

<b>STANDARD SECTOR INDICATOR CODE:</b> HE-089	<b>Educated on newborn care practices:</b> Number of target population reached with individual or small group level education on newborn care.	
<b>HEALTH SECTOR</b>	<b>Sector Schematic Alignment</b> <b>Project Area:</b> Maternal, Neonatal and Child Health <b>Project Activity Area/Training Package:</b> Maternal and Neonatal Care	
<b>Type:</b> Output	<b>Unit of Measure:</b> Individuals	<b>Disaggregation :</b> <b>Sex:</b> Male, Female <b>Age:</b> 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years

**To be counted for this indicator the following criteria must be met:**

- Must have participated in a training on newborn care practices prior to giving birth
- The training must have been provided by the PCV or their partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. PC/Post staff determines what comprises a small group setting
- Attendance at educational session/s must be documented by the Volunteer or their partner

**Definitions:**

**Educated:** Showing evidence of training or practice.

**Small group or individual session:** is defined as an intervention delivered in a small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger or can comprise of a family or couple.

**Individual session:** is defined as an intervention that is provided to one individual at a time.

**Evidence-based newborn care practices** - are defined as practices that improve newborn care such as:

- **Hygienic cord care** – is defined as cutting the cord with at a minimum a new razor blade, using clean ties, and clean hands and not applying any substances other than antiseptics or antibiotic ointment to the stump. Keeping the stump clean and dry is therefore very important if infection is to be prevented.
- **Thermal control** – hypothermia of the newborn occurs throughout the world in all climates. After birth the wet newborn immediately starts losing heat. Therefore the baby should be immediately dried and covered. Skin to skin contact is the best way to keep baby warm. Bathing should be delayed for at least 24 hours and kept to a minimum.
- **Early breastfeeding** is defined as being put on the breast within one-hour of birth. (This behavior should be reported under indicator HE-093)
- **Exclusive breastfeeding** is defined as an infant feeding practice where the infant receives breast milk (including expressed breast milk or breast milk from a wet nurse) but nothing else during the first six months of life, with the exception of vitamin or mineral supplements, medicine or ORS (under recommendation of a medical professional). An infant receiving plain boiled water, soups, porridge, semi-solid foods before six months of age cannot be counted as exclusively breast fed.
- **General hygienic practices** when caring for the newborn is defined as washing the baby's bottom and care givers hands after changing diapers.
- **Promotion of baby WASH** for the first 1,000 days to reduce routes of fecal disease transmission, such as

- protective play space, to protect developing child from contaminated soil and animal feces (especially chickens)
- Infant handwashing with soap, when outside of protective play space.
- Caregiver handwashing with soap after fecal contact and before preparing/serving food
- Safe disposal of feces—especially of children
- Water treatment
- Avoid feeding leftovers, or reheat
- **Early care seeking** is seeking care with a health care provider at the first signs of infection/sepsis in the newborn. These signs are non-specific and include: lethargy, poor feeding, fever, fast heart rate, cyanosis, fast breathing, chest retractions, apnea/gasping, seizures, high pitched or feeble cry, excessive crying/irritability, neck retraction, and bulging fontanel.

**Signs or symptoms of need to seek immediate care** - The first signs of infection/sepsis in the newborn are non-specific and include: lethargy, poor feeding, fever, fast heart rate, cyanosis, fast breathing, chest retractions, apnea/gasping, seizures, high pitched or feeble cry, excessive crying/irritability, neck retraction, and bulging fontanel.

**Rationale:** Safe birth and newborn care practices reduce neonatal mortality. Neonatal mortality (death in the first 28 days) accounts for about 40% of all under-5 deaths. Three-quarters of neonatal deaths occur in the first week, and more than one-quarter occur in the first 24 hours.

**Measurement Notes:**

1. **Sample Tools and/or Possible Methods:** Volunteers should use data collection tools to measure progress against project indicators. For this Standard Sector Indicator, a tracking sheet that collects the names, age, sex, and profession of participants who were trained in newborn care practices will capture the needed data.
2. **General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outputs of the activities and then later at the appropriate time, measurements of specific outcomes (see the bullet on frequency of measurement).
3. **Activity-Level Baseline Data Collection:** Because this is an output indicator that does not measure any change, there is no need to take a baseline measurement before reporting the results of this indicator. However, Volunteers should take baseline measurements for any outcome indicators that are related to this output indicator. Refer to the project framework to review related outcome indicators.
4. **Frequency of measurement:** An output indicator only needs to be measured once—in this case, every time the Volunteer holds a training event (or series of events) on newborn care practices, he/she will want to keep track of the number of unique individuals who participated in the event(s) and report on it in the next VRF.
5. **Definition of change:** Outputs do not measure any changes. However, if desired, a minimum expectation can be set for meeting the output, which can be particularly useful in the area of training. For instance, a Peace Corps project may decide that for any training participant to be counted as having been sufficiently trained in a certain area, he/she needs to attend at least “X% of the training” or “X number of days of the training.” If a specific requirement is not set forth here in the indicator data sheet, it is up to project staff to determine what minimum

criteria they want to set (if at all).

- 6. **Reporting:** In the case of output indicators, Volunteers only have one box to fill in on their VRF: “total # (number).”
- 7. **Reporting on Disaggregated Data in the VRT:** This indicator is disaggregated by “Sex” and “Age”. When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by 1) male and female, and 2) 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years.

**Data Quality Assessments (DQA):** DQA are needed for each indicator selected to align with the project objectives. DQAs review the validity, integrity, precision, reliability, and timeliness of each indicator. For more information, consult the Peace Corps MRE Toolkit.

**Alignment with Summary Indicator:** No link