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

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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.
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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

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

After 28 weeks:
  ➔ 5% Dextrose Saline
  ➔ Refer
**MINOR PROBLEMS IN CURRENT PREGNANCY**

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

**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

**Patient with Labour Pain**
- Take History
- Do a Physical Examination
- Monitor progress of labour
- Complications at labour
  - Manage and refer where necessary
- Ensure Hygienic Delivery
  - Clean surface
  - Clean hands
  - Clean cord
  - Take weight of baby
  - Initiate breastfeeding immediately
- Discharge mother after examination and advise
  - Provide vitamin A (200,000 IU)
  - Provide iron folate tablets for 1 month

**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
### 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 exclusive 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

**Woman Seeking Postnatal Care**

- **Take History**

  **Do a Physical Examination**
  - Of the Mother
  - Of the Baby

  **Inform and counsel**
  - Care and practices for herself
  - Care and practices for the baby

  **Provide Iron and folate tablets for 1 month**

  **Provide Vitamin A - 200,000 I.U within 2 weeks, if not already given**

**Major Problem Present**
- Advise and Refer

**Minor Problem Present**
- Advise and Manage

**History Taking**

**Mother**
- Age
- Date of delivery
- Description of delivery
- Contraceptive use
- Any problem during urination or defecation, 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**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Management and Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast engorgement</td>
<td>Routine expression of milk and continue breastfeeding</td>
</tr>
<tr>
<td>Cracked nipple</td>
<td>Manual expression of Milk</td>
</tr>
<tr>
<td>Anaemia</td>
<td>Iron and folate tablets twice daily for 1 month</td>
</tr>
<tr>
<td></td>
<td>Iron-rich food (e.g. beans, green leafy vegetables, liver, eggs)</td>
</tr>
<tr>
<td>Burning sensation during urination</td>
<td>Advise to drink plenty of water</td>
</tr>
<tr>
<td>Loose motion</td>
<td>Improve nutrition and treat diarrhoea</td>
</tr>
</tbody>
</table>

**Major Problems of the Newborn**

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

**Minor Problems of the Newborn**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Management and Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological jaundice</td>
<td>Expose newborn to morning sunlight (without cloths) keeping eyes and head covered. If not subsiding in 7 days, refer</td>
</tr>
<tr>
<td>Umbilical infection</td>
<td>Spirit wash &amp; local antibiotic</td>
</tr>
<tr>
<td>Caput</td>
<td>Reassure mother</td>
</tr>
<tr>
<td>Succedneum</td>
<td></td>
</tr>
<tr>
<td>Cephalhaematoma</td>
<td>Reassure mother</td>
</tr>
</tbody>
</table>
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)

Patient complains of vaginal discharge

- Take history of patient and partner
- Do a Physical Examination

Partner symptomatic/new partner/multiple partners/spouse back after a long time

Yes

- Treat gonorrhoea and chlamydia
- Inform and counsel
- Advise return after 2 weeks

After 2 weeks
Discharge persists

Yes
- Poor drug compliance
- Re-infection

Repeat treatment

No

After 7 days

Yes
- Treat gonorrhoea and chlamydia
- Inform and counsel

Re-infection

No

After 7 days

Yes
- Treat trichomoniasis and b.vaginosis
- Inform and counsel
- Advise for follow-up after 7 days

Follow up after 7 days

No

Yes
- Treat gonorrhoea and chlamydia
- Inform and counsel

Repeat treatment

Vaginal discharge persists

Yes
Refer
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

Chlamydial 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
Partner has urethral discharge or genital ulcer

Yellow, purulent, cervical discharge

Profuse, watery, offensive, frothy discharge

White curd like discharge

Patient Complains of Vaginal Discharge

- Take history of patient and partner
- Do a Physical Examination including Speculum Examination

Return after 7 days

Vaginal discharge persists:
- Non-compliance of treatment
- Possible re-infection

No
- Refer

Yes
- Repeat treatment

Treat gonorrhoea and chlamydia
Counsel

Treat trichomoniasis and bacterial vaginosis
Counsel

Treat Candidiasis
Counsel

(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))

<table>
<thead>
<tr>
<th>Trichomoniasis and Bacterial Vaginosis</th>
<th>Candidiasis</th>
<th>Gonococcal Cervicitis</th>
<th>Chlamydial Cervicitis</th>
<th>If there is a mixed infection then treat for trichomoniasis, bacterial vaginosis and candidiasis together</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tab. Metronidazole: 2 gm orally single dose or 400 mg orally twice daily x 7 days [Not in 1st trimester of pregnancy]</td>
<td>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</td>
<td>Tab. Ciprofloxacin: 500mg orally single dose [Not in pregnancy or lactation] or Inj. Ceftriaxone: 250mg IM single dose [Not in pregnancy or lactation]</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

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

**Patient Complains of Lower Abdominal Pain**

- Take history
- Do a Physical Examination

**Missed overdue period or**
- Recent delivery/abortion or
- Vaginal bleeding or
- Deep tenderness or
- Abdominal guarding

**No**
- Pelvic tenderness, and
- Tenderness on moving cervix or
- Temperature >38°C or
- Foul smelling vaginal discharge

**Yes**
- Gynaecological referral

**Surgical referral**

- Treat gonorrhoea, chlamydia & anaerobic bacteria
- Remove IUD if present
- Counsel

Follow up within 3 Days

**Symptoms persist**
- Non-compliance of treatment
- Possible re-infection

**Yes**
- Continue treatment

**No**
- Refer

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

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**
- **Tab. Ciprofloxacin:**
  - 500 mg orally single dose or
- **Inj. Ceftriaxone:**
  - 250 mg IM single dose

**Chlamydia**
- **Cap. Doxycycline:**
  - 100 mg orally twice x 7 days or
- **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
### Patient Complains of Genital Ulcer

- Take history of patient
- Do a Physical Examination

#### Painless, single, firm ulcer
- Treat syphilis and chancroid
- Counsel
- Return after 7 days

#### Painful, multiple ulcer, unilateral adenopathy
- Treat Herpes
- Counsel

#### Painful, multiple vesicles, adenopathy

---

### 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

<table>
<thead>
<tr>
<th>Ulcer Type</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td><strong>Inj. Benzathine Penicillin:</strong> 2.4 million units deep IM single dose (after skin test) or <strong>Cap. Tetracycline:</strong> 500 mg orally 4 times x 14 days [Not in pregnancy or lactation] or <strong>Cap. Doxycycline:</strong> 100 mg orally twice x 14 days [Not in pregnancy or lactation] or <strong>Tab. Erythromycin:</strong> 500 mg orally 4 times x 14 days</td>
</tr>
<tr>
<td>Chancroid</td>
<td><strong>Tab. Erythromycin:</strong> 500 mg orally 4 times x 14 days or <strong>Tab. Ciprofloxacin:</strong> 500 mg orally single dose [Not in pregnancy or lactation] or <strong>Inj. Ceftriaxone:</strong> 250 mg IM single dose or <strong>Tab. Cotrimoxazole:</strong> 2 tablets orally 2 times x 7 days</td>
</tr>
<tr>
<td>Herpes</td>
<td>Lesions should be kept clean by washing with soap and water and drying carefully. <strong>1% Gentian violet:</strong> Paint lesions twice daily for 3 weeks.</td>
</tr>
</tbody>
</table>

---

For information, counselling and partner management refer to pages 23, 24
Patient Complains of Scrotal Swelling

- Take history of patient
- Do a Physical and Local Examination

Injury to scrotum, history of trauma, testis rotated, or elevated, or retracted, hernia or hydrocele.

- Treat gonorrhoea and chlamydia
- Counsel

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

No

Refer
day

Yes

Repeat treatment

Surgical Referral

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
Tab. Ciprofloxacin:* 500 mg orally single dose

Chlamydia
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 pregant or lactating

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

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 Inguinal 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

Neonate with Eye Discharge

- Take history
- Examine neonate

Purulent conjunctival discharge present

- Treat baby for gonorrhoea
- Treat parents for gonorrhoea and chlamydia
- Counsel

Return after 3 days

Improved

- Reassure
- Counsel

Persistence

- Treat baby for chlamydia
- Counsel

Return after 7 days

Improvement

Refer

Continue treatment for total 2 weeks

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

<table>
<thead>
<tr>
<th>Treatment of Neonate</th>
<th>Treatment of Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonococcal Ophthalmia</strong></td>
<td><strong>Chlamydial Ophthalmia</strong></td>
</tr>
<tr>
<td>Inj. Ceftriaxone: 50mg/kg (max 125) IM single dose</td>
<td>Erythromycin Syrup: 50mg/kg orally 4 times x 14 days</td>
</tr>
<tr>
<td>or Inj. Kanamycin: 25mg/kg(max 75) IM single dose</td>
<td>or Cotrimoxazole Syrup: 5 ml orally 2 times x 14 days</td>
</tr>
</tbody>
</table>

### 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, doxycycline, tetracycline, 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

New Client seeking FP Service

Yes

Ask and assess: Family Planning needs of the client

Inform about the different FP methods and help client to select a method

Inform about method use, side effects and complications

Take consent

Screen Client

Give pill/condom/ injectables/IUD

Counsel client (Post-method), get feedback, and advise for follow up

No

(Visiting for other services)
Inform about importance of Family Planning and motivate potential clients

Refer
(Sterilization/Norplant)
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

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

Screen for pill

Menstrual history
- LMP

Physical examination
- BP
- Jaundice
- Oedema
- Weight
- Heart
- Breast
- Pain/swollen veins 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

Abnormal
- Provide/advise alternative method and manage accordingly

Normal
- Counsel and inform on side effects/complications

Laboratory test
- Hb. %
- Urine for sugar

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.

Abnormal

Provide/advise alternative method and manage accordingly

Normal

Insert IUD

Counsel and inform on side effects and complications

Laboratory test
- Hb.%
- Urine for sugar

During follow-up

- Ask if client has experienced side effects/complications
- Check for any contraindication
- Check date of IUD insertion
<table>
<thead>
<tr>
<th>Method</th>
<th>Method Use</th>
<th>Side-effects</th>
<th>Complications/Danger Signs</th>
</tr>
</thead>
</table>
| 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
<table>
<thead>
<tr>
<th>Status of the client</th>
<th>Method suitable</th>
</tr>
</thead>
<tbody>
<tr>
<td>* With no children and wish to delay the first child</td>
<td>Condom/Pill</td>
</tr>
<tr>
<td>* With one child and desires no more children</td>
<td>IUD/Norplant/Injectables/Condom/Pill</td>
</tr>
<tr>
<td>* With one/more children, desires more children but wish to space pregnancies (at least one year)</td>
<td>IUD/ Injectables/Condom/Pill</td>
</tr>
<tr>
<td>* With one/more children, desires more children but wish to space pregnancies (more than 5 years)</td>
<td>IUD/ Injectables/Norplant/Condom/Pill</td>
</tr>
<tr>
<td>* With 2 children, want no more children, and youngest child is &lt;2 years old</td>
<td>IUD/Norplant/Injectables</td>
</tr>
<tr>
<td>* With 2 children, want no more children, and youngest child is &gt; 2 years old</td>
<td>Vasectomy/ Tubectomy/IUD/Injectables/Norplant</td>
</tr>
<tr>
<td>* With &gt;2 children, want no more children</td>
<td>IUD/Norplant/Injectables</td>
</tr>
<tr>
<td>* Within 5 months after delivery</td>
<td>IUD/Norplant/Injectables/Condom</td>
</tr>
<tr>
<td>* More than 5 months after delivery</td>
<td>IUD/Norplant/Injectables/Condom</td>
</tr>
</tbody>
</table>
CHILD HEALTH
**Diarrhoea**

### Patient Complains of Diarrhoea

**Ask:**
- Age of child
- Duration, frequency and consistency of stool
- Blood in stool
- Fever
- Convulsion
**Assess:**
- Nutritional status

- Refer immediately with ORS if:
  - Severe undernutrition
  - Persistent diarrhoea* under 6 months

- Assess dehydration

- If any dehydration present
  - Refer immediately with ORS and advise
  - Acute diarrhoea
    - Treatment Plan A plus antibiotics if blood present
  - Persistent diarrhoea
    - Advise special diet plus antibiotics if blood present

* Episodes lasting for 14 days or more

### Assessment of Dehydration

<table>
<thead>
<tr>
<th>General Condition</th>
<th>Well, alert</th>
<th><em>Restless</em></th>
<th><em>Lethargic, unconscious, floppy</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Normal</td>
<td>Sunken</td>
<td>Very sunken and dry</td>
</tr>
<tr>
<td>Tears</td>
<td>Present</td>
<td>Absent</td>
<td>Absent</td>
</tr>
<tr>
<td>Mouth &amp; Tongue</td>
<td>Moist</td>
<td>Dry</td>
<td>Very dry</td>
</tr>
<tr>
<td>Thirst</td>
<td>Not thirsty</td>
<td><em>Thirsty, drinks eagerly</em></td>
<td><em>Drinks poorly or not able to drink</em></td>
</tr>
<tr>
<td>Skin Pinch</td>
<td>Goes back quickly</td>
<td><em>Goes back Slowly</em></td>
<td><em>Goes back very slowly</em></td>
</tr>
</tbody>
</table>

**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

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

Inform and Counsel (Where Appropriate)

- Feeding the child (breastfeeding/complementary feeding)
- Vaccination of the child
- Family Planning
### Acute Respiratory Infections

**Management for age groups**

**2 months–5 years**

- Treat wheezing (If present)
- Treat fever (if present)
- Give 1st dose of antibiotic
- Refer to hospital

**No Pneumonia**

- Advise on home care
- Treat other problems
- If cough>30 days, refer
- If fever>5 days, refer

#### Patient Complains of Cough or Difficult Breathing

**Ask:**
- Age of Child
- Duration of cough
- Drinking/feeding pattern
- Fever/Convulsions

**Look and Listen:**
- Count breaths
- Chest indrawing
- Stridor/wheezing
- Abnormally sleepy/difficult to wake
- Temperature
- Nutritional status

**Management for age groups**

- <2 months
- 2 months–5 years

**Danger Signs of Very Severe Disease**

<table>
<thead>
<tr>
<th>Less than 2 months</th>
<th>2 months–5 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any one of the following</strong></td>
<td><strong>Any one of the following</strong></td>
</tr>
<tr>
<td>Stopped feeding well</td>
<td>Not able to drink</td>
</tr>
<tr>
<td>Convulsions</td>
<td>Convulsions</td>
</tr>
<tr>
<td>Abnormally sleepy/difficult to wake</td>
<td>Abnormally sleepy/difficult to wake</td>
</tr>
<tr>
<td>Stridor in calm child</td>
<td>Stridor in calm child</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Severe malnutrition</td>
</tr>
<tr>
<td>Fever or low body temperature</td>
<td></td>
</tr>
</tbody>
</table>

#### Signs of Severe Pneumonia

<table>
<thead>
<tr>
<th>Less than 2 months</th>
<th>2 months–5 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fast breathing (~60/minute)</td>
<td>Chest indrawing</td>
</tr>
</tbody>
</table>

#### Signs of Pneumonia

<table>
<thead>
<tr>
<th>Less than 2 months</th>
<th>2 months–5 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Fast breathing</td>
</tr>
<tr>
<td>because ≥50/minute (2-12 months)</td>
<td></td>
</tr>
<tr>
<td>Pneumonia is not classified in this age group</td>
<td>≥40/minute (≥12 months)</td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>Age</th>
<th>Cotrimoxazole 2 times x 5 days Paed Tablet (120 mg)</th>
<th>Amoxicillin 3 times x 5 days Adult Tablet Syrup</th>
<th>Ampicillin 4 times x 5 days Adult Tablet Syrup</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2 months</td>
<td>¼</td>
<td>2.5 ml</td>
<td>¼</td>
</tr>
<tr>
<td>2-12 months</td>
<td>½</td>
<td>5.0 ml</td>
<td>½</td>
</tr>
<tr>
<td>12 months</td>
<td>1</td>
<td>7.5 ml</td>
<td>1</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>2.5 ml</td>
<td>10.0 ml</td>
<td>2.5 ml</td>
</tr>
</tbody>
</table>

### 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

**Wheezeing:**
- 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**

### 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

Child Seeking Immunization Services

Ask and determine child’s age

New Child

Give an immunization card

- Give vaccine (Injection and/or oral drop)
- Give Vit.A drop if scheduled

Fill out the immunization card

- Inform about side effects and their management
- Emphasise the need for completing all doses
- Inform about the time of the next visit
- Emphasise the need for preserving the card
- Get feedback

Old Child

Check immunization card* and,
- assess time since last dose;
- determine the vaccines/doses to be given at this visit

Ensure that sterile syringes and needles are used and non-touch technique is followed

* If the card is lost, assess time and give a new card
### Vaccination schedule for children

<table>
<thead>
<tr>
<th>Name of Vaccine</th>
<th>Starting period</th>
<th>Ending period</th>
<th>Number of doses</th>
<th>dose interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>At birth</td>
<td>1 year</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td>At 6 weeks</td>
<td>1 year</td>
<td>3</td>
<td>4 weeks</td>
</tr>
<tr>
<td>OPV</td>
<td>At 6 weeks</td>
<td>1 year</td>
<td>4&lt;sup&gt;1&lt;/sup&gt;</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles</td>
<td>AT 9 months&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1 year</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> The fourth dose of OPV should be given at the time of measles vaccination

<sup>2</sup> 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

### Schedule of Vit A Doses

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

### 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
Patient complains of itching

- Take history
- Do a Physical Examination

Itching, more at night
- Scratch marks
- Localised infection
- Other family members infected
- Often secondary infection

Collection of pus
- Multiple, crusty and bullous lesions

Round, scaly patches
- or Erythematous lesions

Treat scabies
Advise

Treat impetigo
Advise

Treat fungal infection
Advise

Depigmented patch

Test sensitivity with pin prick

Sensation present
Sensation absent

Return after 7 days

Persist

- Non-compliance of treatment
- Possible re-infection

No
Refer

Yes
Repeat treatment

Improved

Not improved

Continue treatment for total 3 weeks

Non-compliance of treatment

No
Refer

Yes
Repeat treatment
### 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 consecutive 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
References

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