbal teas and other safe local home remedies.
- Avoid cough syrups.
- If the child's nose is blocked and interferes with feeding, clear the nose.

Watch for the following signs and return quickly if they occur:

- Child becomes sicker

- Not able to drink or breastfeed
- Fast breathing
- Difficult breathing
- Develops a fever



The MCP card, on page 9 provides details of prevention of pneumonia. Counsel mother/ caregiver on prevention of pneumonia using the MCP card during your home visits.

5.4.5 MANAGING DIARRHOEA

You are aware that diarrhoea is the leading cause of deaths in children. You are also aware that a child is said to be suffering from diarrhoea if s/he is passing stool more than three times a day, which is usually watery. The normally frequent or semi-solid stools of a breastfed baby is **NOT** diarrhoea. You need to follow these steps if you come across a child suffering from diarrhoea during your home visits-

1. Identify the nature of diarrhoea.
2. Ask the mother **about the** duration of diarrhoea; **If the diarrhoea is of 14 days or more,** the child has **severe persistent diarrhoea** and needs to be referred to hospital.
3. Refer if the child is passing blood in stools or is suffering from **dysentery.**
4. Assess for the classification of dehydration and administer appropriate treatment as per the table below.

The MCP card, on page 9 provides details on prevention and treatment of diarrhoea. Counsel mother/caregiver on prevention and treatment of diarrhoea using the MCP card during your home visits.

Table 10– Classification for appropriate management for different types of dehydration in children

Signs/Symptoms	Status	Action to be taken
Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly	Severe dehydration	• Refer URGENTLY to hospital with mother/caregiver giving frequent sips of ORS/fluids on the way.

Signs/Symptoms	Status	Action to be taken
Two of the following signs: • Restless and irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly	Some dehydration	• Refer to a health facility to treat 'Some dehydration' with ORS (as per Plan B). • Follow-up in 2 days if not improving.
Not enough signs to classify as some or severe dehydration. Passing urine normally.	No dehydration	• Give fluids (home-available fluids/ breast milk) and food to treat diarrhoea at home (Plan A). • Follow-up in 2 days if not improving.
Blood in the stool	Dysentery	• Refer for further management.

Source: ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

Refer Annexure-2 for age-specific dose of Paracetamol, Cotrimoxazole and Antimalarials for children.

5.4.6 TEACHING THE CAREGIVERS USE OF ORS TO MANAGE DIARRHOEA

You have already learnt how to prepare an ORS solution using an ORS packet and also home-made ORS. Use your skills to teach the mothers/caregivers both these methods of preparation of ORS during your home visits. As a recap, both these methods are explained below.

1. Preparation of ORS solution

A. Making ORS solution using ORS packet

Teach the mother/caregiver how to prepare ORS

1. Wash your hands thoroughly with soap and water.

2. Pour all the ORS powder from a packet into a clean container.

3. Measure one litre of clean drinking water and pour it into the container in which you poured ORS. (If you have ORS packets for 1/2 liter of water then take 1/2 liter water.)

4. Stir until all the powder in the container has been mixed with water and none remain at the bottom of the container.

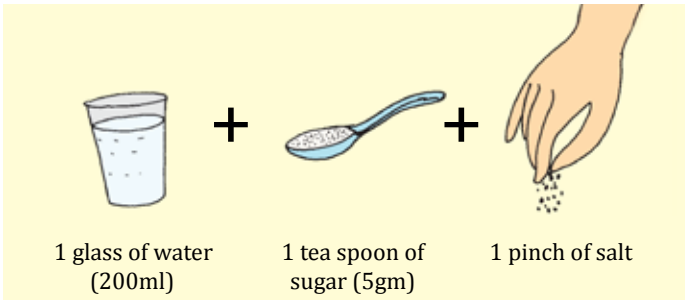
5. Taste ORS solution before giving it to the child. It should taste like tears - neither too sweet nor to salty. If it tastes too sweet or too salty then throw away the solution and prepare ORS solution again.

6. Any ORS solution which is left over after 24 hours should be thrown away.

B. Home-made ORS solution

Teach the mother how to make home-made ORS.

1. Wash hands properly using soap and water.
2. To prepare one glass of ORS, take 1 glass (200 ml) of clean water, add a pinch of salt and one teaspoon of sugar. (See in the diagram given how a pinch of salt is taken with three fingers and how a teaspoon of sugar is measured).
3. Stir the mixture until the sugar and salt dissolve.



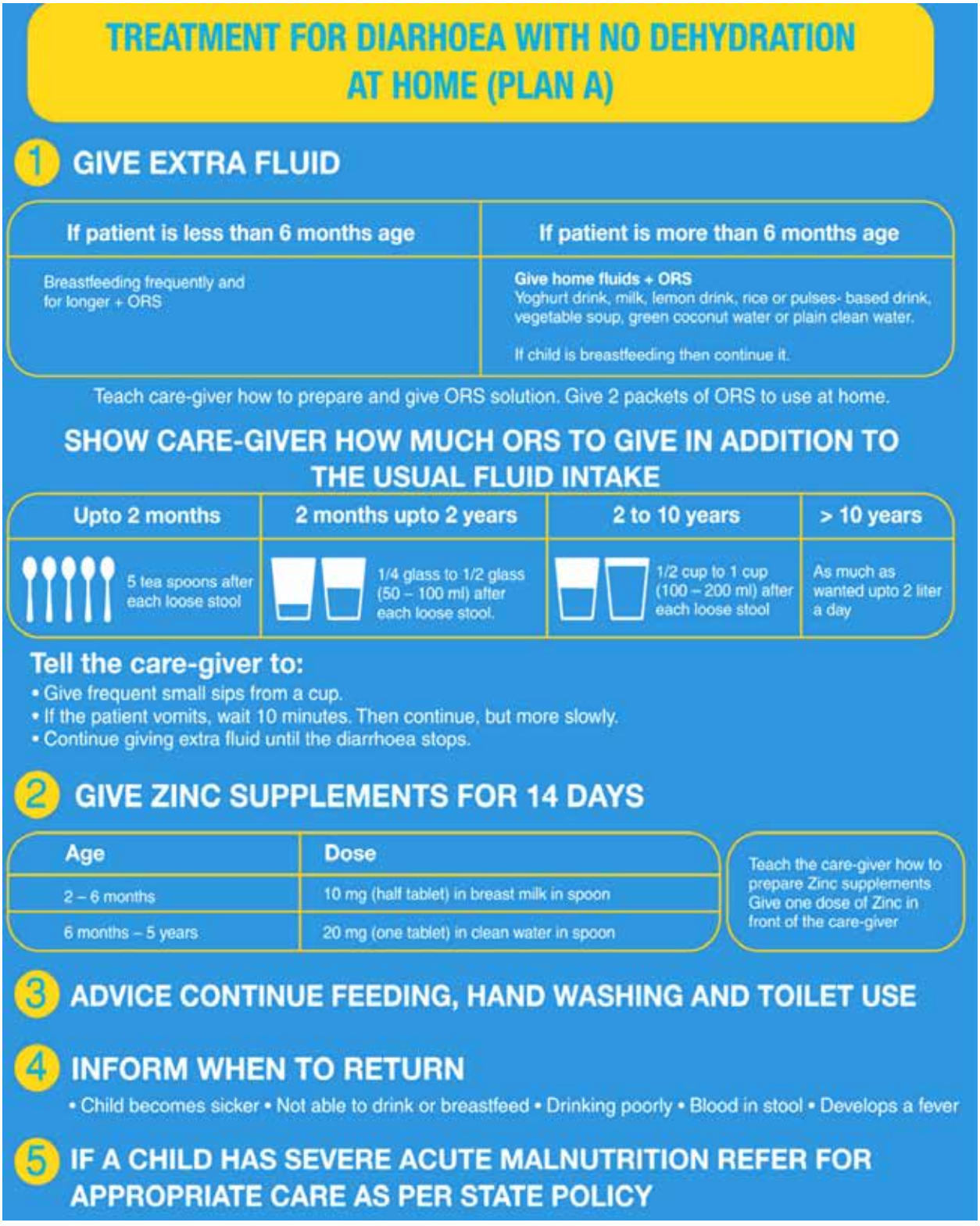
1 glass of water (200ml) | 1 tea spoon of sugar (5gm) | 1 pinch of salt

4. A juice of half a lime can be squeezed in. Taste the ORS solution before giving it to the child. It should taste like tears - neither too sweet nor to salty. If it tastes too sweet or too salty then throw away the solution and prepare ORS solution again.
5. After washing hands again with soap and water, the mother should administer ORS solution to the child.
6. Any ORS solution which is left over after 24 hours should be thrown away.

Remember

- Ask the mother/caregiver to give one teaspoon of the solution to the child. This should be repeated every 1-2 minutes (an older child who can drink it in sips should be given one sip every 1-2 minutes).
- In case of a diarrhoeal or vomit episode during ORS administration, the child and mother/caregiver and the area should be thoroughly cleaned.
- After washing hands again with soap and water, the mother/ caregiver should administer ORS more slowly than before. Breastfed babies should be continued to be given breast milk in between ORS.

5.4.7 INITIATE AND SUGGEST PLAN A TO MOTHERS AND CARE GIVERS: IF THE CHILD HAS DIARRHOEA BUT NO DEHYDRATION



TREATMENT FOR DIARHOEA WITH NO DEHYDRATION AT HOME (PLAN A)

1 GIVE EXTRA FLUID

If patient is less than 6 months age	If patient is more than 6 months age
Breastfeeding frequently and for longer + ORS	**Give home fluids + ORS** Yoghurt drink, milk, lemon drink, rice or pulses- based drink, vegetable soup, green coconut water or plain clean water. If child is breastfeeding then continue it.

Teach care-giver how to prepare and give ORS solution. Give 2 packets of ORS to use at home.

SHOW CARE-GIVER HOW MUCH ORS TO GIVE IN ADDITION TO THE USUAL FLUID INTAKE

Upto 2 months	2 months upto 2 years	2 to 10 years	> 10 years
5 tea spoons after each loose stool	1/4 glass to 1/2 glass (50 – 100 ml) after each loose stool.	1/2 cup to 1 cup (100 – 200 ml) after each loose stool	As much as wanted upto 2 liter a day

Tell the care-giver to:

- Give frequent small sips from a cup.
- If the patient vomits, wait 10 minutes. Then continue, but more slowly.
- Continue giving extra fluid until the diarrhoea stops.

2 GIVE ZINC SUPPLEMENTS FOR 14 DAYS

Age	Dose
2 – 6 months	10 mg (half tablet) in breast milk in spoon
6 months – 5 years	20 mg (one tablet) in clean water in spoon

Teach the care-giver how to prepare Zinc supplements Give one dose of Zinc in front of the care-giver

3 ADVICE CONTINUE FEEDING, HAND WASHING AND TOILET USE

4 INFORM WHEN TO RETURN

- Child becomes sicker • Not able to drink or breastfeed • Drinking poorly • Blood in stool • Develops a fever

5 IF A CHILD HAS SEVERE ACUTE MALNUTRITION REFER FOR APPROPRIATE CARE AS PER STATE POLICY

5.4.8 REFER FOR TREATMENT OF DIARRHOEA WITH 'SOME DEHYDRATION' AT HEALTH FACILITY (PLAN B)

TREATMENT FOR DIARHOEA WITH SOME DEHYDRATION AT HEALTH FACILITY / ORS – ZINC CORNER (PLAN B)

Patient with some dehydration has at least any of the following 2 signs:

- Restless, irritable
- Sunken eyes
- Drinks eagerly, thirsty (do not assess in child less than 2 months age)
- Skin pinch goes back slowly

1 GIVE ORS FOR 4 HOURS IN ORS-ZINC CORNER

AGE*	Up to 4 months	4 months - 1 year	1 – 2 years	2 – 5 years	5 – 14 years	> 15 years
Weight	< 5 kg	5 – 8 kg	8 – 11 kg	11 – 16 kg	16 – 30 kg	> 30 kg
Quantity of ORS	200 – 400 ml (1 – 2 glass)	400 – 600 ml (2 – 3 glass)	600 – 800 ml (3 – 4 glass)	800 – 1200 ml (4 – 6 glass)	1200 – 2200 ml (6 – 11 glass)	2200 – 4000 ml (11 – 20 glass)

* Use the age only when you do not know the weight. The approximate amount of ORS required (in ml) can also be calculated by multiplying the weight (in kg) times 80.
1 glass = 200 ml

- If the patient wants more ORS give more.
- For infants under 6 months who are not breastfed, also give 100-200 ml clean water during this period.

▸ SHOW THE CARE GIVER HOW TO GIVE ORS SOLUTION.

- Give frequent small sips from a cup.
- If the patient vomits, wait for 10 minutes. Then continue, but more slowly.
- Continue breastfeeding whenever the child wants.

2 AFTER 4 HOURS:

- Reassess the patient and classify for dehydration.

If No dehydration	Then shift the patient to Plan A, home based treatment
If Severe dehydration	Then refer the child for admission for Plan C, Intravenous based treatment
	On the way, advice the care giver to give frequent sips of ORS
	If child is less than 2 months age then give first dose of intramuscular Ampicillin / oral Amoxicillin and Injection Gentamycin before referral.

5.4.9 ZINC SUPPLEMENTS FOR A CHILD HAVING DIARRHOEA

- Zinc helps in overall growth and development and supports in proper functioning of the immune system.
- Body loses Zinc during diarrhoea and it needs to be replenished.
- ORS and Zinc have proven to be successful in the prevention and management of diarrhoea and dehydration.
- Zinc is only given to children 2 months up to 5 years for 14 days.
- The mother/caregiver will need to be taught (explained below) the right way to administer zinc tablets at home for a child suffering from diarrhoea (with no dehydration).

Teaching mother/caregiver regarding administration of zinc tablets at home for a child suffering from diarrhoea (with no dehydration)

One zinc tablet in the blister pack contains 20 mg of zinc (zinc tablets will be provided to the ASHAs).

1. If zinc is to be administered to **children 2 – 6 months age**

   a. Half- tablet (i.e. 10 mg). is to be given. Discard the remaining half tablet.

   b. Take a clean teaspoon.

   c. Request the mother to express milk from her breast into the spoon and then add ½ tablet.

2. If Zinc is to be administered to **children 6 months to 5 years age,** the dose is full tablet (20 mg).

   a. Take a clean teaspoon, place one tablet in the spoon.

   b. Pour potable water carefully on the tablet taking care that the water does not reach the brim of the spoon.

   c. Shake the spoon slowly till the tablet dissolves completely. Do not use fingertip or any material to dissolve the tablet.

   d. Tell the mother/caregiver to hold the child comfortably and ask her to feed the solution to the child.

   e. If there is any powder remaining in the spoon, let the child lick or add little more breast milk or water to dissolve it and then ask the mother/caregiver to give it again.

3. Counsel the mother/caregiver to administer zinc once a day for a total of 14 days to children of all ages (2 months - 5 years of age).

SECTION 6

EARLY CHILDHOOD DEVELOPMENT

6.1 IMPORTANCE OF FOCUSSING ON EARLY CHILDHOOD DEVELOPMENT (ECD)

The first two years of life play an important role in early childhood development as much of what children learn, they learn in these early years of life. Children as they grow older learn to talk, walk, run, think and solve problems thus becoming more capable. These changes indicate the child's development. Both girl and boy child require same attention and care from the families to grow and develop properly.

Proper growth and brain development during the early childhood period is closely related to the enabling environment and encouragement of young children provided by parents/ caregivers through-

- Playing
- Communicating-talking and smiling
- Responding appropriately to what the child communicates- for example, hunger, pain and discomfort, interest in something, or affection

Active participation of all family members/caregivers besides the mother like father, mother-in-law, father-in-law, other family members is important for growth and development of the child and also builds a strong, healthy relationship between family members/caregivers and the child. Involvement of family members also provides support to the mother to take adequate rest and provides her time to engage in other activities.

ASHA can play an important role in encouraging and explaining the family members the importance of Early Childhood Development and role of their appropriate communication with the child in ensuring the child's proper growth and development.

6.2 TRACKING DEVELOPMENTAL MILESTONES

Developmental milestones are activities that most children can do by a certain age. It is important for you to learn about the age-specific activities of children and also what parenting tips you can offer to the family members to help the child achieve these milestones.

You must remember-

- That each child is unique.
- Not all children develop at the same rate.
- Timings of development milestone could vary from child to child.

Some children show an interest or skills in an activity earlier than others or later than others. Some children develop very early, such as learning how to walk or talk much earlier than other children of the same age.

- Low weight babies, malnourished children, sick children, children discharged from SNCU/NBSU/NRC etc. need extra stimulation with play and communication activities, to grow and develop well. Families of such children should be constantly encouraged and motivated to play and communicate with their children.
- If the child seems 'slow' or 'unable to respond', families must be encouraged to provide extra care-play and communicate with the child through touch and movement.

6.3 WHAT ARE DEVELOPMENTAL DELAYS?

Child development is the period of growth (physical, mental and social) that begins at birth and continues through early adulthood.

- Developmental delay is a term used when a child's development is delayed in one or more areas compared to other children.
- Parents and others become aware of delay when the child does not achieve some or all of the milestones at the expected age.
- Other children may present with behaviour problems, which may be associated with delayed development.

6.4 UNDERTAKING MILESTONE ASSESSMENT TO TRACK EARLY CHILDHOOD DEVELOPMENT DURING THE HOME VISITS

One of your roles under HBYC is to help the parents/caregivers in providing support for early childhood development during your home visits for young children (3 months up to 15 months).

The MCP card (page 12-25) provides details of milestones of children from 2-3 months of age up to 3 years of age, which is divided in three sections. These are what most babies do, parenting tips for children and "warning" signs.

You will undertake the following activities during the household visits to support the early childhood development-

a. **Help the mother/caregivers understand what most babies do at a specific age-**This is done by using the MCP card section on 'What most babies do' (page 12-21), to track progress on development milestones of the child. There are certain milestones that have been given for 2-3 months to 15-18 months of age children.

b. **Teach the mothers/caregivers to undertake milestone assessment-** You will need to teach mothers and caregivers the right method to observe and elicit information for various milestones at a particular age. This is explained in detail in the Learning Tool for Milestone Assessment (LTMA) that is included as Annexure-4 in the handbook. You will use this tool to teach the mother and caregivers to conduct an assessment for the milestones achieved by the child at a particular age. The tool provides details of normal milestones/ expected activities that are undertaken by the child at a particular age, what are the ways to observe these milestones and warning signs that require referral. You will need to teach the mother/caregiver, age-specific milestone assessments prior to your scheduled HBYC visit for the particular age group. For example- To assess the milestone assessment by mother/caregiver at 3 months, you will have to teach them the assessment during your 42nd day of HBNC visit or any other in-between contact with the family. Likewise, for assessment at 6 months, you will need to inform mother/caregiver about milestone assessment for this age-group during your 3rd month household visit. Such a pattern will be required for subsequent age groups till 15 months of age of the child.

c. **Demonstrate the use of local toys/items to elicit information on milestones-**The LTMA mentions using a set of commonly available items for teaching the mothers/caregivers conduct age-specific milestone assessment for the child. These items are easily available, locally in your village/slum area and can be collected while planning your HBYC visits to demonstrate use of these items to the mothers and caregivers. The items required for ECD screening is given in Annexure-3.

d. **Inform mothers/caregivers to record observations in the MCP Card**- Once the mothers/ caregivers have learnt to conduct the age specific milestone assessment for their child, you will inform them to record their observations for each activity in the child's MCP card on the first day that their child performs these activities. For the child who is able to perform the age specific activity, the parents/caregivers will need to a provide a tick mark (√) against the specific activity in the MCP card. For any activity that the child is unable to perform the parents/ caregivers will leave the box blank (□) in the MCP card for the activity concerned. You will explain the mothers/caregivers that they should not worry or panic even if the child is unable to perform some of these activities at the specific age mentioned in the MCP card because each child is unique and not all children develop at the same rate. Timings of development milestone could vary from child to child. Some children show an interest or skills in an activity earlier than others or later than others. Some children develop very early, such as learning how to walk or talk much earlier than other children of the same age. Thus, at any circumstance a mother/caregiver is **NOT** expected to a put a cross mark (X) in the blank box (□) provided in the MCP card against these activities.

Do not forget to inform the mother/caregiver that the MCP card will serve as a photo-album for their child. They should preserve it because it is the health record for the child and she/he will find it interesting and will be happy to see her/his developmental journey later in life.

e. **Verify the milestone assessment records undertaken by mothers/caregivers-** You or the AWW during the home visits, will verify the milestones by examining the child for all the activities as listed for a particular age of the child. In the MCP card, in 'what most babies do' section, there is a row where you will record your findings after confirming the activities being undertaken by the child. After making the observations, you will provide a tick mark (√) in the box if all the activity milestones for that particular age are being conducted by the child and mark cross (X) on the card, even if one activity is not achieved by the child at that particular age. ***The (X) sign should be put only after you have assessed and ensured that child had cooperated well, is otherwise active but is still unable to perform the particular activity.***

   After making the observations for a particular age group, before leaving the household, do not forget to teach the mother/caregiver, the methods to observe and elicit information for milestone assessments for the subsequent age group.

f. **While verifying the records if the box provided for the mother/caregiver is left blank-** You must confirm whether the mother/caregiver has not marked a tick (√) because she/he has missed recording the particular activity or the child is unable to perform this activity. If any activity for milestone assessment has not been assessed by the mother/caregiver, explain them again the importance of conducting these activities with the child. You should then conduct the assessment for the child and provide a tick mark (√) against that activity if the child is able to do the activity concerned. If not, a cross sign (X) will be included in the box and in your next visit you will follow- up for achievement of that particular milestone which the child was unable to perform.

g. **Look for "warning" signs as provided in the MCP card for each age group of the child and refer the child to ANM (MPW) or AWW or healthcare provider immediately in case you notice even a single 'warning' sign.**

   - **Sensitise the parents/caregivers about the "warning" signs-** This is given in the MCP card (page 12-21) and also in the learning tool for milestone assessment. On completion of a particular age, inform the families to contact ANM (MPW)/ AWW/health care provider or yourself immediately if the family members see any of "warning" sign for a particular age, for providing support and appropriate treatment at the healthcare facility.

h. **Provide parenting tips to support early childhood development in children-**As mentioned above, the parenting tips to the family as given in the MCP card (page 12-21), provides information on how to achieve the age-specific milestones. As you are going to help the parent/caregiver to play and communicate with the child appropriately for the age you need to provide the following counselling tips to the parent/caregiver to support child's development-

- **If the parents/caregivers do not play with the child,** discuss ways to help child see, hear, feel and move, appropriate for child's age and ask caregiver to do play or communication activity, appropriate for age. Encourage the family members to use non-sharp household objects that are clean and safe for the child for playing, if the household does not have toys for the child to play.

- **If the parent/caregiver does not talk to child or talks harshly to child** and child is less than 6 months, ask caregiver to look into child's eye and talk to the child. For older children, give caregiver and child an activity to do together. Help caregiver understand what child is doing and thinking and see if child responds and smiles. Help the caregiver in understanding that talking before the child talks prepares the child for talking, as children copy speech and actions of others around them.
- **If the parent/caregiver tries to force smile or is not responsive to child**, ask caregiver make gestures and cooing sounds; copy child's sounds and gestures and see child's responses. Inform them about ways to make the child smile- e.g. make a funny face, gently rub the child's tummy, clap their hands, play games with the child, etc.
- **If the parent/caregiver shows anger at the child,** help caregiver distract child from unwanted actions by giving alternative toy or activity.
- **If the parent/caregiver is not able to comfort child** and child does not look at the caregiver for comfort, help caregiver look into child's eye and gently talk to child and hold child.
- **If the parent/caregiver says the child is slow to learn,** encourage more activity with the child, check hearing and seeing. Refer child with difficulties to the nearest health centre.

Children learn by playing, trying things out and by observing and copying the actions what others do.

6.5 COUNSEL ON CHILD SAFETY MEASURES

Children need a clean, safe and protected physical environment safe from injuries and accidents while they are playing and learning. Thus, it is also important to inform the parents/caregivers during the HBNC visits, on how to protect children from injuries and accidents. Advise parents to-

- Keep playing objects of a child clean and washed.
- Keep the child in clean surroundings by placing the child on a clean mat or clean carpet (dari) or clean cloth while playing.
- Keep dangerous substances like medicines, poisons, insecticides, bleach, acids and liquid fertilizers and fuels (kerosene) out of children's reach. Store carefully in clearly marked containers.
- Keep children away from fires, cooking stoves, hot liquids and foods, and exposed electric wires to prevent burn injury.

- Never leave young children alone in or near water as they can drown in a very small amount of water, even in a tub/bucket.
- Do not let young children play on or near the road; always have someone older supervise them.
- Secure stairs, roofs and windows using barriers in order to protect children from falling.
- Keep sharp and thin objects like knives, scissors, needles, etc. out of reach of children.
- Keep small objects, such as coins, nuts and buttons, etc. out of reach as young children like to put them in their mouth. This can lead to choking.

You will teach the mother/caregiver to undertake milestone assessment, check for developmental delays and provide appropriate counselling on parenting the child as provided in the MCP card during each home visit.

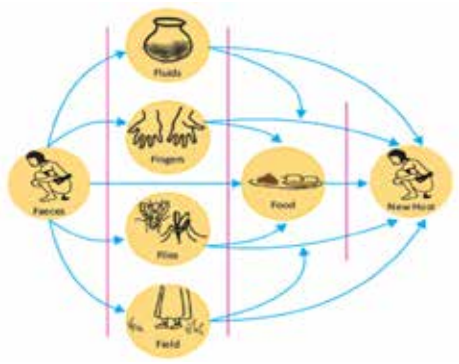
SECTION 7

WATER, SANITATION AND HYGIENE

7.1 EFFECT OF WATER, SANITATION AND HYGIENE (WASH) ON THE HEALTH OF YOUNG CHILD

Clean water supply, adequate sanitation (safe disposal of human urine, faeces, garbage collection and waste water disposal) and maintaining personal and environmental hygiene are all known to have a significant beneficial impact on health, both in households and across communities. Poor hygiene, inadequate quantities and quality of drinking water and lack of sanitation facilities results in deaths from preventable diseases. Women and children are the main victims. Various water-borne diseases can occur due to contaminated water such as food poisoning (vomiting and abdominal pain), typhoid, cholera, worm infestation, dysentery, diarrhoea, etc.

In India, the number of deaths in children particularly due to diarrhoea is very high. Diarrhoeal infection is majorly transmitted through the faecal-oral route. The adjacent 'F-diagram' illustrates the different routes that the microbes of diarrhoea take from faeces, through the environment to a new person. For example- microbes in faeces on the ground by a well can get into the water system and be drunk by a child, hands that have not been washed after going to the toilet can carry microbes onto foods, which are then eaten, infecting another child, who gets diarrhoea and spreads more microbes.



F-diagram

To accelerate the efforts to achieve universal sanitation coverage and to put focus on sanitation, the Government of India launched the Swachh Bharat Mission (SBM) on 2nd October, 2014.

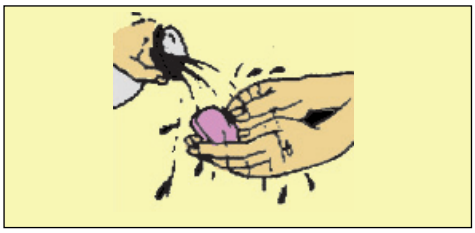
7.2 PROMOTING WATER, SANITATION AND HYGIENE PRACTICES DURING HOUSEHOLD VISITS

Hand-washing is one of the most effective way for reducing water- borne diseases, infections like common cold, flu, pneumonia, etc. Germs can get onto hands through various ways- after people use the toilet, touch any object that has germs on it because someone coughed or sneezed on it or was touched by some other infected object. When these germs get onto hands and are not washed off, they can be passed from person to person and make other people especially children particularly sick.

You must make sure your hands are washed properly with soap before touching the child. Proper hand-washing means washing your hands for at least 30 seconds with soap and water to remove germs and dirt from the hands.

You have been taught the steps of hand-washing in ASHA Module-6. The steps involved in hand-washing are given in the figure below.

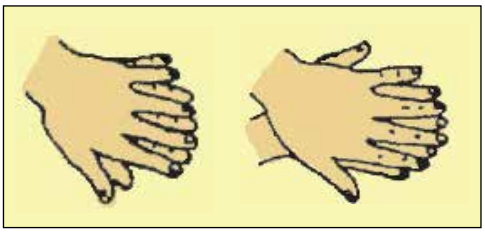
Figure 4 – Steps involved in Hand-Washing



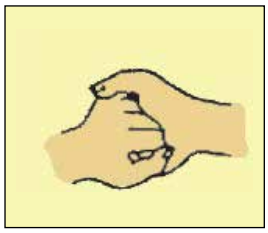
Remove rings, bangles, wrist watch or any other ornament or bands from both hands.

Roll the sleeves of garment up to elbow level. Wet hands and forearm up to elbow with clean water.

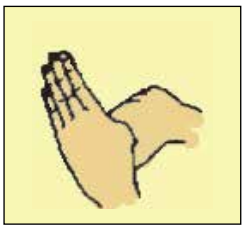
Apply soap properly on wet hands and forearm up to elbow to create good lather (foam).



Scrub your palms of both hands from the front and back and clean the area between your fingers.



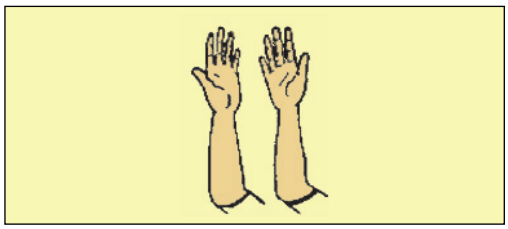
Scrub your knuckles of both hands.



Scrub your thumb of both hands.

Scrub your nails of both hands by rubbing against your palms.

Scrub both the wrists, by moving down slowly scrubbing both the forearms.



Wash your hands and forearms thoroughly with clean water.

Air-dry with hands up, elbows facing the ground.

Do not use towel or any cloth to dry the hands and not touch the ground or dirty objects after washing hands.

ASHA is incentivized for undertaking the following activities.

Drinking Water and Sanitation

Motivating households to construct toilet and promote the use of toilets	Rs. 75 per household	Ministry of Drinking Water and Sanitation (2012)
Motivating households to take individual tap connections	Rs. 75 per household	Ministry of Drinking Water and Sanitation (2013)

7.3 COUNSELLING REGARDING SAFE WASH PRACTICES

During each scheduled home visit under HBYC, ensure that the family is counselled regarding safe WASH practices as listed in the table below.

Table 11 – Advising the families on safe WASH practices

 Drinking water	 Sanitation	 Hygiene	 Hand-washing
• Store drinking water and food items in clean utensils on raised platform, in a covered container.  • Ensure drinking water is clean. Drinking water can be made safe by boiling (especially in case of repeated infections), adding chlorine tablets, using water filter (if possible) and keeping it covered.  • Drinking water to be drawn by ladle/ utensil with a handle designated just for drawing out water. Families can also use water pots which have attached taps, wherever available. 	• Encourage households to build their own toilet. • Promote use of toilets in the house by all household members, including children. • Promote use of community toilets where household toilets are not present. • Encourage families not to practice open defaecation. • Practice safe disposal of faeces. Keep human and animal faeces away from water sources. • Household waste should be regularly thrown or dumped only in the dustbins or places designated for garbage collection. • Inform family members that ward members of municipal corporation (parshad)/gram panchayat members should be contacted on issues related to garbage collection in their areas.	• Ensure that the child's surroundings are hygienic. • Encourage personal hygiene of all family members including children- daily bathing, daily changing of clothes and daily brushing of teeth. • Washing food items before cooking and washing fruits and vegetables before cutting.	Promote hand-washing frequently with soap and clean water for all family members, including children. Wash both hands of children, frequently. Tell family members to wash their hands whenever they do the following: **Most Critical-** • Before eating food or feeding children  • After using the toilet  • After cleaning children- child has passed urine or stool 




Drinking water	Sanitation	Hygiene	Hand-washing
			• After quick and safe disposal of child's faeces **Essential-** • When hands are dirty • Before preparing and serving food  • Before picking up a child • Before attending to a child or sick person • After preparing and eating food • After coughing or sneezing, or being in contact with someone who is ill • After wiping or blowing nose • After being in contact with animals, animal feed and animal waste • After outdoor activities • After touching garbage waste 

7.4 ROLE OF ASHA IN ENSURING SAFE WASH PRACTICES

In addition to the above activities, you will-

1. Teach the steps of hand-washing to the mother/caregivers and educate families on when and why to regularly wash hands as described in the section given above. Pay special attention to teach hand-washing to families reporting frequent episodes of childhood illnesses.
2. Create awareness in the community about the importance of following safe WASH practices, inform them on the ways to achieve them and increase community demand for improved water supply, sanitation facilities and maintaining hygiene. Special emphasis needs to be given to households that have girl child, live in remote areas, vulnerable/marginalized populations, flood prone districts/ areas, etc.
3. Under the Swachh Bharat Mission (SBM), you may be the 'Sanitation Messengers' or 'Swachhata Doots' for attaining sanitation in your community and motivate households (particularly having young children), who do not have toilets for construction of toilets. This will result in the household moving away from open defaecation, thus limiting the spread of water-borne diseases.
4. For creating demand and achieving safe WASH practices in the community and particularly for households having young children, you may work closely with platforms like VHSNC/MAS, gram panchayat members, self-help groups, urban local bodies, religious organizations, AWWs, ANMs/ MPW, non-governmental organizations (NGOs), representatives from department of drinking water and sanitation, municipal corporations, community members, etc. to construct toilets at household and community level, safe disposal of faeces, improving water supply and sanitation facilities in the community, ensuring availability of dustbins and timely collection of waste disposal to control the spread of diseases.
5. Be involved in disseminating information to the community members regarding the 'VISHWAS' (Village based Initiative to Synergise Health, Water and Sanitation) campaign for improving water, sanitation and hygiene situation and its impact on health and quality of life at the community level. You along with the ANM/MPW and AWW will communicate the date, time and venue of campaign day to village community, all VHSNC members, and the teachers and students of school and children in anganwadi, preferably about seven days before the campaign day and arrange information, education and communication materials required to conduct such large village level campaign. This will encourage community participation and help disseminate information to the community regarding the importance of safe WASH practices.

You must practice the steps of hand-washing during each visit. Also, ensure that families are counselled on hand- washing and hand-washing is practised by them to prevent the spread of illness within the household.

ANNEXURES

ANNEXURE 1-HBYC CARD

ASHA to verify at age (√) or (Yes/No)		3 Months	6 Months	9 Months	12 Months	15 Months
Whether child is sick (Yes/No)						
Breastfeeding continued						
Complementary food given	2-3 tablespoons of food at a time, 2-3 times each day	X				
	½ cup/katori serving at a time, 2-3 times each day with 1-2 snacks between meals	X				
	½ cup/katori serving at a time, 3-4 times each day with 1-2 snacks between meals	X				
	¾ to 1 cup/katori serving at a time, 3-4 times each day with 1-2 snacks between meals	X				
Recording of weight-for-age by AWW (Yes/No)						
Recording of weight-for-length/height by AWW (Yes/No)						
Developmental delay checked						
Immunization status checked						
Measles vaccine given		X	X			
Vitamin A given		X	X		X	
ORS at home		X				
IFA syrup at home		X				
ASHA to provide services at age		**3 Months**	**6 Months**	**9 Months**	**12 Months**	**15 Months**
Counsel for exclusive breastfeeding				X	X	X
Counsel for complementary feeding		X				
Counsel for hand washing						
Counsel on parenting						
Family planning counselling						
ORS given		X				
IFA syrup given		X				
Name and Signature of ASHA with Date of completion of activities (DD/MM/YYYY)						
Name and Signature of ASHA Facilitator or ANM/MPW with Date of verification of card (DD/MM/YYYY)						
Amount of incentive paid to ASHA and date of payment (DD/MM/YYYY)						

Village/Slum _____ Block _____ District _____

Sub-Centre _____ PHC/UPHC _____

Name of Child _____ Sex of child- Female ____ Male ____

Mother's Name _____ Father's Name _____

Date of Birth of Child (DD/MM/YYYY) _____ MCTS ID No. _____

Date of submission of HBYC Card to ASHA Facilitator or ANM/MPW (DD/MM/YYYY) _____

Home Based Care for Young Child visits after 6 weeks (To be filled by the ASHA during home visits, verified by ASHA Facilitator or ANM/MPW after completion of each scheduled home visits-3 months, 6 months, 9 months, 12 months and 15 months and submitted to ASHA Facilitator or ANM/MPW after completion of each visit).

HBYC CARD – ASHA COUNTER FOIL

Home Based Care for Young Child visits after 6 weeks *(To be filled by the ASHA during home visits and retained by the ASHA as reference copy).*

Village/Slum Block District

Sub-Centre PHC/UPHC

Name of Child Sex of child- Female Male

Mother's Name Father's Name

Date of Birth of Child (DD/MM/YYYY) MCTS ID No.

Name and Signature of ASHA

Amount of incentive paid to ASHA and Date of payment (DD/MM/YYYY)

Date of submission of HBYC Card after verification by ASHA Facilitator or ANM/MPW

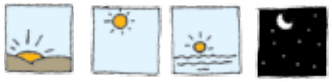
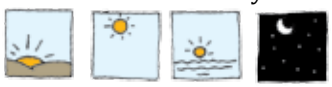
(DD/MM/YYYY)

ANNEXURE 2-MEDICINES DOSAGE AND DISPENSING SCHEDULE FOR SICK CHILD MANAGEMENT

1. Dosage of Paracetamol for High Fever (38.5 degree Celsius or above/101.3 degree Fahrenheit or above)

a. Paracetamol Tablet

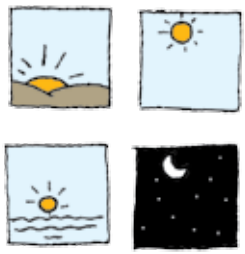
- 1 tablet = 500 mg
- Duration- To be given for 3 days only.
- Frequency- Maximum four times a day at an interval of six hours.

Paracetamol		
Age and weight of the child	**Dose of Tablet**	**Frequency**
2 months up to 3 years (4 - 14 kg)	¼ tablet (One-fourth) 	Maximum 4 times a day 
3 years up to 5 years (14 - 19 kg)	½ tablet (Half) 	Maximum 4 times a day 

Source: ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

b. Paracetamol Syrup

- 5ml (1 tsp) syrup=125 mg/5ml (Each 1ml contains 25mg of paracetamol)
- Per kg dose of paracetamol=10-15 mg/kg/dose
- **Duration:** To be given for 3 days only
- **Frequency:** Maximum four times a day at an interval of six hours

Age	Dose of Syrup		Frequency
	In ml	**In teaspoon (5ml)**	**Max 4 times a day** 
Newborn <3 kg	1ml	¼ tsp (One fourth) 	
<1 year (>3kg-8kg)	2.5ml	½ tsp (Half) 	
1-3 years (>8-14 kgs)	5 ml	1 tsp (One) 	
>3 years (>14 kgs)	7.5 ml	1 ½ tsp (One and a half) 	

Source: ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

2. Dosage of Cotrimoxazole for 5 days

- **Frequency:** Give two times daily for 5 days

S. No	Age of the child	Approximate weight of the child	Formulation used	Strength of drug	Morning Dose 	Evening Dose 
1	New born to 2 months	Cotrimoxazole is not to be given to children below 2 months of age.				
2	2-5 months	3-6 kg	Syrup	40 mg /5ml	2 ml	2 ml
			Tablet	20 mg/tab	½ (Half) tablet	½ (Half) tablet
				40 mg/tab	1/4th tablet	1/4th tablet
4	6-12 months	6-9 kgs	Syrup	40 mg /5ml	3.5 ml	3.5 ml
			Tablet	20 mg/tab	One tablet+half tablet	One tablet + half tablet
				40 mg/tab	3/4th tablet	3/4th tablet
5	12-18 months	9-11 kgs	Syrup	40 mg / 5ml	5 ml	5 ml
			Tablet	20 mg/tab	Two tablets	Two tablets
				40 mg/tab	1 tablet	1 tablet
6	18-24 months	11-14 kgs	Syrup	40 mg /5ml	6.5 ml	6.5 ml
			Tablet	20 mg/tab	Two tablets+ half tablet	Two tablets + half tablet
				40 mg/tab	1 tablet + 1/4th tablet	1 tablet+ 1/4th tablet

Avoid Cotrimoxazole in children less than two months of age who are premature or jaundiced.

Side effects: Nausea, vomiting, mouth ulcers, rashes, headache, etc.

Caution: The dose is 5 to 8mg/kg of trimethoprim per day in two divided doses. Tablets come in 20 mg, 40 mg, 80 mg or sometimes 160 mg trimethoprim. Depending on what tablet is given to you, you would be taught the number of tablets to be dispensed.

Source: Adapted from ASHA Module 7-Skills that Save Lives, Ministry of Health and Family Welfare.

3. Dosage of oral antimalarials (Other than North-East states)

3.1 Falciparum malaria: If RDT or blood smear Plasmodium falciparum (P.f.) positive

Age group (Years)	Day 1		Day 2		Day 3
	Artesunate (AS)	Sulphadoxine-Pyrimethamine (SP)	Artesunate (AS)	Primaquine (PQ)	Artesunate (AS)
0-1 Pink Blister	1 tablet (25 mg)	1 tablet (250 mg+12.5 mg)	1 tablet (25 mg)	Nil	1 tablet (25 mg)
1-4 Yellow Blister	1 tablet (50 mg)	1 tablet (500 mg+25 mg each)	1 tablet (50 mg)	1 tablet (7.5 mg base)	1 tablet (50 mg)

Note-ACT-SP-Artemisinin-based Combination Therapy (Artesunate+Sulfadoxine-Pyrimethamine) -Artesunate 4 mg/kg body weight daily for 3 days plus Sulfadoxine (25 mg/kg body weight) and Pyrimethamine (1.25 mg per kg body weight) on Day-1 and Primaquine 0.75 mg per kg body weight on Day-2.

SP is not to be prescribed for children <5months of age and should be treated with alternate Artemisinin-based Combination Therapy (ACT).

Source: Operational Manual for Malaria Elimination in India. Directorate of National Vector- Borne Disease Control Programme, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2016.

3.2 Vivax malaria: If blood smear positive for Plasmodium vivax (P.v), give Chloroquine for 3 days and Primaquine for 14 days.

Chloroquine for P. vivax:

25 mg/kg body weight divided over 3 days i.e. 10mg/kg body weight on day 1, 10 mg/kg body weight on day 2 and 5 mg/kg body weight on day 3;

Primaquine: 0.25 mg/kg body weight daily for 14 days.

Age group	Chloroquine (CQ)			Primaquine (PQ)
	Day 1	Day 2	Day 3	Given orally from Day 1 to 14
	Tablet (150 mg base)	Tablet (150 mg base)	Tablet (150 mg base)	Tablet (2.5 mg)
Less than 1 year	½ tablet	½ tablet	¼ tablet	0
1-4 years	1 tablet	1 tablet	½ tablet	1

CQ- Chloroquine (250 mg tablet contains 150 mg base); PQ- Primaquine.

Source- Operational Manual for Malaria Elimination in India. Directorate of National Vector- Borne Disease Control Programme, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2016.

3.3 Dosage of oral antimalarials (For North-East States)

Falciparum Malaria: If blood smear positive for Plasmodium falciparum (P.f), give ACT-AL (Artemisinin-based Combination Therapy- Artemether - Lumefantrine) Co-formulated tablet containing 20 mg artemether and 120 mg lumefantrine.

Age group	Chloroquine (CQ)				
	Dose	Times	No. of days	Total dose	Availability under National program
> 5 months to < 3 years (5-14kg)	1 tablet (20 mg)	Twice/day	3	120 mg	Yellow coloured pack with 6 tablets
≥ 3 years to 8 years (15-24 kg)	2 tablets (40 mg)	Twice/day	3	240 mg	Green coloured pack with 12 tablets

Source- Operational Manual for Malaria Elimination in India. Directorate of National Vector- Borne Disease Control Programme, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2016.

3.4 Dosage of oral antimalarials

Treatment of mixed infections with P. vivax and P. falciparum

All mixed infections should be treated with a full course of ACT (ACT-AL in NE States and ACT-SP in other States) for 3 days and primaquine 0.25 mg/kg body weight daily for 14 days.

Source: Operational Manual for Malaria Elimination in India. Directorate of National Vector- Borne Disease Control Programme, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2016.

ANNEXURE-3 ITEMS REQUIRED FOR SCREENING

• Red ring (diameter 2-3") with attached string • Handbell • Torch (appropriate size for eye examination) • Small Mirror with plastic cover • 1-inch cubes: 6 pieces • Beads or Raisins (Kishmish):Few • Tea Cup or Plastic bowl:One made of plastic	• Crayons (wax): 1 packet • Writing pad • Red ball or any toy like car • Small cloth to cover toys • Pull toy with a string • Doll (new born/ infant: 1 made of cloth and 1 of plastic) • Picture book (with 1 picture per page)

1.	**Red Ring with red string**  **If not by 6 months refer**	 	 	**The red ring should be tied with a string of thread and it is dangled in front of the eyes to the baby at a distance of 30 cm from the level of the eyes. This tool is used for-** **a) Testing the visual fixation or eye contact by 2 months of age. And one can see the squint at 2 months.** **b) Tracking of the eyes by 4 months of age.If not by 6 months refer.** **Reaching for object at 4-6 months of age. Hand- eye coordination. If not by 6 months refer.**

2.	Handbell		This simple household handbell is used to test response to sound in young infant (Observe behavioural responses as the head turns towards the bell). If no response by 3 months.	Bell is held at a distance of at least 30 cm away from ear and out of sight of baby and should be rung and the response of the child should be noted.
3.	Torch		If one can see the squint at 2 months which is persistent or no eye contact.	Torch is used to see the eyes, ears and mouth.
4.	Plastic mirror	 		The child loves to look at self in the mirror by age of 4-6 months. ❖ If by 9 months does not look into the mirror ❖ Does not utter pa..pa..pa, ma.. ma, ba..ba..ba, etc by 9 months.

5.	**One-inch cube** 		**Grasp a toy by using all fingers by 7-9 months.** **If no grasp by 6 months, refer.**
6.	**Raisins or Kishmish**		**Some raisins or kishmish are kept in front of the child. The child will pick up these raisins using thumb and index finger. This test should be performed for children at 9-12 months.** ***if cannot pick small objects with finger and thumb by 12 months, refer.**
7.	**Plastic container or Bowl** 		**Does not put small objects or pebbles in a container by 18 months.**

8.	**Crayons with note book**		**The child will scribble spontaneously on the paper using these crayons. This test should be performed by 18 months.**	**If the child does not scribble by 24 months, refer.**
	One-inch cube	 		**Does not seem to understand and follow simple instructions by 24 months.**
9.	**Toy car or any colorful toy and cloth Or Red Ball with a plastic katori or plastic bowl** 	   		**Look for toys that have been hidden in front of them by 7-9 months.** **Does not search for half hidden toys that the child sees you hide by 12 months.**

10.	**Pull toy**	 	**Does not walk steadily while pulling an object by 24 months.**
11.	**Doll**	 	**Pretend play starts by 2 years. Does not play "Pretend" games by 3 years.**
12.	**Pictorial Book with only single photo on each page**	 	**The child will be able to identify and name common objects in the picture book. This test should be performed by 18 months of age.**
	Use two toys: 		**Does not point finger at an object when named by 18 months of age.**

13	**Screening kit bag**		**The screening kit bag contains all the materials used for the screening.**

During delay one can wait, but if the train is derailed, we need not wait but send the information quickly

ANNEXURE 4 - LEARNING TOOL FOR MILESTONE ASSESSMENT

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 2-3 Months	• Make eye contact 	Th ese three tests can be done sequentially: in a quiet and calm room after feeding the child. (a) The mother is asked to lean over the child's face close to a distance of 10 -12 inches and to look into the eyes of the child . He/she will spontaneously make an eye contact with the mother. Does the child make eye contact? (Focus their eyes on the eyes of a care giver)	By the age of 3 months, if the child is observed with: a. Not making an eye contact with the mother during breast feeding or talking  b. No social smile  c. The child is cranky most of the time and may be difficult to console when starts crying even for a mother d. Persistent squinting after 2 months 
	• Develop social smile 	b) After establishing the eye contact the mother at the child and the child will spontaneously smile back at her as response to her smile. The duration of this interaction increases with age. Does the child give a social smile? (Reciprocal, responds to mother expression or smile i.e. smile back at you)	
	• Begin to recognize the mother's face. 	c) By this age, the child also starts identifying the mother's face and shows more interest towards the mother compared to others. Does the child respond to mother's face by looking directly at her face? **Record the responses in the MCP card.** 	
	• Raise head when on tummy at times 	The child should be fed at least half an hour before and should remain awake. Put the child lying on stomach on the bed and observe whether the child lift his/her head at least 2 -3 inches from the surface for a brief period . By the age the child will be able to raise the head more and for a longer period. **Record the response in the MCP card.**	The child cannot lift head at all and unable to clear his or her nose due to very low tone 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 2-3 Months	• Move both arms & both legs, when excited.  • Keep hands open and relaxed. 	Place the child on the bed or observe on mother's lap. The child should be awake and fed. The child should be minimally dressed [in diaper (chaddi) and a vest]. The ambient room temperature should be comfortable in comparison to outside temperature. The child will kick vigorously both legs alternately horizontally and vertically and will throw both arms in different directions. While throwing his or her legs and arms, his or her shoulders and trunk will remain stable in midline. The child will keep his or her hands open most of the time. He or she may voluntarily close and open his or her hands while playing with her fingers or pull mother's saree or in an effort to hold a small toy or rattle. **Record the responses in the MCP card.**	a. The child does not move arms and legs at all. b. The child only moves arm and leg of the same side and do not move the arm and leg of the other side of the body as vigorously as the other side. c. Head pushed back, with stiff arms and legs.  d. The child's hands remain fisted as a part of generalised increased stiffness of the whole body. 
	• The child respond to voice or startles with loud sounds or becomes alert to new sound by quieting or smiling. 	Put the child lying on his/her back. The room should be quiet and free from visual distractions like door or window curtains fluttering or movement of the people in front of the child. Shake a rattle/ handbell three times very gently on one side of his or her head and then on the other beyond the child's visual range. The child may react in any of the following ways: a) Frown b) Stops moving for a while c) Wide opening of eyeballs d) Turns eyes towards the source of sound e) Turns head towards the source of sound	a. The child does not react at all.  b. The child turns his/her head persistently on one side and not on the other.

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 4-6 Months	• Keep head steady when held upright and can sit with support • Turn head towards direction of sound or towards the known faces or visually attractive colourful objects.  	Position of the infant: Hold the child up right in the lap or hold him/ her the child in a sitting position with legs stretched forward. The child should be able to hold his or her head up straight in midline for longer time. During this age the child needs to be held around his or her upper or middle of trunk as the child does not achieve enough stability of the trunk to support his or her head upright. The child will turn his or her head and look around towards the family members or colourful toys etc. **Record the responses in the MCP card.**	a. The child unable to lift his or her head up.  b. The child unable to maintain head upright even if he or she lifts head (wobble).  c. The child cannot be made to a sitting position due to abnormal tone. d. Sudden dropping of head or sudden back thrust that topples his or her balance.
	• Lifts head up bearing weight on forearms. Moves arms forward to reach for an object. Brings elbows in front of shoulders and turns head to follow an object 	Keep the child flat on the tummy on the bed or ground. The child should lift head up through bringing elbows in front of shoulders to put weight on it.	The child is not able to lift the head up despite visual and auditory stimulation. 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 4-6 Months	• Attempt to reach and grasp an object. 	Keep the child lying on his/her back on the bed. The child should be in an alert state. Show a small rattle or a bright coloured toy just at an arm's length in front of his or her eyes. The child will extend his or her elbow to reach for the toy. **Record the response in the MCP card.**	a. The child is unable to raise his or her shoulders and arms against gravity due to low muscle tone. b. The child does not regard the toy held above either due to visual problem or due to lack of understanding and motivation. c. The child only reaches with one arm and the other arm remains stiff with forearm rotated inwardly and fisted hand. d. The child is unable to reach with arms due to strong retraction of shoulders due to stiffness. 
	• Laugh aloud or make squealing sounds. 	Keep the child in mother's lap or in lying position. The child laughs aloud as you talk and shake your head. You can also tickle him or her as you sportingly talk to. You will hear him or her giggling in such interactions. **Record the response in the MCP card.**	The child does not regard an adult's interaction due to lack of understanding. 
	• Begin to babble "ah, ee, oo" other than when crying. • Like to look at self in a mirror. 	The child should be in an alert state. Observe the child's natural interaction with the mother. Explain the mother that you want to observe the child's response as she talks to her or him. The child will look at her and will vocalize with sounds like aaaa, eeee, uuuu. There will be an exchange of smile. More the mother talks to her or him with different tone of voice more the child reacts by vocalizing with higher pitch and increase in body and limb movements. **Record the responses in the MCP card.**	a. The child does not regard her mother's face either due lack of hearing or due to lack of understanding. b. The child does not vocalize or there is no body movements due to excitement that mother's presence bring in the child.

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 7-9 Months	• Can roll over in both directions 	Leave the child on the mat on the floor The child will spontaneously turn into either side depending on the source of motivation such as an attractive toy or the sound of a known person by turning his/ her head first and then shoulder, trunk and pelvis follows towards the source of stimulation. This is type of mobility the child uses to move about the floor. **Record the response in the MCP card.**	a. The child does not roll over due to stiff posture.  b. The child rolls over only from one side of the body and rolls over into one side only c. The child has wide range, flinging movements – unable to maintain symmetry and stability d. The child lacks motivation to move
	• Sits without support. 	Keep the child in sitting posture on the floor mat and observe whether he/she maintains the sitting posture without support.	Needs support to sit 
	• Grasp a toy by using all fingers/ whole hand. 	Keep the child in sitting position on the floor mat and put a block or a small toy within the reach of the child. The child will pick the object by either hand. He or she will keep the block in the palm of his or her hand by flexing all the fingers. **Record the response in the MCP card.**	a. The child keeps his or her hand all the time fisted as a part of generalised stiffness. b. The hands are loosely open and does not close due to generalised floppiness. c. The child is unable to keep the object due to generalised fluctuating tone. d. The child has grasp only in one hand and the other hand remains fisted.

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 7-9 Months	• Turn head to visually follow familiar faces or toys. • Turn head towards the source of sounds.	In lying or in a sitting position on mother's lap. The testing room should be absolutely free of any noise. **Observation by the examiner-** Stand behind the child and call the child in a whispering voice. Do it from both sides. The child will immediately turn his or her head to locate the source of sound. If he or she lacks head control, her facial expression will change such as frowning, wide opening of eyeballs, sudden movement of body and limbs, smile or cry. Repeat three times in a row on each side. **Record the response in the MCP card.**	a. The child does not react at all.  b. The child reacts repeatedly on one side only c. The child changes his or her facial expression but does not turn head due to lack of head control d. The child does not turn his or her head even if he or she hears the sound
	• Look for toys that have been hidden in front of them. 	Show the child a toy and then cover it with a handkerchief in front of him or her. The child will remove the cover to find the toy. **Record the response in the MCP card.**	a. The child does not mind or care to look for the hidden toy. b. The child also has delay in other areas of development.
	• Respond to name being called. 	Keep the child on the floor mat in lying or sitting position and ask the mother to call his/her name. In response the child will immediately look at her. **Record the response in the MCP card.**	Does not respond to own name. 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 7-9 Months	• Utter consonant sounds pa.. pa..pa, ma.. ma, ba.. ba..ba, etc 	The child will utter sounds such as pa.. pa..pa, ma.. ma, ba.. ba..ba, etc while playing on the floor or in the mothers lap.	a. Does not utter any sound. 
	• Maintain the midline symmetrical posture of head while looking at an object.	Keep the child in the lap or in sitting position and show him/her a toy or an object and observe the position of the head. The head should be in midline without any tilt to one side.	a. The head is tilted towards one side.  **Note**: This sign may be of visual problem in the child.
By 10-12 Months	• Sit without support and reach for toys without falling. 	Put the child on the mat in a sitting position and place a toy in front of him/her. The child will be able to reach the toy with one hand independently. The sitting posture will be maintained without falling. **Record the response in the MCP card.**	Cannot sit independently without support.
	• Raise arms to be picked up. 	Let the child play with some toys on the ground alone. After seeing the mother the child will generally stretch his/her arms towards the mother as if he/she wants to be picked up. **Record the response in the MCP card.**	a. Does not stretch hands to be picked up.  b. The child does not show any interest. c. The child also shows delay in other areas of development.

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 10-12 Months	• Crawl to get desired toys without bumping into any objects. 	Asked the mother whether the child bumps against the door ways or furniture while crawling. **Record the response in the MCP card.**	a. The child does not show any interest and not crawl towards the object. b. The child bumps against the objects during crawling.
	• Use one or two commonwords in mother tongue. • Respond to simple requests like "no/ come here". 	Ask the mother whether her child stops doing an activity if she says, "Do not do it." This is to find out whether the child understands the meaning of "No". **Record the responses in the MCP card.**	The child does not understand simple requests and does not respond appropriately to the command.
By 15-18 Months	• Stand and take several independent steps.  • Use a variety of familiar gestures like waving, clapping, etc.	Keep the child on the ground. The child will be able to stand independently and starts walking. **Record the responses in the MCP card.**	Cannot stand on his/her own without support. 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 15-18 Months	• Put pebbles/ small objects in a container. 	Make the child sit on the mat. Keep some raisins or small beads in front of the child. The child will be able to pick up a raisin with his or her index and thumb fingers and will enjoy to put it into the container (cup or katori) if available near the child. **Record the response in the MCP card.**	Cannot pick the raisins to put into the container (cup or katori). 
	• Name and identify common objects and their pictures in a book. 	The mother should show the picture in a picture book with a single picture on a page and ask the child to identify it. The child will be able to identify common daily use objects/birds/animals/fruits etc. **Record the response in the MCP card.**	The child is not able to identify and name even a single common object in the picture book by the age of 18 months.
By 18-24 Months	• Walk steadily, even while pulling a toy. 	Give the child a pull toy with a string attached to it and show him/ her how to pull and play with it, the child will be able to walk steadily without falling down even while pulling the toy. **Record the response in the MCP card.**	Does not walk steadily while pulling a toy. 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 18-24 Months	• Imitate household chores 	The mother should show the child the common household tasks for example-sweeping the floor and the child should be encouraged to participate in the task. The child will be able to perform the task in the same manner as the mother was performing. **Record the response in the MCP card.**	The child does not take any interest in the household activities even if mother's encouragement to participate in.
	• Correctly point out and name one or more body parts in person or in books. 	By this time the child understands and relates some of the body parts with its name. The mother should ask the child to point out a body part. For example: • Show me your nose • Show me your mouth • Show me your eyes **Record the response in the MCP card.**	Does not point to even a single body part. 
By 24 months-3 Years	• Drink from a cup without spilling. 	Put some water or milk in the cup and give it to the child, the child will be able to drink from cup without spilling it outside. **Record the response in the MCP card.**	Cannot eat and drink without help and the food is spilled over during his/her try. 

Age	Normal milestone/ Expected activities	How to Elicit and Observe these milestones	Warning Signs Requiring Referral
By 24 months- 3 Years	• Climb up and down the stairs. 	By this time the child enjoy the climbing stairs up and down. This task should be observe at a safe stair having proper railing to avoid any accident and should be performed under the supervision of the elders. The child will be able to climb the stairs independently without any difficulty. **Record the response in the MCP card.**	Has trouble climbing up and climbing down stairs. Either the child will not be able to climb the stairs or will face great difficulty in climbing the stairs. 
	• Name most familiar things consistently. Identify colours, shapes, etc. **Cat Dog Bird** • Make a sentence by joining 3 or more words.	By this time the child identifies and starts naming most familiar things such as colours, shapes, animals, birds etc. the mother should ask to name the object/colour/shape/animal/bird by showing in the picture book. The child will be able to name most of the objects consistently. **Record the responses in the MCP card.**	a. Not able to name even the single object in the book. b. Does not communicate meaningfully and frequently repeats others' speech.  c. Continuous drooling, unclear speech  d. Does not speak in simple and three word sentences such as "mummy give milk".

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ASHA Ghar Aayi Jaankari Saath Layi

Child Health Division
Ministry of Health and Family Welfare
Government of India

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