September 2013

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ACRONYMS

BPCR	Birth Preparedness& Complication Readiness
CBNC	Community Based Newborn Care
CBO	Community Based Organization
CMNCH	Community Maternal, Newborn & Child Health
EBF	Exclusive Breast Feeding
EDD	Expected Date of Delivery
ENC	Essential Newborn Care
FANC	Focused Ante Natal Care
FBO	Faith Based Organization
FHG	Family Health Card
GALIDRAA	Greet, Ask, Listen, Discuss, Recommend, Agree and Appointment
HC	Health Center
HDA	Health Developmental Army
HEWs	Health Extension Workers
HIV	Human ImmunodeficiencyVirus
HP	Health Post
iCCM	Integrated Community Case Management
IIBF	Immediate Intitaion of Breast Feeding
ITN	Insecticide Treated Net
IRT	Integrated Refreshment Training
LBW	Low Birth Weight
LMP	Last Menstrual Period
MDG	Mellnium Development Goal
MNH	Maternal and Newborn Health
ORPA	Observe, Reflect, Personalize, and Act
PNC	Post Natal Care
PAB	Protected At Birth
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
WRA	Women of Reproductive Age

INTRODUCTION

This Facilitator's Manual presents a four day training course on Community Based Newborn Care (CBNC) for Health Extension Workers (HEWs). It has two main sections organized according to the four "Cs". i.e. part one; contact, counseling and capturing of cases and part two; care, treatment and completion.

Contents are taken from module II (CMNCH) of the Integrated Refresher Training (IRT) materials and will be used in conjunction with the young infant (0-2month) component of module I Integrated Community based Case Management of Common Childhood Illness (ICCM) that will help to increase basic skills of HEWs in assessing, classifying, and treating sick young infants for common causes of morbidity and mortality. It incorporates basic skills and knowledge of HEWs to promote and sustain key household and community practices to prevent diseases and improve health with emphasis to mothers and newborns

The course materials include CBNC facilitator guide, video, participant manual, chart booklet,exercise booklet, job aids and tools. The course duration is four days with competency based methodologyi.e. pre and post tests, class room facilitated discussions, role plays, exercises, demonstrations and home visit practice.

The goal of CBNC is to reduce newborn and child mortality to accelerate the achievement of MDG 4 and in subsequent the MDG agenda.

The CBNC aims to scale up community based MNH services including introduction of newborn sepsis management and to improve maternal and newborn care practices and care seeking through HDAs and other existing effective community mobilization mechanisms;

CORE COMPETENCIES

At the end of this four day training the HEWs will have the following skills:

- Able to effectively work and mobilize HDA to identify pregnant women in thier kebles and generate demand for maternal, newborn, child health and nutrition service
- Able to register all pregnant women in their kebles on ongoing basis
- Be able to provide focused antenatal care and effectively counsel and support pregnant women to have at least one ANC visit at health center
- Able to counsel pregnant woman and family on birth preparedness and complication readiness and delivery by skilled health worker
- Able to identify danger signs in mothers during pregnancy, delivery and post-partum period and refer appropriately
- Able to provide proper essential newborn care
- Able to provide three PNC home visits for all newborns and mothers within one week and three extra visits for low birth weight babies before age 28 days.
- Able to correctly assess, classify and manage sick young infants according to the standard guidelines including proper gentamycin injection and amoxicillin oral and follow-up care
- Able to effectively counsel the mother on how to administer drugs at home, home care and when to bring back the sick young infant
- Able to properly record and report data of the sick young infants managed in their catchment

PLANNING AND ORGANIZING

Training Course

A successful training needs good planning and preparation ahead of time. In planning a training course, the facilitator needs to answer the following questions:

1.1 Who is to be trained?

The facilitator has to identify the characteristics of the learner/participant and tailor the training accordingly. **This training is tailored for Health Extension Workers (HEW) and equivalent individuals who have received IRT module one, i.e.iCCM. Since some of HEWs may not have received module two IRT-CMNCH yet it could be optional.** If HEWs have not received these training; the CBNC training will be difficult to understand so it is important to ensure participants have received these trainings. Participants need to bring their CMNCH participant manual.

1.2 How many participants will be in the training course?

This training, that requires extensive practical skills, should accommodate a number, which is easy to train. The number should not exceed 25 participants per class.

1.3 What is to be taught and how?

- There is a need to have a training schedule or agenda.
- The agenda should contain date, time, and sessions/topics to be covered and responsible persons, tea/coffee and lunch breaks.
- The agenda should also include the objectives of the training program, introduction of participants and of the training program, and methods of evaluation.

1.4 Who is responsible for what?

- A training program needs a course coordinator, facilitators, administrative and support staff.
- Facilitators should divide tasks among themselves before hand and be well prepared on the tasks they are going perform.
- The course coordinator organizes the training program and coordinates activities
- Facilitators provide information, organize learning tasks, supervise skill practice, evaluate the progress of participants and provide feedback.
- Administrative and support staff provide administrative, secretarial, logistics and other services for the training.

1.5 How many facilitators are needed and what qualifications should they have?

- The number of facilitators should be determined depending on the number of staff and trained facilitators available. But it is still good to have up to 5 facilitators conducting a training program. Maximum facilitator to trainee ratio to be 1:5.
- Facilitators should know the content of the training modules and be skilled in the aspects of providing services, which they are teaching.
- Facilitators should be well versed in teaching others different skills as stipulated in the training guides.

1.6 How long should the training last?

This training course on CBNC skills needs four full days for HEWs, who have already completed iCCM (6 days) and optionally the refresher training courses on CMNCH (10 days). The training will be at selected PHCU with capacity to manage training session.

1.7 What facilities are needed?

α) Invitation letters

Ensure with the relevant authorities that the HEWS do not have other competing tasks such as training, meeting or campaign on or around the same date. Writing invitation letters and distributing them in time is very important. It is crucial to follow-up through telephone or any other means of communication to make sure that letters reached the intended people or institutions.

β) Venue

A large room with chairs (if necessary with tables) is required in which all participants can sit comfortably. Space is also needed for small group exercises/discussions and demonstrations.

χ) Field practice

Identify pregnant women and or recentlydelivered mothers (less than one month) for home visit activity in close proximity to the training venue. (If postnatal mother less than one month is not possible take less than two months)

δ) Logistics needed for HEWs' CBNC training for a class of 25 participants

Make sure you have all the equipment and materials before the beginning of the training program

No	Description	Quantity
1.	Exercise booklet	1 per participant
2.	Chart booklets	1 per participant
3.	Photo booklets	1 per 2 participant
4.	Facilitators guide plus one set of other guides	1 per facilitator
5.	Registration book for sick young infant	1 per session
6.	Enlargements (set)	2 sets
7.	Course agenda	1 per participant (all)
8.	Recording form sick young infant age birth to 2 months, Front side	100
9.	Regstration forms	1
10.	TV and Video deck or DVD player	1 set per room
11.	Video Cassette/ VCD/DVD	2 sets per room
12.	Course Registration Form	1 per course

No	Description	Quantity
13.	CBNC course evaluation, pre and post test	1 per participant
14.	CBNC A3 paper wall chart	1 set/room
15.	Newborn mannequin complete set (suction bulbs and ambu bag , 2 towels+)	4 sets per room
16.	Scissors	2 sets per room
17.	Baby Weighing scale spring type with sling	4 sets per room
18.	Pointer (long stick) to conduct wall chart presentations	1 per session
19.	Family health guide/counselling cards	1 per participant
20.	Flip charts	2 per session
21.	Copy of Family folder-Integrated maternal and child care card	1 per participants
22.	Bin cards	1 per participants
23.	Traning reporting forms	1 per session
24.	Watches/Timers	4 per room
25.	Digital Thermometers	4 per session
26.	Syringes with needles(1cc and 2cc)	10 per session
27.	Pair of clean gloves	1 per participants
28.	Gentamicin, Amoxicillin, Vitamin K, Vitamin A, Tetracycline eye ointment, alcohol swab and Cholorhexidine,	5 each per room
29.	Safety box	4 per session
30.	Stationary(note book, pencil, pen and folder)	1 of each/ partcipants
31.	Marker and masking tape	2 per session

Community Based Newborn Care (CBNC)
Health Extension Workers' Training
Course Agenda

DAY AND TIME	TOPIC	RESPONSIBLE
DAY ONE		
08:00 – 08:30	Registration of Participants	
08:30 – 09:30	Introduction of participants, conduct pre-test; presentation on the CBNC course, and administrative announcements	
09:30-10:00	The story of Almaz	
10:00-10:15	**TEA BREAK**	
10:15-12:30	Pregnancy identification and antenatal care	
12:30-01:30	**LUNCH BREAK**	
01:30-03:30	Continue Pregnancy identification and antenatal care	
03:30- 03:45	**TEA BREAK**	
03:45– 11:30	Continue Pregnancy identification and antenatal care	
DAY TWO		
08.30 – 10:00	Birth preparedness and complication readiness	
10:00 – 10:15	**TEA BREAK**	
10:15-11:45	Delivery care	
11:45-12:30	Postpartum care	
12:30-01:30	**LUNCH BREAK**	
01:30-02:45	Continue Postpartum care	
02:45-03:30	Essential Newborn care	
03:30-03:45	**TEA BREAK**	
03:45-04:45	Continue Essential Newborn care	
DAY THREE		
08:30 – 10:00	Case management of the sick young infant	
09:45 – 10:00	**TEA BREAK**	
10:00 – 12:30	Continue Case management of the sick young infant	
12:30 – 01:30	**LUNCH**	
01:30 – 02:20	Continue Case management of the sick young infant	
02:20 – 03:30	Assess the Sick Young Infant for Feeding Problem and Underweight	
03-30– 03:45	**TEA BREAK**	
03:45-04:35	Assess the Sick Young Infant for Feeding Problem and Underweight	
04:35- 05:30	Identify treatment, Treat, Counsel the Mother and Follow up the sick young infant	
DAY FOUR		
08:30 – 9:00	Identify treatment, Treat, Counsel the Mother and Follow up the sick young infant	
09:00 –11:00	ANC/PNC home visit	
11:30 –11:45	**TEA BREAK**	

11:45 –12:30	When Referral is Not Possible	
12:30 –01:30	**LUNCH**	
01:30 –02:20	Continue with When Referral is Not Possible	
02:20 – 03:30	Counsel the mother; Give Follow up Care to the Sick Young Infant	
03:30 – 03:45	**TEA BREAK**	
03:45 –05:30	Develop Action Plan, Post Test, and Closing of Training	

CHECKLIST OF ACTIVITIES

Activity	Type of Activity	Time
DAY ONE		
Section 1: Introduction		
Activity 1.1	Introduction of participants and Facilitators	15 min
Activity 1.2	Lay ground rules and announce any administrative arrangements,	10 min
Activity 1.3	Pre-test	15 min
Activity 1.4	Introduction to the CBNC -Rationale, major objectives of the course	20 min
Activity 1.5	Read and discuss story of Aberash	30 min
Section 2: Pregnancy Identifcation and Antenatal care		
Activity 2.1	Introduction of pregnancy identification	15 min
Activity 2.2	Group discussion-how to identify pregnant women and conduct home visits	30 min
Activity 2.3	Video demonstration on basic communication during home visit to list WRA (introduction included)	5 min
Activity 2.4	Presentation and discussion on communication skill	20 min
Activity 2.5	Practice registering pregnant women and calculating EDD	40 min
Activity 2.6	Introduction of focused antenatal care	10 min
Activity 2.7	Presentation and discussion on schedule and content of antenatal care	20 min
Activity 2.8	Video demonstration on communication skill counselling for ANC	10 min
Activity 2.9	Group discussion on barriers to antenatal care	30 min
Activity 2.10	Presentation and discussion on home care during pregnancy	15 min
Activity 2.11	Use FHG and reciting danger signs during labour and delivery	15 min
Activity 2.12	Role play to practice interpersonal communication	60 min
	Lunch and tea breaks	90 min
	Day one total time	**450 min**
DAY TWO		
Section 3: Birth Prepardness and Complication Readiness		
Activity 3.1	Introduction to bith preparedness complication readiness (BPCR)	10min
Activity 3.2	Discussion of the Case of Chaltu	20 min
Activity 3.3	Discussion of the Case of Mihret	20 min
Activity 3.4	Video demonstration on counseling skill for birth planning	10min
Activity 3.5	Group discussion using FHG- on BPCR	30min
Section 4: Delivery		
Activity 4.1.	Introduction on delivery	5 min
Activity 4.2	Discussion skilled delivery	10 min
Activity 4.3	Group work on barrier to skilled delivery	30 min
Activity 4.4	Discussion on danger signs during labour and delivery	30 min

Activity	Type of Activity	Time
Activity 4.5	Practice completing family folder	5 min
Section 5: Postpartum Care		
Activity 5.1	Introduce postpartum care	5 min
Activity 5.2	Content and Timing of PNC home visit	20 min
Activity 5.3	Video demonstration on hand washing, measuring temperature and weight and counseling skill during routine PNC home visit	15 min
Activity 5.4	Group discussion on maternal danger signs in the postpartum period	15 min
Activity 5.5	Group work on barriers and solutions on PNC home visit	60 min
Activity 5.6	Introduction to the family folder and practice filling the Integrated Maternal and Child Care Card story of Almaz	40 min
Section 6: Essential Newborn Care (ENC)		
Activity 6.1	Brief introduction and distribution of learning/job aids	5 min
Activity 6.2	Brainstorming on newborn care in the local community and introduction of essential newborn care on the wall chart	40 min
Activity 6.3	Demonstration - video demonstration on essential newborn care,	20 min
Activity 6.4	Demonstrate the steps of immediate newborn care using a mannequin. *Participants practice the steps*	40 min
	Lunch and tea breaks	90 min
	Day two total time	**644 min**
DAY THREE		
Section 7: Management of the Sick Young Infant		
Activity 6.5	Wall chart presentation of birth asphyxia	7 min
Activity 6.6	Wall chart presentation of preterm and/or low birth weight	7 min
Activity 7.1	Introduction to the young infant wall chart, and assessment for very severe disease, local bacterial infection and jaundice	25 min
Activity 7.2	Introduce how to fill a young infant record form (cases Hiwot and Robel)	40 min
Activity 7.3	EXERCISE A part 1: Video demonstration (A) - Assessing for possible bacterial infection	20 min
Activity 7.4	Exercise A Photograph excersice on skin, umbilical infections and Jaundice	10 min
Activity 7.5	Introduce the classification of the young infant for very severe disease, local bacterial infection and jaundice on wall chart	30 min
Activity 7.6	Using enlarged blank record Form, demonstrate the classification of Hiwot, and then allow participants to do the classification of Robel	30 min
Activity 7.7	Introduction to the assessment and classification of diarrhoea in the young infant on wall chart and do the example of Fola and allow partcipants to do the case of Abdissa	40 min
Activity 7.8	EXERCISE B: case studies (Ababu, Hanna and Shashe)	40 min
Activity 7.9	EXERCISE C: video case study (Ikram)	35 min
Activity 7.10	Assess for HIV infection –brain storming discussion by wall chart presentation	10 min
Section 8: Assess the Sick Young Infant for Feeding Problem and Underweight		
Activity 8.1	Introduce how to assess for feeding problem and underweight on the wall chart	20 min
Activity 8.2	Demonstrate how to read a weight for age chart	15 min
Activity 8.3	DRILL reading a weight for age chart for young infants	05 min
Activity 8.4	EXERCISE D Part 1: Video demonstration on how to check for feeding problems and assess breastfeeding (replaced by demonstration and practice on dolls)	20 min

Activity	Type of Activity	Time
Activity 8.5	EXERCISE D Part 2: Photographs on signs of good attachment	10 min
Activity 8.	EXERCISE G Part 1: Video demonstration of how to teach correct positioning and attachment for breastfeeding	10 min
Activity 8.7	EXERCISE F: Assess Young infants for underweight and feeding problems (recording by using an example cases of Hewan, and then Tezera)	20 min
Activity 8.8	Assessment of a young infant for Immunization status	5 min
	Lunch and tea breaks	90 min
	Day three total time	**484 min**
DAY FOUR		
Section 9: Identify Treatment, Treat, Counsel the Mother and Follow up in Sick Young Infants		
Activity 9.1	Practical session on ANC/PNC hime visit	180 min
Activity 9.2	Introduce the actions to be taken according to the" Identify treatment" on the wall chart	10 min
Activity 9.3	Referring the sick young infant	10min
Activity 9.4	Video demonstration on counselling and negotitation skills during post natal home vist-sick young infant	15 min
Activity 9.5	Demonstrate the steps of newborn resuscitation *Participants practice the steps*	30 min
Activity 9.6	Immunize the sick young infant if he/she needs it today and if not to be referred	2 min
Activity 9.7	Expressing and Feeding the preterm with breast milk wall chart presentation	10min
Activity 9.8	Expressing and Feeding the preterm with breast milk video demonstration	10 min
Section 10: when referral is not possible		
Activity 10.1	Introduction to when referral is not possible on the wall chart	5 min
Activity 10.2	Wall chart presentation on Amoxicillin and gentamycin dose on the Dose Schedule and Duration (DSD)	10min
Activity 10.3	Drill to calculate correct doses of amoxicillin and gentamycin	10 min
Activity 10. 4	Wall chart presentation on giving gentamycine injection	15 min
Activity 10. 4	Demonstration of giving gentamycin injection	10 min
Activity 10.5	Practice of giving gentamycin injection	40 min
Section 11: Counsel the mother		
Activity 11.1	Using the wall chart introduce *Counsel the mother*	5 min
Section 12: Follow up Care of the Sick Young Infant		
Activity 12.1	Introduction to the follow-up of the young infant -wall chart presentation	10 min
Activity 12.2	**Provide follow-up care to complete treatment for very severe disease-role play negotiation skill with care taker**	15 min
Activity12.3	Practicing Filling Young Infant's Register the case of Ababu & Hanna	20min
Activity12.4.	Devloping action plan	30 min
Activity12.5.	Post test	10 min
Activity12.6	Reflections, closing and distribution of essential commodities Reflection	15min
	Lunch and tea breaks	90 min

Activity	Type of Activity	Time
	Day four total time	**547 min**

PART ONE: CONTACT, COUNSELING AND CAPTURING CASES

DAY ONE

SECTION ONE

INTRODUCTION

Activity 1.1 Introduction of yourself and participants

Introduce yourself and participants in a simple and entertaining way covering the following points: *Use a pre-prepared flip chart.* **(Flip chart-1)**

- Name
- Working place
- Responsibilities
- Expectation from the training
- Personal interest and hobbies

One of the facilitators writes the expectations of the participants on a flip chart, so that it can be compared with the course/learning objectives.

Activity 1.2: Laying ground rules and announce any administrative arrangements

Discuss with participants and get agreement.

Discuss with participants to lay ground rules to follow during the training time. Write it on a flip chart and paste it on visible site **(Flip chart-2**)

Agree on:

Starting time, finishing time, tea/lunch break time , punctuality, active participation, no side-talks, explain about payment of per diem and if there are any other arrangements, listen to and respect other people's opinions, expressing one's opinion freely, speaking loud and flexibility

Activity 1.3: Pre test

Pass out copies of the pre test to the participants and ask them to complete individually.

Ask participants to write their code number (previously assigned by random drawing of numbers) on the front page of pre test paper or preferably prepare the pre test paper with randomly assigned number on it.

PRE/POST-TEST Say True or False			
	Statement	**True**	**False**
1. 1	Early identification of pregnancy mothers in a kebele is a key activity to deliver timely antenatal care	***X***	
2. 2	If the health of a pregnant women is normal during the first ANC check up, there is no need for further ANC visits		***X***
3.	The role of HDA in timely identification and follow up of pregnant women is very important	***X***	
4.	Focused ANC has a role in preventing complications in pregnant mothers but not in newborns		***X***
5.	During ANC HEW can help the family to have the knowledge and skill to recognize danger signs during pregnancy and seek care promptly	***X***	
6.	Birth preparedness plan includes planning for place of delivery, money, and transport only		***X***
7.	Husband and other family members have very limited role in birth preparedness plan as the mother and HEW alone can handle it.		***X***
8. 3	Strong crying by a newborn immediately after birth is a sign of health problem		***X***
9. 4	Initiation of breastfeeding to the baby is one of the late postnatal actions of essential newborn care		***X***
10. 5	Hand washing with soap and water, before and after touching the newborn is one of the most important interventions to prevent infection	***X***	
11. 6	When a young infant has 60 breaths per minute counted twice, it should be classified as pneumonia		***X***
12. 7	When a young infant has a temperature of 37.5ºc this is not a serious problem		***X***
13. 8	Essential Newborn Care should be given only in health centers and above by a skilled health workers		***X***
14. 9	Since most deaths of mothers and newborns occur at the sixth week HEW should conduct the PNC visit at this time		***X***
15. 10	When the birth weight of a newborn is less than 1500 gm, keep warm, give expressed breast milk, and refer urgently to a health center/hospital	***X***	
16. 11	Drying and wrapping; cutting and tying of the cord; giving prophylaxis eye care; putting the baby immediately to breast and weighing the baby are components of essential newborn care	***X***	
17. 2	Severe headache with blurring of vision is common phenomenon in mothers during pregnancy, and HEW should not take it seriously		***X***
18. 3	A newborn baby that is sleeping a lot, not moving and cold to touch has a danger sign	***X***	

PRE/POST-TEST Say True or False			
	Statement	**True**	**False**
19.4	HEWs should make at least two PNC visits within the first week of life	***X***	
20.5	The first dose of Pentavalent vaccine should be given during the first PNC visit		***X***
21.6	When referring a newborn to a health centre, the HEW should counsel the mother to keep the baby warm and breastfeed on the way	***X***	
22.	A newborn with diarrhea with some dehydration will be treated with plan A		***X***
23.8	If you attend a delivery and the baby didn't cry this is a normal phenomenon and you should not do anything		***X***
24.9	A newborn that is receiving breast feeding less than eight times in 24 hours does not have feeding problem		***X***
25.20	All the ANC visits should be given at health center level		***X***

Activity 1.4 Introductory presentations

- Ask participants what are major causes of newborn death in the community? Lead brief brainstorming session. Then present the pie-chart of diseases, (*rationale)* on a flip chart.
- *Present the major objectives* and *learning objectives* of the course as described below:
    - Relate with the expectations of participants.

Major Objectives:

1. To scale up community-based MNH services including introduction of newborn sepsis management;
2. To improve maternal and newborn care practices and care seeking behaviour through HDA,1 to 5 network, and other existing effective community mobilization mechanisms and
3. To strengthen the capacity of HP and HCs in providing quality maternal, newborn and child health services;

Learning objectives:

At the end of the training the participants will be able to:

- Identify, register all pregnant mothers and promote focused ANC
- Identify danger signs in mothers during pregnancy, delivery and post-partum period
- Provide essential newborn care
- Provide three PNC home visits for all newborns & mothers and two extra visits for low birth weight babies
- Assess, classify and manage sick young infants according to the standard guidelines-including administration of proper gentamycin injection and provide follow-up care
- Counsel the mother on how to administer drugs at home, home care and when to bring back the sick young infant
- Properly record and report data of the sick young infants managed in their catchment

- Create demand for MNH services through the HDA network.

Flip Chart 3

Figure 1: What are newborns dying from in Ethiopia?

Diarrhoea

Source: Liu L et at 2012 Global, Regional, and National cuases of child mortality in 2000-2010; an updated systematic analysis. The lancet

As can be seen above, the three main causes of neonatal mortality accounting for about 90% of deaths are preterm birth; intrapartum causes (asphyxia) and infections.

- Another underlying factor for high neonatal mortality is low birth weight. According to the 2011 EDHS, an estimated 11% of newborns are low birth ure may underestimate the extent of the problem as most newborns are not w low institutional delivery coverage (only 5% of newborns are weighed at birt

Preterm birthComplicatio

90% of deaths are caused by conditions related to preterm birth, intrapartum and infections

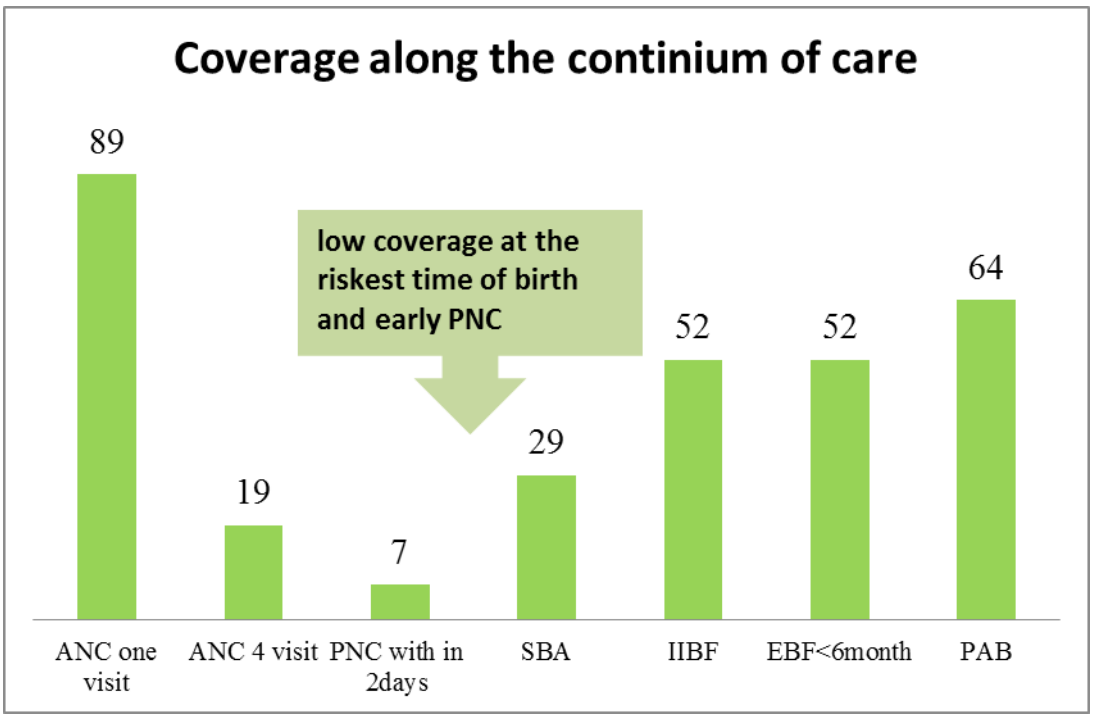
Birthday is the riskiest day of life

- Upto 50% of ne first 24 hours
- 75% of neonata ek-3million
- Birth and the fi
- Yet coverage of care is the lowest for mothers and babies
- 80% of Ethiopian mothers deliver at home

Intrapartum related

Flip Chart 5

Figure 2: What is the coverage of key interventions in Ethiopia to prevent maternal and newborn deaths? (Source EDHS 2011 and national HMIS)



Continuum of Care to Improve MNH "Four Cs

1. **Contact:**prenatal and postnatal contact with the mother and newborn and provide FANC, delivery care, PNC at health facility or home visits
2. **Capture:** case identification of newborns with pre term/LBW, birth asphyxia or infections and mothers with danger signs during ANC or PNC at health facility, or home visits
3. **Care:** treatment that is appropriate and initiated as early as possible; and
4. **Completion**: completing of appropriate treatment

Activity 1.5: Story of Aberash

Read the story of Aberash and at the end of the reading you will open a discussion by raising few questions before you present the key findings on a flip chart

Story 1: The Story of Aberash

Aberash is a married woman living in a rural village. She has three children ages 3, 2 and 1 year old. She had wanted the first pregnancy as she was curious to become a mother and prove her fertility. She had wished to wait a little bit after her first birth, but she never used contraceptives. The second and third births were too soon for her.

She delivered all her children in the village with the assistance of a traditional birth attendant. Her children are thin and not growing well. They frequently catch diarrhea. She is now pregnant with her fourth child and is feeling particularly unwell and tired. She has not attended antenatal care, as she did not have to in her past pregnancies. This pregnancy is no different from the past, she thought.

Labor started when Aberash was nine months pregnant. After two days of labor she delivered at home. The baby was well until the third day when she failed to feed well. The family called on the health extension worker on the fourth day because Aberash was weak and the baby was not feeding well. The health extension worker found Aberash had fever and was very weak. The baby was also weak, not feeding and not moving when stimulated. The HEW advised the parents to take both the mother and the baby to the nearest health center immediately.

The family waited one more day before they finally decided to carry Aberash and her baby on home-made stretcher to the health center. The baby died on the way to the HC. On examination at the health center, the midwife found that Aberash was seriously sick and she referred her to the nearest hospital for further management. Aberash has got well.

Questions:

1. What are the major events in the story? (Write the participants' answer on a flip chart)
2. Does the story represent a reality in their community? (Ask participants to give examples that they have witnessed)
3. What could the HEW and the community have done differently to prevent this tragedy?

Flip Chart 6

Key Events from Aberash's Story

Facts from the story of Aberash

1. Main events of the story
   - Does not use Family planning
   - No birth planning or emergency readiness
   - No ANC follow up
   - Home delivery
   - Her children are malnourished and have frequent bout of illness
   - Prolonged labour
   - Maternal danger sign during post partum period-fever
   - Newborn danger sign- not able to feed and not moving when stimulated
   - Delay in recognizing newborn illness and in seeking care
   - Newborn death
   - Aberash was seriously sick and referred from nearby HC to Hospital

2. Aberash's story is common in Ethiopia

3. HEW's role in preventing such incident
   - Identification of pregnant mothers and proper documentation
   - Provision of ANC
   - Timely PNC visit
   - Promoting family planning to make pregnancy wanted, planned and well spaced and and improving access
   - Access to delivery service
   - Growth promotion and development

4. Community's role in preventing such incident
   - Maternal and newborn health issues topic of discussion and monitoring command post and keble cabinet
   - Transport and financial support for pregnant women for facility delivery

SECTION TWO

PREGNANCY IDENTIFICATION AND ANTENATAL CARE

Learning Objectives:

At the end of this session, HEWs will be able to:

- Timely identify all pregnant women using HDA
- Work effectivly with HDA on the process of taking women to first ANC service
- Provide quality focused antenatal care (FANC)
- Refer all pregnant women to have at least one ANC visit at HC
- Identify the danger signs during pregnancy and take recommended actions
- Counsel pregnant mothers and families on birth preparedness and complication readiness

Activity 2.1 Introduction of pregnancy identification - before you go to the introduction of pregnant women identification, briefly brainstorm with participants how they identify pregnant women in the community.

Ask in order:

- When do women usually reveal pregnancy?
- What are the ways your community identify pregnant women (PW)?
- Do you use family folder to identify pregnant women and follow up?
- What are the different ways HEWs can identify pregnant women in their kebeles?
- Why do we need to identify pregnant women?
- How many pregnant women do you expect in a 5,000 populationkebele per year?

Listen their answers and present Flip chart

Emphasize the fact that often, the ones that are not identified are the most vulnerable and at risk of illness and death.

Flip Chart 7

Importance of Pregnancy Identification

- Every pregnancy is at risk and pregnancy related complications are unpredictable at the individual level
- If pregnant women are not identified; they will not get important services and it may not be possible to prevent problems during pregnancy,labor and birth, and during postnatal period
- Pregnant women who have started their follow up early will have timely investigation, treatment and counseling
- The recommendation is to have the first visit in the first three months of pregnancy
- Families need time to prepare for birth, to save money for transport and any costs, and to gather supplies and clothes for the baby

Activity 2.2: Group discussionhow to identify pregnant women (MODIFIED)

Read out loudly the following story and ask their opinion about the HEWs plan. Use the listed questions in the bottom of the story to ask their opinion.

Story 2: Working together

Tigist and Kore are HEWs in Kata kebele. One of their tasks is to identify all pregnant women timely and encourage them to come for ANC. In order to do their work, they had to think how they could identify all pregnant women in their Kebele. To help their decision, they called together key group of people who can assist them in identifying pregnant women. They discussed and agreed to assemble in two groups. One group consisted Ato Gebessa the Kebele chair man, the four representatives of women structures, two religious leaders, Ato Debela the school director, and two Agricultural developmental agents. In the second group were HDA, 1 to 5 network leaders, TTBAs and Ato Bekele the traditional healer.

The meeting was held at the kebele office; each HEW in the two groups briefly introduced the magnitude and type of maternal and newborn health problems in the kebele. They presented that ANC is a good entry point to solve the problems. They emphasized the importance of pregnant women identification and expected roles of each community members.

After the discussions on the matter, it was decided for the HDA 1 to 5 network leaders to visit every household in their village frequently; to counsel pregnant women and their families on the importance of ANC follow up, register all pregnant women and submit to HEWs. Ato Bekele and the TTBAS will also advise pregnant women and link with the HEWs.

The Kebele chairman, representatives of women structures, religious leaders, school director, and agricultural developmental agents decided they will explain the importance of ANC for pregnant women and their families, and encourage all pregnant women to visit the health post and have ANC.

At the end of the meeting the HEWs showed their gratefulness to the community leaders and influential and planned to attend the next kebele cabinet meeting time.

Ask participants the following question and lead the discussion

- What method did the HEWs use to identify pregnant women?
- Do you think this method will help in identifying all pregnant women timely? (Ask their reason whether the answer is yes or no)
- What methods have you been using to identify pregnant women in your kebele? (Encourage them to share their experience).

Then present the following and summarize the session

Flip Chart 8

Strategies to Identify Pregnant Women

1. **Using the kebele command post:**
   Sensitizing kebele command post members, women structures leaders, teachers, on the importance of early identification of pregnant women and ANC and have their active participation and support.

2. **Using HDA**
   Orient and support HDA, 1 to 5 network leaders,to attentively follow their respective households, gather information, and report as soon as possible to HEWs about pregnant women using different methods as soon as possible
3. **Using Faith based and Community based organizations:**
   HEWs will orient FBO and CBO leaders on the importance of early identification of pregnant women and ANC and get their active participation
4. **Using traditional influential persons:**
   Orient traditional healers, wise men, TTBAs to have their active participation in early identification and ANC of pregnant women
5. **Using home visits and outreach services by HEW:**
   Home visits and outreach services are opportunities for pregnancy identification and ANC
6. **Friendly and quality MNCH service provision:**
   Providing friendly and quality MNCH service is important to build confidenceof the community on the HEWs to declare pregnancy timely and have continuous ANC follow up visits

Note for the facilitator: before doing the above flip chart presentation facilitators read the below detailed on strategies for early pregnancy identification

1. Using different community structures
   - HEWs sensitize and increase the knowledge of different key community groups i.e., kebele command post members on the importance of pregnancy identification and services available at health post. These key community groups are expected to resonate the importance of ANC in their daily activities in village and families
   - The kebele command post compile list of pregnant women from the developmental team heads and ensures that the pregnant mother is registered and receives ANC at the health post.
   - Give orientation to developmental team on how to identify pregnant women in their respective sub kebeles.
2. Using HDA

   HEWs orient HDA, 1 to 5 network leaders,
   - On the maternal and newborn health problem of their kebele
   - On the key intervention package, importance of early identification of pregnant women and ANC.
   - How to approach pregnant women in their local community.
   - How to register on the registration format and how to report to HEWs.
   - HDA, 1 to 5 network leaders, goes house to house and shares key messages and list all women of reproductive age and update their reproductive history and report to HEWs.
   - This gives the HEWs a more accurate picture of actual and potential pregnancies in the kebeles
3. Using community social events through FBO and CBO.
   - HEWs will orient FBO and CBO on the importance of pregnant women identification. The leaders of each organization transmit messages to their members, collect information and will report to HEWs.

HEWs develop master list of all identified pregnant women and uses this list to identify when and who needs ANC, who has received ANC, and who needs follow up to encourage subsequent ANC visits.

HEWs map out all identified pregnant women in their specific localities make home to home visits (especially defaulter pregnant women, will be followed during home visit)

Providing quality of ANC services to pregnant women and approaching pregnant women friendly and kindly to satisfy their need to have the continuity of ANC follow up visits

HEWs work closely with HAD,1 to 5 network leaders and women structures, encouraging them to inform whenever they hear about the presence of pregnant women in continuous fashion.

HEWs and HDA, 1 to 5 network leaders, will have regular meeting on the progress and new information in the community, and HEWs will provide feedback on their performance.

For ANC sustainability, pregnant women conference in all kebeles is important.

Introduce Pregnancy identification registration format (See sample annex 3)

Activity 2.3 Video demonstration on interpersonal Communication during home visit to list WRA and identify pregnant women

- Call for them to see video attentively**;**
- Answer any question and summarize the session

Activity 2.4 presentation and discussion on communication skill

- Brain storm with participants by raising the following points

What it is: Communication is a process of exchanging ideas, views, information, knowledge, skills, practice, etc. among individuals, groups, and the community at large.

Benefits:

- Improve utilization and quality of MNH services
- Sustainability of high MNH service coverage
- Promote use of participatory learning and decision making method/s to improve community involvement, ownership and partnership

Then present flip chart 9 on GALIDRAA and flip chart 10 on ORPA

Flip Chart 9

"GALIDRAA"

1. **Greet**
2. **Ask**
3. **Listen**
4. **Identify**
5. **Discuss**
6. **Recommend and Negotiate**
7. **Agree**
8. **Appointment**

Flip Chart 10

"ORPA"

1. **Observe**
2. **Reflect**
3. **Personalize**
4. **Act**

Note for the facilitator

Interpersonal communication/ Negotiation skill

Negotiation an individual has the following steps widely known as "**GALIDRAA"**.

1. **GREET:** greet the pregnant woman/caretaker. Be respectful and friendly; explain the reason for your visit.
2. **ASK:** Ask the mother open ended questions about her current practices to get a better sense of her or her family member's understanding of an issue to see what they already know.
3. **LISTEN:** to the mother as she explains; empathize – show that you understand how she feels:
    a. Paraphrase what the mother says so that you are clear about what she is saying. "So what I'm hearing you say is…."
    b. Praise her for important practices she is doing well
4. **IDENTIFY**: identify current health or care practice, any problems and challenges to taking action on optimal practices.
5. **DISCUSS**: discuss about different options to overcome any challenges using the visual aids to help you explain.
    a. Sit next to her when discussing issues and presenting visual aids, ensuring that she sees the visual aids being used.
6. **RECOMMEND AND NEGOTIATE ACTIONS**: present options and help the her to identify those options she can try
7. **AGREE**: see if the mother will agree to try one of the options, if caretaker says no, ask why and try to addresses any concerns she may have. Ask her to **repeat** what she has agreed to confirm her understanding and decision
8. **APPOINTMENT**: make an appointment for a follow-up visit.

Using Visual Aids- Family health card [ORPA]

OBSERVE: Have the caretaker observe the illustration

1. What is happening in the picture?
2. How do the caretakers feel about what they are doing?

REFLECT: Have the caretakers reflect on what they see

What is the advantage of adopting the practice in the picture?

PERSONALIZE: Have the caretakers personalize/put themselves in the situation

1. What would you do the same thing in the situation?
2. What difficulties would you expect if you practice these actions?
3. How do you think you will overcome them?

ACT: See if the caretakers are willing to act on what they have seen and discuss

1. Would you try to carry out these actions?
2. What exactly would you try to do?
3. How can you overcome any barriers to trying the new practice?

2.5. Practice registering pregnant women and calculating expected date of delivery (EDD)

Ask participants what EDD means; if they are already practicing it ask how they calculate it.

Accept some responses and then demonstrate how to calculate EDD on a flip chart

Show them the 4 scenario examples by writing it on a flip chart, and let them do one additional calculation for each scenario given below in a group of 2-3 individuals; facilitators supervise, assist them as needed. Give feedback for the whole group by presenting the answers

Calculating Expected date of Delivery (EDD)

There are four variables in the calculation of EDD

Assumption: the EDD is assumed to be 280 starting from the last menstrual period

1. Last Menstrual Period (LMP)
2. Days
3. Months
4. Year

Examples using the Formula in different 4 Scenarios

I. When Pagume is not included

EDD = LMP+9 month+10days

Example 1: if the LMP was on 05/01/2005 Then

Day:5+10 days= 15

Month: 1+9 = 10

Therefore the EDD will be on 15/10/2005

II. When Pagume of 5 days long is included

EDD = LMP+9month + 5

Example 2: if the LMP was on 20/06/2005

The coming Pagume is 5 days long, then

Day:20+5 days= 25

Month: 6+9 = 15 since one year is 12 months, 15-12 will be 3 months

Therefore the EDD will be on 25/03/2006

III. When Pagume is 6 days long

EDD = LMP+9month + 4

Then the previous example will be

Day:20+4 days= 24

Month: 6+9 = 15 since one year is 12 months, 15-12 will be 3 months

Therefore the EDD will be on 24/03/2006

IV. All the above examples will be right if the LMP lies between the days of a month 01 to 20. If the day is from 21 to 30 then we have to add one month to 9 month (total 10 months)

When Pagume is not included

EDD = LMP+9 month+10days

Example 1: if the LMP was on 21/01/2005 , then

Day:21+10 days= 31 (since one month is 30 days; 31-30=1)

Month: 1+10 = 11

Therefore the EDD will be 01/11/2005

LMP dates for practicing by participants

1. LMP was on 10/02/2005
2. LMPwas on 16/06/2005 (coming pagume is 5 days)
3. LMP was on 16/06/2005 (coming pagume is 6 days)
4. LMP was on 28/07/2005 (coming pagume is 5 days)

Answers

1. 20/11/2005
2. 21/03/2006
3. 20/03/2006
4. 03/05/2006

Answer any question and summarize the session

Activity 2.6: Introduction of focused antenatal care – reminds them their CMCH training and describe that the objective of this session is to refresh their memory in FANC

Lead brief brainstorming session on FANC

A. Ask participants to briefly describe what FANC means:

   What?it is an action based ANC which takes that every pregnant woman is at risk of complications and delivers essential service-components to pregnant women through four visits to all pregnant women (basic component) and more than four visits for women with complications (special components)

B. Ask participants the benefit of FANC and receive answer from few participants and then present the benefits on the flip chart below.

Flip Chart 11

Benefits of FANC

- Prevention of diseases and complications during pregnancy
- Early detection of problems & complications and solve/treat them
- Birth preparedness and complication readiness
- Health promotion
- Helps to ensure healthy outcomes and prevent illness for the mother and the newborn(e.g., iron/foliate, TT vaccination, ITN, HIV counseling and testing and PMTCT)
- Can identify problems and treat them (e.g. malaria, syphilis, and hypertension)
- Can help families to plan and prepare for birth and be aware of danger signs and seek medical care when it happens.
- Helps toprovide counseling on maternal nutrition; breastfeeding, postpartum family planning and others.

Activity 2.7: Presentation and discussion on schedule and content of FANC

Ask participantswhen and where the four recommendedschedules of FANC happen.

Make sure they mentioned the following:-

When? Following is the schedule of four focused antenatal care visits in HFs recommended for a woman without problems:

First Visit	Before 16 weeks (4month)
Second Visit	24–28 weeks (6month)
Third Visit	30–32 weeks (8 month)
Fourth Visit	36–40 weeks (9 month)

Where? Prefferably at HC and if this not feasible three visits at HP and one at health center

Discuss the minimum schedule and tasks of pregnancy home visits by HEWs

Delineate tasks to be carried out at HP and /or at home visit

Ask participants the content of the first FANC visit and add if they miss the following points:-

Tasks to be carried during 1st ANC visit by HEWs

- Assess general Health conditions of the pregnant women
- Take history of present pregnancy (last menstrual period)
- Ask for any complaint from past pregnancy; if there was any problem in the past her FANC follow up should be in a health center.
- Gather other important information as put in the FANC card
- Check for presence of any danger signs from the FHG; if danger sign exists ,refer to health center
- Measure blood pressure, and weight; check for pallor in the conjunctiva or palm; check for any swelling in the breasts
- Inject TT vaccine if she is eligible
- Provide iron table to be taken every day for 6 months
- Use FHG and counsel about nutrition, ITN use, pregnancy danger signs, mother to child transmission of HIV, and birth preparedness and complication readiness planning
- Encourage pregnant women to visit health centers for more health services

- Link with the respective HAD, 1 to 5 network leaders, to get more counseling and care
- Counsel on HIV testing and STI management

Tasks to be carried during subsequent FANC visit by HEWs

Ask participants the content of the subsequent FANC visit and add if they miss the following points:-

- Ask if she has any problem since the last visit and take action accordingly
- Check for any danger sign; refer urgently to higher health facility if there is any
- Measure her weight and check whether she is gaining weight or not (at least she has to gain one kilogram additional weight every month)
- Encourage to continue Iron supplementation
- Ask about her feeding and give advice using the FHG
- Help her to decide place of delivery, specially negotiate to give birth in health centre; try your best to support her in finding solution for existing problem
- Link with the respective HDA, 1 to 5 network leaders, to get more counseling and care

Activity 2. 8 Video demonstrations on communication skill for ANC

- Call participants to watch the video attentively
- Answer any question and summarize the session

Activity 2.9 Group discussion on barriers to antenatal care

Ask participants what they think the coverage of FANC in general is in their catchment

- Inform them that the first FANC coverage in Ethiopia is 89% while the 4th FANC follow up visit is very low-19%(HMIS 2004)
- Tell them that they will examine this in detail in a group work; divide participantsinto four groups and help them work on the following points; groups will present their work on flip chart in a plenary.

Discussion points:

1. What is the expected number of pregnant women in a kebele of 5,000 population?
2. What is the proportion of pregnant women who attend FANC the first and fourth?
3. What are the barriers preventing pregnant women from getting FANC?
4. What are the proposed solutions?

After the discussion present the flip chart on barriers and proposed solutions and summarize the topic

Flip Chart Barriers of Proposed

Barriers	Proposed Solution
Lack of awareness	Increase awareness through HDA, and other strategies
Absence of problem during previous pregnancy.	FANC is mandatory: Every pregnancy potentially risky
Too much work to do	Negotiation and support with pregnant women & their families to overcome the barrier
Distance of health facilities,	
Lack of transportation	counselling and support: Explore for options of transportation
High cost of care	Counselling: Any ANC service is free of charge; weigh the benefits of FANC
Poor quality of care,	Improve quality of service and create friendly atmosphere (training, supply, follow up, reviews)
Uncaring attitude of health workers	
Lack of decision-making power by women	Involving the Husband, grand mom in the counselling and decision making process

12Table 1: ANC and Solution

Activity 2.10 Presentation and discussion on home care practices during pregnancy

Brain storming: Ask participants to mention the good practices during pregnancy in their communities then ask them to mention the bad or harmful practices. Write the answers on a flip chart as they mention practices.

The answers may include the following depending on the particular cultures and tradition in the locality; add points participants have not mentioned from the list below:

A practice which has to be encouraged:

- Good nutrition (eating well-eating well means eating enough food and eating a variety of foods) getting one additional meal
- Getting more rest,
- Avoiding heavy work,
- Hygiene (keeping clean),
- Sleeping under ITN
- Taking iron and folate

Harmful traditional practices-context specific:

- Drinking alcohol,
- Food and other taboos during pregnancy
- Smoking (using tobacco, shisha)
- Presence of harmful chemicals in the area
- Taking herbal medicine
- Abdominal massage

- HIV testing
- Use iodized salt
- Have a birth plan

Brain storming: Ask participants to mention the reasons why pregnant women need to eat more during pregnancy, write on a flip chart as they give their answers; add any point missed from the below list.

- Helps a woman resist illness and stay healthy
- Keeps a woman's teeth and bones strong
- Helps the baby grow well and healthy in the mother's womb
- Helps a mother to recover quickly after birth

Then ask them what would happen if a pregnant woman does not eat well. Listen to their answers add any point missed from the below list.

Not eating well (poor nutrition) can cause:

- Tiredness,
- Weakness,
- Difficulty in fighting infections, and other serious health problems.
- It can cause miscarriage
- It cause a baby to be born very small or with birth defects
- It also increases the chances of a baby or a mother dying during or after birth.

Activity 2.11 Use FHG and reciting danger signs during pregnancy

Ask participant to turn the family health card danger sign during pregnancy page ask them to read the danger signs and link with the pictures

Note to facilitators: danger sign is serious condition that threatens the life of the mother or her unborn child or both. During every FANC contact, the HEW should ask and check if the pregnant woman has danger sign. *If she has danger sign, the HEW should refer her immediately to the health centre*. If she does not have any danger sign, the pregnant woman should be counseled on the need to recognize danger signs and seek care immediately.

Present flip chart # 13

After the presentation make a ball from paper and explain to participants that they will play a game to recite danger signs during pregnancy. You throw the ball to one participant and have her to name one danger sign. Then she throws the ball to another participant who in return mentions another danger sign. Let everyone take turn.

Flip Chart 13

Danger Signs for Pregnancy

The following are the most important danger signs during pregnancy:

1. Convulsion or unconsciousness
2. Headache, dizziness, or blurred vision
3. Swollen hands and face
4. Vaginal bleeding
5. Severe lower abdominal pain
6. Fever

Activity 2.12 Roleplays to practice interpersonal communication

Use role play negotiation skill checklist and let participants use the FHG and

- Inform them that in this session they will practice promoting FANC to pregnant women in the community and counselling a woman that has come for FANC using family health card.
- Provide them instructions for small group activity
  - Divide them into four groups,
  - Two participants act out the role play (one as HEW and the other as pregnant woman) at a time while the others observe. Tell them to follow GALIDRAA and ORPA from the checklist.
  - Observers provide feedback for group member acting as HEW based on the checklist.
  - Then they change roles, observers doing the role play and the others becoming observers
  - Participants practice the different role play scenarios and all group members need to practice both scenarios below (For each role play provide 15minutes)

Among the three teams, allow two groups to present role play of two of the scenarios in the large group. For each team provide 20 minutes.

ROLE PLAYS

Story for Pregnancy Role Plays

Promoting Institutional Delivery to a Family who are Reluctant

Nigatua is an 8 months pregnant woman. She is para one gravida two. She has attended antenatal care 3 times (two at HP and one at nearby HC) for the current pregnancy. She was told that she should go to a nearby health centre for delivery. However, she does not think it is necessary to deliver in a health facility, because she delivered her first child at home with the assistance of her mother in-law. She wants to discuss with her husband and decide later. You planned to visit her at home to convince her and her husband to decide for institutional delivery. You took appointment to visit at convenient time for her and her husband. Demonstrate how you will negotiate with them during your home visit. Four participants will do the role play (one acts as the health extension worker, one as the pregnant woman and one as the husband and one as her mother in law).

Script for Niagtuwa and her family

W/ro Nigatua: I gave birth normally during my first birth, now I do not see the reason why I should give birth at HC. My mother in law is very experienced in assisting delivery in our village and home delivery gives me more comfort than health centre

Ato Mitiku, Nigatuwa's husband: he wants to do all what he can for his wife and coming newborn, but he can't take her to HC because he has no money to take her to the HC and he fears the cost is unaffordable for him. He is busy in harvesting his crop and there is no one to care for the three year old child at home if they go to HC for delivery.

Her mother in law w/ro Bontu: she suggested she has many experiences in assisting home delivery with out problem including Nigatua's first pregnancy. Nigatuwa is healthy, so no need to go to HC for such healthy lady. I know sick pregnant women need assistance from Hc. But Nigatuwa is not. Moreover, St.Marry will help her.

The HEW using GALIDRAA negotiates with the W/ro Nigatwa and her family. Finally the family became convinced of the need of delivery at the health centre.

Summarize the session of role play by asking participants:

- Are all family members convinced by this role play?Is Nigatwa likely to go to HF for delivery?
- How they felt about the process of role play
- What challenges did they face and how did they address them
- Ask participants if they implement similar techniques in their practice

Ask participants if they have any questionand summarize the session

SECTION THREE

BIRTH PREPAREDNESS AND COMPLICATION READINESS (BPCR)

Learning Objective:

Explain the importance of birth preparedness and complication readiness

Activity 3.1: Introduction

Lead brain storming and presentation of BPCR

Lead a brain storming sessionby raising the below questions and enriching participants' answers with the below descriptions

What is it?

Birth Preparedness and Complication Readiness (BPCR) is the process of planning on important matters for normal birth and anticipating the actions needed in case of an emergency.

Whose responsibility is it?

Responsibility for BPCR must be shared among all family members and others especially husband, pregnant women, mother in law, communities, HDA, 1 to 5 network leaders as a coordinated effort is needed to reduce the delays that contribute to maternal and newborn deaths.

When should it be done?

Timely planning together for the care that women and newborns need during pregnancy, childbirth, and the postpartum period, helps to take action in emergencies, and build an enabling environment for maternal and newborn survival.

What are the benefits of BPCR?

- Increase awareness of family, shared responsibility and the need for strategic action during the three phases(Pregnancy, Labour/birth and PNC period)
- Encourage shared solutions to life-threatening delays;
- Disclose barriers, which hinders her not deliver at HF and propose solutions. And
- Focus on the implementation of priority of actions

Activity 3.2: Discussion on the Case of Chaltu

Read the following story to participants and facilitate discussion around the questions that follow. Make sure issue contributing to delay in deciding to seek care that comes out in the discussion.

Story 3: The Story of Chaltu

Chaltu was an 18-years old woman living in a rural village far from the town. She was pregnant with her first child. She had never attended antenatal care. She does not rember her LMP but thinks she is around the seventh month of her pregnancy. She started to have headache and leg swelling. At first she did not take it seriously. When the headache got worse and the body swelling increased spreading to her face, she talked to her neighbors and mother-in-law. They reassured her that these are normal experiences during pregnancy. She decided to ignore the problem.

Two weeks later she suddenly developed abnormal body movement, while her husband was in the town for business. The family was caught off guard. Her neighbors gathered including Lelisie, the HDA, 1 to 5 network leader, Lelisie insisted that Chaltu should immediately be taken to the health post or nearby health center for medical assistance. W/z Genet, who herself has had five children in the past without any problem, insisted this is because of evil spirit possession and Chaltu should be taken to traditional healer. Since her husband was not around for the decision-making and preparing money to go to the health center, the family decided to wait until her husband returned. In the mean time, they decided to take her to holy water. Chaltu suffered with repeated fits and passed away three days later.

Ask participants the following question, and relate with facilitator note below.
What istheoverall scenario of Chaltu andthe problem she faced?

- She didn't started ANC visit timely
- She developed head ache and leg swelling spreading to face.
- She ignored the problem
- She developed abnormal body movement (fit)and suffered repeatedly
- The family assumed, it is normal phenomenon
- Suggested to take her to traditional healer, because they thought it is evilspirit
- Went to holy water
- Lelisie insisted that Chaltu should go to HC but not strong as a leader 1 to 5 network.
- Chaltu died

What could the family have done?

- Birth preparedness plan
- Can take her to HC even the husband is not available
- Early notification to HEWs

How could the death of Chaltu have been avoided?

- Early start up of ANC service
- Early health seeking behavior for the problem she faced.
- Developed self-confidenceand independence
- Plan for BPCR

What could Lelisie 1 to 5 team leader have done?

- She has to report to HEWs
- Early identification of danger sins during pregnancy (Using FHG)
- She can coordinate neighbor to take Chaltu to HC

What could the HEWs have done?

- Early identification pregnant women in their kebele
- Strong communication with 1 to 5 network leaders
- Health promotion activities
- Home visit of pregnant women

Activity 3.3: Discussion of the Case of Mihret

Read the following story and facilitate discussion based on the subsequent questions. Make sure issues contributing to delay in seeking care and reaching appropriate health facility come out in the discussion.

Story 4: The Story of Mihret

Mihret has had five children, one stillbirth and is pregnant for the seventh time. Her LMP was on 16/06/2005 (coming pagume is 5 days). Following advice by the HDA, 1 to 5 network leaders, she went to the health post for antenatal care. She went back to the health post around eighth month for a second time. Most women in the community deliver at home and the HEW is called upon only a few times. At about nine months Mihret went into labor at night and delivered at home. The baby came out fine, but the placenta did not, Mihret started having heavy vaginal bleeding. When the bleeding failed to stop, the family decided to call the HEW. When the HEW arrived, she found Mihret still bleeding and extremely weak. She advised the family to take Mihret to the health center immediately. Her family took her to nearby HC. After some assistance to stabilize Mihret, the health center referred her to the hospital for further management and treatment. She died at the gate of hospital.

Ask participants the following question and relate with facilitator guide:

Describe major events in the story

What is the problem faced by Mihret?

- Many pregnancies,
- Home delivery,
- Bleeding and extremely weak,
- Referred to HC and the HC referred to Hospital
- She Died at the gate of hospital

What could the family have done?

- Plan for birth preparedness
- Decide to give birth at HF

- Family planning

How could the death of Mihret have been avoided?

- Birth preparedness to deliver at HF
- Deliver at HF
- Early referral
- Use family planning

What could the HEW have done?

- Confirm BPCR plan
- Counsel to deliver at HF because she is multi para

What could the HDA, 1 to 5 network leader, have done?

- Counsel to give birth at HF
- Early identification of danger sign during delivery and prompt referral

Ask Participants to Share if they have Similar Stories

Activity 3.4: Video demonstration on counseling skill to develop birth preprdeness plan

- Call participants to watch the video attentively
- Answer any question and summarize the session

Activity 3.5: Group discussion using FHG on BPCR

Brainstorm participants on the components of birth preparedness and complication readiness.List their reponses on the flip chart.

Then ask two volunteers to read from the FHC/FHG the section of Birth Preparedness and Complication Readiness page and elaborate the message accordingly and summarize the discussion.

Distribute a birth plan (annex 2) form to participants and briefly introduce it how to fill it.

Table 2: FHG Birth Preparedness and Complication Readiness

Pregnant Women and Family	Prepare the following material ahead of the time of delivery in order to protect both mother and newborn from being exposed to any infections. Soap and water for washing of hands New blade to cut the umbilical cord and sterilized thread to tie the cord Clean cloth to wipe and wrap the baby A clean space and a carpet or mat
Father	Make sure to set aside a certain amount of money and also arrange for transportation and people to help you take your pregnant wife to a higher health facility in case any complications arise during your wife's labor.
Pregnant Women and Family	Make sure the pregnant mother delivers at a health facility with assistance from a trained health professional. If this is not possible, she must at least get assistance from a health extension worker. This will ensure that both the mother and child are not at risk of losing their lives.
Pregnant Women and Family	Make sure there is someone other than the midwife who will take the newborn and care for him/her.
Pregnant Women and Family	If the mother happens to give birth without the assistance of a trained health care provider, make sure to immediately report to a health extension worker, so that she can be provided with the proper postnatal care early.

SECTION FOUR

DELIVERY AND POSTNATAL PERIOD

Learning Objectives

Health extension workers will be able to: at the end of this unit,

HEWs will be able to promote key household behaviors and community practices during delivery and postpartum period.

- Will be able to properly use Family Folder
- Explain importance of skilled delivery
- Describe components of essential maternal and newborn care after delivery
- Describe danger signs during delivery and post partum period
- Describe what actions to take when danger signs appear during delivery and post-partum period
- Discuss the content and timing of postpartum home visit

Activity 4.1: Introduction on delivery

Start with brief brainstorming on the following points:-

Discuss participants' experiences in attending delivery by posing the following questions.

- Where do women deliver in their community?
- Who attends delivery?
- Have you ever assisted delivery?
- Where did you assist delivery- at home, health post or both?
- For home births, how soon after delivery did you hear about it?

Tell participants that most of the deliveries in Ethiopia take place at home and are not attended by a health professional. Most deliveries are assisted by a relative or other persons and the remaining by a traditional birth attendant.

Activity 4.2: Discussion on skilled delivery

Discussion of their answers should not take more than 20 minutes.

- What is the importance of delivering in a health facility by skilled professional?
- What harmful practices exist in your area during labor?

Then lead a brief discussion and ensure the below points are mentioned and summarize the activity.

Note for the facilitator: reinforce key information, as needed by providing the following information.

- 15 out of 100 pregnant women develop some kind of obstetric complications.
- Their survival depends on the time and quality of emergency care they receive.
- Most life-threatening obstetric complications are neither preventable nor predictable. But most complications are treatable.
- Births delivered at home are usually more likely to be delivered without assistance from a health professional, and mothers and newborns are more likely to die from birth complications.
- More than 3/4th of maternal deaths happen during delivery or immediately after delivery. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause the death or serious illness of the mother and the baby or both. Hence, an important component in the effort to reduce the health risks of mothers and children is to increase the proportion of mothers who deliver in a safe and clean environment and under the supervision of health professionals.
- The “three delays” contribute to high maternal mortality rates: delay in seeking help for complications; delay in reaching a health-care facility; and delay in receiving treatment from health-care providers.

Activity 4.3 Group discussion on barriers and solution on skilled delivery

Divide participants in to small groups of about 4-5 people each. Let them discuss the following questions and write their answers on flipchart or note book. When they are done; one person from each group presents.

- Ask participants the proportions of pregnant women in their kebele who delivered at HC or hospital
- Inform them that skilled delivery coverage in Ethiopia is very low low
- Ask them to list the barriers for pregnant women to receive a skilled assistance during delivery and the solutions for these challenges. Let them to think and discuss with their neighbor and invite volunteers to share sample responses. Ensure they mention the possible reasons and solution listed in facilitators note below.

Table 3: Note for facilitator: ensure the following key points are discussed in the group work

Possible Barriers	Possible solutions
Cost of delivery	▪ Tell the family that delivery service is totally free of charge in all facilities including hospitals. ▪ Let families know the hidden costs' even if the delivery itself is free. ▪ Help them understand that saving a small amount of money each week adds up to a significant amount over the pregnancy, ▪ Stress that delivering in a health facility helps ensure a safer delivery and a healthy baby.
Perception that home birth is safe	▪ Explain to the family that the health facility is the best place to prevent and treat delivery complications. ▪ Explain that complications such as prolonged labour, delayed placenta and bleeding after delivery can happen to any woman, even those who usually have normal deliveries.
Feeling more comfortable delivering with TBA at home/Relatives	▪ Acknowledge that it is comforting having TBA/relatives who you feel comfortable with at the birth but if complications occur the mother or the baby could pay with their lives. ▪ Suggest that possibly the TBA/relatives could go with you to the health facility and be a support (or birth companion) during labour and childbirth.
Lack of transport	▪ Help families identify a means of getting to the facility foreither a day or night delivery. ▪ Encourage families to make advanced arrangements with ambulance, including taking his or her phone number. ▪ Community planning to provide transport (traditional ambulance, kareza) for birth and emergencies. ▪ Towards the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) nearby the health facility.
Fear of the procedures at a health facility or of health facility staff Delivery position Not user friendly services	▪ Explain to the family that the health facility procedures are always done to save lives. If these procedures arenot conducted when they are required it is likely that the woman or her baby bothmay die. ▪ Explain that mature person could accompany the pregnant woman to the health facility to support her and help communicate with health facility staff
Birth sometimes occurs very quickly at home or on the way to the facility	▪ Explain that it is important to go to health facility for delivery as soon as labour starts. That is why it is important to plan for the delivery during pregnancy. ▪ Help families ensure they have everything they need for a safe home delivery in case the labour is very quick. ▪ Towards the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend)Close nearby health facility.
Lack of disscusion on importance of Labor/birth notification	▪ Receive skilled birth attendant or safe and clean delivery ▪ Prevent problems to the mother and the newborn ▪ Early recognition of danger signs ▪ Early referral

Activity 4.4: Discussion on danger sign during labour and delivery

Ask participants if they have used FHG? Ask them to open the family health card page on danger signs during labor and delivery and reinforce the key danger signs with pictures from the FHG with the following danger signs posted on flip chart (keep the flip chart displayed on the wall throughout the training session)

Flip Chart 14

Danger Signs during Labour and Delivery

- Severe headache (may signify high blood pressure)
- Fever (Temperature ≥38 0 C)
- Labour has not started by 6 hours after the membranes have ruptured
- Baby's hand, foot or cord come out before head
- Bleeding during labour
- Heavy bleeding after delivery
- Abnormal body movement
- Tearing feeling in her abdomen
- Low or un-recordable blood pressure
- baby feels loose (signifies uterine rupture)
- Prolonged labour-active labour for more than 12 hours and no progress

SECTION FIVE

POSTPARTUM CARE

Learning Objectives:

At the end of this session participants will be able to:

- Explain importance of postpartum care
- List components of essential postpartum care
- Describe the content and timing of postpartum home visit
- Describe barriers and solution on PNC home visit
- Identify maternal and newborn danger signs and recommended actions during the postpartum period

Activity 5.1: Introduce postpartum care

Brainstorm by raising the following questions; get their answers and enrich with that of yours and write their responses on flip chart.

- Ask participants what they understand by postpartum care?
- Do women in your area seek postpartum care?
- If yes when do they seek the care? If no what are the reasons and beliefs in their area?
- Do you provide post-partum home visit? If yes when and how many?
- What is the importance of PNC?

Summarize by presenting the following on the flip chart

Flip Chart 15

Importance of Postpartum Care

Postpartum care is important for the following reasons:

- To counsel the woman and her family about normal care for both the mother and baby and signs of complications
- To screen the mother and baby for any problems
- To begin care for any problems early

Activity 5.2: Content and Timing of Home Visit (35 Minutes)

Facilitator emphasizes:

- That birth and first week of life are riskiest period for both mothers and newborns and coverage of key interventions are the lowest in this period
- That PNC visit at six weeks reaches the survivors and the critical need to conduct PNC home visit within 24 hours of delivery, 3rd and 7th day
- That the visits are important to identify sick newborns and provide care(which they learned in iCCM and will recap in the next session) and teach care takers how to recognize sick newborns
- Thenread for themcontent and timing of PNC visit from the tables

Table 4: Timing and Content of essential maternal and newborn postnatal care

During the first 24hours After Delivery

For the Mother	For the Baby
1. Check for post-partum danger signs using family health card and if they are present, referring to a higher health facility 2. Taking body temperature. If it is ≥ 38^0C refer 3. Give TT vaccine as relevant 4. Giving Vit A (200,000IU) 5. If she has not completed taking Iron tablet, for a total of 6 months encourage her to continue 6. Counsel about nutrition, hygiene and use of bed net	1. Checking for the presence of danger signs on the newborn. Refer if there is any (chart booklet) 2. Check for any congenital abnormalities 3. Measure body temperature and weight 4. Encouraging exclusive breastfeeding 5. Applying TTC eye ointment on both eyes 6. Advise not to bath/wash the newborn in the first 24 hours. 7. Make sure that the baby is placed in skin to skin contact with his mother and his whole body including the head and legs is covered and counsel on the importance of keeping the newborn warm. 8. Provide cord care and counsel on appropriate care of the cord 9. Vaccinate for polio and BCG and counsel on the next vaccinations 10. Show proper hand washing and counsel on hygiene and sanitation 11. Teach the mother how to recognize newborn danger signs Use the family health card during counseling

Visits on 3rd, 7thDays and on 6thWeek after Delivery	
For the Mother	**For the Baby**
1. Check for danger signs. If there is any, refer 2. Asking if there is any problem related with breast feeding and solving the problem 3. Counsel about family planning, personal hygiene, nutrition, danger signs using family health card (follow up and reinforce what was agreed on the first visit) 4. Giving contraception of her choice 5.	1. Check for newborn danger signs, and refer if there is any 2. Assess breastfeeding and counsel accordingly 3. Keeping the baby's temperature, cover the head, legs, hands and establish skin to skin contact 4. Advise to hand wash before touching and caring the baby and to keep the baby's hygiene 5. Vaccinate with polio,PCV1, Penta1 and Rota1(give BCG if not given previously) 6. Advise to keep the cord clean 7. check the baby's weight (6 week)

Activity 5.3: Video demonstration on hand washing,measuring temperature and weight and, conducting routine PNC Home visit

- Ask for any question from participants and summarize the session

Activity 5.4: discussion on maternal danger sign in Postpartum postpartum period

- Ask participants to identify maternal danger signs.
- What actions should be taken for managing danger signs
- Then present danger signs described in flip charts#14; provide explanation as necessary. Tell participants to relate to the family health card by turning on the page for danger signs.

Flip Chart 16

Danger Signs during post partum period

- Vaginal bleeding (heavy or sudden increase)
- Fever (temperature ≥ 38 ^{0}C)
- Severe abdominal pain
- Severe headache/blurred vision
- Abnormal body movement/loss of consciousness
- Foul-smelling discharge from vagina or tears/incisions
- Severe pain in calf, with or without swelling: may be a sign of clot in the blood vessel and is dangerous. The woman should be referred immediately. She should lie down with her legs elevated above the hips during transportation. The lump should not be massaged.
- Verbalization/behaviour indicating she may hurt herself or baby; hallucinations: signifies psychosis which is a life-threatening emergency

Activity 5.5: Group work on barriers and solutions on PNC home visit

Divide participants into four to five small groups and let them discuss the major barriers and proposed solutions in their locality to uptake of PNC home visit during the first week after delivery.

Let them present to the large group on a flip chart; enrich the points by referring the points in below table.

Table 5: Barriers to PNC and proposed solutions

SN	Major Barriers	Possible Solution
1	Cultural barriers in some areas prevent delivered mother to be touched by someone before relegiouse leaders blessing (Ayyantu's)	Discussion with community leaders, 'Aba-gada/Nebseabat, kebele influential, Woreda culture and tourism bureaus on cultural issues
2	Mothers are not aware of the benefit of notification of their delivery	Strengthen pregnant women forum monthly, which make the opportunity for them to know and utilize the services
3	HDAs, 1 to 5 network leaders don't notify delivery promptly to HEWs	Awareness creation to all HDA, 1 to 5 network leaders on promtbirth notification and strengthening the community mobilization/sensitization
4	Low HEWs commitment to visit delivered mothers promptly with in 48-72 hours as well as the first week of delivery.	Strengthening PHCU to support HEWs to visit delivered mothers
5	HPs are closed in some areas, so that HDA,1 to 5 network leaders cannot submit report of notification to HEWs	HEWs should avail themselves for clinical service in the HP all the time(HPs should be open all the days)
6	HEWs report distance as one barrier to visit delivered mothers	HEWs prioritize saving lives of mothers and newborns espcialy in inaccessible places as they are more at risk

Activity 5.6: Introduction to the family folder and practice filling the Integrated Maternal and Child Care Card story of Almaz

- Ask partcipnat if they use family folder and give a brief introduction to the family folder
- Describe that in this and the three subsequent session (ANC, Labour /delivery & PNC) they will practice using the "Integrated Maternal and Child Care Card"(IMCC)
- Divide participnats in four groups

- Using story of Almaz, let particpants fill individual identification, general condition, obstetric history, current pregnancy, general medical history, remarks, pregnancy follow-up, birth preparndess,labour.delivery, delivery out come, PNC and immunization

Ask one group to present and using pre-filled IMCC lead a plenary discussion let the other groups comment and make correction as needed

Story of Almaz-family folder and Integrated maternal and child care card

W/zo. Almaz Abebe who was born on Hidar 23, 1980 E.C. is now 26 years old. She lives in SNNPR region, Hawela Tulla Woreda, Gamato Kebele. Her husband Ato Hailu Mathewos Kitesa is two years older than her, born on the same month and date. They live in Got 1 and H. No. 361. Almaz gave birth to her first child Girma on Tir 15, 2001 E. C. at home without major problem.

Before she gave birth to her second child Frehiwot, Almaz's menstruation ceased on 16/06/2004 E.C. making EDD 21/03/2005 E.C. Almaz have had 3 ANC visits on days 04/13/2004 E.C., 26/02/2005, 17/03/2005 E.C. at her 6th, 8th and 9th months of pregnancy at Gameto HP. Her BP and weight at 1st ANC visit 110/70 mm Hg and 68 kg, 2nd ANC visit 110/70 mm Hg and 68.5 kg and 3rd ANC visit 110/70 mm Hg and 68.5 kg. First Almaz was sent to Tulla HC to have all the necessary tests including HIV/STI. Her test results are normal. Almaz did not have bad obstetric and medical history and she has got two shots of tetanus toxoid injections during her ANC visits.

During her ANC visits, Almaz and her husband Hailu have planned for all necessary expenses and transport to deliver at Tulla HC. They have prepared clothes for new born baby, on 20/03/2005 E.C., at 8:00 pm in the evening; Almaz went to Tulla HC accompanied by her husband Hailu and their neighbourhood Kabeto, when she felt mild contractions. Her membrane was not ruptured, BP100/70 mm Hg and FHB 120 mmg. After 8 hours of stay at Tulla HC she gave birth to Frehiwot at 4 am on 21/03/2005 E.C. Frehiwot's weight was 3,200 grams.

Almaz was given all the necessary PNC care including Vit. A and Frehiwot was given the 1st two vaccines (Polio 0 & BCG) on discharge. After 7 hours of stay at Tulla HC after delivery Almaz and family were discharged getting all important counselling and care.

On 3rd day of post natal visit by HEW at her home, Almaz and her baby girl frehiwot were doing well. The HEW congratulated the family and did all the necessary counselling. Frehiwot weighted 3,100 grams this time. The HEW counselled Almaz on EBF, postnatal maternal and neonatal danger signs, FP and others. She gave appointment to visit again on 7th day to see how well they are doing.

PART TWO: CARE, TREATMENT AND COMPLETION

Activity 6.1 Brief introduction and distribution of learning/job aids

- Chart booklet
- Exercise booklet

Chart booklet

- Distribute the chart booklet. Introduce it by briefly stating the following points:

This booklet is called a chart booklet. It is an important job aid for assessing and classifying sick young infants and children. It also contains detailed information about treatment, counselling of mothers/care takers and follow-up care. The chart booklet contains the same information as what is on the wall charts.

The chart you are learning now is called ESSENTIAL NEWBORN CARE, ASSESS AND CLASSIFY THE SICK YOUNG INFANT AGE BIRTH UP TO 2 MONTHS. All the assess column boxes and all the classification tables from the ASSESS and CLASSIFY wall chart are in the first section of the chart booklet. The assessment box and classification table for each main symptom are grouped together like this.

> (Show a sample page so that participants see it matches with the assess box, the classification arrow and classification table on the wall chart.)

The chart booklet is convenient to use when you practice assessing and classifying sick children during clinical sessions. We will begin using the chart booklet today so you can become familiar with it before using it during clinical practice over the coming days.

Look at the table of contents on the cover. It tells you where to find each part of the chart. The ASSESS and CLASSIFY charts are listed in the first column. They begin on page 5 where you see the charts that tell you how to check *THE NEWBORN FOR BREATHING PROBLEM.*

Exercise booklet

Explain that the exercise booklet is a booklet that contains exercises to be done under each relevant section; case scenarios and blank forms to be filled are included. The exercise booklet after completion will be important reference document for the HEW

Full understanding of the above three and other job aids will be achieved when all the relevant topics are covered

Activity 6.2: Brainstorming on newborn care in the local community and introduction of essential newborn care (ENC) on the wall chart - *before you go to the introduction of ENC, briefly brainstorm* with participants on the current practices of newborn care in the community.

Ask:

- When a baby is born what do families do to care for him/her?
- What do HEWs do to care for the newborn?
- In your opinion which practice is useful, harmful?

When the brainstorming is over; call participants to gather around the wall chart for the introduction of Essential Newborn Care.

- Facilitator introduces the wall chart and the section showing essential newborn care.
- Tell participants to refer to the section of "*Immediate Assessment and Care of the Newborn*".
- *Tell participants to see* on page four in their chart booklets.
- Describe the meaning of pink, yellow and green rows.
- Ask if there is any question and respond.

Activity 6.3: Video show on ENC,

Show the video demonstration of ENC including the following techniques/procedures:

- Hand washing
- Weighing the baby,
- Measuring body temperature

Note: Use every opportunity either in the health facility or in the community to show cases of delivery and sick children and young infants to the participants.

Activity 6.4: Demonstrate the steps of immediate newborn care using mannequins

1. Deliver the baby on to mother's abdomen
2. Dry with a dry towel, wrap with another dry one and cover head
3. Assessing breathing
4. Delay cord clamping for three minutes
5. Tie and cut the cord appropriately
6. Skin-to-skin contact and initiation of breastfeeding
7. Apply TTC eye ointment to both eyes
8. Apply Chloerhexidine on the cord
9. Give Vitamin K 1mg, IM on the mid antero-lateral thigh
10. Weigh baby

Let participants practice in a group of 4-5

Activity 6.5: Wall chart presentation on birth asphyxia

- Ask participants to hold their chartbooklets and gather around the wall chart and introduce birth asphyxia
- Answer if there is any question from participants and proceed to the next wall chart presntation

Activity 6.6: Wall chart presentation on preterm and or low birth weight

Explain that "Birth weight" is defined as weight taken within one week for age for operational reasons (the definition of birth weight in the standard text books is weight taken within 72 hours of age)

MANAGEMENT OF THE SICK YOUNG INFANT

Assessment, Classification, Treatment And Giving Follow-Up Care for The Sick Young Infant Birth Up To 2 Months On The Wall Chart

Activity 7.1: Introduction to the young infant wall chart and assessment for very severe disease, local bacterial infection and jaundice

General and very briefly touch the sections on the wall chart:

- Assess, classify, and identify treatment
- Treat the young infant and counsel the mother
- Give follow-up care for the young infant

Specific and in detail:

- Cover the assessment steps for very severe disease and local bacterial infection, and checking for jaundice

Explain that there are differences between young infants and 2 months up to 5 year old children because the problems and treatments of sick young infants are some what different from older infants and children. For example, when sick young infants are sick, they may have only general, nonspecific signs of illness such as few movements, fever, or low body temperature. Mild chest in drawing is normal in young infants, so only severe chest in drawing is a serious sign. Young infants may need different antibiotics than older infants.

Activity 7.2: Introduce how to fill a young infant record form

Using an Enlarged Record form, demonstrate the different parts and how to fill the parts of assessing a young infant for very severe disease and local bacterial infection and for jaundice. Show by filling an example of case 1 and let them exercise filling the form for case 2 while they are standing for the demonstration and give them feedback.

Case 1*: Hiwot is 12 hours old young infant. Her weight is 2,800g, axillary temperature 37°C and this is her initial visit to the health post. Her mother brought Hiwot because she has rash and she is yellow. When the health extension worker asked if Hiwot has convulsions she said no, she also said that Hiwot was breastfeeding well. The HEW assessed Hiwot for very severe disease and local bacterial infection and for jaundice. Hiwot was breathing 44 times in one minute, no chest indrawing, no no redness or pus on umbilicus, was moving normally, there were a few pustules in Hiwot's body, her skin was yellow.*

Case 2: *Robel is 5 days term newborn whose weight is 3000g, axillary body temperature 38.5°C and this is his initial visit to the health post. When the Health Extension Worker (HEW) asked the mother what the problem of this child is, she answered that the newborn has difficult breathing and stopped breastfeeding but no convulsions. When the HEW examined Robel for very severe disease and local bacterial infection and for jaundice, he was breathing 80 breaths in one minute. When the HEW counted again the breathing rate was 80 in one minute. Robel was not moving even when stimulated and his palms and soles were yellow, there was not any other sign of illness.*

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name**:** **Hiwot** Age*:* **12 hours** Weight: **2,800kg** Temperature**: 37°C**

ASK: What are the infant's problems? **Has rash and yellow skin** Initial visit? √ Follow-up Visit? ___

ASSESS (Circle all signs present)		**CLASSIFY**
ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)		
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g, 1,500-<2,500g, ≥ 2,500g		
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE		
• Has the infant had convulsions? • Has the infant stopped feeding well?	• Count the breaths in one minute. **44** breaths per minute Repeat if elevated Fast breathing? • Look for severe chest in drawing. • Look at umbilicus. Is it red or draining pus? • Measure temperature (if axillary temperature 38°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) • Look for skin pustules • Look for the young infant's movement. Does the infant move only when stimulated? Does the infant not move even when stimulated • Look for, jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name**:** **Robel** Age*:* **5 days** Weight: **3,000g** Temperature**: 38.5°C**

ASK: What are the infant's problems? **Difficult breathing, stopped feeding** Initial visit? √ Follow-up visit? __

ASSESS (Circle all signs present)	**CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping breathing poorly (less than 30 breaths per minute)		
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks > 37 wks, Birth wt: <1,500g, 1,500-<2,500g, > 2,500g		
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE		
• Has the infant had convulsions? • Has the infant stopped feeding well?	• Count the breaths in one minute. **80** breaths per minute Repeat if elevated **80** Fast breathing? • Look for severe chest in drawing. Look at umbilicus. Is it red or draining pus? • Measure temperature (if axillary temperature 38°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) Look for skin pustules Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated? Look for, jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	

Then let them sit for video demonstration:

Activity 7.3: EXERCISE A Part 1: **Video demonstration (A)** -- Assessing for *very severe disease and local bacterial infection, and checking for jaundice*

When all the participants are ready, arrange for them to move to where the video exercise will be shown. Make sure they bring their chart booklets.

To show the video exercise:

1. Tell participants that they will watch a demonstration of how to assess a young infant for *very severe disease and local bacterial infection and for jaundice*. The video will show examples of abnormal signs.
2. Ask if participants have any questions before you start the video. When there are no additional questions, start the video.
3. Show the video. Follow the instructions given in the video.

clear about the assessment of

ecause of irregular breathing.
ute or more.

dice

venient

notographs 63-65 by filling in

60 (example)	Normal newborn umbilicus
61 (example)	Umbilical redness
62 (example)	Skin pustules
63	Umbilical redness
64	Normal newborn umbilicus
65	Pus draining umbilicus

Activity 7.5: Introduce how to classify the young infant for *very severe disease, local bacterial infection and jaundice* on the wall chart.

Activity 7.6: Using enlarged blank classification table, demonstrate the classification of Hiwot, and then allow participants to do the classification of Robelwhile they are aroundthe wall chart.

CLASSIFICATION TABLE

SIGNS	CLASSIFY AS
• Convulsions **or** • Stopped feeding well **or** • Fast breathing (60 breaths per minute or more) **or** • Severe chest in drawing **or** • Fever (axillary temperature 37.5°C or above (or feels hot to touch) **or** temperature less than 35.5°C (or feels cold to touch) **or** • Movement when stimulated or no movement even when stimulated	**VERY SEVERE DISEASE**
• Umbilicus red or draining pus or • Skin pustules	**LOCAL BACTERIAL INFECTION**
None of the signs of severe disease or local bacterial infection	**INFECTION UNLIKELY**

• Palms and or soles yellow **or** • Skin and or eyes yellow AND age less than 24 hours **or** • skin and or eyes yeloow AND age 14 days or more	**SEVERE JAUNDICE**
• Only skin or eye yellow and age two to 13 days	**JAUNDICE**
• No yellowish disclorasion	**NO JAUNDICE**

P TO 2 MONTHS

perature**: 37°C**

t? √ Follow-up visit?

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)	
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g, 1,500-<2,500g, ≥ 2,500g	**Term and normal weight**
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE	
• Has the infant had convulsions? • Has the infant stopped feeding well? • Count the breaths in one minute. **44** breaths per minute Repeat if elevated Fast breathing? • Look for severe chest in drawing. Look at umbilicus. Is it red or draining pus? • Measure temperature (if axillary temperature 37.5°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) Look for skin pustules • Look for the young infant's movement. Does the infant move only when stimulated? Does the infant not move even when stimulated? Look for jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	**LOCAL BACTERIAL INFECTION** **SEVERE JAUNDICE**

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name**: Robel** Age*:* **5 days** Weight: **3,000g** Temperature**: 38.5°C**

ASK: What are the infant's problems? **Difficult breathing, stopped feeding** Initial visit? √ Follow-up visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)		
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks > 37 wks, Birth wt: <1,500g, 1,500-<2,500g, > 2,500g		**Term and Normal Birth weight**
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE		
• Has the infant had convulsions? • Has the infant stopped feeding well?	• Count the breaths in one minute. 80 breaths per minute Repeat if elevated 80 Fast breathing? • Look for severe chest indrawing. • Look at umbilicus. Is it red or draining pus? • Measure temperature (if axillary temperature 38°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) • Look for skin pustules Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated? • Look for, jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	**VERY SEVERE DISEASE** **SEVERE JAUNDICE**

Activity 7.7: Introduction to the assessment and classification of diarrhoea in the young infant on wall chart and do the example of Fola and allow partcipants to do the case of Abdissa

- Introduce the steps for assessing and classifying a young infant with diarrhoea on the wall chart.
- Before you proceed to the next step make sure all participants understand the questions to ask and the key signs to look for. Check by asking questions.

Using an enlarged recoding form show **assessment and classification of diarrhoea** by filling an example of case one and let participants practice filling the blank form in their exercise booklets for case two while they are standing for the demonstration and give them feedback.

Case 1: *Fola is a seven days old male baby whose weight is 2,300g, axillary body temperature 39.5 °C and this is his initial visit to the health post. The HEW asked the mother what the problem of this child is she answered that he has diarrhoea for two days but no convulsions and he breastfeeds well. When the HEW examined Fola for, very severe disease and local bacterial infection and for jaundice he was breathing 60 breaths in one minute with repeat 54 breaths in one minute, there is no severe chest in drawing, no redness*

or pus on umbilicus, no skin pustule, moves normally without stimulation. When Fola was assessed for jaundice his skin was not yellow. The HEW assessed Fola for his diarrhoea. She asked if there is blood in the stool, there was no blood in the stool. Fola was assessed for dehydration. He is restless and irritable, has sunken eyes and skin pinch goes back slowly (less than two seconds).

***Case 2**: Abdissa is three weeks old baby whose weight is 4000g, axillary body temperature 37 ^{o}C and this is his initial visit to the health post. When the HEW asked the mother what the problem of this child is, she answered that he has bloody diarrhoea for 15 days but no convulsions and he breastfeeds well. When the HEW examined Abdissa for very severe disease and local bacterial infection and for jaundice, he was breathing 40 breaths in one minute, there is no severe chest indrawing, no redness or pus on umbilicus' there are skin pustule on the abdomen, He moves normally without stimulation. When Abdissa was assessed for jaundice he was not yellow. The HEW assessed Abdissa for his diarrhoea. He is not restless and irritable, has sunken eyes and skin pinch goes back very slowly (greater than two seconds).*

Answers to case 1 and 2

[**UP TO 2 MONTHS**

Follow-up Visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)	
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g,1,500-2,500gm≥ 2,500g	**Pre term and/or low birth weight**
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE	
▪ Has the infant had convulsions? ▪ Has the infant stopped feeding well? ▪ Count the breaths in one minute. **60** breaths per minute ▪ Repeat if elevated **54** Fast breathing? ▪ Look for severe chest in drawing. ▪ Look at umbilicus. Is it red or draining pus? ▪ Measure temperature (if Axillary temperature 37.5 ºC or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) ▪ Look for skin pustules ▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated ▪ Look for, jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	**VERY SEVERE DISEASE**
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes √ No	
▪ For how long? **2** Days ▪ Is there blood in the stools? ▪ Look at the young infant's general condition. Is the infant: Does the infant move only when stimulated? Does the infant does not move even when stimulated? Restless or irritable? ▪ Look for sunken eyes. ▪ Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?(less than 2 seconds)	**SOME DEHYDRATION**

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name**:** **Abdissa** Age*:* **3 weeks** Weight: **4000g** Temperature**:** **37°C**

ASK: What are the infant's problems? **Diarrhoea for 15 days,** Initial visit? √ **,** Follow-up Visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)		
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g, 1,500-<2,500g, ≥ 2,500g		
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE		
▪ Has the infant had convulsions? ▪ Has the infant stopped feeding well?	▪ Count the breaths in one minute. **40** breaths per minute ▪ Repeat if elevated Fast breathing? ▪ Look for severe chest in drawing. ▪ Look at umbilicus. Is it red or draining pus? ▪ Measure temperature (if axillary temperature 37.5°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) ▪ Look for skin pustules ▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated ▪ Look for, jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days	**LOCAL BACTERIAL INFECTION**
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes √ No _____		
▪ For how long? **15** Days ▪ Is there blood in the stools?	▪ Look at the young infant's general condition. Is the infant: Does the infant move only when stimulated? Does the infant does not move even when stimulated? Restless or irritable? ▪ Look for sunken eyes. ▪ Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?(less than 2 seconds)	**SEVERE DEHYDRATION** **DYSENTERY** **SEVERE PERSISTENT DIARRHOEA**

Activity 7.8: EXERCISE – B, case studies (Ababu, Hanna and Shashe) page seven on the exercise booklet

Individual work followed by individual feedback -- Assess and classify for very severe disease and local bacterial infection, for jaundice and diarrhoea in case studies.

Be sure that each participant has an exercise booklet with blank Young Infant recording forms and understands that she should record the information about each case in Exercise B on these forms.

The *facilitator reads each case loudly using local language if necessar*y

As participants do the exercises, facilitators move around and if any participant seems confused, they explain or show her how to fill the Recording Forms, so that she can get started on the exercise without delay.

Tell participants to do the following for each case:

1. Label a recording form with the young infant's name.
2. Write the infant's age, weight, temperature and problem. Check "Initial Visit". (All the infants in this exercise are coming for an initial visit.)
3. Record the assessment results on the form.
4. Classify the infant very severe disease and local bacterial infection and for jaundice and diarrhoea.
5. Then go to the next case.

- When participants are through with the cases, discuss the answers individually.
- Where the participant has recorded something different, discuss why she did that, and go back to the case study as needed to verify the reason for the answer.

Case studies

Case 1: *Ababu is six days old infant. His weight is 2,600g. His axillary temperature is 36.5° C. He is brought to the clinic because he is having difficulty of breathing. The health extension worker first checks the young infant for signs of very severe disease and local bacterial infection and for jaundice. His mother says that Ababu has not had convulsions, and does not have feeding problem. The health extension worker counts 74 breaths per minute. She repeats the count. The second count is 70 breaths per minute. She finds that Ababu has mild chest indrawing. The umbilicus is normal, and there is no skin pustule. Ababu is calm and awake, and his movements are normal. He does not have yellow skin or diarrhoea.*

Case 2: *Hana is 3 weeks old. Her weight is 3,000g. Her axillary temperature is 36.5 ºC. Her mother has brought her because she has diarrhoea with blood in the stool for 3 days. The health extension worker first assesses her for signs of very severe disease and local bacterial infection and for jaundice. Her mother says that she has not had convulsions. Her breathing rate is 58 per minute. She was sleeping in her mother's arms but awoke when her mother un-wrapped her and moving her arms and legs normally. She has slight chest indrawing, her umbilicus is not red or draining pus. She has a rash in the area of her diaper, but there are no pustules. She does not have yellowness of the body. Hana is crying. She stopped once when her mother put her to the breast. She began crying again when she stopped breastfeeding. Her eyes look normal, not sunken. When the skin of her abdomen is pinched, it goes back slowly.*

Case 3: *Shashe is two days old. Her weight is 1,400gms. Her axillary temperature is 40.0℃. Her mother brought her to the health post because she feels hot and stopped feeding well. The health extension worker assesses for signs of very severe disease and local bacterial infection and for jaundice. When the health extension worker asked the mother if the baby had convulsion she said yes. Shashie's breathing rate is 55 per minute. She has no chest indrawing. Her umbilicus is red and has pus. Shashe moves only when stimulated. She does not have yellowness of the body or diarrhoea.*

Answers to Exercise B exercise booklet page 8-9

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name**:** **Ababu**Age*:* **6 days** Weight: **2,600g** Temperature**:** **36.5°C**

ASK: What are the infant's problems? **Difficulty of breathing.** Initial visit? √ , Follow-up Visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping breathing poorly (less than 30 breaths per minute)	
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks, ≥37 wks, Birth wt: <1,500g, 1,500-<2,500g, ≥2,500gm	**TERM and NORMAL BIRTH WEIGHT**
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE ▪ Has the infant had convulsions? ▪ Has the infant stopped feeding well? ▪ Count the breaths in one minute. 74 breaths per minute Repeat if elevated 70 Fast breathing? ▪ Look for severe chest indrawing. ▪ Look at umbilicus. Is it red or draining pus? ▪ Measure temperature (if axillary temperature 37.5°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) ▪ Look for skin pustules ▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated? ▪ Look for jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days?	**VERY SEVERE DISEASE**
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes _____ No √ ▪ For how long? _____ Days ▪ Is there blood in the stools? ▪ Look at the young infant's general condition. Is the infant: Does the infant move only when stimulated? Does the infant does not move even when stimulated? Restless or irritable? ▪ Look for sunken eyes. ▪ Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly? (Less than two seconds)?	

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name*:* **Hana** Age: **3 weeks**Weight**: 3,000g** Temperature: **36.4°C**

ASK: What are the infant's problems? **Diarrhea for 3 days,** Initial visit? √ , Follow-up Visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping breathing poorly (less than 30 breaths per minute)	
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g, 1500-<2,500g, ≥ 2,500g	
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE ▪ Has the infant had convulsions ▪ Has the infant stopped feeding well? ▪ Look if unable to feed ▪ Count the breaths in one minute. **58** breaths per minute Repeat if elevated _____ Fast breathing? ▪ Look for severe chest in drawing. ▪ Look at umbilicus. Is it red or draining pus? ▪ Measure temperature (if axillary temperature 37.5°C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) ▪ Look for skin pustules ▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated? ▪ Look for jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days?	**INFECTION UNLIKELY**
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes √ No _____ ▪ For how long? 3 Days ▪ ▪ Is there blood in the stools? ▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated Restless or irritable? ▪ Look for sunken eyes. ▪ Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly? (less than 2 seconds)	**SOME DEHYDRATION** **DYSENTERY**

Activity 7.9: EXERCISE – C, video case study (Ikram)

Group viewing and discussion of assessing and classifying a young infant for very severe disease & local bacterial infection and for jaundice and diarrhoea

When all the participants are ready, arrange for them to move to where the video exercise will be shown. Make sure they bring their modules and chart booklets.

To conduct the video exercise:

1. Tell participants that during this exercise they will watch a case study of a young infant. The young infant will be assessed for very severe disease and local bacterial infection and for jaundice and diarrhoea. They should record their assessment results on the recording form in the module. They will be given time to classify the young infant and write the classifications on the form. *Remind participants that they will be some differences between what they learned and what they will watch in the video because the video does not include some updates from WHO.*

MANAGEMENT OF THE SICK YOUNG INFANT AGE FROM BIRTH UP TO 2 MONTHS

Name: **Shashe** Age: **2 days** Weight: **1,400g** Temperature: 40°C

ASK: What are the infant's problems? Fever and not feeding well Initial visit? √ Follow-up Visit? ___

ASSESS (Circle all signs present)		CLASSIFY
ASSESS FOR BREATHING PROBLEM (immediately after birth) Not breathing at all, gasping, breathing poorly (less than 30 breaths per minute)		
ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,5001500-<2,500, ≥ 2,500g		**VERY PRETERM and/or VERY LOW BIRTH WEIGHT**
CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE		
▪ Has the infant had convulsions? ▪ Has the infant stopped feeding well?	▪ Look if unable to feed ▪ Count the breaths in one minute. 55 breaths per minute Repeat if elevated _____ Fast breathing? ▪ Look for severe chest in drawing ▪ Look at umbilicus. it is red or draining pus ▪ Measure temperature (if Axillary temperature 37.5 °C or above (or feels hot to touch) or temperature less than 35.5°C (or feels cold to touch) ▪ Look the umbilicus; is it read or draining pus? ▪ Look for skin pustules Look for the young infant's movement. Does the. Infant moves only when stimulated Does the infant does not move even when stimulated? ▪ Look for jaundice Only skin or eye yellow Are the palms and soles yellow? Is the age less than 24 hours or more than 14 days?	**VERY SEVERE DISEASE**
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes ___ No √		
or how long? ____ Days ▪ Is there blood in the stools?	▪ Look for the young infant's movement. Does the infant move only when stimulated? Does the infant does not move even when stimulated Restless or irritable? ▪ Look for sunken eyes. ▪ Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?	

2. Ask if participants have any questions before you start the video. When there are no additional questions, start the video.

3. At the end of the video, lead a short discussion. If participants are not clear about the assessment of any signs, rewind the video and show the relevant portions again. If there are any questions about the classifications, review the infant's signs and how they were classified, referring to a classification table.

Note: At the end of the participants' review of the case study lead a group discussion on their findings on the case study.

Video Case Study MANAGEMENT OF THE SICK YOUNG INFANT

Answers to Exercise C (Video)

MANAGEMENT OF THE SICK YOUNG INFANT AGE 0 UP TO 2 MONTHS

Name: **Ikram** Age in days/weeks: **10 days** Weight: **3,000g** Temperature: **35.7°C**

ASK: What are the infant's problems? **Sick** Initial visit? √ Follow-up visit? ___

ASSESS (Circle all signs present) **CLASSIFY**

<table>
<tr><td colspan="2">ASSESS FOR BREATHING PROBLEM (immediately after birth)
Not breathing at all, gasping breathing poorly (less than 30 breaths per minute)</td><td></td></tr>
<tr><td colspan="2">ASSESS FOR BIRTH WEIGHT AND GESTATIONAL AGE
Gestational age: <32 wks, 32-<37 wks ≥37 wks, Birth wt: <1,500g, 1,500-<2,500g, ≥ 2,500g</td><td></td></tr>
<tr><td colspan="2">CHECK FOR VERY SEVERE DISEASE & LOCAL BACTERIAL INFECTION AND FOR JAUNDICE</td><td></td></tr>
<tr><td>▪ Has the infant stopped feeding well?
▪ Has the infant had convulsions?</td><td>▪ Count the breaths in one minute. 44 breaths per minute
Repeat the count if 60 or more ____ Fast breathing?
▪ Look for severe chest indrawing.
▪ Look at umbilicus. Is it red or draining pus?
▪ Fever (axillary temperature 37.5°C or above or feels hot) or
▪ Low body temperature (below 35.5°C or feels cool).
▪ Look the umbilicus; is it read or draining pus?
▪ Look for skin pustules
▪ Look at young infant's movements.
Does the infant move only when stimulated?
Does the infant not move even when stimulated?
▪ Look for jaundice
Only skin or eye yellow
Are the palms and soles yellow?
Is age less than 24 hours or more than 14 days?</td><td>VERY SEVERE DISEASE</td></tr>
<tr><td colspan="2">DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes __√__ No____</td><td></td></tr>
<tr><td>For how long? __4_ Days
Is there blood in the stools?</td><td>▪ Look for the young infant's movement.
Does the infant move only when stimulated?
Does the infant does not move even when stimulated
Restless or irritable?
▪ Look for sunken eyes.
▪ Pinch the skin of the abdomen. Does it go back:
Very slowly (longer than 2 seconds)?
Slowly?</td><td>NO DEHYDRATION</td></tr>
</table>

Activity 7.10: Check for HIV Infection

Brainstorming discussion on

- What are the HIV risk behaviours in your community?
- What is being done by HEWs and health centres to encourage people and do testing
- What are the challenges/constraints for testing

Do wall chart presentation

SECTION EIGHT

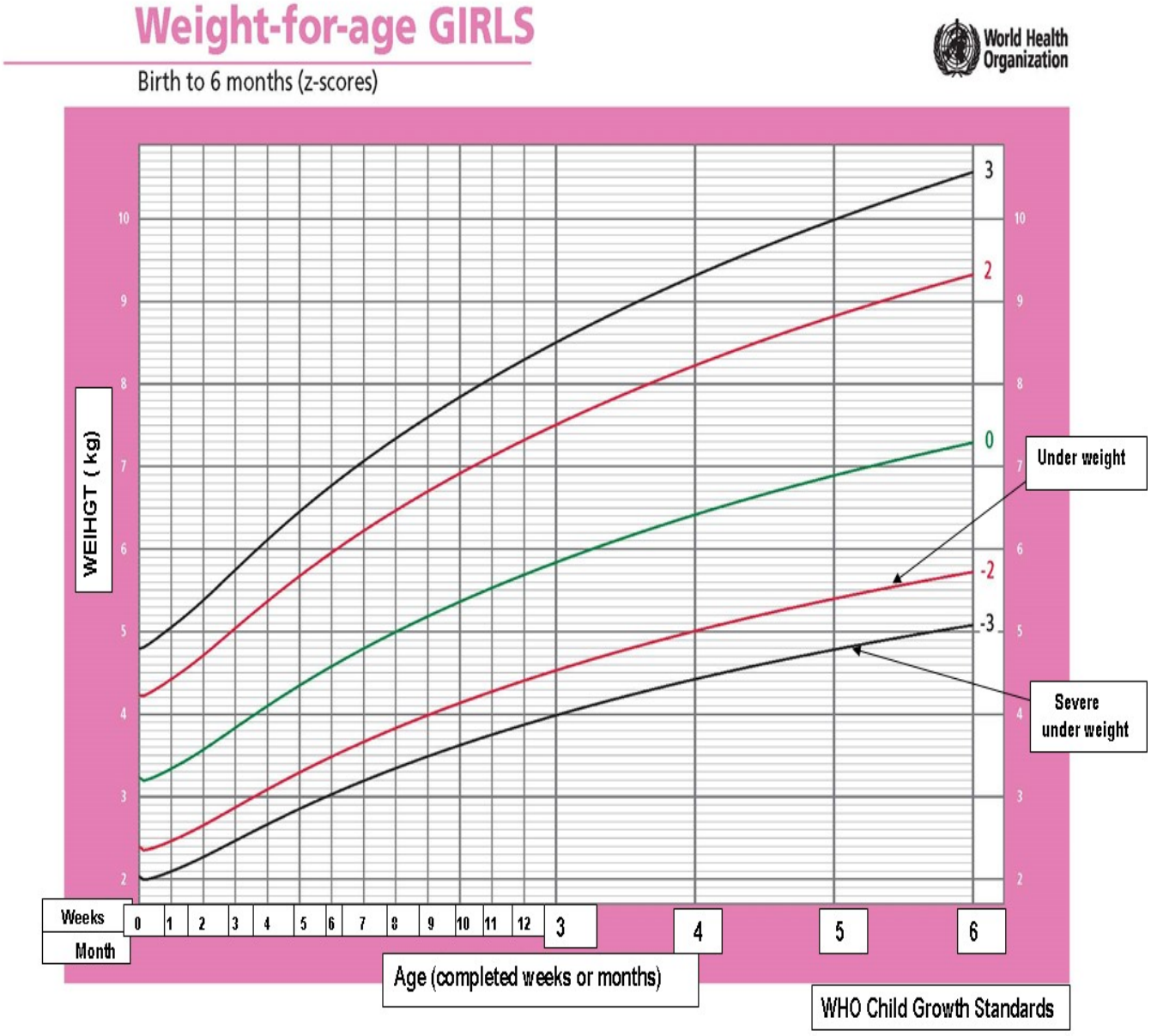
ASSESSMENT OF THE YOUNG INFANT FOR FEEDING PROBLEM AND UNDERWEIGHT AND IMMUNIZATION

Activity 8.1: Introduce how to assess for feeding problem and underweight on the wall chart.

- Tell participants to gather around and introduce the steps on the wall chart.
- Answer any questions they have

Activity 8.2: Demonstrate how to read a weight for age chart

- Use an enlarged weight for age chart
- Tell participants to look to the ***weight for age curve*** for the young infant (mention that the underweight curve is for a child age 2 months up to 5 years)
- The young infant will have underweight only if the weight is below the underweight curve
- The ages in the chart are in months and you should approximately divide a month into 4 weeks in the young infant (need to replace by young infant which is divided by week like on Chart booklet)


Weight-for-age GIRLS
Birth to 6 months (z-scores)
World Health Organization
WEIHGT (kg)
3
2
0
-2
-3
Under weight
Severe under weight
Weeks
Month
0 1 2 3 4 5 6 7 8 9 10 11 12
3
4
5
6
Age (completed weeks or months)
WHO Child Growth Standards

QUESTIONS		ANSWERS
IS THE YOUNG INFANT UNDERWEIGHT FOR AGE?		
Age	**Weight**	
3 weeks old female	3.0 kg	no
6 weeks old female	4 kg	no
7 weeks old female	3 kg	yes
4 weeks old female	2.5 kg	yes
5 weeks old female	3.25 kg	yes
2 weeks old male	2.5 kg	yes
6 weeks old male	3.75 kg	yes
5 weeks old male	2.9 kg	yes

Activity 8.3: DRILL: Reading a weight for age chart for young infants

Tell participants that in this drill they will practice determining whether or not a young infant is underweight for age. Ask them to take out their chart booklets and turn to the Weight for Age chart.

- Ask the question in the left column. Participants should answer in turn.

Activity 8.4: EXERCISE D, part 1: Video demonstration on how to check for feeding problems and assess breastfeeding (*another option is demonstration and practice using **a doll** and **artificial breast** do both exercise 4.4 & 4.6 at the same time)*

- Tell participants that they will see a demonstration of assessing feeding. In particular they will see how to assess breastfeeding. Point to the enlargement and review the steps of assessing breastfeeding. (Or, ask participants to turn in the chart booklet to the *YOUNG INFANT* chart and read over the steps to assess feeding of a young infant.) The video will show examples of the signs of good and poor attachment and effective and ineffective suckling.
- Ask if participants have any questions before you start the video. When there are no additional questions, start the videotape.
- At the end of the video, lead a short discussion. If participants are not clear about the assessment of any signs, rewind the video and show the relevant portions again.

Important points to emphasize in the discussion are:

- The four signs of good attachment.
    - Chin touching breast, mouth wide open, lower lip turned outward, more areola showing above

      (*Point to these on the enlargement as you review them*)
- An infant who is well attached does not cause any pain or discomfort to the breast. Good attachment allows the infant to suckle effectively. Signs of effective suckling are:
    - The infant suckles with slow deep sucks
    - You may see or hear swallowing
- An infant who is suckling effectively may pause sometimes and then start suckling again. Remember that the mother should allow her baby to finish the feed and release the breast himself. A baby who has been suckling effectively will be satisfied after a breastfeed.

Activity 8.5: EXERCISE D - Part 2: Group discussion of example photographs and then individual work followed by group feedback----On recognizing signs of good attachment (optional)

- Talk about each of the first 4 photographs, pointing out or having participants point out and tell how they can see each sign of good or poor attachment. Participants should refer to the descriptions of each photograph in their module.
- Then ask participants to work individually to study the rest of the photographs for this exercise and write the answers in the chart. They should look for the signs of good attachment present in each photograph and make an overall assessment of the infant's attachment.
- When the participants have completed the exercise, conduct group discussions. Then look at photographs 22 and 23 (thrush) with the participant. Answer any questions that the participant may have about these photographs.

Answers to Exercise D (Optional)

Photo No. (Photo booklet)	Signs of Good Attachment				Assessment	Comments
	Chin Touching Breast	Mouth Wide Open	Lower Lip Turned Outward	More Areola Showing Above		
66	Yes (almost)	Yes	Yes	Yes	Good attachment	
67	No	*No*	Yes	no (equal above and below)	Not well attached	
71	*No*	*No*	Yes	*no (equal above and below)*	*Not well attached*	
72	*Yes*	Yes	Yes	Yes	*Good attachment*	
73	*Yes (almost)*	Yes	Yes	Yes	*Good attachment*	
74	*Yes*	*No*	*No*	*No (more below)*	*Not well attached*	*lower lip turned in*

Photographs 75 and 76 in photo booklet: White patches (thrush) in the mouth of an infant.

Activity 8.6: EXERCISE G Part 1: Video demonstration of how to teach correct positioning and attachment for breastfeeding (*Another option is demonstration and practice using a doll and do both exercise 4.4 & 4.6 at the same time).* When all the participants are ready, arrange for them to move to where the video will be shown. Make sure they bring their modules.

If it is possible in the room where the video is shown, display the enlargement of "Teach Correct Positioning and Attachment for Breastfeeding." and review positioning and attachment before the video show.

To show the video demonstration:

1. Tell participants that they will watch a demonstration of helping a mother to improve positioning and attachment for breastfeeding.
2. Ask if participants have any questions before you start the video. When there are no additional questions, start the video.
3. At the end of the video, lead a short discussion. Ask participants to look at the box, "Teach Correct Positioning and Attachment for Breastfeeding." Explain that the video showed exactly these steps. Then make the following points:
   - Good positioning is important for good attachment. A baby who is well positioned can take a good mouthful of breast.

- Review the four steps to help her position the infant. (As you speak, point to the steps on the enlargement)
- When you explain to a mother how to position and attach her infant, let her do as much as possible herself.
- Then review the 3 steps to help the infant to attach.
  - Touch her infant's lips with her nipple
  - Wait until her infant's mouth is opening wide
  - Move her infant quickly onto her breast, aiming the infant's lower lip well below the nipple.
- Check for signs of good attachment and effective suckling. It may take several attempts before the mother and baby are able to achieve good attachment.
- If participants are not clear about the steps, rewind the tape and show it again.

Activity 8.7: Exercise F. Assess young infants for underweight and feeding problems

Before you start doing the case of Tezera, demonstrate how assess and fill an **enlarged recordform** using an example case of Hewan, which reads as following–

Hewan *is 3 weeks old, weight 3500g, temperature 37°C. Her mother brought Hewan because she became irritable. Hewan has no sign of very severe disease, local bacterial infection, jaundice or diarrhoea. She breastfeeds 7 times in 24 hours, mother switches Hewan to the second breast before the first one is emptied. Hewan takes water in addition to breast milk. When the HEW assessed her breastfeeding condition she has observed the following.*

Positioning

- Infant's head and body not straight
- Head and body not facing breast
- Infant's body close to mother's body
- Mother not supporting infant's whole body

Attachment

- Chin not touching breast
- Mouth not wide open
- Lower lip turning in wards
- Areola visible equal above and below

After you have completed the demonstration answer any question from participants and then, **tell them to perform the following (***You may read the case for them if you think there is language problem)*

- Practice filling the classification table
- Fill the blank record form below
- Classify the young infant's illness using the classification table
- Compare the young infants signs to the signs listed in the feeding classification table below and choose and circle the appropriate classification and counselling to be provided

Case 1: *Tezera is a 30 days old male baby whose weight is 3,000g, axillary body temperature 36.5°C and this is his initial visit to the health post. The HEW asked the mother what the problem of this child was. She answered that he has diarrhoea for two days but no convulsions and he breastfeeds well. When the HEW examined Tezera for very severe disease and local bacterial infection, he is breathing 42 breaths in one minute; there is no severe chest indrawing, no redness or pus on umbilicus, no skin pustule, moves normally. When Tezera was assessed for jaundice his body was not yellow. The HEW assessed Tezera for his diarrhoea. She asked if there is blood in the stool, there is no blood in the stool. Tezera was assessed for dehydration and there is no sign of dehydration. Next the HEW assessed for feeding problem. She asked the mother if Tezera is breastfeeding the mother answered yes. He is breastfeeding six times in 24 hours.The mother breastfeeds Tezera when he cries. She switches to the other breast before one is empty. She gives him nothing except breastmilk.*

The health extension worker then assessed Tezera for positioning and attachment to the breast. The HEW observed the following:

Positioning

- *Infant's head and body straight*
- *Head and body not facing breast*
- *Infant's body close to mother's body*
- *Mother not supporting infant's whole body*

Attachment

- Chin touching breast

- *Lower lip turned inwards,*
- *Mouth not wide open*
- *More areola was seen above than below*
- *The young infant was sucking fast without pausing*

Tezera has taken BCG and OPV 0 at birth

MANAGEMENT OF THE SICK YOUNG INFANT AGE 0 UP TO 2 MONTHS

Name: **Tezera** Age in days/weeks: **30 days** Weight: **3 kg** Temperature: **36.5 °C**

ASSESS BREASTFEEDING: Has the infant breastfed in the previous hour?	If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes. Is the infant well positioned? Check for signs of good positioning Infants body and head straight yes_√__ No___ Head and body facing breast Yes___ No_√___ Infant's body close to mother's Yes__√_ No____ Mother supporting infant's whole body Yes____ No__√__ Is the infant able to attach? To check attachment, look for: Chin touching breast Yes _√__ No ___ Mouth wide open Yes ___ No _√__ Lower lip turned outward Yes ___ No _√__ More areola above than below the mouth Yes _√_ No _ no attachment at all not well attached good attachment Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? Not suckling at all Not suckling effectively Suckling effectively Look for ulcers or white patches in the mouth (thrush).	
CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS: Circle immunizations needed today. _____ _____ BCG Pentavalent -1 _____ Pneumococcal-1, rotavirus-1 _____ _____ OPV0 OPV-1		Return for next immunization on: _____ (Date)
For how long? __**2**_ Days Is there blood in the stool?	Look at the young infant's general condition. Does the infant move only when stimulated? Does the infant not move even when stimulated? Is the infant Restless and irritable? Look for sunken eyes. Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly? (less than 2 seconds)	**NO DEHYDRATION**
ASSESS FOR HIV INFECTION Has the mother had positive HIV test? Has the child had HIV positive test?		
THEN CHECK FOR FEEDING PROBLEM OR UNDERWEIGHT		
Is there any difficulty feeding? Yes __ No_√_ Is the infant breastfed? Yes _√___ No____ If Yes, how many times in 24 hours? **_6**_times Does the infant usually receive any other foods or drinks, even water? Yes __ No _√_**_** If Yes, how often? Do you empty one breast before switching to the other Yes __ No _√_ What do you use to feed the child?	Determine weight for age. underweight _√_ Not underweight __	
If the infant is feeding less than 8 times in 24 hours, is taking any other food or drinks even water or is underweight for age or switches breast before one is emptied AND has no indications to refer urgently to hospital:		**FEEDING PROBLEM OR UNDER WEIGHT**

Classification Table

Not well attached to breast or Not suckling effectively or Less than 8 breastfeeds in 24 hours or Switching to the other breast before emptying one Receives other foods or drinks, even water or „ Not breastfeeding more frequently and for longer during sickness underweight for age or Thrush (ulcers or white patches in mouth)	**FEEDING PROBLEM OR UNDERWEIGHT**	Advise the mother to breastfeed as often and for as long as the infant wants, day and night. If not well positioned, attached or not suckling effectively, teach correct positioning and attachment. If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Empty one breast before switching to the other If receiving other foods or drinks even water, counsel mother about exclusive breastfeeding and gradually stop other foods or drinks If not breastfeeding at all: Counsel mother on starting breastfeeding and possible re-lactation. If breastfeeding is not possible: advise mother about giving modified animal milk and teach the mother to feed with a cup and spoon If thrush, teach the mother to treat thrush at home. Advise mother to give home care for the young infant. Follow-up any feeding problem or thrush in 2 days. Follow-up underweight for age in 14 days.
Not underweight for age and no other signs of inadequate feeding.	**NO FEEDING PROBLEM**	Advise mother to give home care for the young infant. Advise mother on optimal breastfeeding Praise the mother for feeding the infant well.

Activity 8.8: Assess the Young Infants whose mother is HIV positive for feeding problem and underweight

- Using a wall chart introduce the steps of assessment for feeding problem or underweight
- Answer any questions (Delet it because it is stated on activity 7:10)

Activity8. 8: Assessment of a young infant for immunization status:

- Using the enlarged Assessment table, demonstrate how to assess a young infant for immunization status.
- Emphasize that every young infant who is not having severe classification needing referral should be assessed for his immunization status and immunized if needed

SECTION NINE

IDENTIFY TEATMENT AND TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

Activity 9.1: Practical session on ANC/PNC home visit

- Pre-arrange 3-4 homes where there are pregnant women or delivered in the last one month period
- Divide participant in 3-4 groups
- Let them have all the essential supplies for home visit: supplies listed in annex 5, BPER form and BP apartus,
- During home visit assume this is the first home visit and let participant practice cunsleing skills with pregnant women and provide PNC. Let one volunteer do the counselling and assessment while the other participants follow
- For counseling of pregnant women let partcipant mesure BP, conduct counseling
- Give feedback at the end of the visit
- At the plenary get feedback from each group and lead discussion on counselling steps, PNC assessment and counselling for both the baby and the mother

Activity 9.2: Introduce the actions to be taken according to the" Identify Treatment" on the wall chart

- Participants refer their chart booklets
- remind participants these are only examples and they need to be able to refer their chart booklets for the treatment identification for the rest of the classifications when needed
- Answer if there are any questions- involve participants in answering questions

Drill

No.	Classification of the young infant	Treatment Identified (Actions to be taken by the HEW)
1	Very Severe Disease	▪ Breastfeed more frequently (or expressed breastmilk if unable to suck and is conscious) ▪ Advise mother on the need for referral ▪ Give a dose of pre-referral amoxicillin, and gentamycin ▪ **Refer URGENTLY to hospital/health centre.** ▪ Advice mother to cover the baby well, including head with blanket/Gabi and hold close to her body on the way to hospital ▪ **When referral is not possible treat the young infant with amoxicillin and gentamycin for 7 days**
2	Local bacterial Infection	▪ Give amoxicillin for five days ; and follow up care after two days ▪ Advise mother when to return back immediately ▪ Advice mother to Breastfeed more frequently ▪ Advice mother to keep the young infant warm
3	Severe Dehydration	▪ **Refer URGENTLY to health center/hospital with mother giving frequent sips of ORS on the way.** ▪ Advise mother to breastfeed more frequently and longer ▪ Advise mother to keep young infant warm
4	Feeding problem or underweight	▪ Refer the feeding problem classification box in the Chart booklet
5	Severe Jaundice	▪ Breastfeed more frequently ▪ Advise mother on the need for referral ▪ **Refer URGENTLY to health center/ hospital** ▪ Advice mother to cover the baby well, including head with blanket/Gabi and hold close to her body on the way to hospital /health center
6	Jaundice	▪ Breastfeed more frequently ▪ Advice mother to keep the young infant warm ▪ Expose to sunshine 20 to 30 minutes every day ▪ Advise mother when to return back immediately ▪ Follow-up in two days

Activity 9.3: Referring the sick young infant

- Explian to partcipants that the best treatment option for the SYI is at hospital level

- Emphasize the need to have good counselling and negotation
- Emphasize that SYI with following problems need urgent referral and should not be treated at HP level; HEWs need to counsel and facilitate reffearl to hospital:
    - Unable to feed
    - Convulsing (having abnormal movement) now
    - Not moving when touched(unconscious)

For sick young infants being reffered:

Demonstrate how to write a referral paper

- Using the sample referral form in annex 7 describe for participants the items to be included in the form and their importance
- Give them an case of Ikram to exercise filling the form
- Give first dose of Amoxicillin and Gentamycin and refer child urgently to health centre

Activity 9.4: Video demonstration on PNC home visit for sick young infant

- Let participant observe the video demonstration where HEWs make a home visit and identify a sick newborn, negotiates with care taker on referral
- At the end summarize the key points

Activity 9.5: Demonstrate the steps of newborn resuscitation

- Introduce the steps of resuscitation of asphyxiated newborn on the wall chart
- Then using a mannequin, and self-inflatable-bag and mask demonstrate to participants how to resuscitate an asphyxiated baby
- Let participants in groups of 3-4 practice resuscitation one by one under your direct supervision

Activity 9.6: Immunize the sick young infant if he/she needs it today and only if there is no classification that needs urgent referral

Activity 9.7: Expressing and feeding the pre-term with breast milk wall chart presentation

- Tell participants to gather around and introduce the steps on the wall chart
- Answer any questions they have

Activity 9.8 Expressing and feeding the pre-term with breast milk; video demonstration

Tell participants that they will watch a demonstration on expressing and feeding the pre-term with breast milk

1. Ask if participants have any questions before you start the video. When there are no additional questions, start the video
2. Tell partcipants to pay close attention to the techniques of expressing and feeding breast milk
3. At the end of the video, lead a short discussion.

Make the following points:

- The most important consideration is the baby's ability to suck, swallow and coordinate swallowing and breathing,
- The sucking reflex may be absent or weak in smaller premature or LBW babies at first. Therefore, LBW babies are at risk for not getting enough food. All low birth weight babies need to breastfeed often, at least every two to two and half hours. As the LBW baby grows she will be able to take in more and will not breastfeed as often so they should not feed on demand but they may need to be fed on a schedule
- Position the baby: Awaken the baby and hold her
- Do not pour the milk into the baby's mouth
- Keep the cup at the baby's lips, letting the baby take the milk
- When the baby has had enough, the baby will close her mouth and refuse to take more:
    - A baby who has not taken enough may take more at the next feeding, or
    - The mother may increase how often she feeds
- Advise the mother to hold the baby to her shoulder and rub the baby's back to help him burp (bring up air)

SECTION TEN

TREAT THE SICK YOUNG INFANT BIRTH UP TO 2 MONTHS WHEN REFFERAL IS NOT POSSIBLE

Activity 10.1: Introduction to when referral is not possible on the wall chart

Introduce Identify Treatment for the young infant on the wall chart

- Participants refer their chart booklets
- Remind participants these are only examples and they need to be able to refer their chart booklets for the treatment identification for the rest of the classification when needed
- Answer if there are any questions-involve participants in answering questions

General and very briefly touch the sections on the wall chart:

- Barriers to completion of referral
- Treatment options for the sick young infant when referral is not possible

Ask participant the possible referral barriers are, listen to their answers

In most case the following are barriers:

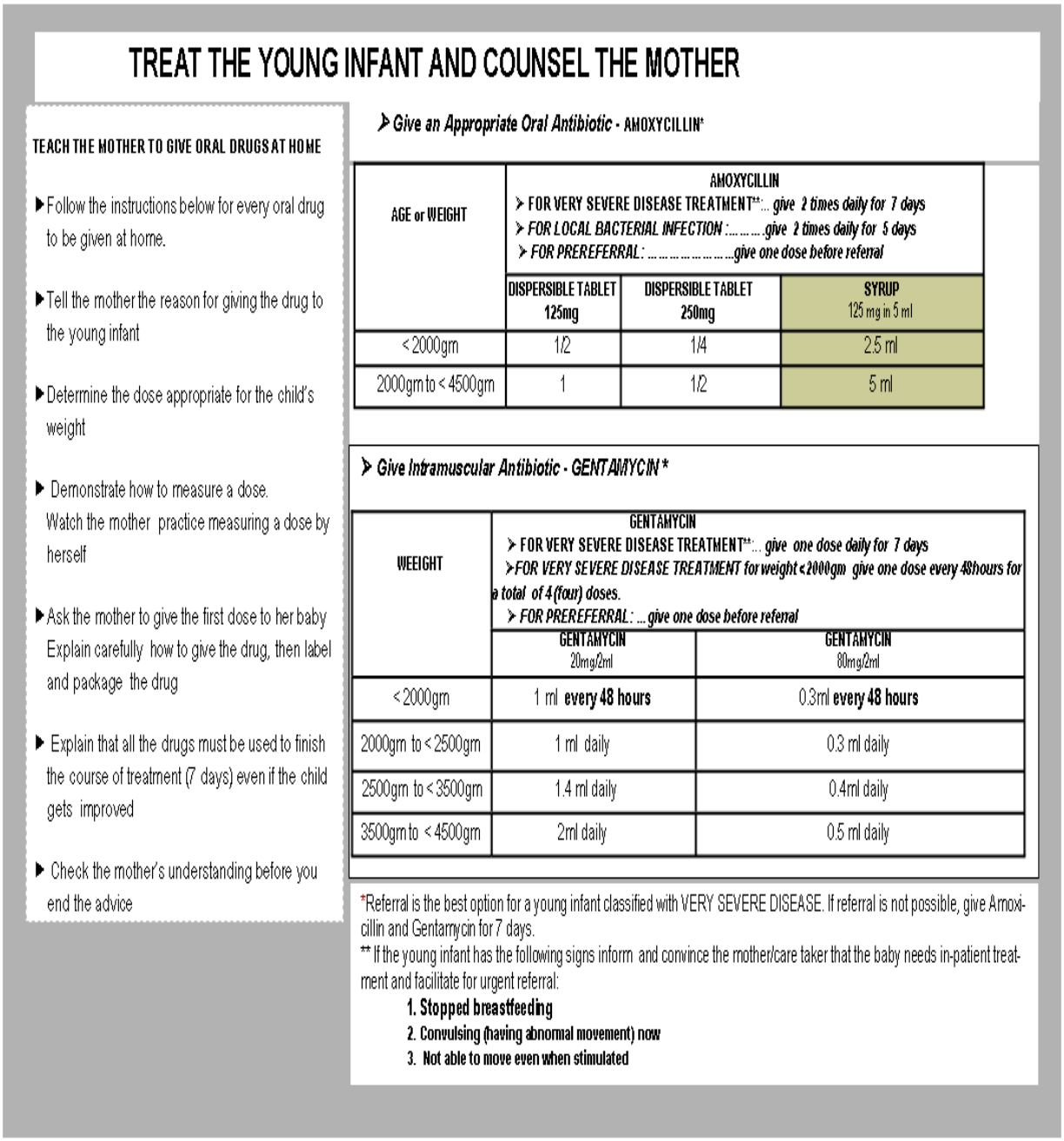
- Distance to hospital/health centre is far
- Costs related to transport, time, payment of medicines and staying in large towns
- Cultural and religious belief preventing recently delivered women and newborn to go outside home and travel long distances
- Inability to travel daily to and from health centre due to issues of distance and time

Describe that SYI with very severe disease classification is at risk of death and needs to have treatment immediately as the disease can progress fast

Emphasize the following points:

- The best possible treatment for a child with a very severe illness is at a hospital. However, compliance with referral is not possible in most cases as distances to hospitals are far; the family may not have money for medicine, transport, lodging and food in larger towns, and transportation might not be available. Parents may not be able to take a child to a health center/hospital, in spite of the health extension worker's effort to explain the need for referral. The reality is that very few newborns are seen at health centers/hospitals due to barriers to referral mentioned above. In that case, the HEWs should do all that she can do to help the family care for the baby
- In many cases, families cannot comply with referral due to an inability to travel to and from the health center/hospital. For newborns with VSD this will be at least seven days of treatment. Costs related to travel, staying in a large town or travelling several hours per day to access treatment may not be acceptable or possible
- HEWs who classify newborns with Very Severe Disease need to discuss referral options with mothers/caretakers so that she can decide with the family what treatment options are available to families.
- To help reduce deaths in severely ill children who cannot be referred, HEWs can offer treatment and negotiate and agree place of daily gentamycin injection

Activity 10.2: Wall chart presentation on Amoxicillin and gentamycin dose on the DSD



TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

- Follow the instructions below for every oral drug to be given at home.
- Tell the mother the reason for giving the drug to the young infant
- Determine the dose appropriate for the child's weight
- Demonstrate how to measure a dose. Watch the mother practice measuring a dose by herself
- Ask the mother to give the first dose to her baby Explain carefully how to give the drug, then label and package the drug
- Explain that all the drugs must be used to finish the course of treatment (7 days) even if the child gets improved
- Check the mother's understanding before you end the advice

➢ *Give an Appropriate Oral Antibiotic* - AMOXYCILLIN*

AGE or WEIGHT	AMOXYCILLIN ➢ FOR VERY SEVERE DISEASE TREATMENT**... *give 2 times daily for 7 days* ➢ *FOR LOCAL BACTERIAL INFECTION :.....give 2 times daily for 5 days* ➢ *FOR PREREFERRAL: .....give one dose before referral*		
	DISPERSIBLE TABLET 125mg	DISPERSIBLE TABLET 250mg	SYRUP 125 mg in 5 ml
< 2000gm	1/2	1/4	2.5 ml
2000gm to < 4500gm	1	1/2	5 ml

➢ *Give Intramuscular Antibiotic - GENTAMYCIN **

WEEIGHT	GENTAMYCIN ➢ FOR VERY SEVERE DISEASE TREATMENT**... *give one dose daily for 7 days* ➢*FOR VERY SEVERE DISEASE TREATMENT for weight <2000gm give one dose every 48hours for a total of 4 (four) doses.* ➢ *FOR PREREFERRAL: ...give one dose before referral*	
	GENTAMYCIN 20mg/2ml	GENTAMYCIN 80mg/2ml
< 2000gm	1 ml **every 48 hours**	0.3ml **every 48 hours**
2000gm to < 2500gm	1 ml daily	0.3 ml daily
2500gm to < 3500gm	1.4 ml daily	0.4ml daily
3500gm to < 4500gm	2ml daily	0.5 ml daily

*Referral is the best option for a young infant classified with VERY SEVERE DISEASE. If referral is not possible, give Amoxicillin and Gentamycin for 7 days.

** If the young infant has the following signs inform and convince the mother/care taker that the baby needs in-patient treatment and facilitate for urgent referral:

1. **Stopped breastfeeding**
2. **Convulsing (having abnormal movement) now**
3. **Not able to move even when stimulated**

Activity 10.3: Drill to calculate correct doses of amoxicillin and gentamycin

- Participants refer their chart booklets
- As stated in the table below give the classification of the young infant and the treatment identified in the first two columns and askthe steps to be taken by HEW in giving the drug
- At the end of the session answer if there are any questions- involve participants in answering questions

The following SYI have very severe disease classifications, identify correct dose of amoxicillin and gentamycin from the chart booklet

Weight of young infant	Amoxicillin dispersible tablet for 7 days		Gentamycin injection for 7 days	
	125 mg	250mg	20mg/2ml	80mg/2ml
1480 gm	½ tablet 2 times a day	¼ tablet 2 times a day	1 ml every 48 hours	0.3 ml every 48 hours
2300 gm	1 tablet 2 times a day	½ tablet 2 times a day	1 ml daily	0.3 ml daily
2700 gm	1 tablet 2 times a day	½ tablet 2 times a day	1.4 ml daily	0.4ml daily
2800 gm	1 tablet 2 times a day	½ tablet 2 times a day	1.4 ml daily	0.4ml daily
3600 gm	1 tablet 2 times a day	½ tablet 2 times a day	2ml daily	0.5ml daily
4400 gm	1 tablet 2 times a day	½ tablet 2 times a day	2ml daily	0.5ml daily

Activity10.4: Demonstration of giving gentamycin injection

Let participant observe carefully as you explain and demonstrate drawing and administering correct dose of gentamycin

Demonstrate the following:

- Show dispersible amoxicillin and explain that caretakers should mix with drops of breast milk and it becomes a suspension
- Show the 1cc and 2cc syringe and explain the parts
- Provide a syringe to each of the participants so that they can see the gradients listed on the syringe.
- Explain that ‘sterilization’ means something is cleaned by special means (boiling water, steam or chemicals) so that no germs are on it. This syringe has been pre-sterilized (sterilized beforehand) and prepackaged (put in a package and sealed) so it is *sterile.* The syringe should not be used if the package is open or the seal is broken. Only sterilized syringes (and needles) may be used as it prevents infection.
- Draw the scale of the 1cc and 2 cc syringe barrel on the board and explain.
- Show the Gentamycin vial
- Expose the top of the vial by using the file to score the thin part of the vial. Make sure to collect the removed part in the plastic syringe box (safety box).
- Show how to take off the protective cap from the needle, fix the needle into the syringe and insert the needle in to the vial, pull back on the plunger to bring the liquid into the barrel (use the Gentamycin vial and/or from a small cup) until it reaches the required mark.
- Show how the syringe should be held at eye level with clear light on the marks.
- Show how to dispel the air bubble, and push the plunger to dispel excess liquid until the liquid reaches the required mark.
- Clear up any confusion.
- Discuss safety measures on flip chart 15 “Mistakes and Consequent Dangers” and review with participants
- Ask for any questions

Explain the following points:

- Gentamycin is given to young infants who have very severe disease and not to any other condition or to children 2-59 months.

- HEW needs to refer to chart booklet all the time and never try to memorize to determine the Gentamycin dose to be given to the baby. It is easy to make mistakes so by referring to the chart booklet the HEW will assure that the correct classification and course of action is undertaken for the newborn
- The injection is given in the front and side (anterior-lateral) of the baby's mid-thigh, half way from the knee to the top of the leg. The injection is given in the muscle in the thigh, just like the Pentavalent injection. It is an intramuscular injection
- Emphasize the need for the HEW to complete the full course of treatment (seven days) and this will mean that she has to be present on weekends
- For newborns weiging less than 2,000gm, give gentamycin every 48 hours for a total of four dose
- Distribute the illustration of injection sites. It can be given in either the right or left thigh.
- Demonstrate where to give the injection on oranges
- Explain the need to use proper infection prevention techniques and that used syringe and needle should be put into a safe box after giving the injection.
- Demonstrate proper disposal of syringe and needle.
- HEW should ONLY inject ONE injection of Gentamycin daily and alternate the site on subsequent injections
- They should give the following information to the caretakers:
  - Explain what drugs are to be given, Gentamycin (IM) and Oral Amoxicillin to be given by the family
  - Explain to the mother why the drug is given
  - Instruct the mother that the young infant should get the drug for 7 continuous days even if improved
  - Have mother give first dose of oral antibiotic in front of HEW to check for understanding
  - Discuss with the mother where the young infant could receive the injection. It could be at HP, home or other suitable place

Flip chart 17: Injection Possible Mistakes and Consequent Dangers

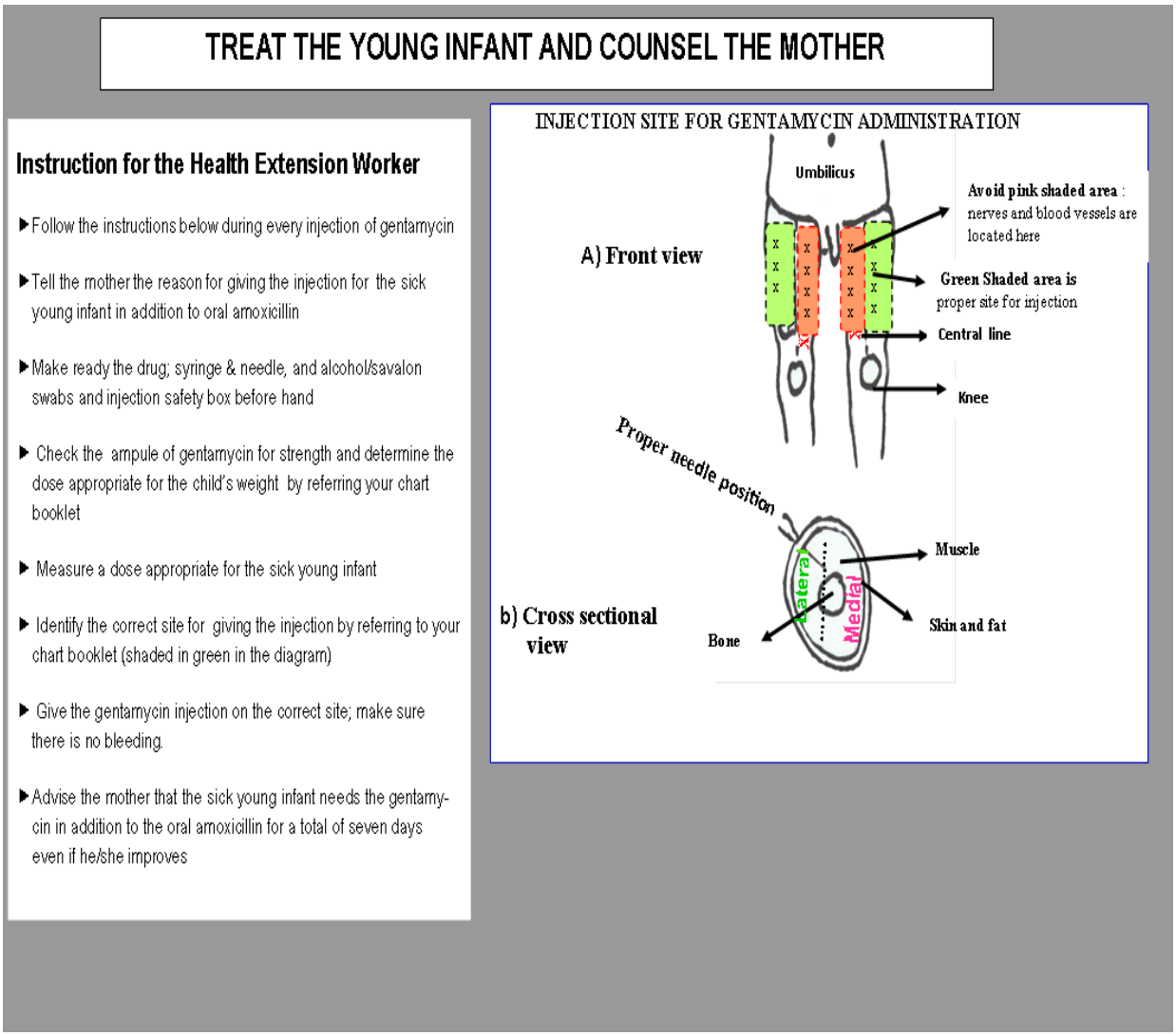
Possible Mistakes	**Consequent Dangers**
Mistakes regarding cleanliness and disinfections, or using the same syringe and or needle	Infection; swelling at the injection site, pus Tetanus AIDS
Incorrect dose	Medicine not effective or dangerous if excessive dose given
Injection at wrong place	Bleeding Paralysis; show photograph
Leg moving during injection	Needle could get stuck in leg causing injury
Not explaining or educating the parents about the injection(s).	Blame in case of injury or death. Gossip in the village
Not following up for any possible complication	Complication worsens without any corrective action. Blame

Activity 10.5: Practice of giving gentamycin injection

- Divide participants into four groups
- Distribute syringes, Gentamycin vials, and files
- Have trainees become acquainted with the syringes, the needle, fixing the needle to the syringe, removing the caps of the vial, removing the thin part of the vial, inserting the needle, pulling on the plunger, drawing liquid into the barrel, dispelling the air bubble, and measuring the amount of 'medicine' required (until the required mark)
- As facilitators observe and support let participant practice drawing correct dose of gentamycin-getting the appropriate amount in the syringe is crucial
- Using the illustration in flip chart 16 as a guide, have trainees practice locating a proper injection site
- Using oranges let participant practice infection prevention techniques and giving injections
- Circulate in the room and make sure each trainee can find a correct injection site and administer gentamycin

Flip Chart 18 Illustration of Injection Site (Antero- lateral thigh)

Injection site for injecting newborn



SECTION ELVEN

COUNSEL THE MOTHER

Activity11. 1: Using the wall chart introduce *Counsel the mother* about:

- Optimal breastfeeding for infants who have feeding problems or underweight
- Care of the preterm or low birth weight newborn
- Prevention of infection for the newborn
- Home care feeding and when to return back immediately
- On completion of treatment
- Emphasise on counsel on ***FOOD***, ***FLUID***, and ***WHEN TO RETURN***
- Explain that it is also important to counsel the mother about her own health, as noted at the bottom of the chart
- Remind partcipants thaty have practied good coomunication skills in part one

SECTION TWELVE

GIVE FOLLOW-UP CARE FOR YOUNG INFANTS

Activity 12.1: Introduction to the follow-up chart – wall chart presentation

- On the wall chart demonstrate the tasks to be done during follow-up
- With participants, review the follow-up of the following classifications (participants refer their chart booklet)
    a. Very severe disease
    b. Jaundice
    c. Diarrhea and on plan A or B
    d. Feeding problem
    e. Underweight
    f. Thrush

Ask participants if they have any questions

Activity 12.2: Provide follow-up care to complete treatment for very severe disease-plenarry discussion

- Describe what treatment completion means (following the correct dose, schedule and duration)
- Explain to participants the treatment of newborn with very severe disease is more challenging than treatment of the sick child as it needs daily injection in addition to the oral amoxicillin but it is possible and we are the only one there to save the life of the helpless newborn. Saving the life of children and mothers is a big national agenda now more than ever.
- Then lead a discussion by asking the following two questions and probing to get some of the points described under each (Flip chart xx).
- When you think there is no more coming from participants present the flip chart

Flip chart 18

1. **How do we make it successful?**
    - HEW builds good rapport with and confidence of family during ANC and PNC visits
    - Good counselling during case identification and initiation of treatment that includes:
        - Brief description of health problem and its dangers
        - The importance of completing treatment
        - There is dedicated person from the family to support treatment completion
        - Potential challenges identified and solutions agreed
2. **Consequences of incomplete treatment**
    - loss of life of the newborn
    - Wastage of expensive drugs (harms the nation)
    - encourages emergence of drug resistant strains of bacteria (harms the nation)
    - wastage of efforts by the family and HEW (ANC, delivery and PNC)
    - HEW lose thrust by community

Activity 12.3 Introduce the ICCM out patient registers for sick young infant 0-2 months and assist participants to practice filling them

- Using sample pages describe each item of the registers to the participants:
- Then show how to fill each part by taking the case of Ababu & Hanna and let the trainees work while you read the cases for them loudly.
- Show and let them practice how to record signs, put the classifications and appropriate treament for each classification

Activity 12.4: Devlop action plan

- Start by asking HEWs and supervisors what they are going to do when the go back to their work places
- Encourage them to express their ideas and try to get adequate response from them
- Then distribute work plan matrix and let HEWs devlop action aplan for next three months
- Ensure the following activites are included:
    - Sensitizing the command post and the community about new service avilabale
    - Engaging the HDA in listing of pregnant women, birth notification, PNC home visit and referral of sick young infants
    - Registering of all pregnant women, expected deliveries and post natal care in their kebele
    - Provide CBNC service at HP and during home visit
    - Provide iCCM/CBNC integrated services

Activity 12.5: Post test & course evaluation and closing

- Using the course evaluation questionnaire given in the introductory section of this facilitator's guide
- Tell participants to be free to evaluate the course genuinely and there is no need to write a name or a code number.
- Answer any question from participants

Activity 12.6: Reflections, closing and distribution of essential commodities

Reflection:

- Receive a reflection about the training from few participants (HEW and supervisors). Even though they have evaluated the course in writing this session will help to get some additional comments

Closing:

- Repeat that the objective of the training is to save lives of the children dying and HEW should start the CBNC immediately as they reach their health posts
- Explain that follow up after training will be part of the implementation
- Thank all participants for their active participation during the training

Distribution of essential commodities:

- Make sure that they collect at least registration books, amoxicillin, gentamycin, syringes, chlorhexidinesufficient for 6-12 months, spring wieghing scale with sling from a relevant person of the woreda who should be ready to distribute at the training site.

ANNEX 1: BPCR PLAN

Name of PW_____ _____age___ Gravida __Para__LMP__/__/__EDD__/__/__

SN	Activities (Circle on responses)	Responsible person	If yes Write important note
1	Health facility for birth is identified yes/no		Name of HF
2	Means of transportation to get the health facility is arranged yes/no		Mention it
3	Money for transport and other expenses is ready to get the health facility for delivery yes/no		Mention amount

4	Check for availability of supplies needed o Soap and water for washing of hands yes/no o New razor blade to cut the umbilical cord yes/no o Sterilized thread to tie the cord (if labour is sudden) yes/no o Clean clothes to wipe and wrap the baby because you need to keep the baby warm yes/no o A clean space and a carpet or mat yes/no		
5	Assistant is identified /someone who accompany the pregnant woman during labour to the facility yes/no		
6	Person who will care for the household while the pregnant woman and other family members are in the facility is/are identified yes/no		
7	Assistant is identified for home delivery in case of very quick labour		

- Discuss on the birth preparedness & complication readiness plan with your family, reach on consensus, and post at visible area to remind for next action.

ANNEX 3:2 : PREGNANT WOMEN IDENTIFICATION REGISTRATION FORMAT

Kebele_____

SN	Name of pregnant women	Age	Name of Husband	Got/house #	Tel. #	Name HAD, network leader	EDD	LMP/ Pregnancy in Month	Started ANC	
									Yes	No

ANNEX 4: 3:CHECK LIST FOR ESSENTIAL EQUIPMENT AND SUPPLIES FOR FOCUSED ANTENATTAL CARE

1. Blood pressure cuff
2. Stethoscope
3. Fetoscope
4. Watch or clock
5. Family folder
6. Antenatal register book
7. Weighing scale
8. Tape measure
9. Examination couch
10. Drape
11. Washable mackintosh
12. Dustbin
13. Thermometer
14. Uristix (if available)
15. Lab request forms
16. Prescription forms
17. HIV rapid kits (if available)
18. Cups/drinking water
19. Drugs: Iron and folate, antihelminths (if available and indicated), TT vaccine
20. Syringes/needles
21. Sharps container
22. All IP equipment
23. Chlorine bleach
24. Bucket for decontamination solution
25. Contaminated waste container

ANNEX 5: 4:CHECK LIST FOR ESSENTIAL SUPPLIES FOR POSTPARTUM NEONATAL CARE

1. Blood pressure cuff
2. Stethoscope
3. Gloves
4. Clean pad
5. Plastic bag for pad
6. Thermometer
7. Baby scale with sling
8. Soap and towel or handrub
9. Chart booklet
10. Family Health Guide
11. Copy of recording form/SYI registration book
12. Family folder
13. Medications:
    i. Baby: vitamin K, chlorhexidine, gentamycin, amoxaciline,
    ii. Mother: vitamin A 200,000 IU capsule, paracetamole

ANNEX 6:5: CHECKLIST FOR POSTPARTUM HOMEVISIT

The mother:

- Has no worries about the baby's behavior
- Responds appropriately when the baby cries
- Keep the baby warm, handles the baby gently
- Knows the newborn danger signs and what to do
- Is comfortable with exclusive breast feeding
- Has taken one vitamin A capsule(200, 000IU) after birth
- Checked for danger signs and is healthy
- Gets support form the family, keeps her personal hygiene, gets sufficient rest and nutrition

The newborn:

- Is on exclusive breast feeding and feeds well (8-12 times in 24 hour)
- Sleeps between feeds and wakes for feedings
- Has axillary temperature of 36.5-37.4^{0}C
- Is breathing quietly, between 30-60 breaths in one minutes
- Has skin no pustules or rashes, and is not yellow, blue or pale, has clean eyes and dry umbilicus
- Checked for danger sign and is healthy
- Has received his/her first immunizations
- **Annex 6**
- Interpersonal negotiacion skill check list

GALIDRAA contents	Yes	No	Comment
Greet make the woman/mother feel relaxed by smiling, eye contact, body language			
Ask how the woman/mother is doing. What are her concerns/issues related to her health or the health of her child.			
Listen carefully Show that you are listening (head nodding, eye contact, acknowledging sounds, yes…hmm)			
Identify issues problems on current practices			
Discuss with the woman/mother optimal practices and benefits			
Recommend actions woman/mother should try			
Agree the woman/mother on what actions to take			
Appointment made for follow-up or next meeting			

ANNEX 7: SAMPLE REFERRAL FORM

Date: ……..

Referred to: ……
Referring health post: ……..
iCCM registration No. ……..
Name: ……..... Age.……
Key Signs identified: ……
……
Classifcations: ……
……
Pre-refearl treatment given: ……
……..
Classifications: ……
……..
Treatment given: ……
Name of the HEW: …….. ..... ……..

Signature…….....

Feed back from health center

.....
.....
.....
.....

Name.....
Signature.....
Date.....