The Essential Services Package (ESP)

Protocols for Primary Health Care

Operations Research Project
Health and Population Extension Division
International Centre for Diarrhoeal Disease Research, Bangladesh
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Protocol Development Team

Shams El Arifeen

Selina Amin

Suraiya Begum

Shameem Ahmed

Mohsin U. Ahmed

Rasheda Khanam

Cristobal Tunon

Samina Manaf

Sadia D. Parveen

Farzana Sobhan

Abdullah H. Baqui

Barkat-e-Khuda

Secretary
Ministry of Health & Family Welfare
Govt. of the People's Republic of Bangladesh

FOREWORD

The Government of Bangladesh and the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) Operations Research Project (formerly MCH-FP Extension Projects) have been working in close collaboration for over a decade and a half. This Project has been involved in many operations research activities and innovations that have been studied at Projects field sites, and then applied and replicated in the national programme. The Project has concentrated its efforts on research activities designed to improve management, quality of care, and sustainability of the national programme.

At present, one of the key concerns of the national health and population sector is to ensure nation-wide availability and utilisation of an essential services package (ESP). Quality of care is the cornerstone for increased service utilisation. Quality of services can be ensured, if standard protocols are followed by the health care providers.

This document contains a set of service delivery protocols adapted by the Operations Research Project from various national and international documents, and reviewed extensively by experts from both Government and non-Government organisations. The set of protocols has been developed as part of an intervention to implement the ESP in primary health care facilities. These protocols are simple and easy to follow. They can be used both in rural and urban areas. This set of protocols will provide ready reference for paramedics and physicians providing services at facilities managed by both Government and non-Government organisations.

I compliment the ICDDR,B Operations Research Project for taking on this timely task of developing the protocols. I sincerely hope that the service delivery partners both in the Government and non-Government sector will make use of these protocols, and thereby contribute toward providing high-quality health care services.

Muhammed Ali

Acknowledgements

The Operations Research Project (ORP) is a collaborative effort of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Ministry of Health and Family Welfare (MOHFW) of the Government of the People's Republic of Bangladesh. Its primary purpose is to improve the national health and population programme (GoB, NGO and commercial sector) through conducting applied research, disseminating results, and providing technical assistance.

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Introduction

One of the key concerns of the national health and population sector strategy of Bangladesh is to ensure the nationwide availability and use of an essential package of health services. The need is also recognized by the National Integrated Population and Health Programme (NIPHP). This document contains a set of service delivery protocols adapted by the Operations Research Project (ORP) of the Health and Population Extension Division of ICDDR,B as part of an intervention to implement an Essential Services Package (ESP) in primary health care facilities managed by government and non-government organizations, both in urban and rural areas. The handbook will provide ready reference for the paramedics and physicians offering services from the primary health care setting. The protocols are represented in different colours which guides the providers to deliver the services without forgetting any step.

The handbook will be supported by a manual which is under preparation. A comprehensive participatory training containing practical sessions will be required for its effective use. A translation in Bangla is also underway.

The service delivery protocols for the services included in this handbook were adapted from national and international guidelines. For example, the diarrhea protocol was adapted from the guidelines produced by the national CDD Project from WHO standards, the acute respiratory infection (ARI) protocol was adapted from a manual on management of young children with acute respiratory infection which was prepared by WHO, and reproductive tract infection (RTI) protocols were adapted from the WHO's Syndromic Management flow charts. The reference list appears at the end of the protocols. The draft protocols were finalized after consultation with partners having expertise in the relevant fields.

INDEX

REPRODUCTIVE HEALTH

Antenatal Care

Woman Seeking Antenatal Care

Take History

The Woman is High Risk
- Advise for regular check-up and refer for institutional delivery

Factors Contributing to Risk pregnancy
- Advise for regular check-up

- Do a Physical Examination
- Do Laboratory Tests

Major Problem Present:
- Advise/manage and refer

Minor Problem Present:
- Manage and advise

Inform and counsel
Care during pregnancy, delivery and after delivery

- Provide Iron-folate tablets
- Ensure full TT immunization (Provide/refer)

- Ask patient to come for next ANC visit
[each pregnant woman should receive at least 3 ANC visits]

History Taking

First visit only:
- Age
- Parity/Gravidity
- Birth Interval
- LMP, EDD
- Past obstetric history
- Medical problems
- Family H/O diabetes, hypertension, multiple pregnancy

Every visit
- Any complaints
- TT Immunization

Physical Examination

First visit only:
- Height
- Breast examination

Every visit:
- Pulse
- Temperature
- Weight
- Blood pressure
- Oedema
- Anaemia
- Jaundice

Every visit after 12 weeks
- Fundal height

Every visit after 16 weeks
- Foetal movement

Every visit after 20 weeks
- Foetal Heart Sound

Every visit after 32 weeks
- Presentation

Laboratory Tests (every visit)
- Haemoglobin
- Urine Albumin
- Urine Sugar

HIGH RISK PREGNANCY

Past obstetric history:

- Pre-eclampsia
- Eclampsia
- Abortion/Miscarriage
- Ante-partum hemorrhage
- Multiple pregnancy
- Prolonged/Obstructed/Premature labour
- Previous Caesarean Section/Instrumental delivery
- Post-partum hemorrhage
- Retained placenta
- Intra uterine death/Still birth
- VVF or Perineal tear
- Death of new born within 48 hours of delivery

Medical Problems:

- Hypertension
- Diabetes
- Heart disease
- Bleeding disorder
- Jaundice

Factors Contributing to Risk Pregnancy:

- Age<18 or>35 years
- 1st or 4+ pregnancy
- Pregnancy interval <2 years
- Height <145 cm 58 inches

MAJOR PROBLEMS IN CURRENT PREGNANCY

Advise and refer

- Jaundice
- Severe anaemia (Hb<8gm/dl or <57%)
- Diabetes
- Heart disease
- Tuberculosis
- Height of the uterus - more or less than the period of amenorrhoea
- Low weight gain (< 1kg/month)
- Excessive weight gain (>2.5 kg/month)
- Poor foetal movement (Kick count <10/day for 2/3 consecutive days)
- Malpresentation - refer after 36 weeks in case of primi gravida
- Deformed pelvis or leg with no previous vaginal delivery

Manage and refer

- Pre-Eclampsia:

Diastolic B.P. between 90-100 mm/Hg.

- ⇨ complete bed rest
- ⇨ normal diet, no extra salt
- ⇨ explain situation to relatives
- ⇨ advise delivery in a hospital
- ⇨ advise to come after 1 week

If no improvement: Tab. Diazepam 5 mg and refer

Diastolic B.P. above 100 mm/Hg.

- ⇨ Tab. Diazepam 5 mg. and refer

Manage and refer (Contd.)

- Convulsion - Inj. Diazepam, 10 mg I.V and mouth gag
  Refer after patient is stable

- PV bleeding: No internal examination

  Before 28 weeks: absolute rest for 7 days

  - ⇨ Tab. Diazepam 2 mg twice daily for 7 days
  - ⇨ If fever, add Cap. Ampicillin 250 mg 6 hourly for 5 days
  - ⇨ If bleeding continues or partial expulsion of product, refer
  - ⇨ 5% Dextrose Saline
  - ⇨ Refer

  After 28 weeks:

  - ⇨ 5% Dextrose Saline
  - ⇨ Refer

MINOR PROBLEMS IN CURRENT PREGNANCY

Problem	Management	Advice
Anaemia (Hb<11gm/dl or <78%)	Iron-Folate tablet (Ferrous sulphate 60 mg, folic acid 0.25 mg) twice daily in 2nd and 3rd trimester	Routine antenatal check-ups Iron rich food (e.g. beans, green vegetables, meat and fruits) To expect dark stools, constipation or loose motion
Oedema	Bed rest for 1 week	Routine antenatal check-ups Sleep with legs raised over pillows
Nausea/ Vomiting	Frequent small dry snacks (puffed rice, toast biscuit)	
Backache	No medicine	Advise rest
Heartburn	No medicine	Sleep in a slightly raised position with pillow beneath the shoulders
Varicose veins	No medicine, only bed rest	Sleep with legs raised over pillows

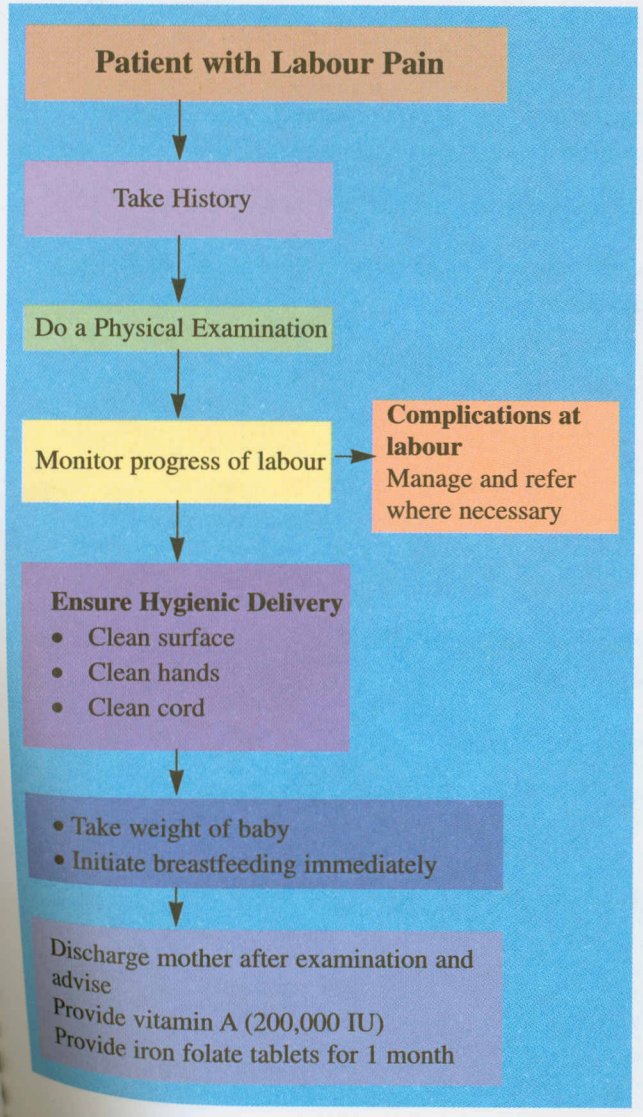
WARNING SIGNS

- Bleeding during pregnancy
- Oedema/headache/blurring of vision
- Fever for more than 3 days
- Leaking membrane
- Labour pain for more than one day and one night for primi gravida and more than 12 hours for multi gravida
- Excessive bleeding during or after delivery

Inform and counsel

- Personal care
- Diet during pregnancy and lactation
- Rest
- Time of antenatal visits
- Warning signs of complications of pregnancy and what to do
- Where to deliver
- Warning signs of complications during and after labour and what to do
- Feeding the newborn (colostrum, exclusive breastfeeding)
- Vaccinating the newborn
- Contraception after delivery
- Post partum visit

Delivery Care



History Taking

- Age
- Any problems during current pregnancy
- Parity/gravidity
- LMP
- Time of onset of labour pain
- Frequency and duration of labour pains
- Membrane- ruptured or not. If ruptured, how many hours liquor - clear or meconium stained
- Past obstetric history

Physical Examination

A. Pulse, BP, anaemia, oedema

B. Per abdominal examination:

Fundal height
Presentation
Foetal heart sound

C. Per vaginal examination:

Show
Cervix: dilatation
Membrane: ruptured or intact
Liquor: Clear or meconium stained
Feel for presenting part, prolapse of cord

Management of Labour

First Stage:

- Supervise closely, give moral support
- Give liquid diet
- Encourage to walk. Can take rest in left lateral position
- Boil necessary instruments (thread, blade, cotton, gauze)
- Keep other necessary things ready (plastic sheet, brush, soap, clean old clothes)
- Record pulse, BP, uterine contractions (intensity, frequency, duration) and fetal heart sounds half hourly
- Clean vaginal discharge with cotton
- Ask patient to evacuate bladder frequently
- Give enema
- Monitor for signs of second stage

Second stage:

- Record BP and fetal heart sound more frequently if possible
- Wash hands and wear sterile gloves
- Give perineal guard during crowing with clean pad
- Do an episiotomy, if needed
- Check for cord around neck after delivery of head
- After delivery of head, clean airway by mucus sucker
- Cut cord after cessation of pulsation using aseptic precautions
- Dry and wrap baby in clean clothes
- Clean eyes, nose and mouth of newborn with a clean gauze

Third stage:

Look for signs of separation of placenta

- Examine placenta after delivery
- In case of complication; manage and refer

Caution:

- Avoid unnecessary vaginal examination. Can do a vaginal examination every four hours when the woman is in active labour
- Do not try to enlarge vaginal orifice with hands or oil
- Ensure clean delivery - clean surface, clean hands, sterile blade and sterile thread
- Use of analgesics are not recommended

Immediate care of newborn

- Clean airway
- Keep baby warm
- Care of the cord
- Physical examination
- Put the baby on the breast

Management of complications and referral

Advise and Refer

- Malpresentation
- Foetal heart sound less than 120/min or more than 160/min or meconium stained liquor
- First stage of labour more than 12 hours with no progress
- 2nd stage more than 2 hours in case of primi and more than 1 hour in case of multigravida
- Labour pain before 32 weeks of pregnancy
- Hand or leg prolapse

Advise at Discharge

- To come for postnatal visit at any time specially if there is severe bleeding, foul smelling discharge, fever for more than 3 days or convulsion
- Care and practices during puerperium (diet, rest, personal hygiene)
- Care of baby (cord care and execlusive breastfeeding)

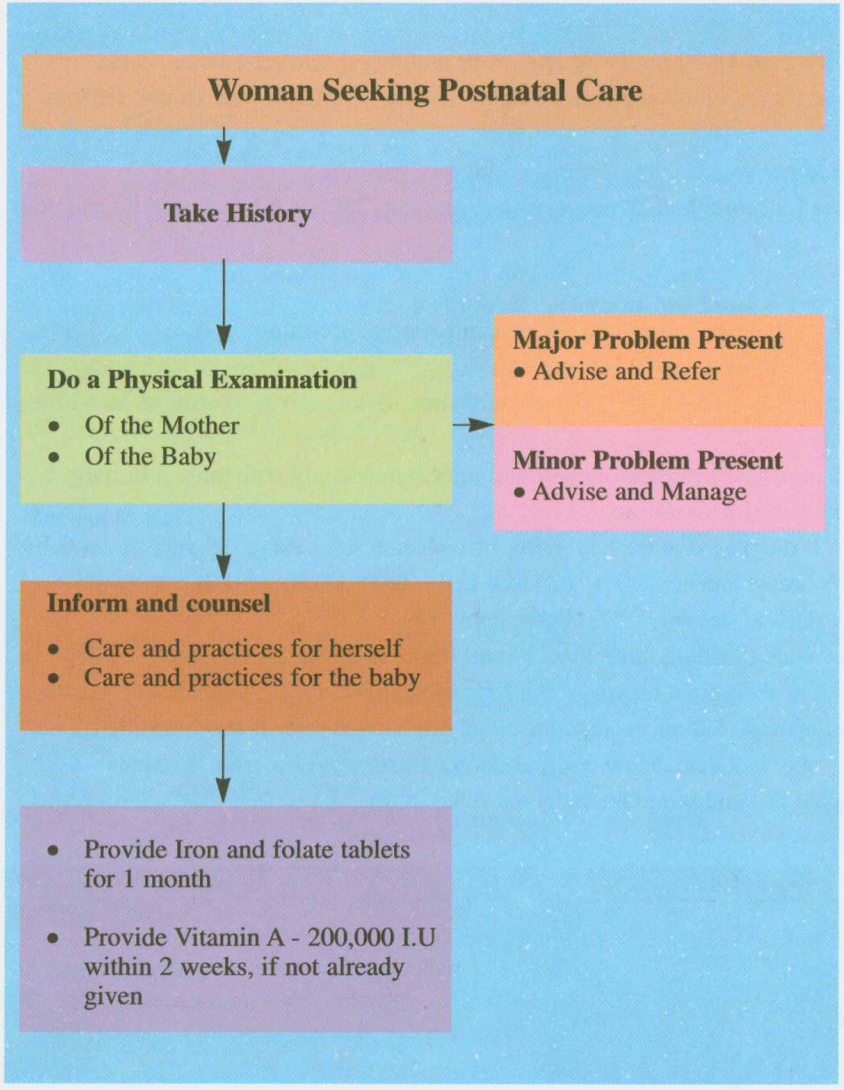
Manage and Refer

- Convulsions: Inj. Diazepam 10-20 mg IV or IM, insert mouth gag and refer when stable
- Headache, blurring of vision, blood pressure >140/90 mm Hg - Inj Diazepam 10 mg. IM and refer
- Passage of fresh blood per vagina : 5% Dextrose Saline IV and refer
- Rupture of membrane for more than 24 hours: Cap Ampicillin 250 mg 6 hourly, sterile pad and refer
- Cord around neck
  - ⇒ If the loop of the cord is loose slip around neck
  - ⇒ If loop is tight, tie cord at two points and divide using aseptic precautions
- If baby does not breathe, start artificial respiration
- Ruptured uterus: refer immediately with 5% Normal Saline. Ask relatives to arrange blood for transfusion
- Cord prolapse: Push cord above presenting part and refer immediately with patient in lying position and buttocks raised with pillow
- Multiple pregnancy: If diagnosed at the beginning of 1st stage, refer. After delivery of 1st baby, let it suckle mother's breast immediately to enhance delivery of 2nd baby. If 2nd baby not delivered within 15 mins. of delivery of 1st baby, refer
- After delivery of placenta, bleeding more than 300 ml (more than one glass): empty bladder, let baby suckle breast, give abdominal massage, Inj. Ergometrine 0.5 mg IV, IV drip with Oxytocin - 20 units in 500 cc Dextrose Saline, arrange for blood donors and refer if not controlled
- Retained placenta: empty bladder, suckle baby, abdominal massage of uterus. If initial management fails, give IV fluid with Oxytocin and refer

Inform and counsel at discharge

- To come for postnatal visit at or after 6 weeks
- Vaccination of the newborn
- Feeding the newborn (colostrum, exclusive breastfeeding)
- Contraceptive counselling

Postnatal Care



History Taking

Mother

- Age
- Date of delivery
- Description of delivery
- Contraceptive use feeding
- Any problem during urination or defaecation, abdominal pain, excess or foul smelling vaginal discharge
- Any other problem

New Born

- Any health problem
- Any problem with feeding

Physical Examination

Mother

- Temperature
- Pulse
- Blood pressure
- Anaemia
- Oedema
- Breast and nipple
- Height of uterus
- Perineum
  If C/S, abdominal wound
- Vaginal bleeding/ discharge

Newborn

- Weight
- Temperature
- Umbilicus
- Eyes
- Skin
- Fontanelle
- Mouth for thrush

Major Postpartum Problems

- Excessive vaginal bleeding - inj. Ergometrin 0.5 mg. IV
- Puerperal pyrexia*
  - Puerperal sepsis-Inj. Ampicillin 500mg IM
  - Urinary Tract Infection (UTI)
  - Breast abscess
  - Thrombosis
  - Acute Respiratory Infection (ARI)
  - Wound infection
- Perineal tear
- Post-partum eclampsia - Inj. Diazepam 10-20 mg IV, mouth gag and refer after stable
- Sub-involution of the uterus
- Vesico-vaginal fistula/recto-vaginal fistula

* Fever more than 100.4° F and persisting more than 24 hours

Minor Postpartum Problems of Mother

Problem	Management and Advice
Breast engorgement	Routine expression of milk and continue breastfeeding
Cracked nipple	Manual expression of Milk Help in correct positioning of the baby to the breast Continue breastfeeding in correct positions
Anaemia	Iron and folate tablets twice daily for 1 month Iron-rich food (e.g. beans, green leafy vegetables, liver, eggs)
Burning sensation during urination	Advise to drink plenty of water
Loose motion	Improve nutrition and treat diarrhoea

Major Problems of the Newborn

- Reluctant to feed
- Hypothermia
- Fever
- Umbilical sepsis
- Jaundice within 1st day
- Purulent eye discharge

Minor Problems of the Newborn

Problem	Management and Advice
Physiological jaundice	Expose newborn to morning sunlight (without cloths) keeping eyes and head covered. If not subsiding in 7 days, refer
Umbilical infection	Spirit wash & local antibiotic
Caput	Reassure mother
Succedneum	
Cephalhaematoma	Reassure mother

Contraceptive Advice After Delivery
(Screening should be done for all cases)

- Injectables - after 6 weeks
- IUD- after 6 weeks. If caesarean section, after 3 months
- Condom-any time
- Sterilization-six weeks after delivery
- For Non -lactating mothers (Intra-uterine death/still birth or death of the baby):
  In addition to above
  Pills - after 6 weeks
- For lactating mothers:
  In addition to above
  Explain that chance of pregnancy is very low for 5 months if breastfeeding exclusively, menses have not returned, interval between feeds is not more than 6 hours, baby feeds day and night

Inform and Counsel

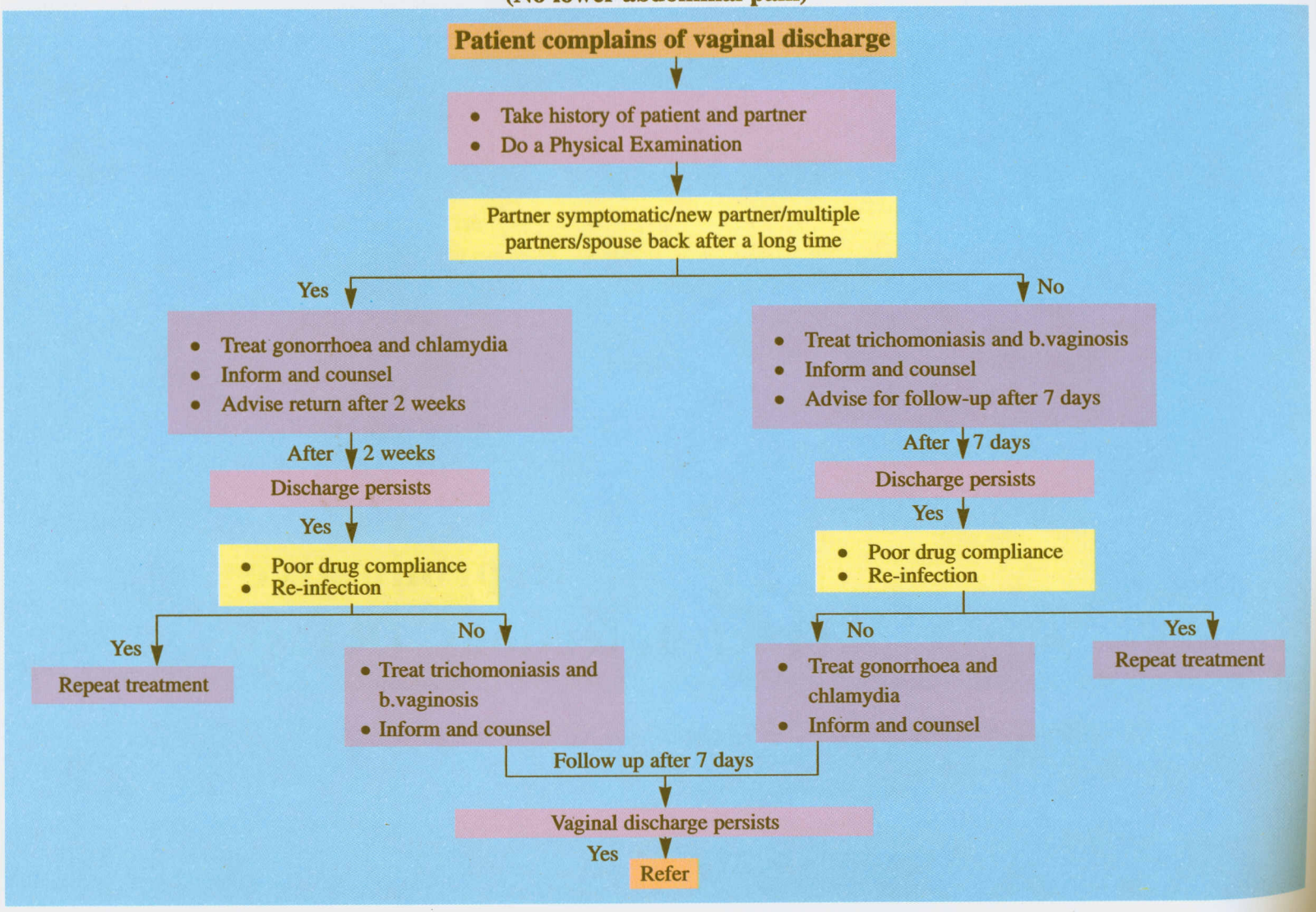
- Personal hygiene
- Diet of the mother during lactation
- Care of the breasts
- Exclusive breastfeeding
- Cord care (keep open and dry)
- Vaccinating the newborn (immunization schedule)
- Contraception after delivery

Reproductive Tract Infections (RTIs)

Vaginal Discharge

[without Speculum Examination]

(No lower abdominal pain)



History taking:

- History and nature of vaginal discharge
- Pain in lower abdomen
- Partner symptoms/Recent new partner/Multiple partners/Spouse home after long stay away
- Pregnancy history
- Present contraceptive use

Physical Examination

- Abdominal examination
  - ⇨ Palpate the lower abdomen and look for pelvic tenderness

Check for other Reproductive Tract Infections (RTIs)/ Sexually Transmitted Infections (STIs)

Treatment of Vaginal Discharge Syndrome
[Without Speculum Examination]

Gonorrhoea

Tab. Ciprofloxacin 500 mg orally as a single dose
(not in pregnancy or lactation)
or
Inj. Ceftriaxone 250 mg IM as a single dose

Chalmydial infection

Cap. Doxycycline 100 mg orally 12 hrly x 7 days
(not in pregnancy or lactation)
or
Cap. Tetracycline 500 mg orally 6 hrly x 14 days
(not in pregnancy or lactation)
or
Tab. Erythromycin 500 mg orally 6 hrly for x 7 days

Trichomoniasis and Bacterial Vaginosis

Tab. Metronidazole 2 gm orally as a single dose
or 400 mg 2 times daily x 7 days
(not recommended in 1st trimester of pregnancy)

Candidiasis

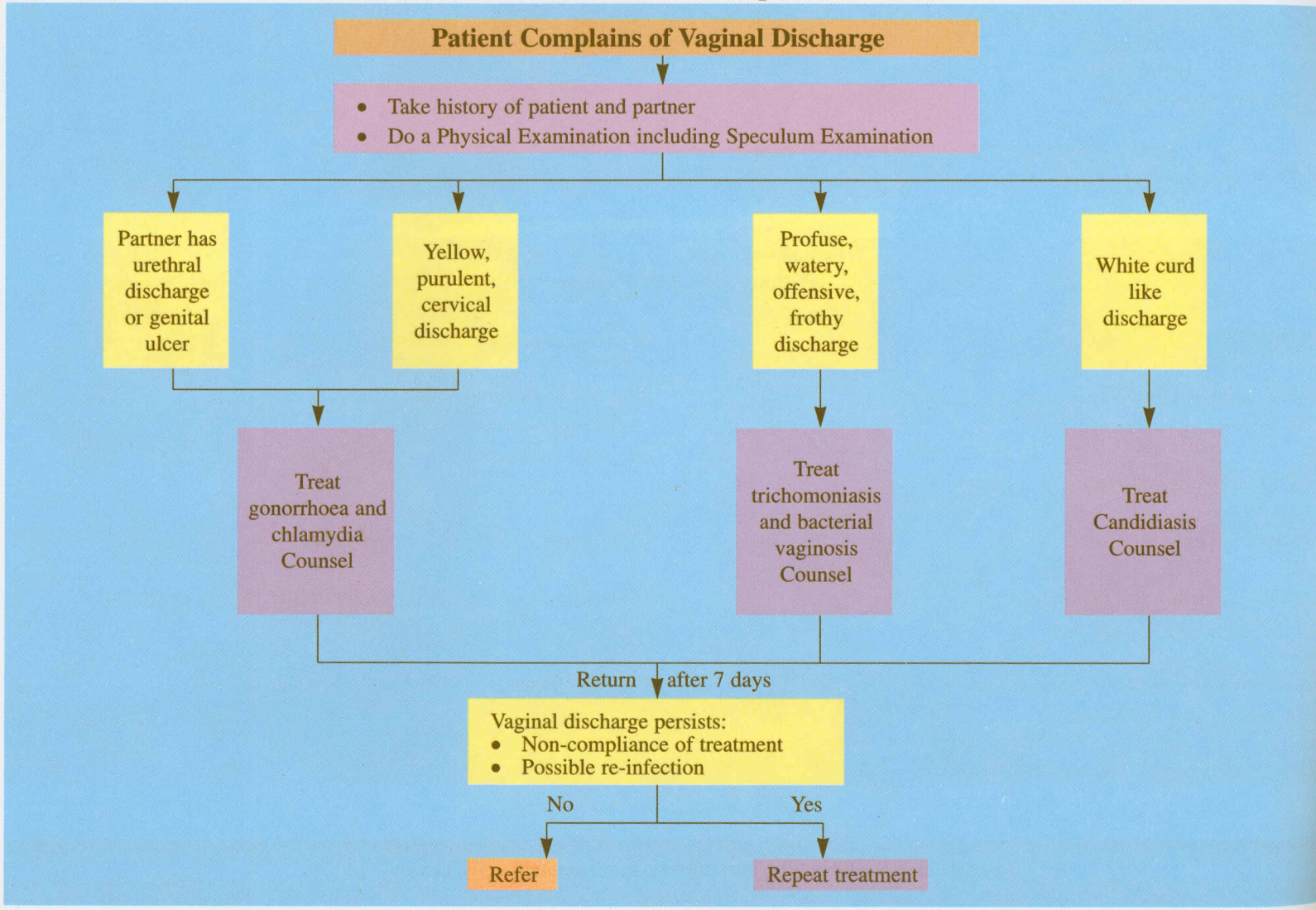
Clotrimazole or Miconazole vaginal tab. 150 mg intravaginally for 3 days
or
Cap. Fluconazole 150 mg orally as a single dose

For information, counselling and partner management, refer to pages 23, 24

Vaginal Discharge

[speculum examination]

(No lower abdominal pain)



History taking:

- History and nature of vaginal discharge
- Pain in lower abdomen
- Partner symptoms/Recent new partner/Multiple partners/Spouse home after long stay away
- Pregnancy history
- Present contraceptive use

Physical Examination:

- Abdominal examination
  - ⇒ Palpate the lower abdomen and look for pelvic tenderness
- Use a speculum to examine vagina and cervix
  - ⇒ Note type, colour, odour, amount and origin of discharge
  - ⇒ Look for IUD thread where applicable

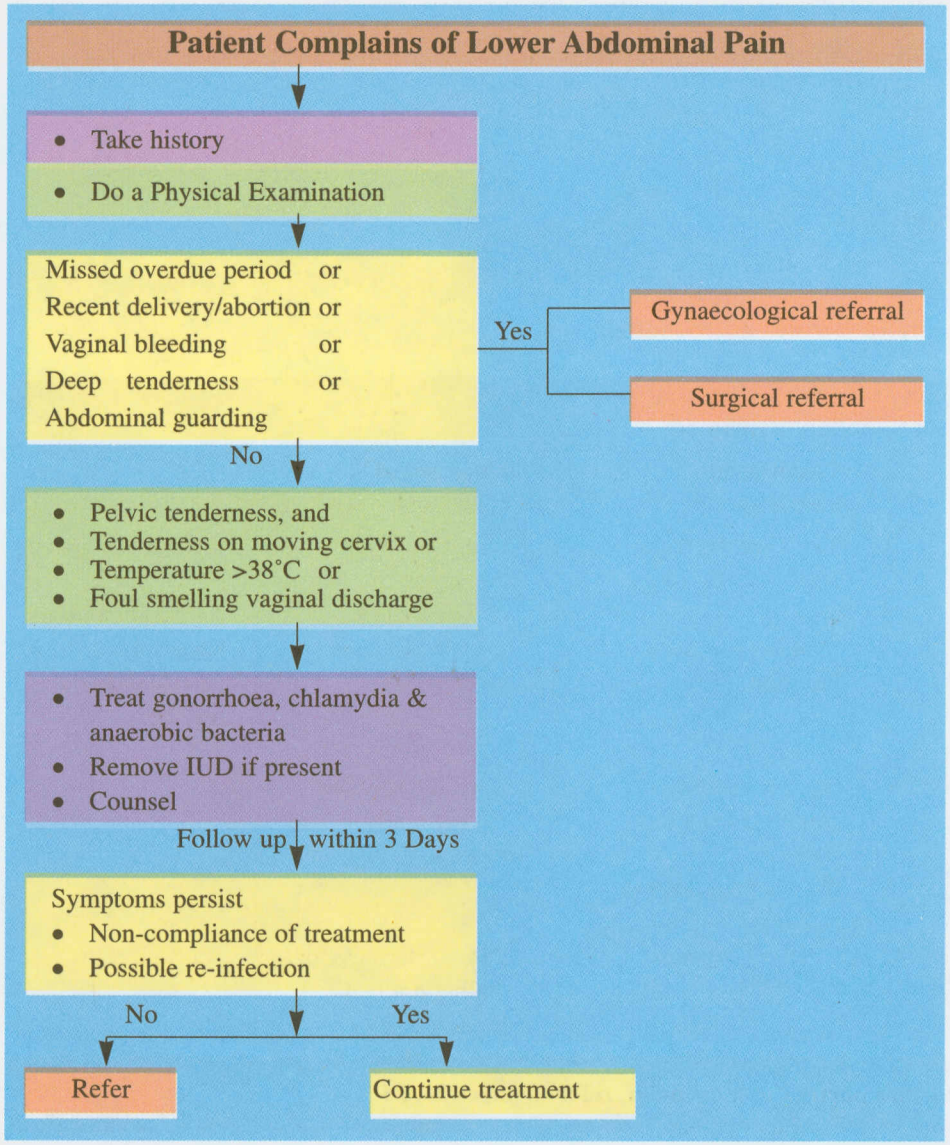
Check for other Reproductive Tract Infection (RTI) / (Sexually Transmitted Infections (STIs)

Treatment for Vaginal Discharge [With Speculum Examination]

Trichomoniasis and Bacterial Vaginosis	**Candidiasis**	**Gonococcal Cervicitis**	**Chlamydial Cervicitis**	
Tab. Metronidazole: 2 gm orally single dose or 400 mg orally twice daily x 7 days [Not in 1st trimester of pregnancy]	Any one of the following: Clotrimazole vaginal tab. 500mg once only Clotrimazole/ Miconazole vaginal tab. 150 mg once x 3 days Nystatin vaginal tab.: 100,000 units once x 14 days 1% Gentian Violet: Local application for 3 consecutive nights Cap. Fluconazole 150 mg orally as a single dose	Tab. Ciprofloxacin: 500mg orally single dose [Not in pregnancy or lactation] or Inj. Ceftriaxone: 250mg IM single dose [Not in pregnancy or lactation]	Cap. Doxycycline: 100 mg orally twice daily x 7 days [Not in pregnancy or lactation] or Cap. Tetracycline: 500mg orally 4 times x 14 days or Tab. Erythromycin: 500mg orally 4 times x 7 days	If there is a mixed infection then treat for trichomoniasis, bacterial vaginosis and candidiasis together

For information, counselling and partner management, refer to pages 23, 24

Lower Abdominal Pain



History taking:

- History and nature of pain in lower abdomen
- Other symptoms:
  - Missed or overdue menses
  - Recent delivery or abortion
  - Abnormal vaginal bleeding
- Contraceptive use

Physical Examination:

- Palpate the abdomen and look for:
  - Rebound tenderness
  - Abdominal guarding
  - Swelling or lump in the abdomen
- Do a pelvic examination and look for:
  - Abnormal vaginal bleeding
  - Pain during examination (tenderness on moving the cervix)
  - Abnormal (foul smelling) vaginal discharge
  - Look for IUD thread
- Check for other Reproductive Tract Infection(RTI) / Sexually Transmitted Infections (STIs)

Surgical referral for:

- Deep tenderness
- Abdominal guarding
- Missing IUD thread

Gynaecological referral for:

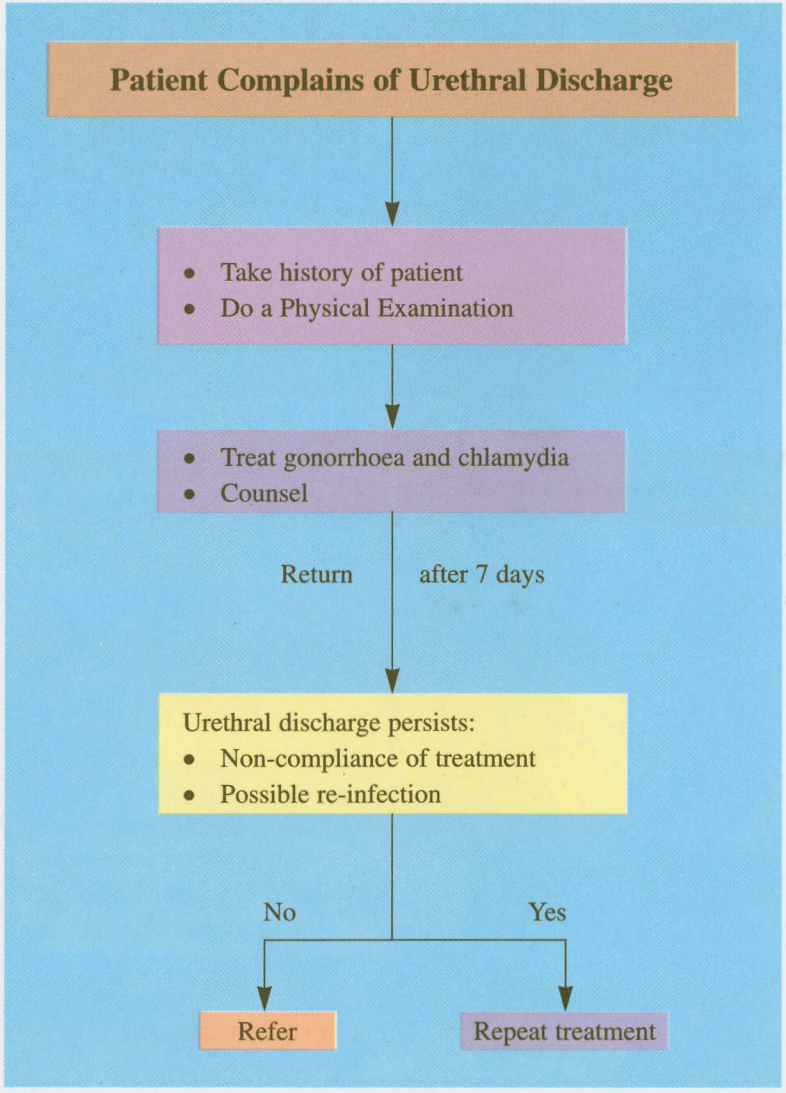
- Missed or overdue menses
- Recent delivery or abortion
- Abnormal vaginal bleeding

Treatment for Pelvic Inflammatory Disease (PID)

Gonorrhoea	Chlamydia	Anaerobic Bacteria
Tab. Ciprofloxacin: 500mg oral single dose [Not in pregnancy or lactation] or Inj. Ceftriaxone: 250mg IM single dose	Cap. Doxycycline: 100mg orally twice x 14 days [Not in pregnancy or lactation] or Cap. Tetracycline: 500mg orally 4 times x 14 days [Not in pregnancy or lactation] Tab. Erythromycin: 500mg orally 4 times x 7 days	Tab. Metronidazole: 400mg orally twice daily x 14 days [Not in 1st trimester of pregnancy]

For information, counselling and partner management refer to pages 23, 24

Urethral Discharge



History taking:

- History and nature of urethral discharge

Physical Examination:

- Inspect the genital organs and look for urethral discharge (milk urethra, if necessary)
- Check for other Reproductive Tract Infections (RTIs) / Sexually Transmitted Infections (STIs)

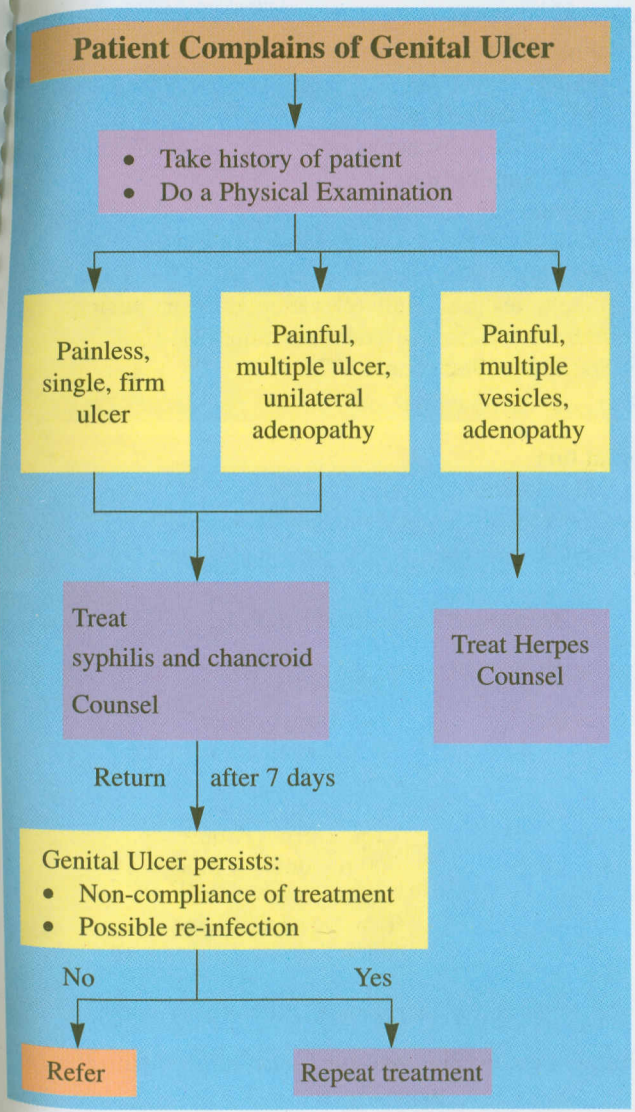
Treatment for Urethral Discharge

Gonorrhoea	Chlamydia
Tab. Ciprofloxacin:* 500 mg orally single dose or	**Cap. Doxycycline:*** 100 mg orally twice x 7 days or
Inj. Ceftriaxone: 250 mg IM single dose	**Cap. Tetracycline:*** 500 mg orally 4 times x 7 days or **Tab. Erythromycin:** 500 mg orally 4 times x 7 days

* Should not prescribe for partner if she is pregnant or lactating

For information, counselling and partner management refer to pages 23, 24

Genital Ulcer



History taking:

- History and nature of ulcer
- History of exposure

Physical Examination:

- Inspect the genital organs and look for
  ➙ Ulcers
- Check for other Reproductive Tract Infections (RTIs) / Sexually Transmitted Infections (STIs)

Treatment for Genital Ulcer

Syphilis

Inj.Benzathine Penicillin:
2.4 million units deep IM single dose (after skin test) or

Cap. Tetracycline:
500 mg orally 4 times x 14 days
[Not in pregnancy or lactation] or

Cap. Doxycycline:
100 mg orally twice x 14 days
[Not in pregnancy or lactation] or

Tab. Erythromycin:
500 mg orally 4 times x 14 days

Chancroid

Tab. Erythromycin:
500 mg orally 4 times x 14 days or

Tab. Ciprofloxacin:
500 mg orally single dose
[Not in pregnancy or lactation] or

Inj. Ceftriaxone:
250 mg IM single dose or

Tab. Cotrimoxazole:
2 tablets orally 2 times x 7 days

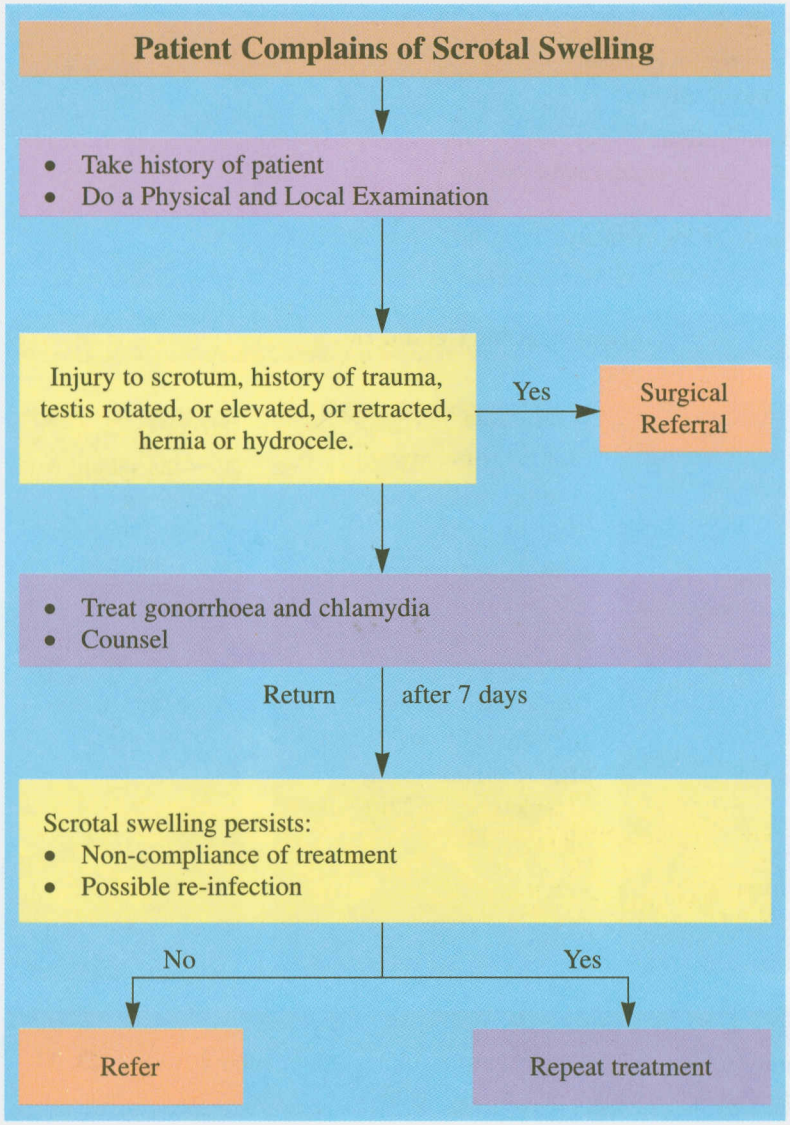
Herpes

Lesions should be kept clean by washing with soap and water and drying carefully.

1% Gentian violet:
Paint lesions twice daily for 3 weeks.

For information, counselling and partner management refer to pages 23, 24

Scrotal Swelling



History taking:

- History and nature of scrotal swelling
- History of injury
- History of STI in last 6 weeks
- History of any urethral discharge

Physical and Local Examination:

- Inspect the scrotal skin for bruises
- Compare two sides of the scrotum and scrotal sacs
- Swelling and tenderness of testes
- Position of the testes in scrotum (elevation, rotation, torsion)
- Check for other Reproductive Tract Infection(RTI) / Sexually Transmitted Infections (STIs)

Surgical referral for:

- Swelling and tenderness of testes
- Elevation, rotation, torsion or trauma of the testes
- Inguinal hernia/hydrocele

Treatment for Scrotal Swelling

Gonorrhoea	Chlamydia
Tab. Ciprofloxacin:* 500 mg orally single dose	**Cap. Doxycycline:*** 100 mg orally twice x 10 days or
or	
Inj. Ceftriaxone: 250 mg IM single dose	**Cap. Tetracycline:*** 500 mg orally 4 times x 10 days or
	Tab. Erythromycin: 500 mg orally 4 times x 10 days

* Should not prescribe for partner if she is pregment or lactating

For information, counselling and partner management refer to page 23, 24

Inguinal Bubo

Patient Complains of Enlarged and Painful Inguinal Lymph Nodes

- Take history of patient
- Do a Physical Examination

Enlarged and painful inguinal lymph nodes present

- Treat lymphogranuloma venereum
- Counsel

Return after 14 days

Inguinal swelling persists:
- Non-compliance of treatment
- Possible re-infection

No → Refer

Yes → Repeat treatment

History taking:

- History of groin pain
- Recent or past genital ulcer
- Recent or past swelling anywhere in the body
- History of exposure or contact

Physical Examination:

- Palpate inguinal lymph nodes for:
  - Tenderness, warmth, fluctuation
- Draining area
- Inspect genital organs for ulcers
- Check for other Reproductive Tract Infection(RTI) / Sexually Transmitted Infections (STIs)

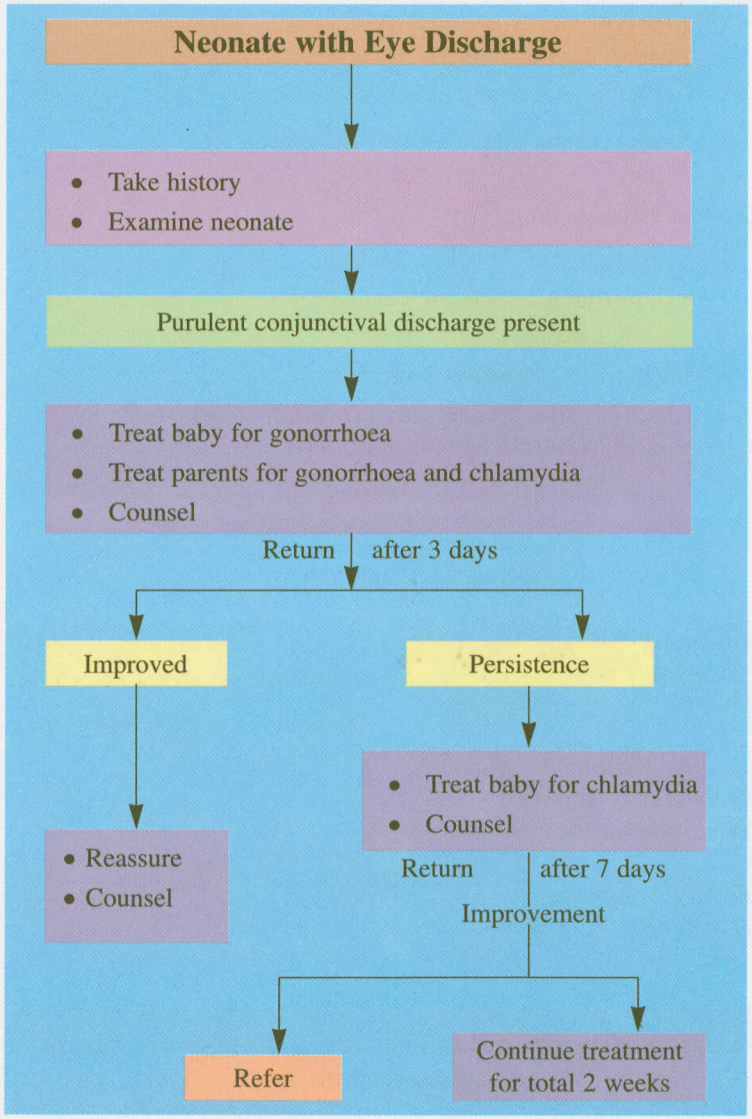
Treatment for Inguial Bubo Lymphogranuloma Venereum

Cap. Doxycycline:
100 mg orally twice x 14 days
(Not in pregnancy and lactation)
or
Cap. Tetracycline:
500 mg orally 4 times x 14 days
(Not in pregnancy and lactation)
or
Tab. Erythromycin:
500 mg orally 4 times x 14 days

- Buboes should not be incised
- Refer for surgical aspiration of fluctuant bubo

For information, counselling and partner management refer to pages 23, 24

Neonatal Conjunctivitis



History taking:

- History of Sexually Transmitted Infections (STI) in mother or father

Examination of the baby:

- Inspect baby's eyes for purulent discharge:
  (Separate or press the eye lids, to look for pus pouring out from beneath them)

Treatment for Neonatal Conjunctivitis

Treatment of Neonate		Treatment of Parents	
Gonococcal Ophthalmia	**Chlamydial Ophthalmia**	**Gonorrhoea**	**Chlamydia**
Inj. Ceftriaxone: 50mg/kg (max 125) IM single dose	Erythromycin Syrup: 50mg/kg orally 4 times x 14 days	Tab. Ciprofloxacin: 500 mg orally single dose [Not in pregnancy or lactation]	Cap. Doxycycline: 100 mg orally twice x 7 days [Not in pregnancy or lactation]
or	or	or	or
Inj. Kanamycin: 25mg/kg(max 75) IM single dose	Cotrimoxazole Syrup: 5 ml orally 2 times x 14 days	Inj. Ceftriaxone: 250mg IM single dose	Tab. Tetracycline: 500 mg orally 4 times x 7 days [Not in pregnancy or lactation] or Tab. Erythromycin: 500 mg orally 4 times x 7 days

Care of Baby's Eyes:

- Clean baby's eyes with saline or water using a swab
- Clean from inside to the outside edge of each eye
- Wash hands carefully afterwards

For information, counselling and partner management, refer to pages 23, 24

Information, Counselling and Partner Management for Reproductive Tract Infections (RTIs)/ Sexually Transmitted Infections (STIs)

Information

- Give necessary instructions for the patient to complete full course of treatment
- Emphasize treatment completion even if symptoms disappear
- To prevent re-infection: avoid sexual contact during treatment and till partner is treated (if necessary, use condom in the meantime)
- Encourage follow-up visit if not cured

Counselling for Prevention

Every patient with RTI/STI must understand:

- Some of the RTIs (Bacterial vaginosis, candidiasis) are due to lack of personal hygiene
- He/she may get the infection through sexual contact
- He/she can get other infections, including HIV/AIDS which can result in serious complications
- Safer sex practices and use of condoms
- Assess, identify and inform patient of risky practices and help the patient to adapt.

Provide and Encourage Condom Use

- Inform all clients about condom use to minimize spread of STIs/AIDS
- Demonstrate use of condoms to all RTI/STI clients
- Provide condoms for all RTI/STI clients

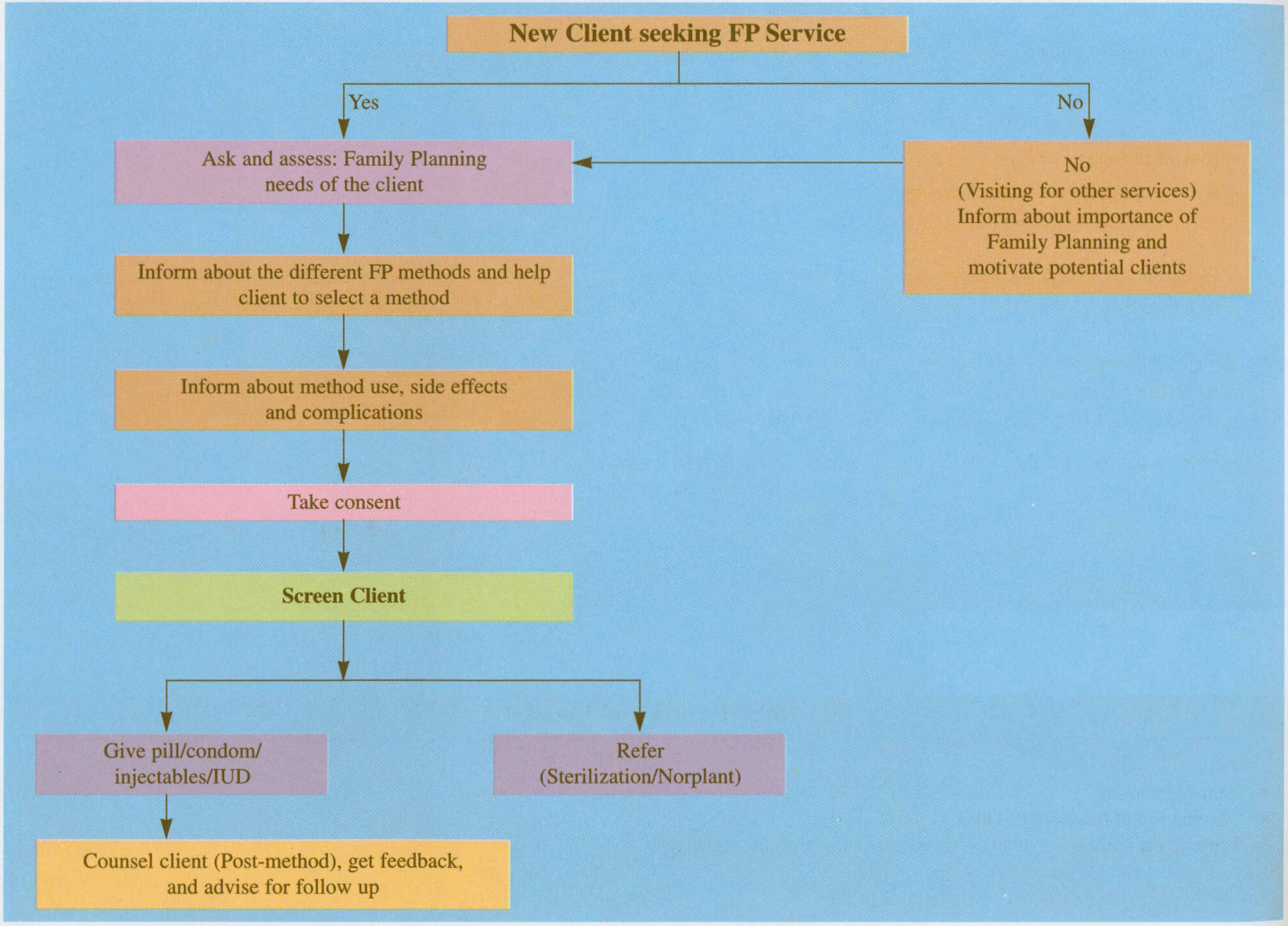
Partner Management

- Help the patient to understand the importance of partner management even if partner is asymptomatic:
  - Risk of re-infections from partner
  - Risk of complication of the partner
  - Partner should be treated even if asymptomatic
- If the partner is a pregnant woman or a lactating mother, use the alternative medicines for ceprofloxacin, doxycyline, tetracyline, and metronidazol in 1st trimester of pregnancy
- Possible ways of partner management:
  - Bring the partner to the clinic
  - Giving the drugs for the partner
  - Using a partner referral card with unique identification number for linkage

also Inform and Counsel

- Family Planning
- Vaccination of the child (if child <1 year)
- Feeding the child < 2 years (breastfeeding/complementary feeding)

Family Planning Service



Family Planning needs of the client

Ask and Assess:

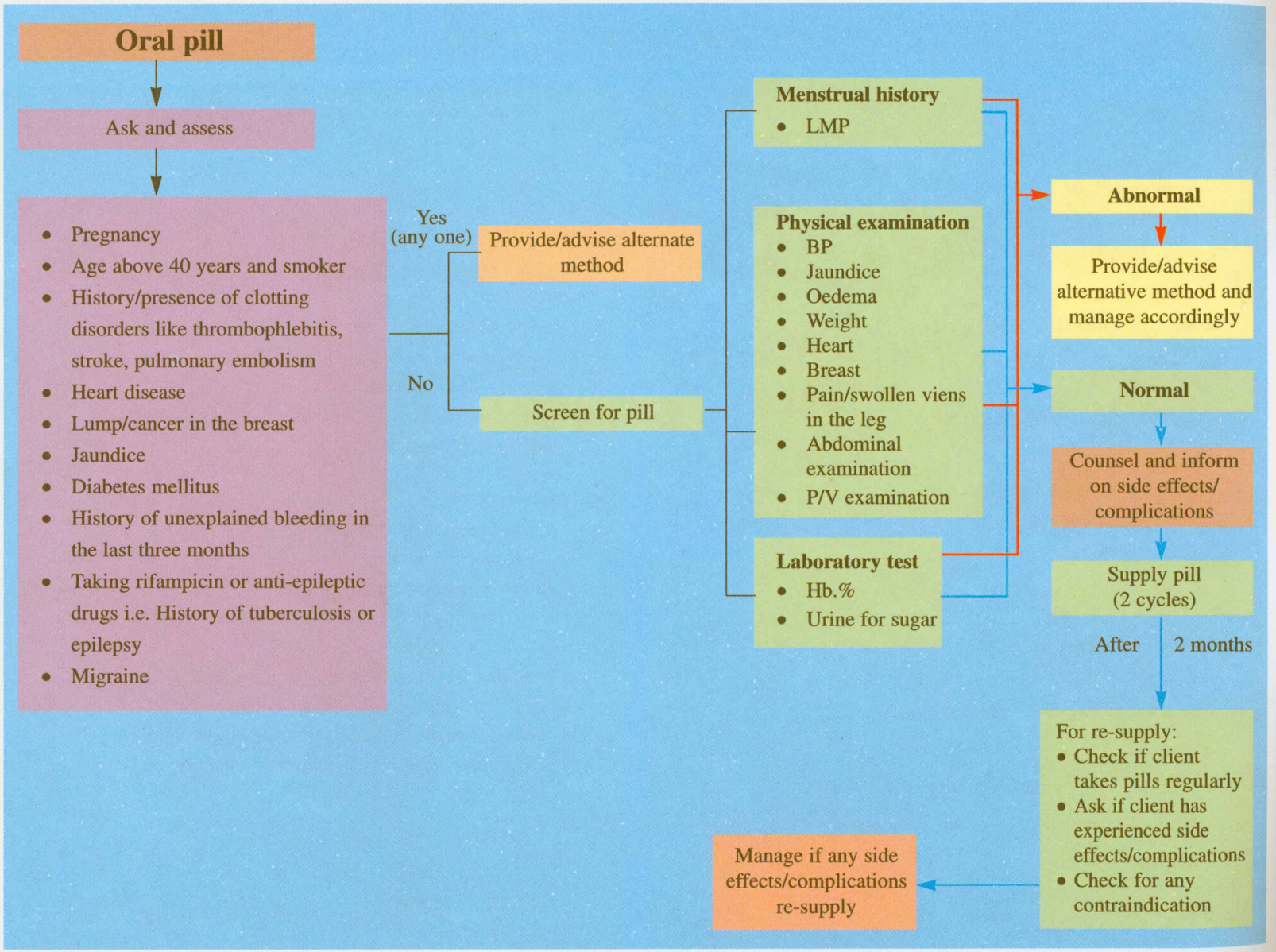
- Client's reproductive status
  - Number of living children
  - Age of last child
  - Obstetric history
- Client's reproductive goals
  - Whether more children desired
  - If yes, when next child desired
- Client's knowledge of contraceptive methods
- Preference for any particular contraceptive method

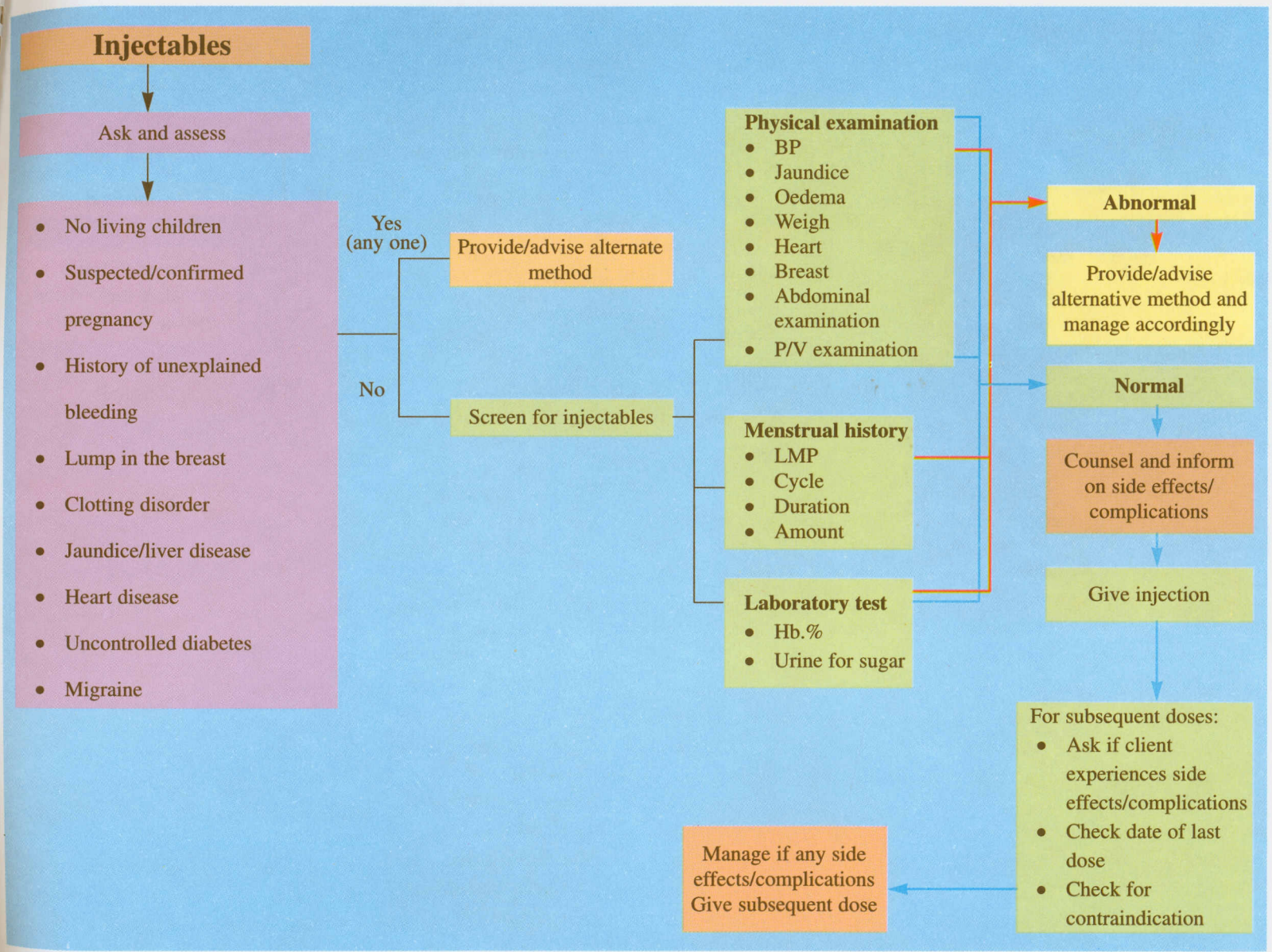
Screening of the client

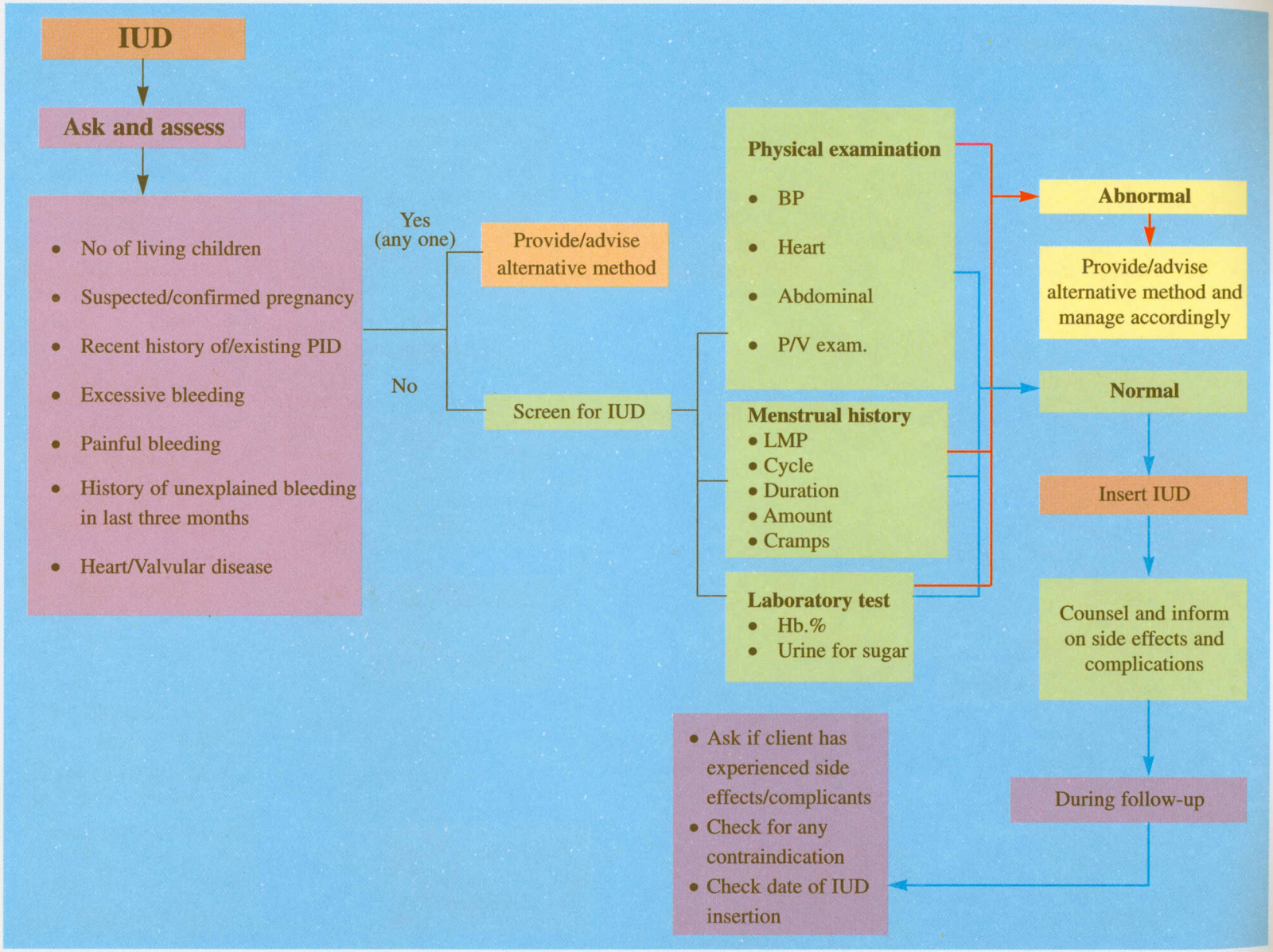
- **Client's medical and menstrual history**
  - Age
  - Previous use of contraceptives and side-effects
  - Physical examination, including any psychological abnormalities
  - Menstrual history

Screening of the client (continued)

- **Obstetric history**
  - Total number of pregnancies
  - Number of living children
  - Age of last child, whether currently breastfeeding, and, if so, whether exclusively
- **Take history of:**
  - previous abdominal/uterine surgery
  - hypertension and diabetes
  - stroke or severe pain in the legs
  - lump/swelling in the breast
  - jaundice in the past one year
  - heart disease, chest pain, shortness of breath
  - swollen painful veins in the legs
  - severe lower abdominal pain, or low back pain
  - ectopic pregnancy, caesarean section, uterine prolapse


Oral pill
Ask and assess
Pregnancy
Age above 40 years and smoker
History/presence of clotting disorders like thrombophlebitis, stroke, pulmonary embolism
Heart disease
Lump/cancer in the breast
Jaundice
Diabetes mellitus
History of unexplained bleeding in the last three months
Taking rifampicin or anti-epileptic drugs i.e. History of tuberculosis or epilepsy
Migraine
Yes (any one)
Provide/advise alternate method
No
Screen for pill
Menstrual history
LMP
Physical examination
BP
Jaundice
Oedema
Weight
Heart
Breast
Pain/swollen viens in the leg
Abdominal examination
P/V examination
Laboratory test
Hb.%
Urine for sugar
Abnormal
Provide/advise alternative method and manage accordingly
Normal
Counsel and inform on side effects/ complications
Supply pill (2 cycles)
After
2 months
For re-supply:
Check if client takes pills regularly
Ask if client has experienced side effects/complications
Check for any contraindication
Manage if any side effects/complications re-supply


Injectables
Ask and assess
No living children
Suspected/confirmed pregnancy
History of unexplained bleeding
Lump in the breast
Clotting disorder
Jaundice/liver disease
Heart disease
Uncontrolled diabetes
Migraine
Yes (any one)
Provide/advise alternate method
No
Screen for injectables
Physical examination
BP
Jaundice
Oedema
Weigh
Heart
Breast
Abdominal examination
P/V examination
Menstrual history
LMP
Cycle
Duration
Amount
Laboratory test
Hb.%
Urine for sugar
Abnormal
Provide/advise alternative method and manage accordingly
Normal
Counsel and inform on side effects/ complications
Give injection
For subsequent doses:
Ask if client experiences side effects/complications
Check date of last dose
Check for contraindication
Manage if any side effects/complications Give subsequent dose


IUD
Ask and assess
No of living children
Suspected/confirmed pregnancy
Recent history of/existing PID
Excessive bleeding
Painful bleeding
History of unexplained bleeding in last three months
Heart/Valvular disease
Yes (any one)
Provide/advise alternative method
No
Screen for IUD
Physical examination
BP
Heart
Abdominal
P/V exam.
Menstrual history
LMP
Cycle
Duration
Amount
Cramps
Laboratory test
Hb.%
Urine for sugar
Abnormal
Provide/advise alternative method and manage accordingly
Normal
Insert IUD
Counsel and inform on side effects and complications
During follow-up
Ask if client has experienced side effects/complicants
Check for any contraindication
Check date of IUD insertion

Method use, Side-effects and Complications

Method	Method Use	Side-effects	Complications/Danger Signs
Pill	• Start pills on first day of menstruation • Take a pill same time every day	• Amenorrhoea • Spotting • Nausea • Headache • High blood pressure • Breast tenderness or heaviness • Depression •Unwanted weight gain or loss • Acne • Chloasma	• Severe abdominal pain • Severe chest pain, cough, shortness of breath • Severe headache, vertigo, or paralysis of any part of the body • Eye problem (blurred vision) or difficulty in speech • Severe leg pain
Injectable	• Within 5 days of onset of menstruation • After 6 weeks of delivery or immediately after abortion • Follow up doses (15 days of schedule (2/3 months)	• Amenorrhoea • Spotting or breakthrough bleeding • Excessive vaginal bleeding (menorrhagia) • Minor problems (significant unwanted weight gain, headache, dizziness, depression) • Sore or abscess at the site of injection • Eye or skin is yellow	• Excessive bleeding • Excessive weight gain • Severe headache • Severe abdominal pain
IUD	• Within 5-7 days of onset of menstruation • After 6 weeks of delivery or immediately after abortion (within 2 weeks)	• Vaginal bleeding and/or lower abdominal pain • Pain and uterine cramps	• Expulsion of IUD/missing thread • Perforation of uterus • Pregnancy or ectopic pregnancy • PID

Inform and Counsel

If client has a child < 1 year of age:

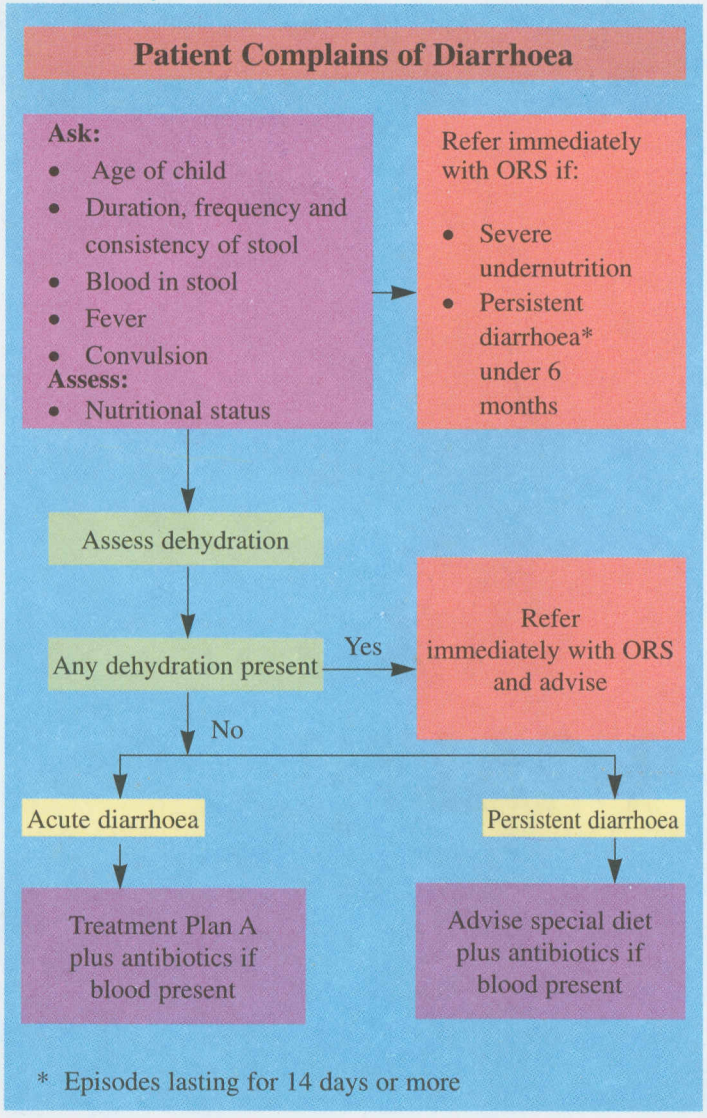
- Vaccination of the child (if child <1 year)
- Breastfeeding

Methods suitable for different types of clients

Status of the client	Method suitable
* With no children and wish to delay the first child	Condom/Pill
* With one child and desires no more children	IUD/Norplant/Injectables/Condom/Pill
* With one/more children, desires more children but wish to space pregnancies (at least one year)	IUD/ Injectables/Condom/Pill
* With one/more children, desires more children but wish to space pregnancies (more than 5 years)	IUD/ Injectables/Norplant/Condom/Pill
* With 2 children, want no more children, and youngest child is <2 years old	IUD/Norplant/Injectables
* With 2 children, want no more children, and youngest child is > 2 years old	Vasectomy/ Tubectomy/IUD/Injectables/Norplant
*With >2 children, want no more children	Vasectomy/Tubectomy/IUD/Injectables/Norplant
* Within 5 months after delivery	IUD/Norplant/Injectables/Condom
* More than 5 months after delivery	IUD/Norplant/Injectables/Condom

CHILD HEALTH

Diarrhoea



Assessment of Dehydration

General Condition	Well, alert	***Restless Irritable***	***Lethargic unconscious, floppy***
Eyes	Normal	Sunken	Very sunken and dry
Tears	Present	Absent	Absent
Mouth & Tongue	Moist	Dry	Very dry
Thirst	Not thirsty	***Thirsty, drinks eagerly***	***Drinks poorly or not able to drink***
Skin Pinch	Goes back quickly	*Goes back **Slowly***	*Goes back **very slowly***
Decision:	NO SIGNS OF DEHYDRATION	If 2 or more signs present including 1 ***sign*** there is SOME DEHYDRATION	If 2 or more signs present, including 1 ***sign*** there is SEVERE DEHYDRATION
Treatment:	Treatment Plan A	Give ORS, counsel and refer	Give ORS and refer

Treatment Plan A (Home Treatment)

Explain the 3 rules of home treatment of diarrhoea:

1. Give the child more FLUIDS than usual:
   - ORS: Give packet (enough for 2 days) and explain preparation and use (amount and frequency)
   - Give as much of home fluids as the child can take (cereal gruel, coconut water, rice water, plain water)
   - Continue fluid until diarrhoea stops

2. Give plenty of FOOD:
   - Frequent breastfeeding
   - If over 5 months: cereal/starchy food mixed with pulses, vegetable, meat/fish, and vegetable oil
   - Frequent feeding (at least 6 times/day) plus an extra meal for 2 weeks after diarrhoea stops

3. Go immediately to the hospital/clinic if not better in 2 days or any of the following develops:
   - Frequent watery stools
   - Repeated vomiting
   - Marked thirst
   - Eating and drinking poorly
   - Fever
   - Blood in stool

Treatment of Other Problems

Blood in stool:

- Cotrimoxazole*:
  Children: ⇒ <2 months 1/2 t.s.f x 2 times x 5 days
  ⇒ 2-12 months 1 t.s.f x 2 times x 5 days
  ⇒ >12 months - 5 years 1 & 1/2 t.s.f x 2 times x 5 days
  (TMP 5 mg/kg and SM x 25 mg/kg orally 2 times x 5 days)
  Adult: 2 tablets orally 2 times x 5 days
  OR
- Nalidixic Acid*:
  Children: 15 mg/kg orally 4 times x 5 days
  Adult: 1 gm orally 3 times x 5 days
- Follow up after 2 days. If still blood stained, change to second antibiotic. If still not better after 2 more days then refer

Persistent Diarrhoea in child of more than 6 months:

- Feed child as in Plan A except:
  Halve amount of milk or give yogurt
  6 meals/day of thick cereal, and oil, vegetable, pulses, meat/fish
- Follow up after 5 days
  If not improved, refer
  If improved, resume milk after 1 week and give extra food each day for at least 1 month

Fever (38° C 100.4° F):

- If under 2 months, refer to hospital without paracetamol
- If over 2 months then give paracetamol
  Treat/refer for malaria in malaria area

Convulsion:

- If temperature exceeds (40°C or 104°F) treat with paracetamol and tepid sponging

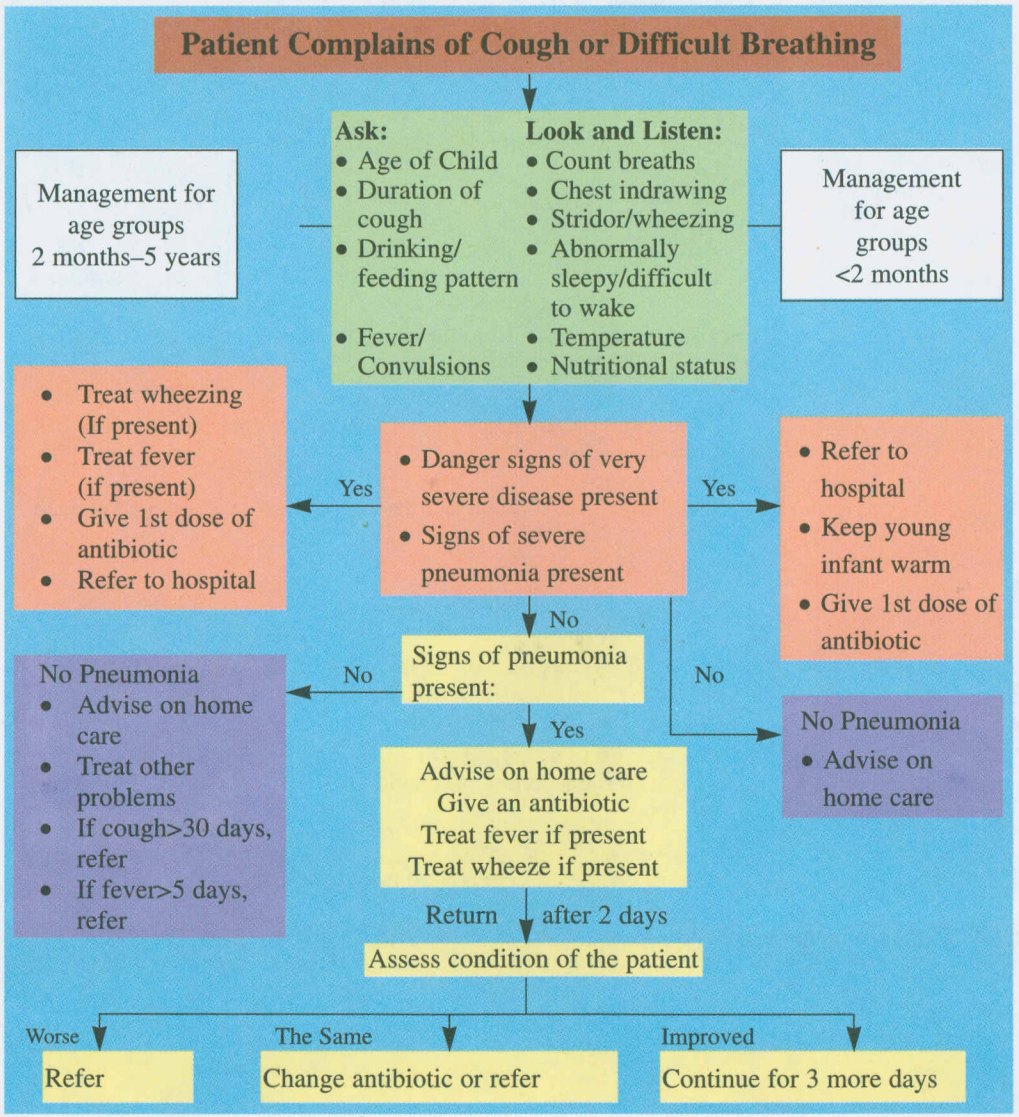
Dose of Paracetamol
2 months - 3 years:
125 mg or 1/4 tab.
every 6 hours
3 years - 5 years:
250 mg or 1/2 tab.
every 6 hours

*Choice of antibiotic depends on drug resistance in the area

Inform and Counsel (Where Appropriate)

- Feeding the child (breastfeeding/complementary feeding)
- Vaccination of the child
- Family Planning

Acute Respiratory Infections



Danger Signs of Very Severe Disease

Less than 2 months	2 months- 5 yrs
Any one of the following	**Any one of the following**
• Stopped feeding well • Convulsions • Abnormally sleepy/difficult to wake • Stridor in calm child • Wheezing • Fever or low body temperature	• Not able to drink • Convulsions • Abnormally sleepy/ difficult to wake • Stridor in calm child • Severe malnutrition

Signs of Severe Pneumonia

Less than 2 months	2 months - 5 yrs
• Severe chest indrawing and/or • Fast breathing (≥ 60/minute)	• Chest indrawing

Sings of Pneumonia

Less than 2 months	2 months - 5 yrs
None	• Fast breathing
because	≥ 50/minute (2-12 months)
Pneumonia is not classified in this age group	≥ 40/minute (≥ 12 months)

Advice on Home Care

For **All Children:**

- Breastfeed frequently/give frequent feeds during illness
- Increase feeding after illness
- Clear nose if blocked

For **2 months to 5 years**

- Increase intake of home fluids
- Soothe the throat and relieve cough with safe remedy*

For**<2 months**

- Keep young infant warm

If **No Pneumonia:**

- Go to hospital if:
  - ⇒ Breathing becomes difficult/fast
  - ⇒ The child is not able to drink or is unable to feed properly
  - ⇒ The child becomes sicker

If **Pneumonia:**

- Go to hospital if condition worsens:
  - ⇒ Not able to drink
  - ⇒ Has chest indrawing
  - ⇒ Has other danger signs
- **Signs of improvement in pneumonia cases:**
  - ⇒ Breathing slower
  - ⇒ Less fever
  - ⇒ Eating better

*Honey, tea, warm water

Antibiotic Doses

Age	Cotrimoxazole 2 times x 5 days			Amoxicillin 3 times x 5 days		Ampicillin 4 times x 5 days
	Adult Tablet (480 mg)	Paed Tablet (120 mg)	Syrup	Adult Tablet	Syrup	Syrup
<2 months	1/4	1	2.5 ml	1/4	2.5 ml	2.5 ml
2-12 months	1/2	2	5.0 ml	1/2	5.0 ml	5.0 ml
12 months -5 years	1	3	7.5 ml	1	10.0 ml	10.0 ml

Treatment of Other Problems

Fever

- If 38° C -39° C or 100·4°F-102·2°F then advise to give more fluids
- If ≥ 39° C or 102·2°F then give paracetamol
- Refer if fever for more than five days
- Treat/refer for malaria in malaria area

Wheezing:

- 0-2 months old children; **refer urgently**
- Older children with first episode of wheezing:
  - ⇒ In respiratory distress: **Oral Salbutamol and refer**
  - ⇒ Not in respiratory distress : **Oral Salbutamol**
- Older children with recurrent wheezing:
  - ⇒ **Oral Salbutamol and assess after 30 minutes:**
  - ⇒ Still in respiratory distress: **refer**
  - ⇒ Not in respiratory distress:

  Fast breathing: **Oral Salbutamol and treat pneumonia**

  No fast breathing: **Oral Salbutamol and treat no pneumonia**

Dose of Paracetamol:

- 2 months - 3 years: 125 mg. or 1/4 tab. every 6 hours
- 3 years - 5 years: 250 mg or 1/2 tab. every 6 hours

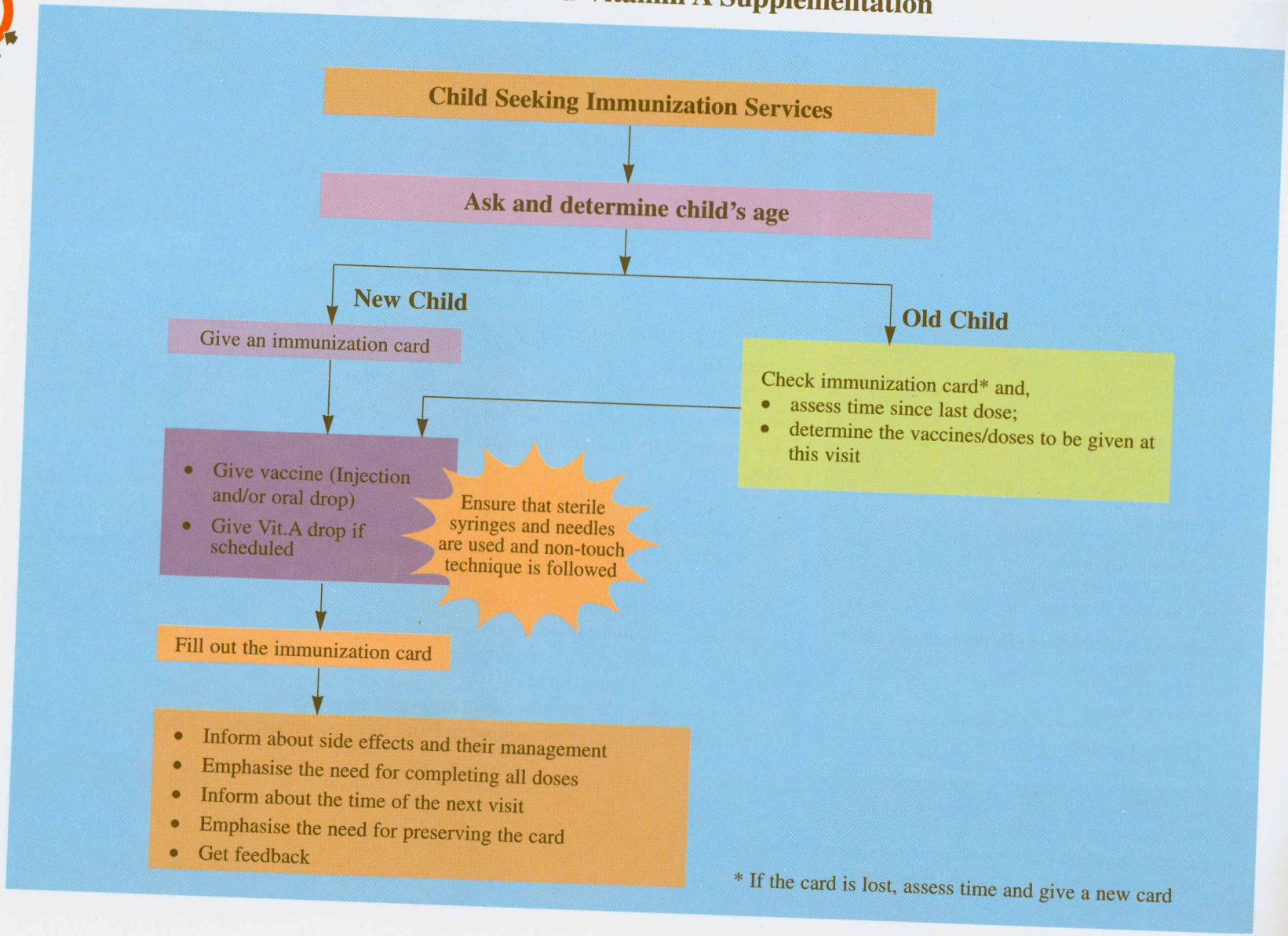
Dose of oral Salbutamol:

- 2 months - 1 year: 1 mg 3 times x 5 days
- 1 year - 5 years: 2 mg 3 times x 5 days

Inform and Counsel

- Vaccination of the child
- Feeding the child (breastfeeding/complementary feeding)
- Supplementation of Vitamin A to the Child
- Family Planning

Immunization and Vitamin A Supplementation



Vaccination schedule for children

Name of Vaccine	Starting period	Ending period	Number of doses	dose interval
BCG	At birth	1 year	1	_
DPT	At 6 weeks	1 year	3	4 weeks
OPV	At 6 weeks	1 year	4[1]	4 weeks
Measles	AT 9 months[2]	1 year	1	_

[1] The fourth dose of OPV should be given at the time of measles vaccination

[2] Measles vaccine is given when the infant has completed 9 months and has started the 10th month of life

All doses must be completed within 1 year of age

Vaccination schedule-TT for all women (15-49), including pregnant women

Dose	When to give TT
TT1	At first contact (15 years) or after 1st trimester of pregnancy
TT2	At least 4 weeks after TT-1
TT3	Minimum six months after TT-2 or during next pregnancy
TT4	Minimum one year after TT-3 or during next pregnancy
TT5	Minimum one year after TT-4 or during next pregnancy

- If not immunizaed, then first dose of TT is started from fourth month of pregnancy
- Second dose of TT is given one month after first dose or at least one month before delivery
- If two doses of TT were received in the past, one booster dose should be given every time the woman becomes pregnant

Schedule of Vit A Doses

Age/Time period	Dose
Six weeks or during first dose of DPT	1 drop/25,000 I.U.
Fourteen weeks or during third dose of DPT	1 drop/25,000 I.U.
After completion of nine months or during measles vaccination	1 drop/25,000 I.U.
One- six years	1 capsule/2,00,000 I.U. every six months

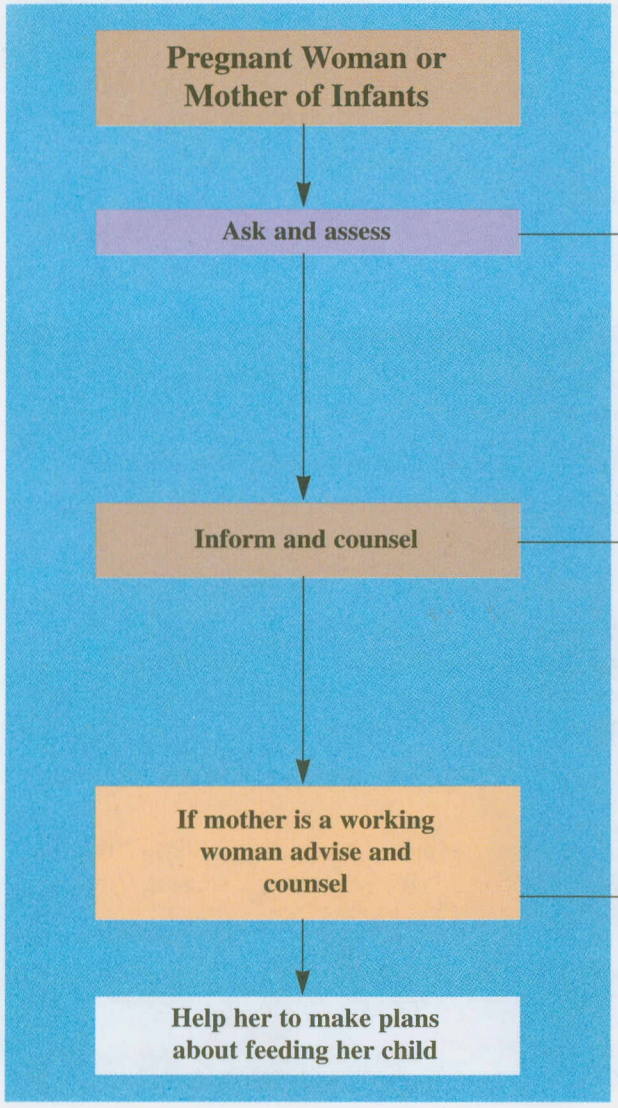
Key messages

- For complete immunization, a child has to be taken to the immunization centre 4 times
- Measles vaccine is given after 9 months have been completed
- BCG vaccination is to be started at birth or at first contact with health services
- Vaccination is not contraindicated in mild illness
- There may be mild fever and pain following a vaccination. An ulcer appears at the site of BCG vaccination; this is expected, and one should not worry about it. Re-vaccination is necessary if the ulcer does not appear within 3 months
- It is very important to preserve the immunization card for future reference
- It is important to remember that, Vit.A is given with first, third and with measles vaccination schedule and every six months from one to six years of age

Inform and Counsel

- Feeding the child (breastfeeding/complementary feeding)
- Family Planning

Counselling on Infant Feeding



- Current or previous experience with child care
  - feeding practices, including breastfeeding, and use of bottle
  - factors/persons influencing mother's decisions
- Future plans about child feeding
- Concerns and fears about child care and feeding

- Address mother's misconceptions and information gaps
- Address mother's concerns and fears
- Counsel on:
  - initiation of breastfeeding immediately after birth and giving colostrum
  - no pre-lacteal feeds like honey, sugar water, mustard oil or water
  - frequent suckling, especially at night
  - exclusive breastfeeding for 5 months
  - no bottle-feeding
  - no complementary feeds, not even water, up to 5 months
  - complementary feeding after 5 months,
- Assure the mother that she can return to the facility anytime for any advice

- On:
  - expressing breastmilk and storing properly
  - taking short breaks or taking the baby to work place

Counsel pregnant women and mothers of infants on infant feeding during

- Antenatal visits
- Postnatal visits
- Child immunization visits
- Post partum contraception visits
- others, i.e. when mother comes to the facility for consultation

It is important to understand the woman's

- Knowledge about infant and child feeding
- Beliefs regarding infant and child feeding
- Experience in infant feeding and practice with current child
- Plants for next child

Give the mother a growth card and explain

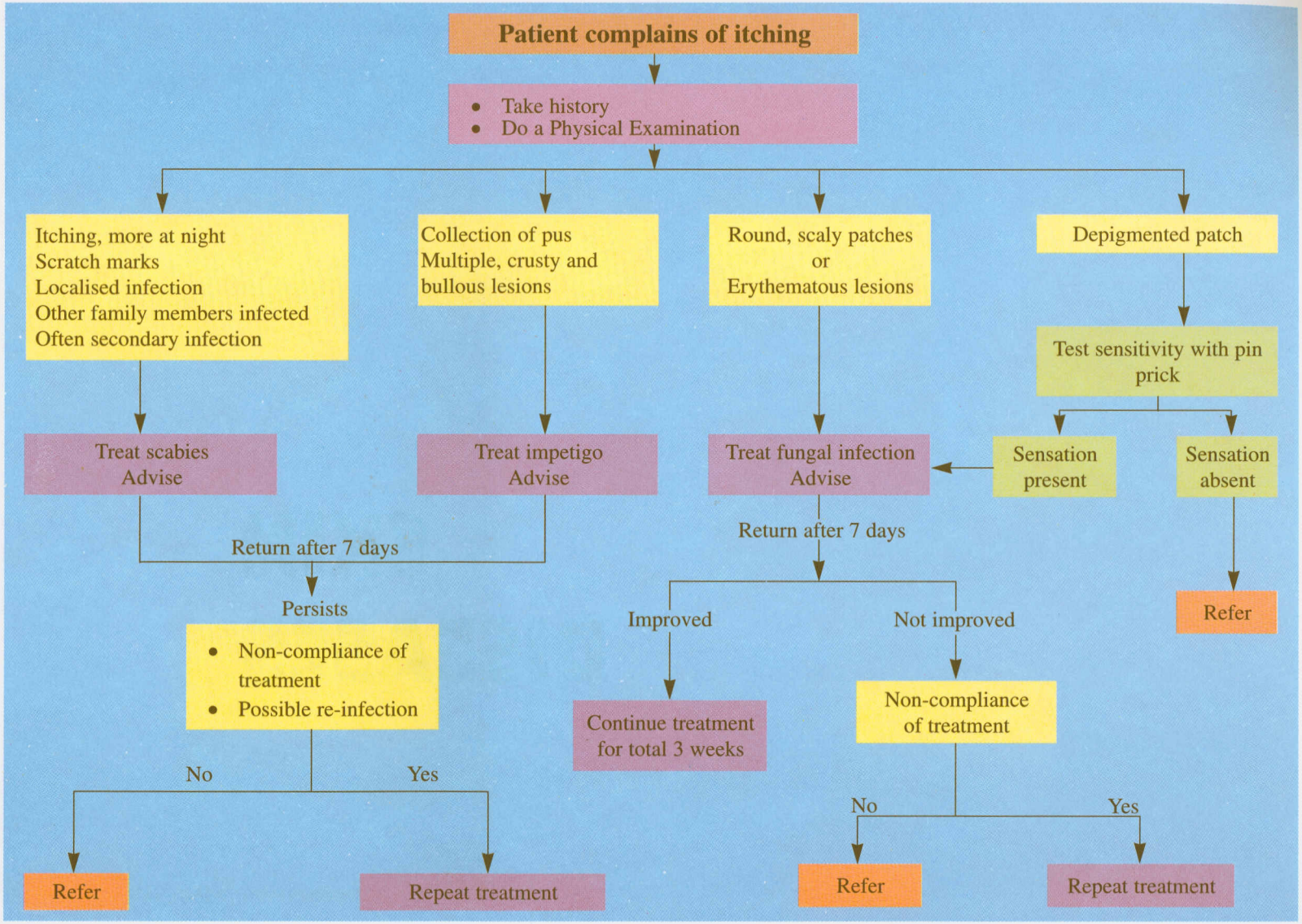
- Importance of maintaining the card
- When to start weaning foods
- When to take the child to a service provider for growth faltering
- When to give the child Vitamin A capsules
- Child immunization
- Management of Acute Respiratory Infection (ARI)
- Management of Diarrhoea
- Keeping record of the illnesses suffered by the child

Key messages

- Breast milk is the best and only food
  ⇨ no other food or drink is needed for the first 5 months of life, not even water
- Breastfeeding should be started immediately after birth (colostrum)
  ⇨ no pre-lacteal feeds
  ⇨ correct positioning of the baby on the breast is important
- Frequent suckling produces more milk
  ⇨ encourage frequent suckling, especially at night
- Give weaning foods after completion of 5 months, along with breast milk
  ⇨ continue breastfeeding for at least 2 years
- Never use a bottle to give drinks to the baby
- Continue breastfeeding and other foods (if baby is more than 5 months old) as usual during illness
- At the end of five months, the child needs other foods in addition to breast milk
  ⇨ oil and sugar/molasses in addition to a variety of other foods
- All children need foods rich in Vit.A-breast milk, green leafy vegetable and yellow coloured fruits and vegetable
- Other foods (if baby is more than 5 months old) as usual during illness
- Exclusive breastfeeding protects against pregnancy for 5 months after giving birth
  ⇨ if her baby breastfeeds frequently, day and night, if the baby is not given other food or drinks, and if the mother's menses have not returned

SKIN DISEASES

Skin Diseases



History

- Any itching
- Any pustule
- Other family members suffering from same skin disease
- Condition of family hygiene

Physical Examination

- Colour and type of the rashes/ulcers
- Location of the rashes (specially in between finger and toes, wrist and inguinal region

Treatment for Skin Diseases

Scabies

BB Lotion: 150 ml diluted

- Bathe with hot water and soap
- Apply over whole body excluding head and face, but including the genitals
- Reapply the lotion for 3 consequitive days without taking a bath
- If secondary infection: Penicillin 250 mg orally 4 times x 7 days
- Treat with BB after the infection has been treated

Impetigo

Gentian Violet (0.5%- 1%): Apply twice a day

Penicillin 250 mg orally 4 times x 7 days

Fungal infection

Whitfield ointment: Apply twice a day for 10 days

Treatment may be necessary for as long as 2 to 3 weeks

Advice

- Wash all clothing
- Sun-dry bed, pillows, etc
- Most of the skin diseases are highly contagious and can infest other family members who need to be treated
- Cleanliness can prevent skin infection

Inform and counsel

- If the patient is ≤1 year of age:
  - Vaccination
  - Feeding
- If the patient is adult:
  - Family Planning

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GPO Box 128, Dhaka 1000, Bangladesh
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Fax: 880-2-871568 and 880-2-883116
E-mail: barkat@cholera.bangla.net

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