|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post Facility Information Sheet** | | | | | | | | | | |
| **Name of Area** | |  | | | | | **Date** | |  | |
|  | | | | | | | | | | |
|  | | | **Woman Name** | **Woman Name** | **Woman Name** | **Woman Name** | | **Woman Name** | | **Woman Name** |
|  | | | **Woman ID** | **Woman ID** | **Woman ID** | **Woman ID** | | **Woman ID** | | **Woman ID** |
| **Visit details** | **Name of Village / Area visited by study team** | |  |  |  |  | |  | |  |
| **Day of visit(1st,2nd,3rd,6th,14th,21st day of Discharge)** | |  |  |  |  | |  | |  |
| **Due date of visit** | |  |  |  |  | |  | |  |
| **Date of visiting** | |  |  |  |  | |  | |  |
| **Observed / Facilitated by (mention study team member)** | |  |  |  |  | |  | |  |
| **Home Counselling** | **Visited by ASHA (Yes / No)**  **Specify reason if not visited by ASHA** | |  |  |  |  | |  | |  |
| **Counselled & supported by ASHA (as reported or observed) / due for counselling** | |  |  |  |  | |  | |  |
| **Duration of Counselling (In Minutes:**  **as reported or observed)** | |  |  |  |  | |  | |  |
| **Father / Family member present at the time of counselling (Yes/No). If yes, specify** | |  |  |  |  | |  | |  |
|  | | | | | | | | | | |
| **Counselling Content for Community Health Workers** | **SSC Technique** | |  |  |  |  | |  | |  |
| **SSC Duration, Benefits , Skin to Skin contact** | |  |  |  |  | |  | |  |
| **How to give SSC at Home** | |  |  |  |  | |  | |  |
| **Breast feeding Technique** | |  |  |  |  | |  | |  |
| **Exclusive Breast Feeding** | |  |  |  |  | |  | |  |
| **Breast feeding benefits** (Effective thermal control, Increased breastfeeding rates, Early discharge, Less morbidities such as apnoea and infection, Less stress, Better infant bonding) | |  |  |  |  | |  | |  |
| **Duration, Frequency** | |  |  |  |  | |  | |  |
| **Breastfeeding during SSC** | |  |  |  |  | |  | |  |
| **Prelacteal feed** | |  |  |  |  | |  | |  |
| **Diet of Mother** | |  |  |  |  | |  | |  |
| **Family Support** | |  |  |  |  | |  | |  |
| **Sanitation & Hygiene Practices** | |  |  |  |  | |  | |  |
| **Danger Signs of neonate illness** | |  |  |  |  | |  | |  |
| **Referral System (When & How)** | |  |  |  |  | |  | |  |
| **Follow Up Visit in KMC Unit**  **(Only at Discharge)** | |  |  |  |  | |  | |  |

|  |  |  |
| --- | --- | --- |
| **Additional Information / Key Points** | | |
|  | | |
|  | | |
| **Issues** | **Action Taken** | **Outcome** |
|  |  |  |