

<b>STANDARD SECTOR INDICATOR CODE:</b> HE-091	<b>Adopted Behaviors to Improve the Care of a Newborn:</b> Number of individuals adopting one or more new evidence-based behaviors or practices to improve the care of newborns.	
<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> Intermediate-term Outcome	<b>Unit of Measure:</b> Individuals	<b>Disaggregation:</b> <b>Sex:</b> Male, Female <b>Age:</b> 0-9 years, 10-14 years, 1-17 years, 18-24 years, 25+ years

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

- Must have received training on newborn care 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 Training must have been provided by the PCV or their partner in an individual or small group setting comprised of no more than 25 people
- Attendance at educational session/s must be documented by the Volunteer or their partner
- The individual must have adopted one of the five behaviors defined below

**Definitions:**

**Adopting a new behavior** - for this indicator it is defined as consistently practicing one of the new behaviors specified below

**Evidence –based newborn care practices** - are defined as behaviors 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.

**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 (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. A data collection tool to measure this indicator could be based on one of the following methods—survey—though there may be other data collection methods that are appropriate. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.
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:** This indicator builds off of indicator **HE-089: Educated on Newborn Care Practices** and **HE-090: Able to Identify Signs and Symptoms Indicating the Need to Seek Care for the Newborn**, which measure the knowledge and attitudes of individuals regarding both modern and non-modern contraception methods. To measure whether the woman adopted one or more behaviors to improve the care of the newborn, Volunteers should survey the individual to take a baseline measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information early in their work with community members, and may use their judgment to determine timing because the information will be more accurate if the Volunteer has built some trust with the individual first. The same tool used to collect baseline information will be used to take the follow-on measurement (see the bullet on “frequency of measurement”). The follow-on measurement should be taken after the Volunteer has conducted his/her activities (in this case, training on newborn care practices).

Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the “unit of measure” above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at “0.” It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have been able to do some relationship and trust-building with the person/people the Volunteer is working with, and

developed an understanding of cultural norms and gender dynamics.

- 4. Frequency of Measurement:** After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same women, to assess if they have adopted one or more new evidence-based behaviors or practices to improve the care of newborns. This measurement is typically taken after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time. Once Volunteers have measured that at least one woman has achieved the indicator, they should report on it in their next VRF.

Volunteers may determine to take more than one baseline and one follow-on measurement with the same individual (or group of individuals) for the following valid reasons:

- Volunteers may want to measure whether or not any additional individuals initially reached with activities have now achieved the outcome in the indicator, particularly for any activities that are on-going in nature (no clear end date);
- Volunteers may want to enhance their own learning and the implementation of their activities by using the data collected as an effective monitoring tool and feedback mechanism for the need to improve or increase their activities;
- A Peace Corps project in a particular country may choose to increase the frequency of measurement of the indicator and Volunteers assigned to that project will be required to follow in-country guidance.

In all cases, any additional data collection above the minimum expectation should be based on the time, resources, accessibility to the target population, and the value to be gained versus the burden of collecting the data. Following any additional measurements taken, Volunteers should report on any new individuals achieving the outcome in their next VRF.

- 5. Definition of Change:** The minimum change to report against this indicator is a woman adopted one or more new evidence-based behaviors or practices to improve the care of newborns as compared to what was measured initially at baseline. In the case of this indicator, if the woman the Volunteer/partner works with already adopted one or more evidence-based practices/behaviors to improve newborn care before beginning to work with the Volunteer/partner, then the Volunteer would not be able to count her for this activity because the Volunteer's work did not actually lead to the desired change. However, if as a result of working with the Volunteer/partner, the woman decided to adopt one or more of these behaviors/practices that would count because the Volunteer's work influenced this change.
- 6. General Reporting in the VRF:** The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRFs is the number of women who, after working with the Volunteer/partner, adopted one or more new evidence-based behaviors or practices to improve the care of newborns. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of individuals who participated in the activities designed to meet this indicator.
- 7. Reporting on Disaggregated Data in the VRF:** 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