|  |  |  |  |
| --- | --- | --- | --- |
|  | Date of filling (dd/mm/yyyy) |  |    |
|  | Time of filling  |  |      |
|  | Worker code |  |    |
|  | Woman ID |  |     |
|  | Child ID |  |         |
|  | Date of birth of infant  |  |   |
|  | Time of birth of infant |  |      |
|  | Age in hours  |  |    |
|  | Is the infant able to breastfeed or drink other fluids (1=yes, 2=No, 3=could not assess, specify) |  |   |
|  | Is the infant able to breathe normally (RR ≥ 20/minute, no grunting, central cyanosis, severe chest indrawing) |  |   |
|  | Is the infant active with normal movements  |  |   |
|  | Does the infant have any other danger signs (convulsions, unconsciousness, severe hypothermia <32°C) |  |    |
|  | Does the infant have any major congenital malformation |  |  |
|  | If yes, specify |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | What is the sex of the infant (3=Male, 4=Female) |  |   |
|  | What was the date of first day of the last menstrual period (dd/mm/yyyy) |  |   |
|  | At which month of pregnancy was your infant born |  |  |
|  | As reported by mother or caregiver |  |    |
|  | As checked from other records (ANC card, discharge record) |  |    |
|  | As checked from USG if available  |  |    |
|  | Was the infant born single, twins or triplets (11=single birth, 12=twins, 13=triplets, 14= > triplets) |  |    |
|  | Has the infant been put to breast or did you ever breastfeed infant prior to contact with study team  |  |   |
|  | How many hours after birth did you first put the infant to the breast (if <1 hour, fill 00; if not put to breast, fill 99) |  |    |
|  | Did you give colostrum or first milk to your infant i.e., the yellowish thick milk secreted during the first few days after the infant is born |  |   |
|  | Did you offer any fluids or foods to the infant anytime since birth? Check all that apply: |  |   |
|  | Plain water |  |   |
|  | Breast milk from another mother |  |   |
|  | Any milk other than breast milk such as tinned, powdered, or fresh animal milk or commercially produced infant formula |  |   |
|  | Other fluids (juice, tea, sugar or glucose water, honey or ghutti) |  |   |
|  | Medicines or vitamins or ORS |  |   |
|  | Any foods (semi solids/solids)Nothing offered |  |    |
|  | How many times did you breastfeed during the day (day defined as: 7am to 7pm yesterday) |  |    |
|  | How many times did you breastfeed during the night (night defined as: 7pm yesterday to 7am today) |  |    |
|  | How many hours after birth was SSC initiated |  |  hours     |
|  | Did you give SSC |  |  |
|  | Did someone else give SSC, if yes, who? |  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Time during day (00:00) and duration (min) and who? |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Time during night (in am/pm) and duration (min) |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Were you/or others unable to give SSC |  |  |
|  | If yes, reasons  |  |   |
|  | Convulsions of mother  |  |  |
|  | Severe anemia, mother weak |  |   |
|  | Mother having fever/unwell  |  |   |
|  | Engorged breast |  |   |
|  | Family member did not allow  |  |    |
|  | Baby very unwell  |  |  |
|  | Baby having skin rash/pustule |  |   |
|  | Blood/pus from baby’s umbilicus |  |   |
|  | Baby placed in incubator  |  |   |
|  | No privacy in hospital  |  |   |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |   |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | If home birth, how long after home birth was the baby admitted?Was this a readmission, if yes, how long after discharge was baby readmitted  |  |  hours    |