Team Leader Name:	CHW Name:

Evaluation of CHW Antenatal home assessment

Rate CHW action by placing number in applicable box.
0= not done
1= done but not satisfactorily
2= done satisfactorily
If not applicable, write NA in space.

Tick applicable ANC home visit column.
Write date of visit below box (dd/mm/yy)

		ANC Home visit 1	ANC Home visit 2	ANC Home visit 3	ANC Home visit 4
		dd/mm/yy			
1.	Encourages early booking if client not booked yet				
2.	Re-enforcement of importance of 4 ANC clinic visits				
3.	Checks previous ANC clinic visit was completed				
4.	Checks that recommended tests are done (BP, urine) (N/A if client has not been to clinic yet)				
5.	Checks ANC card for pertinent information				
6.	Counsels for health promotion during pregnancy				
7.	Discusses maternal nutrition				
8.	Provides/ reinforces HIV prevention messages				
9.	Encourages VCT (N/A if client knows status)				
10.	Provides education on PMTCT program				
11.	Encourages safe sex during pregnancy				
12.	Encourages EBF for 6 months				
13.	Discusses immunization				
14.	Discusses danger signs in pregnancy				
15.	Discusses delivery plan/ emergency prep with family				
16.	Screens for STI signs and symptoms				
HIV positive mothers [1] 17.	Encourages HIV disclosure				
18.	Checks that CD4 count completed/ results known				
19.	Supports ARV adherence				
20.	Suggests support group				
21.	Decides on date for follow up visit with mother				
22.	Makes appointment to see mother and baby on day 1 of discharge from hospital				
23.	Provides referral if necessary				
Sum numbers in columns		/	/	/	/

Assessment date_____ TL signature_____CHW signature_____

[1] Write NA if the client is **NOT** HIV positive or if HIV status remains unknown