WEB APPENDIX

Table A. Table of Outcomes

	Publication Status
PRE-SPECIFIED PRIMARY AND SECONDARY OUTCOMES	
A. Mortality outcomes	
Post day 1 neonatal mortality (deaths between 1 to 28 days of age)	Reported in BMJ 2012
Neonatal mortality (deaths between birth to 28 days of age)	Reported in BMJ 2012
Infant mortality (deaths between birth to 365 days)	Reported in BMJ 2012
B. Newborn care practices	Reported in BMJ 2012
Initiation of breastfeeding within 1 hour	Reported in BMJ 2012
Prelacteal feeds not given	Reported in BMJ 2012
Exclusive breastfeeding at 4 weeks	Reported in BMJ 2012
Skin to skin contact any time on day of birth	Reported in BMJ 2012
Infant clothed appropriately on first day of life	Reported in BMJ 2012
Infant bathed ≥24 hours after birth	Reported in BMJ 2012
Nothing or Gentian violet paint applied on the cord	Reported in BMJ 2012
C. Exposure to components of intervention	Reported in BMJ 2012
Proportion of neonates with at least one home visit by community health workers (Anganwadi Worker/Accredited Social Health Activist) within 48 hours of birth	Reported in BMJ 2012
Proportion of neonates with at least one, at least two or at least three home visits by community health worker in the first 10 days after birth	Reported in BMJ 2012
Proportion of mothers who attended women group meetings in previous 3 months	Reported in BMJ 2012
D. Treatment seeking for illness	
Proportion of neonates identified to be sick by caregivers in the previous 4 weeks, who sought care	Current manuscript
Proportion of neonates identified to be sick by caregivers in the previous 4 weeks, who received timely care outside home and from an appropriate provider	Current manuscript
Proportion of infants identified to be sick by caregivers in the previous 2 weeks, and for whom care was sought outside home, at ages 6 and 12 months	Current manuscript
Proportion of infants identified to be sick by caregivers in the previous 2 weeks, and for whom timely care was sought from an appropriate provider outside home, at ages 6 and 12 months	Current manuscript
E. Process of intervention delivery	
Observations of the quality of care provided by health workers at health facilities and by Accredited Social Health Activist/*Anganwadi* workers in the community, to sick young infants	
Exit interviews with mothers who have recently visited a health care provider for treatment of illness in their infants, to ascertain their knowledge and skills about care for the illness	Future publication
Interviews with mothers of infants who were home visited recently by health workers (*Anganwadi* Worker/ Accredited Social Health Activist)	
POST-HOC (EXPLORATORY) ANALYSIS	
F. Morbidity and hospitalizations	
Illness reported during the neonatal period (danger signs, local infections)	Current manuscript
Illness (diarrhea, pneumonia) in the previous 2 weeks; ascertained at ages 6 and 12 months	Current manuscript
Hospitalizations in the neonatal period (birth to 28 days), between ages 3 to 6 months, and ages 9 to 12 months	Current manuscript (based on reviewers' suggestions)

	Publication Status
G. Post neonatal infant care practices and nutritional status	
Exclusive breastfeeding at ~6 months of age	Current manuscript (based on reviewers' suggestions)
Continued breastfeeding at 12 months of age	Current manuscript (based on reviewers' suggestions)
Complementary feeding indicators (received solid, semi-solid or soft foods in the last 24 hours and started complementary feeding between 6 to 8 months of age; received foods from ≥4 food groups in last 24 hours; received solid, semi-solid or soft foods 3 times for breastfed infants and 4 times in non breastfed infants in last 24 hours)*	Current manuscript (based on reviewers' suggestions)
Immunization coverage by 12 months of age for BCG, the third dose of DPT and measles vaccines	Current manuscript (based on reviewers' suggestions)
Nutritional status at 12 months of age: proportion wasted and stunted	Current manuscript (based on reviewers' suggestions)
H. Other possible publications in the future	
Operational lessons for the national government from implementing IMNCI including cost effectiveness of the intervention. Cost of delivering IMNCI intervention through community level workers (J Trop Pediatr 2013;59:489-95). This analysis was done at the request of the Ministry of Health. A small facility survey to report the cost of delivery of child health care services through community health care workers. The manuscript also includes data from the District Level Household and Facility Survey-3 (http://www.rchiips.org/pdf/rch3/report/HR.pdf).	
Was the IMNCI intervention equitable i.e. reached different socioeconomic and other strata equally	
Observational analysis, examples:	
Analysis of verbal autopsies to ascertain causes of still births, neonatal and post neonatal deaths	
Use of Oxytocin and birth outcomes in pregnant women in Haryana	
Predictors of mortality and morbidity in infants	

**World Health Organization. Indicators for assessing infant and young child feeding practices, WHO 2008*

Table B. Classification of Health Care Providers

It was our *a priori* decision to categorize the providers as appropriate and inappropriate based on the rationale provided in the table below.

Category of health care provider	Appropriate? Yes/No	Reason
Anganwadi worker	Yes	Government employee who has attended 30 days of the *Anganwadi* worker training course conducted by the government in both intervention and control areas. Additionally trained in IMNCI through the study in the intervention areas
Accredited Social Health Activist	Yes	Government employee who has attended 42 weeks of the Accredited Social Health Activist training course conducted by the government in both intervention and control areas. Additionally trained in IMNCI through the study in the intervention areas
Auxiliary Nurse Midwife	Yes	Government employee who has attended 1.5 years of Auxiliary Nurse Midwife training course conducted by the government in both intervention and control areas. Additionally trained in IMNCI through the study in the intervention areas.
Primary Health Centre physician	Yes	Government employee, usually a medical graduate, sometimes with postgraduate specialization, in both intervention and control areas. Additionally trained in IMNCI through the study in the intervention areas
Chemist	No	No formal clinical training. Usually prescribe over the counter medicines without examining the child, based on past experience or information provided by company representatives
Private practitioner in village or outside village*	No	These informal providers (including traditional healers) are called “private doctors” by the population. Almost all of them have no medical degree. They usually have past experience of working with a medical practitioner. They do not display their qualifications and refuse to answer questions about their qualifications (see photographs below).
Private nursing home and hospital	Yes	Medically qualified providers, with postgraduate specialization. They display their qualifications on boards outside the facility. The population differentiates them from informal providers by calling them “private nursing homes”.
District/Government hospital	Yes	Recruit medically qualified doctors usually MBBS, sometimes with postgraduate degree.

*Based on our experience of the study area, and enumeration of providers during this study for the sensitization session, we know that in this community it is challenging to ascertain qualifications of private providers except those with medical qualifications, who are almost always based in towns. The private providers practicing in villages do not share their qualifications as they are apprehensive that a complaint may be registered against them and forced to discontinue practice in the community. This is particularly true in Haryana where there are periodic drives against such providers. These providers may also take offence or provide

wrong information about their qualifications and there is no way to confirm what is reported. It is difficult to extract information from caregivers about the type of provider visited as they are only able to differentiate government workers, private or government hospitals, and private providers based in villages.

Private practitioners in the village