



**SOMALI GUIDELINES ON
INTEGRATED MANAGEMENT OF NEWBORN AND CHILDHOOD ILLNESSES**

CHARTBOOKLET

Version 1: March 2019

Assess and classify the sick child aged 2 months up to 5 years

ASSESS AND CLASSIFY

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ASSESS AND CLASSIFY

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Ministry of Health
Federal Republic of Somalia

Assess and classify the sick child aged 2 months up to 5 years

ASSESS AND CLASSIFY

ASSESS

CLASSIFY

IDENTIFY TREATMENT

ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE

- Determine if this is an initial or follow-up visit for this problem.
 - if follow-up visit, use the follow-up instructions on TREAT THE CHILD chart.
 - if initial visit, assess the child as follows:

USE ALL BOXES THAT MATCH THE CHILD'S SYMPTOMS AND PROBLEMS TO CLASSIFY THE ILLNESS

URGENT PRE-REFERRAL TREATMENTS ARE IN BOLD PRINT***

CHECK FOR GENERAL DANGER SIGNS

Ask:

- Is the child able to drink or breastfeed?
- Does the child vomit everything?
- Has the child had convulsions?

Look:

- See if the child is lethargic or unconscious.
- Is the child convulsing now?

URGENT attention

- Any general danger sign

Pink:
VERY SEVERE DISEASE

- Give diazepam if convulsing now
- Quickly complete the assessment
- Give any pre-referral treatment immediately
- Treat to prevent low blood sugar
- Keep the child warm
- Refer **URGENTLY**.

A child with any general danger sign needs **URGENT** attention; complete the assessment and any pre-referral treatment immediately so referral is not delayed.

THEN ASK ABOUT MAIN SYMPTOMS:

Does the child have cough or difficult breathing?

If yes, ask:

- For how long?

Look, listen, feel*:

- Count the breaths in one minute.
- Look for chest indrawing.
- Look and listen for stridor.
- Look and listen for wheezing.

CHILD
MUST BE
CALM

If wheezing with either fast breathing or chest indrawing:

Give a trial of rapid acting inhaled bronchodilator for up to three times 15-20 minutes apart. Count the breaths and look for chest indrawing again, and then classify.

If the child is:

2 months up to 12 months

Fast breathing is:

50 breaths per minute or more

12 Months up to 5 years

40 breaths per minute or more

Classify
COUGH or
DIFFICULT
BREATHING

• Any general danger sign or • Stridor in calm child.	Pink: SEVERE PNEUMONIA OR VERY SEVERE DISEASE	■ Give first dose of an appropriate antibiotic. ■ Treat to prevent low blood sugar. ■ Refer URGENTLY to hospital**.
• Chest indrawing or • Fast breathing.	Yellow: PNEUMONIA	■ Give oral Amoxicillin for 5 days*** ■ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days**** ■ If chest indrawing in HIV exposed/infected child, give first dose of amoxicillin and refer. ■ Soothe the throat and relieve the cough with a safe remedy ■ If coughing for more than 14 days or recurrent wheeze, assess or refer for possible TB and asthma. ■ Advise mother when to return immediately ■ Follow-up in 3 days
• No signs of pneumonia or very severe disease.	Green: COUGH OR COLD	■ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days**** ■ Soothe the throat and relieve the cough with a safe remedy ■ If coughing for more than 14 days or recurrent wheezing, assess or refer for possible TB or asthma. ■ Advise mother when to return immediately ■ Follow-up in 5 days if not improving

*If pulse oximeter is available, determine oxygen saturation and refer if < 90%.

** If referral is not possible see instructions in the Give appropriate Intramuscular antibiotics.

***Oral Amoxicillin for 3 days could be used in patients with fast breathing but no chest indrawing in low HIV settings.

**** In settings where inhaled bronchodilator is not available, oral salbutamol may be tried but not recommended for treatment of severe acute wheeze.

Does the child have diarrhoea?

If yes, ask:

- For how long?
- Is there blood in the stool?

Look and feel:

- Look at the child's general condition. Is the child:
 - Lethargic or unconscious?
 - Restless and irritable?
- Look for sunken eyes.
- Offer the child fluid. Is the child:
 - Not able to drink or drinking poorly?
 - Drinking eagerly, thirsty?
- Pinch the skin of the abdomen. Does it go back:
 - Very slowly (longer than 2 seconds)?
 - Slowly?
 - Immediately?

Classify DIARRHOEA

for DEHYDRATION

- Two of the following signs:
- Lethargic or unconscious
 - Sunken eyes
 - Not able to drink or drinking poorly
 - Skin pinch goes back very slowly.

Pink:
SEVERE DEHYDRATION

- If child has no other severe classification:
 - Give fluid for severe dehydration (Plan C)
 OR

If child also has another severe classification:

 - Refer **URGENTLY** to hospital with mother giving frequent sips of ORS on the way
 - Advise the mother to continue breastfeeding
- If child is 2 years or older and there is cholera in your area, give antibiotic for cholera

- Two of the following signs:
- Restless, irritable
 - Sunken eyes
 - Drinks eagerly, thirsty
 - Skin pinch goes back slowly.

Yellow:
SOME DEHYDRATION

- Give fluid, zinc supplements, and food for some dehydration (Plan B)
- If child also has a severe classification:
 - Refer **URGENTLY** to hospital with mother giving frequent sips of ORS on the way
- Advise mother when to return immediately
- Follow-up in 5 days if not improving

Not enough signs to classify as some or severe dehydration.

Green:
NO DEHYDRATION

- Give fluid, zinc supplements, and food to treat diarrhoea at home (Plan A)
- Advise mother when to return immediately
- Follow-up in 5 days if not improving

and if diarrhoea 14 days or more

- Dehydration present.

Pink:
SEVERE PERSISTENT DIARRHOEA

- Treat dehydration before referral unless the child has another severe classification
- Give multivitamins minerals and zinc
- Refer to hospital

- No dehydration.

Yellow:
PERSISTENT DIARRHOEA

- Advise the mother on feeding a child who has PERSISTENT DIARRHOEA
- Give multivitamins minerals and zinc supplements
- Follow-up in 5 days

and if blood in stool

- Blood in the stool.

Yellow:
DYSENTERY

- Treat for 5 days with an oral antibiotic recommended for shigella in your area
- Follow-up in 2 days

Does the child have fever?

(by history or feels hot or temperature 37.5°C* or above)

If yes:

Decide Malaria Risk: high or low or No Malaria risk

Then ask:

- For how long?
- If more than 7 days, has fever been present every day?
- Has the child had measles within the last 3 months?

Look and feel:

- Look or feel for stiff neck.
- Look for runny nose.
- Look for any bacterial cause of fever**.
- Look for signs of MEASLES.
 - ◊ Generalized rash and
 - ◊ One of these: cough, runny nose, or red eyes.

Do a malaria test***: If NO general danger sign or severe classification

- In all fever cases if High malaria risk.
- In Low malaria risk if no obvious cause of fever present.

If the child has measles now or within the last 3 months:

- Look for mouth ulcers. Are they deep and extensive?
- Look for pus draining from the eye.
- Look for clouding of the cornea.

High or Low Malaria Risk

Classify FEVER

• Any general danger sign or • Stiff neck.	Pink: VERY SEVERE FEBRILE DISEASE	■ Give first dose of artesunate or quinine for severe malaria ■ Give first dose of an appropriate antibiotic ■ Treat the child to prevent low blood sugar ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Refer URGENTLY to hospital
• Malaria test POSITIVE.	Yellow: MALARIA	■ Give recommended first line oral antimalarial ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Give appropriate antibiotic treatment for an identified bacterial cause of fever ■ Advise mother when to return immediately ■ Follow-up in 3 days if fever persists ■ If fever is present every day for more than 7 days, refer for assessment. ■ Advise mother on the use of Insecticide Treated Nets (ITN).
• Malaria test NEGATIVE • Other cause of fever PRESENT.	Green: FEVER: NO MALARIA	■ Assess for other cause of fever** and treat with appropriate drugs. (annex 1) ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Advise mother when to return immediately ■ If fever is present every day for more than 7 days, refer for assessment ■ Follow-up in 3 days if fever persists ■ Advise mother on the use of Insecticide Treated Nets (ITN).

No Malaria Risk and No Travel to Malaria Risk Area

• Any general danger sign • Stiff neck.	Pink: VERY SEVERE FEBRILE DISEASE	■ Give first dose of an appropriate antibiotic. ■ Treat the child to prevent low blood sugar. ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above). ■ Refer URGENTLY to hospital.
• No general danger signs • No stiff neck.	Green: FEVER	■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Give appropriate antibiotic treatment for any identified bacterial cause of fever ■ Advise mother when to return immediately ■ Follow-up in 2 days if fever persists ■ If fever is present every day for more than 7 days, refer for assessment

If MEASLES now or within last 3 months, Classify

• Any general danger sign or • Clouding of cornea or • Deep or extensive mouth ulcers.	Pink: SEVERE COMPLICATED MEASLES****	■ Give Vitamin A treatment ■ Give first dose of an appropriate antibiotic IM ■ If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment ■ Refer URGENTLY to hospital ■ Fill measles surveillance form ■ Inform CHMT.
• Pus draining from the eye or • Mouth ulcers.	Yellow: MEASLES WITH EYE OR MOUTH COMPLICATIONS****	■ Give Vitamin A treatment ■ If pus draining from the eye, treat eye infection with tetracycline eye ointment ■ If mouth ulcers, treat with gentian violet ■ Follow-up in 2 days ■ Fill measles surveillance form ■ Inform CHMT.
• Measles now or within the last 3 months.	Green: MEASLES	■ Give Vitamin A treatment

* These temperatures are based on axillary temperature. Rectal temperature readings are approximately 0.5°C higher.

**Look for local tenderness; oral sores; refusal to use a limb; hot tender swelling; red tender skin or boils; lower abdominal pain or pain on passing urine in older children.

*** If no malaria test available: High malaria risk - classify as MALARIA; Low malaria risk AND NO obvious cause of fever - classify as MALARIA.

**** Other important complications of measles - pneumonia, stridor, diarrhoea, ear infection, and acute malnutrition - are classified in other tables.

Does the child have an ear problem?

If yes, ask:

- Is there ear pain?
- Is there ear discharge?
 - If yes, for how long?

Look and feel:

- Look for pus draining from the ear.
- Feel for tender swelling behind the ear.

Classify EAR PROBLEM

• Tender swelling behind the ear.	Pink: MASTOIDITIS	■ Give first dose of an appropriate antibiotic IM ■ Give first dose of paracetamol for pain ■ Refer URGENTLY to hospital
• Pus is seen draining from the ear and discharge is reported for less than 14 days, or • Ear pain.	Yellow: ACUTE EAR INFECTION	■ Give an appropriate oral antibiotic for 5 days ■ Give paracetamol for pain ■ Dry the ear by wicking ■ Follow-up in 5 days
• Pus is seen draining from the ear and discharge is reported for 14 days or more.	Yellow: CHRONIC EAR INFECTION	■ Dry the ear by wicking ■ Treat with appropriate topical antibiotic eardrops for 14 days ■ Follow-up in 5 days
• No ear pain and no pus seen draining from the ear.	Green: NO EAR INFECTION	■ Assess and manage other ear conditions

THEN CHECK FOR ACUTE MALNUTRITION

CHECK FOR ACUTE MALNUTRITION

LOOK AND FEEL:

Look for signs of acute malnutrition

- Look for oedema of both feet.
- Determine WFH/L* ____ z-score.
- Measure MUAC** ____ mm in a child 6 months or older.

If WFH/L less than -3 z-scores or MUAC less than 115 mm, then:

- Check for any medical complication present:
 - Any general danger signs
 - Any severe classification
 - Pneumonia with chest indrawing
- If no medical complications present, do appetite test:
 - Child is 6 months or older, offer RUTF*** to eat. Is the child:
 - Not able to finish RUTF portion
 - Able to finish RUTF portion?

Classify
NUTRITIONAL
STATUS

• Oedema of both feet - OR • WFH/L less than -3 z-scores OR MUAC less than 115 mm AND any one of the following: ◦ Medical complication present or ◦ Not able to finish RUTF.	Pink: COMPLICATED SEVERE ACUTE MALNUTRITION	■ Give first dose appropriate antibiotic. ■ Treat the child to prevent low blood sugar. ■ Keep the child warm. ■ Refer URGENTLY to Stabilisation Centre (SC).
• WFH/L less than -3 z-scores - OR • MUAC less than 115 mm - AND • Able to finish RUTF.	Yellow: UNCOMPLICATED SEVERE ACUTE MALNUTRITION	■ Give oral antibiotics for 5 days. ■ Refer for Outpatient management for SAM nearby or ◦ Give ready-to-use therapeutic food for a child aged 6 months or more. ■ Counsel the mother on how to feed the child. ■ Assess for possible TB infection.. ■ Advise mother when to return immediately. ■ Follow up in 7 days.
• WFH/L between -3 and -2 z-scores - OR • MUAC 115 up to 125 mm.	Yellow: MODERATE ACUTE MALNUTRITION	■ Refer for the child for Supplementary feeding program if available. ◦ if not available; Assess the child's feeding and counsel the mother on the feeding recommendations and refer for growth monitoring and health promotion. ■ If feeding problem, follow up in 7 days ■ Assess for possible TB infection. ■ Advise mother when to return immediately ■ Follow-up in 30 days
• WFH/L - 2 z-scores or more - OR • MUAC 125 mm or more.	Green: NO ACUTE MALNUTRITION	■ If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding according to the feeding recommendations ■ If feeding problem, follow-up in 7 days

*WFH/L is Weight-for-Height or Weight-for-Length determined by using the WHO growth standards charts.

** MUAC is Mid-Upper Arm Circumference measured using MUAC tape in all children 6 months or older.

***RUTF is Ready-to-Use Therapeutic Food for conducting the appetite test and feeding children with severe acute malnutrition.

THEN CHECK FOR ANAEMIA

LOOK

- Look for
 - Severe palmar pallor
 - Some palmar pallor
 - No palmar pallor

Classify ANAEMIA

• Severe palmar pallor.	Pink: SEVERE ANAEMIA	■ Refer URGENTLY
• Some palmar pallor.	Yellow: ANAEMIA	■ Give iron ■ Give Mebendazole if child is one year or older and has not had a dose in the previous six months ■ Follow up in 14 days
• No palmar pallor.	Green: NO ANAEMIA	■ No additional treatment needed

THEN CHECK FOR TUBERCULOSIS

ASK:

- If child has household//other contact with a known case of TB.
- Determine if child has cough for more than 14 days.
- Determine if the child has unexplained or prolonged fever for more than 7 days.
- unexplained fatigue, reduced playfulness, less active.
- Does the child have Growth faltering or UNCOMPLICATED SEVERE ACUTE MALNUTRITION or MODERATE ACUTE MALNUTRITION?

LOOK AND FEEL:

- For generalized lymphadenopathy.
 - Are there any enlarged lymph glands in two or more of the following sites: neck, armpit, or groin?

Classify for Tuberculosis

• Two or more criteria present.	Yellow: POSSIBLE TUBERCULOSIS	■ Trace contacts. ■ Check for HIV infection. ■ Refer TB centre for management as per TB guideline. ■ Refer caretaker for TB investigation. ■ Notify to TB District coordinator. ■ Follow up monthly.
TB contact only - no other criteria	Green: TB contact	■ Refer for TB treatment.
If none of the above criteria is present	Green: NO TUBERCULOSIS	■ Advice on Growth monitoring and Promotion concerning ◦ Breastfeeding ◦ Immunization ◦ General nutrition ◦ Deworming

THEN CHECK FOR HIV INFECTION

Use this chart if the child is **NOT** already enrolled in HIV care.

ASK

- Has the mother and/or child had an HIV test?

IF YES: Then note mother's and/or child's HIV status:-

- Mother's HIV status: POSITIVE or NEGATIVE
- Child's HIV status:
 - Virological test POSITIVE or NEGATIVE
 - Serological test POSITIVE or NEGATIVE

IF NO: Mother and child status unknown, then TEST mother.

- If positive, then test the child.

If mother is HIV positive and child is negative or unknown, ASK:

- Was the child breastfeeding at the time or 6 weeks before the test?
- Is the child breastfeeding now?
- If breastfeeding ASK: Is the mother and child on ARV prophylaxis?

Classify HIV status

• Positive virological test in child OR • Positive serological test in a child 18 months or older	Yellow: CONFIRMED HIV INFECTION	■ Give cotrimoxazole prophylaxis* ■ Refer or give HIV care and initiation of ART treatment ■ Assess the child's feeding and provide appropriate counselling to the mother ■ Advise the mother on home care ■ Refer for TB assessment and INH preventive therapy ■ Follow-up regularly as per national guidelines
• Mother HIV-positive AND negative virological test in child breastfeeding or if only stopped less than 6 weeks ago OR • Mother HIV-positive, child not yet tested OR • Positive serological test in a child less than 18 months old	Yellow: HIV EXPOSED	■ Give cotrimoxazole prophylaxis ■ Start or continue ARV prophylaxis as recommended ■ Refer to CTC for confirmatory test and ARV prophylaxis as recommended** ■ Assess the child's feeding and provide appropriate counselling to the mother. ■ Advise the mother on home care. ■ Follow-up regularly as per national guidelines.
• Negative HIV test in mother or child	Green: HIV INFECTION UNLIKELY	■ Treat, counsel and follow-up existing infections

* Give cotrimoxazole prophylaxis to all children less than 1 year old and to children 1- 4 years old who are CONFIRMED HIV POSITIVE

** If virological test is negative, repeat test 6 weeks after the breastfeeding has stopped; if serological test is positive, do a virological test as soon as is possible to do so.

ASSESS MOUTH AND GUM CONDITIONS

(FOR CHILDREN ON ART OR HIV EXPOSED, HIV INFECTION OR HIV EXPOSED: POSSIBLE HIV INFECTION***)

Ask:

- Does the child has mouth or gum ulcers?
- Is the child not able to eat due to painful mouth ulcers ?

Look:

- Look for mouth or gum ulcers?
- Are they deep or extensive?

Classify MOUTH or GUM CONDITIONS

• Deep or extensive ulcers of mouth or gums or • Not able to eat due to painful mouth ulcers.	Pink: SEVERE GUM OR MOUTH INFECTION	■ Refer URGENTLY to hospital ■ If possible, give first dose of acyclovir pre-referral ■ Start metronizadole if referral is not possible (<i>see doses in annex 3: mouth or gum ulcers</i>) ■ If the child is on anti retroviral therapy this may be a drug reaction so refer to secondary level for assessment
• Ulcers of mouth or gums	Yellow: GUM OR MOUTH ULCERS	■ Show the mother how to clean the ulcers with saline or peroxide or sodium bicarbonate solution ■ If lips or anterior gums are involved, give acyclovir, if not possible refer (<i>see doses in annex 3: mouth or gum ulcers</i>) ■ If the child received cotrimoxazole or anti retroviral drugs or isoniazid (INH) prophylaxis for TB within the last month, this may be a drug rash especially if the child has a skin rash so refer ■ If thrush, teach the mother to treat oral thrush at home (<i>see annex 3</i>) ■ Provide pain relief ■ Follow up in 7 days
• No ulcers of the mouth or gums	Green: NO GUM OR MOUTH ULCERS	■ Treat, counsel and follow up existing infections ■ Advise the mother about feeding and her health

THEN CHECK THE CHILD'S IMMUNIZATION, VITAMIN A SUPPLEMENTATION AND DEWORMING STATUS

IMMUNIZATION SCHEDULE

IMMUNIZATION SCHEDULE

AGE	VACCINE	VACCINATION ROUTE/SITE	DOSE
At Birth	BCG*	Intradermal, Right shoulder	0.05ml
	OPV-0**	Oral drops	2 drops
6 Weeks	OPV-1	Oral drops	2 drops
	Pentavalent	Left thigh	0.5ml
10 Weeks	OPV-2	Oral drops	2 drops
	Pentavalent 2	Left thigh	0.5ml
14 weeks	OPV-3	Oral drops	2 drops
	Pentavalent3	Left thigh	0.5ml
	IPV	Right thigh	0.5ml
9 Months	Measles 1	Subcutaneous or IM, Left shoulder	0.5ml
15 Months	Measles 2	Subcutaneous or IM, Left shoulder	0.5ml

VITAMIN A AND DEWORMING STATUS

• VITAMIN A SUPPLEMENTATION

Give every child a dose of Vitamin A every six months from the age of 6 months. Record the dose on the child's chart. For dosages see TREAT THE CHILD CHART.

• ROUTINE WORM TREATMENT

Give every child mebendazole or Albendazole every 6 months from the age of one year. Record the dose on the child's passport. For dosages see TREAT THE CHILD CHART.

IMPORTANT: Vitamin A and a deworming medicine that was given during mass immunization campaigns should be recorded in the child health Passport book at the follow up schedule.

* If an infant is less than 12 months old and did not receive BCG, the vaccine can be given at any time the child comes for the initial visit.

** Do not give OPV 0 to an infant who is more than 14 days.

IMPORTANT: Give Penta1, PCV1 and OPV1 at the age of six weeks. Keep an interval of 4 weeks between the subsequent vaccines.

ASSESS OTHER PROBLEMS

ASSESS MOTHER'S OWN HEALTH

TREAT THE CHILD

CARRY OUT THE TREATMENT STEPS IDENTIFIED ON THE ASSESS AND CLASSIFY CHART

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Follow the instructions for every oral drug to be given at home. also follow the instructions listed with each drug's dosage table.

- Determine the appropriate drugs and dosage for the child's age or weight.
- Tell the mother the reason for giving the drug to the child.
- Demonstrate how to measure a dose.
- Watch the mother practise measuring a dose by herself. Ask the mother to give the first dose to her child.
- Explain carefully how to give the drug, then label and package the drug. If more than one drug will be given, collect, count and package each drug separately.
- Explain that all the oral drug tablets or syrups must be used to finish the course of treatment, even if the child gets better.
- Check the mother's understanding before she leaves the clinic.

Give Appropriate Oral Antibiotic for HIV INFECTION and HIV EXPOSED: POSSIBLE HIV INFECTION

- Give cotrimoxazole for PCP prophylaxis from 6 weeks

AGE or WEIGHT	COTRIMOXAZOLE (Trimethoprim + Sulphamexoxazole) Give once daily		
	ADULT TABLET (80/400mg)	PAEDIATRIC TABLET (20/100mg)	SYRUP (40/200mg/5ml)
6 weeks up to 12 months (4 - < 10kg)	1/2	2	5 ml
12 months up to 5 years (10 - < 19kg)	1	4	10 ml

*Avoid giving cotrimoxazole to a young infant who is premature or jaundiced.

Give Appropriate Oral Antibiotic for PNEUMONIA or ACUTE EAR INFECTION

- FIRST LINE ANTIBIOTIC*: Amoxicillin/Cotrimoxazole
- SECOND LINE ANTIBIOTIC: Erythromycin.

AGE or WEIGHT	AMOXICILLIN* (Give two times daily for 5 days) ■ Give 40mg per kg Bwt		ERYTHROMYCIN Give four (4) times daily for 5 days 50mg/kg per day	
	TABLET (250 mg)	SYRUP (125 mg/5ml)	ADULT TABLET (250 mg)	SYRUP (125mg/5ml)
2 months up to 4 months(4-<6kg)	1/2	5 ml	1/4	2.5 ml
4 months up to 12 months (6 - < 10 kg)	1	10 ml	1/2	5.0 ml
12 months up to 5 years (10 - 19 kg)	1.5	15 ml	1	10

*Use Cotrimoxazole if Amoxycillin is not available. See dosage in the chart below.

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Give an Appropriate Oral Antibiotic for DYSENTERY

Give antibiotic recommended for Shigella in your area for 5 days.

- FIRST-LINE ANTIBIOTIC FOR SHIGELLA: Ciprofloxacin.
- SECOND-LINE FOR SHIGELLA: Ceftriaxone*

AGE or WEIGHT	CIPROFLOXACINE 15mg/kg/dose Give 2 times daily for 5 days	
	ADULT TABLET (250mg)	SYRUP (?mg/5ml)
2 months up to 4 months (4 - < 6 kg)	1/4	5.0ml
4 months up to 12 months (6 - < 10 kg)	1/2	5.0ml
12 months up to 5 years (10 - < 19kg)	1	10ml

*Ceftriaxone should be used for severely sick children or children who have another severe classification. See Chart give these treatment in the clinic only.

Give an Appropriate Oral Antibiotic for Cholera

- FIRST-LINE ANTIBIOTIC FOR CHOLERA: Erythromycin
- SECOND-LINE ANTIBIOTIC FOR CHOLERA: Cotrimoxazole (trimethoprim + sulphamethoxazole)

AGE or WEIGHT	ERYTHROMYCIN Give four times daily for 3 days	COTRIMOXAZOLE (Trimethoprim + sulphamethoxazole) Give two times daily for 3 days		
	TABLET (250mg)	ADULT TABLET (80/400mg)	PAEDIATRIC TABLET (20/100mg)	SYRUP (40/200mg/5ml)
2 months up to 4 months (4 - 6 kg)	1/4	1/2	2	5.0ml
4 months up to 12 months (6 - < 10 kg)	1/2	1/2	2	5.0ml
12 months up to 5 years (10 - < 19kg)	1	1	4	10.0ml

Give an Oral Antimalarial

- FIRST- LINE ANITMALARIAL: Artemether Lumefantrine (ALu)
- SECOND - LINE ANTIMALARIAL: Dihydroartemisinin + Piperaquine (DPQ)

AGE or WEIGHT	Artemether-Lumefantrine (ALu) tablets* (20 mg artemether and 120 mg lumefantrine)					
	Day1		Day 2		Day 3	
	Start	After 8hrs	Morning	Night	Morning	Night
5 up to 15kg (3 months up to 3 years)	1	1	1	1	1	1
15 kg up to 25kg (3 years up to 8 years)	2	2	2	2	2	2

*If the child vomits within 30 minutes, repeat the dose and return to the clinic for additional tablets. Children 2 months or older, weighing less than five kg should be treated as severe malaria.

GIVE SECOND LINE ANTIMALARIAL

- A target dose: 4 mg/kg/day of Dihydroartemisinin and 18 mg/kg/day of Piperaquine. Once a day for 3 days

WEIGHT	Dihydroartemisinin Daily dose (mg)	Piperaquine Daily dose (mg)	Combined formulation (DPQ) Number of tablets per dose (D+PQ)	
			160mg Piperaquine/20mgDihydroartemisinin)	(320mg Piperaquine/40mg Dihydroartemisinin)
5-7kg	10	80	1/2	
7-13kg	20	160	1	1/2
13-24kg	40	320	2	1

Give Quinine Tablets

(Children 2 months or older, weighing less than five kg should be treated with quinine as first line)

AGE or WEIGHT	QUININE (Tablet 300 mg) Give three times daily for up to 7 to 10 days
2 months up to 12 months (up to 11 kg)	1/4
12 months up to 5 years (11 kg to 19 kg)	1/2

Give Paracetamol for High Fever (38.5°C or above) or Ear Pain

- Give paracetamol every 6 hourly until high fever or ear pain is gone.

AGE or WEIGHT	PARACETAMOL	
	PAEDIATRIC TABLET (100 mg)	ADULT TABLET (500 mg)
2 months up to 3 years (4 - <14 kg)	1	1/4
3 years up to 5 years (14 -<19 kg)	2 1/2	1/2

Note: Young infant should not be given antipyretic for the risk of permanent liver damage. If necessary to lower temperature undress the child and the temperature will be lowered.

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

GIVE ZINC FOR CHILDREN HAVING DIARRHOEA

AGE	Zinc Give one dose per day for 10 days
	Tablet (20mg/tablet)
Up to 6 months	1/2
6 months to 5 years	1

Give Multivitamin for SYMPTOMATIC or POSSIBLE/EXPOSED HIV INFECTION and for PERSISTENT DIARRHOEA

(See doses in the manufacturers instructions supplied as insert in the pack)

Give Vitamin A

VITAMIN A TREATMENT:

- For measles give three doses
 - Give first dose in clinic
 - Give mother one dose to give at home the next day
 - Give third dose in clinic after one month.
- For a child with **SEVERE MALNUTRITION** or **SEVERE MEASLES**, give one dose in clinic then refer.

VITAMIN A SUPPLEMENTATION:

- For a routine vitamin A supplementation for children aged 6 months up to 5 years.
 - Give Vitamin A supplementation every six months.
 - Give one dose in clinic if the child has not received a dose in the previous 6 months

AGE and WEIGHT	VITAMIN A CAPSULES		
	200000IU	100000IU	50000IU
Up to 6 months		1/2	1
6 up to 12 months and any child >12 months weighing <8 kg	1/2	1	2
12 months up to 5 years if child weight 8 kg or more	1	2	4

Give Iron

■

AGE or WEIGHT	IRON/FOLATE TABLET* Give one dose daily for 14 days	IRON SYRUP* Give one dose daily for 14 days	
	Ferrous sulfate 200 mg + 250 µg Folate (60 mg elemental iron)	Ferrous fumarate 100 mg per 5 ml (20 mg elemental iron per ml)	Ferrous Sulphate 100g per 5 mls
2 months up to 4 months (4 - <6 kg)		1.00 ml (< 1/4 tsp.)	1.00 ml
4 months up to 12 months (6 - <10 kg)		1.25 ml (1/4 tsp.)	1.25 ml
12 months up to 3 years (10 - <14 kg)	1/2 tablet	2.00 ml (<1/2 tsp.)	2.00 ml
3 years up to 5 years (14 - 19 kg)	1/2 tablet	2.5 ml (1/2 tsp.)	2.5ml

* Don't give Iron to a child with sickle cell anaemia

Give Mebendazole or Albendazole

- Give 500 mg mebendazole as a single dose in clinic if: the child is 1 years of age or older, and has not had a dose in the previous 6 months. or
- Give 400 mg Albendazole as a single dose in clinic if: the child is 2 years of age or older, and has not had a dose in the previous 6 months

Important: Do not give Albendazole if the child is less than 2 years give mebendazole instead.

TEACH THE MOTHER TO TREAT LOCAL INFECTIONS AT HOME

- Explain to the mother what the treatment is and why it should be given.
- Describe the treatment steps listed in the appropriate box.
- Watch the mother as she does the first treatment in the clinic (except for remedy for cough or sore throat).
- Tell her how often to do the treatment at home.
- If needed for treatment at home, give mother the tube of tetracycline ointment or a small bottle of gentian violet.
- Check the mother's understanding before she leaves the clinic.

Treat Eye Infection with Tetracycline Eye Ointment

- Clean both eyes 3 times daily.
 - Wash hands.
 - Ask the child to close the eye
 - Use clean cloth and water to gently wipe away pus.
- Then apply tetracycline eye ointment in both eyes 3 times daily.
 - Ask the child to look up
 - Squeeze a small amount of ointment on the inside of the lower lid.
 - Wash hands again.
- Treat until redness is gone.
- Do not use other eye ointments or drops, or put anything else in the eye.

Clear the Ear by Dry Wicking and Give Eardrops

- Dry the ear at least 3 times daily.
 - Roll clean absorbent cloth into a wick.
 - Place the wick in the child's ear.
 - Remove the wick when wet.
 - Replace the wick with a clean one and repeat these steps until the ear is dry.
 - For CHRONIC EAR INFECTION instill quinolone (e.g ciprofloxacin, ofloxacin or norfloxacin) ear drops after dry wicking 3 times daily for 2 weeks.

Treat for Mouth/Gum Ulcers

- For a child with measles.
 - Wash hands.
 - Wash the child's mouth with clean soft cloth wrapped around a stick and wet with salt water.
 - Paint the mouth with half-strength gentian violet (0.25% dilution).
 - Wash hands again.
- For children on ART or HIV INFECTION or HIV EXPOSED: POSSIBLE HIV INFECTION
 - Wash hands.
 - Wash the child's mouth with clean soft cloth wrapped around a stick and wet with saline, peroxide or sodium bicarbonate.
 - Give acyclovir 20mg/kg 4 times daily for 5 days, if lips or anterior gum is involved
 - Provide pain relief
 - Wash hands again.

Soothe the Throat, Relieve the Cough with a Safe Remedy

- Safe remedies to recommend:
 - Breast milk for a exclusively breastfed infant
 - Tea with honey
 - Tea with lemon
- Harmful remedies to discourage:
 - Any remedy containing atropine, codeine, alcohol and codeine derivatives

GIVE THESE TREATMENTS IN THE CLINIC ONLY

- Explain to the mother why the drug is given.
- Determine the dose appropriate for the child's weight (or age).
- Use a sterile needle and sterile syringe when giving an injection.
- Measure the dose accurately.
- Give the drug as an intramuscular injection.
- If child cannot be referred, follow the instructions provided.

Give an Intramuscular Antibiotic

GIVE TO CHILDREN BEING REFERRED URGENTLY

- Give both first dose of intramuscular Ampicillin and gentamicin then refer the child urgently to hospital.
- Give Ampicillin (50 mg/kg) or Benzylpenicillin (50,000 U/kg) and Gentamicin (7.5 mg/kg).
- If Ampicillin is not available, give benzylpenicillin.

For children with COMPLICATED SEVERE ACUTE MALNUTRITION give benzylpenicillin and gentamicin then refer urgently.

FOR CHILDREN WITH DYSENTERY AND OTHER SEVERE CLASSIFICATION OR GENERAL DANGER SIGN

- Give first dose of Ceftriaxone injection and refer urgently to hospital.

IF REFERRAL IS NOT POSSIBLE OR DELAYED OR REFUSED

- Continue giving both antibiotics as follows;
- Repeat Benzylpenicillin or ampicillin injection every 6 hours for 5 days.
 - Then change to an appropriate oral antibiotic to complete 10 days of treatment.
- Where there is a strong suspicion of meningitis, the dose of ampicillin can be increased 4 times
- Give gentamicin once daily for at least 5 days.
- For children having dysentery repeat ceftriaxone injection every 12 hours for 3 days.

AGE or WEIGHT	AMPICILLIN	BENZYLPENICILLIN		GENTAMICIN	CEFTRIAXONE
	Dose: 50mg per kg/day Add 2.5 mls sterile water to vial containing 500 mg	To a vial of 600 mg (1 million units) Add 2.1 ml sterile water = 2.5 ml at 400,000 U/ml ■ Give 50,000 U per kg, or:	To a vial of 3 g (5 million units): Add 8 ml sterile water = 10 ml at 500,000 U/ml ■ Give 50,000 U per kg or:	To a 2 mls vial containing 40mg/ml ■ Give 7.5 mg/kg.	To a vial of 1g/10mls. ■ Give 50-80mg/kg/day
2 to 4kg		0.5ml	1.5ml		1.5ml
2 up to 4 months (4 - <6 kg)	1.0 ml	0.8 ml	0.6 ml	1.0 ml	3.0ml
4 months up to 9 month (6 - <8kg)	1.5 ml	1.0 ml	0.8 ml	1.3 ml	6.0ml
9 months up to 12 months (8 - <10kg)	2.0 ml	1.2 ml	1.0 ml	1.5 - 1.8 ml	7.0ml
12 months up to 3 years (10 - <14 kg)	3.0 ml	1.5 ml	1.2 ml	1.9 - 2.7 ml	10.0ml
3 years up to 5 years (14 - 19 kg)	5.0 ml	2.5 ml	1.5 ml	2.8 - 3.5 ml	13.0ml

GIVE THESE TREATMENTS IN THE CLINIC ONLY

Give Artesunate Suppositories or Intramuscular Artesunate or Quinine for Severe Malaria

FOR CHILDREN BEING REFERRED WITH VERY SEVERE FEBRILE DISEASE:

- Check which pre-referral treatment is available in your clinic (rectal artesunate suppositories, artesunate injection or quinine) formulation is available in your clinic.
- Artesunate suppository: Insert first dose of the suppository and refer child urgently
- Intramuscular artesunate or quinine: Give first dose and refer child urgently to hospital.

IF REFERRAL IS NOT POSSIBLE:

- For artesunate suppository:**
 - Give first dose of suppository
 - Repeat the same dose of suppository every 24 hours until the child can take oral antimalarial.
 - Give full dose of oral antimalarial as soon as the child is able to take orally
- For artesunate injection:**
 - Give first dose of artesunate intramuscular injection
 - Repeat dose after 12 hrs and daily until the child can take orally
 - Give full dose of oral antimalarial as soon as the child is able to take orally.
- Two steps dilutions for Injectable Artesunate**
 - Step 1: The powder for injection should be diluted with 1ml of 5% sodium bicarbonate and shaken vigorously two to three minutes till the solution becomes clear.
 - Step 2: For I.V. add 5 ml (for I.M. add 2ml) of normal saline or 5% of glucose and mix again.
 - That is for slow intravenous infusion (3-4 minutes), add 5 ml of 5% dextrose or normal saline, to obtain a Artesunate concentration of 10 mg/ml and for deep intra-muscular injection, add 2 ml of 5% dextrose or normal saline to obtain a Artesunate concentration of 20 mg/ml.
- For quinine:**
 - Give first dose of intramuscular quinine.
 - The child should remain lying down for one hour.
 - Repeat the quinine injection at 4 and 8 hours later, and then every 12 hours until the child is able to take an oral antimalarial. Do not continue quinine injections for more than 1 week.

AGE or WEIGHT	RECTAL ARTESUNATE SUPPOSITORY		INTRAMUSCULAR ARTESUNATE	INTRAMUSCULAR QUININE	
	50 mg suppositories Dosage 10 mg/kg	200 mg suppositories Dosage 10 mg/kg		60 mg vial (20mg/ml) 2.4 mg/kg	150 mg/ml* (in 2 ml ampoules)
2 months up to 4 months (4 - <6 kg)	1		1/2 ml	0.4 ml	0.2 ml
4 months up to 12 months (6 - <10 kg)	2		1 ml	0.6 ml	0.3 ml
12 months up to 2 years (10 - <12 kg)	2		1.5 ml	0.8 ml	0.4 ml
2 years up to 3 years (12 - <14 kg)	3	1	1.5 ml	1.0 ml	0.5 ml
3 years up to 5 years (14 - 19 kg)	3	1	2 ml	1.2 ml	0.6 ml

* quinine salt

Alternative treatment for Severe malaria.

Administration and Dosage:

- Artemether should be administered in a dose of 3.2 mg/kg body weight loading dose IM stat then 1.6mg/kg body weight (time = 0h then at 24 hrs and 48 hrs).
- If the patient can tolerate oral medication after 24 hours provide a full treatment course of ALu. Initiate the first dose of ALu 8 hours after the last injection.

Treat Convulsing Child With Diazepam Rectally

Manage the Airway

- Turn the child to his/her side to avoid aspiration.
- Do not insert anything in the mouth.
- If the child is blue (cyanosis), open the mouth and make sure the airway is clear
- If necessary, remove secretions from the throat.

If High Fever

Undress and fan the child to lower the fever.

FOR CHILDREN AGED MORE THAN 1 MONTH GIVE DIAZEPAM RECTALLY

- Draw up the dose from intravenous preparation of diazepam into small syringe, then remove the needle
- Insert approximately 5 cm of nasogastric tube into the rectum.
- Inject the diazepam solution into the nasogastric tube and flush it with room temperature water.

AGE or WEIGHT	DIAZEPAM RECTALLY* 10 mg/ml solution Dose 0.2-0.4 mg/kg
1 month up to 2 months (3-<4 kg)	0.125 ml*
2 months up to 4 months (4-<6 kg)	0.25 ml
4 months up to 12 months (6-<10 kg)	0.50 ml
12 months up to 3 years (10-<14 kg)	0.75 ml
3 years up to 5 years (14-19 kg)	1.00 ml

* Do not give diazepam to young infant less than 1 month. Give phenobarbitone instead. See table below.

Treat Convulsing Child With (IM) phernobarbitone

Manage the Airway

- Turn the child to his/her side to avoid aspiration.
- Do not insert anything in the mouth.
- If the child is blue (cyanosis), open the mouth and make sure the airway is clear
- If necessary, remove secretions from the throat.

If High Fever

Undress and fan the child to lower the fever.

FOR CHILDREN AGED LESS THAN 1 MONTH GIVE INTRAMUSCULAR PHERNOBARBITONE

- Select an appropriate vial of phernobarbitone concentration before giving the medicine.

WEIGHT	PHERNOBARBITONE	
	200mg/ml	Give at a dose of 15mg/kg
1.5-<2.5kg		0.2ml
2.5-<4.0kg		0.3ml
4.0-<6.0kg		0.4ml
6.0-<10.0kg		0.6ml

GIVE THESE TREATMENTS IN THE CLINIC ONLY

Treat the Child to Prevent Low Blood Sugar

- **If the child is able to breastfeed:**
 - Ask the mother to breastfeed the child.
- **If the child is not able to breastfeed but is able to swallow:**
 - Give expressed breast milk or another milk.
 - If neither of these is available, give sugar water.
 - Give 30 - 50 ml of milk or sugar water before departure.
 - To make sugar water: Dissolve 4 level teaspoons of sugar (20grams) in a 200-ml cup of clear water.
- **If the child is not able to swallow:**
 - Give 50 ml of milk or sugar water by nasogastric tube.

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING (See FEEDING advice on COUNSEL THE MOTHER chart)

Plan A: Treat Diarrhoea at Home

Counsel the mother on the 4 Rules of Home Treatment:

1. Give Extra Fluid
2. Give Zinc Supplements (for children above 2 months old)
3. Continue Feeding
4. When to Return.

1. GIVE EXTRA FLUID (as much as the child will take)

■ TELL THE MOTHER:

- Breastfeed frequently and for longer at each feed.
- If the child is exclusively breastfed, give ORS or clean water in addition to breast milk.
- If the child is not exclusively breastfed, give one or more of the following:
ORS solution, food-based fluids (such as soup, rice water, and yoghurt drinks), or clean water.

■ It is especially important to give ORS at home when:

- the child has been treated with Plan B or Plan C during this visit.
- the child cannot return to a clinic if the diarrhoea gets worse.

■ TEACH THE MOTHER HOW TO MIX AND GIVE ORS. GIVE THE MOTHER 2 PACKETS OF ORS TO USE AT HOME.

■ SHOW THE MOTHER HOW MUCH FLUID TO GIVE IN ADDITION TO THE USUAL FLUID INTAKE:

Up to 2 years	50 to 100 ml after each loose stool
2 years or more	100 to 200 ml after each loose stool

Tell the mother to:

- Give frequent small sips from a cup.
- If the child vomits, wait for 10 minutes. Then continue, but more slowly.
- Continue giving extra fluid until the diarrhoea stops.

2. GIVE ZINC

■ TELL THE MOTHER HOW MUCH ZINC TO GIVE (20 mg tab):

2 months to 6 months	1/2 tablet daily for 10 days
6 months or more	1 tablet daily for 10 days

■ SHOW THE MOTHER HOW TO GIVE ZINC SUPPLEMENTS

- Infants - dissolve tablet in a small amount of expressed breast milk, ORS or clean water in a cup.
- Older children - tablets can be chewed or dissolved in a small amount of water.

3. CONTINUE FEEDING (exclusive breastfeeding if age less than 6 months)

4. WHEN TO RETURN

Plan B: Treat Some Dehydration with ORS and Zinc

In the clinic, give recommended amount of ORS over 4-hour period

■ DETERMINE AMOUNT OF ORS TO GIVE DURING FIRST 4 HOURS

WEIGHT	< 6 kg	6 - <10 kg	10 - <12 kg	12 - 19 kg
AGE*	Up to 4 months	4 months up to 12 months	12 months up to 2 years	2 years up to 5 years
In ml	200 - 400	400 - 700	700 - 900	900 - 1400

* Use the child's age only when you do not know the weight. The approximate amount of ORS required (in ml) can also be calculated by multiplying the child's weight (in kg) times 75.

- If the child wants more ORS than shown, give more.
- For infants under 6 months who are not breastfed, also give 100 - 200 ml clean water during this period

■ SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.

- Give frequent small sips from a cup.
- If the child vomits, wait for 10 minutes. Then continue, but more slowly.
- Continue breastfeeding whenever the child wants.

■ AFTER 4 HOURS:

- Reassess the child and classify the child for dehydration.
- Select the appropriate plan to continue treatment.
- Begin feeding the child in clinic.

■ IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:

- Show her how to prepare ORS solution at home.
- Show her how much ORS to give to finish 4-hour treatment at home.
- Give her enough ORS packets to complete rehydration. Also give her 2 packets as recommended in Plan A.
- Explain the 4 Rules of Home Treatment:

1. GIVE EXTRA FLUID

2. GIVE ZINC (for children age 2 months or above)

3. CONTINUE FEEDING (exclusive breastfeeding if age less than 6 months)

4. WHEN TO RETURN

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING (See FEEDING advice on COUNSEL THE MOTHER chart)

Immunize Every Sick Child, Give Vitamin A and Deworm as Described in the Assess and classify part

Plan C: Treat Severe Dehydration Quickly

FOLLOW THE ARROWS. IF ANSWER IS "YES", GO ACROSS. IF "NO", GO DOWN.

START HERE

Can you give intravenous (IV) fluid immediately?

YES →

NO



- **Start IV fluid immediately.** If the child can drink, give ORS by mouth while the drip is set up. Give 100 ml/kg Ringer's Lactate Solution (or, if not available, normal saline), divided as follows

AGE	First give 30 ml/kg in:	Then give 70 ml/kg in:
Infants (under 12 months)	1 hour*	5 hours
Children (12 months up to 5 years)	30 minutes*	2 1/2 hours

* Repeat once if radial pulse is still very weak or not detectable.

- **Reassess the child every 1-2 hours.** If hydration status is not improving, give the IV drip more rapidly.
- Also give ORS (about 5 ml/kg/hour) as soon as the child can drink: usually after 3-4 hours (infants) or 1-2 hours (children).
- Reassess an infant after 6 hours and a child after 3 hours. Classify dehydration. Then choose the appropriate plan (A, B, or C) to continue treatment.

Is IV treatment available nearby (within 30 minutes)?

YES →

NO



Are you trained to use a naso-gastric (NG) tube for rehydration?

YES →

NO



Can the child drink?

YES →

NO



Refer URGENTLY to hospital for IV or NG treatment

- **Refer URGENTLY to hospital for IV treatment.**
- If the child can drink, provide the mother with ORS solution and show her how to give frequent sips during the trip or give ORS by naso-gastric tube.

- **Start rehydratin by tube (or mouth) with ORS solution:** give 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- **Reassess the child every 1-2 hours while waiting for transfer:**
 - If there is repeated vomiting or increasing abdominal distension, give the fluid more slowly.
 - If hydration status is not improving after 3 hours, send the child for IV therapy.
- After 6 hours, reassess the child. Classify dehydration. Then choose the appropriate plan (A, B or C) to continue treatment.

NOTE:

- If the child is not referred to hospital, observe the child at least 6 hours after rehydration to be sure the mother can maintain hydration giving the child ORS solution by mouth.

COUNSEL

COUNSEL MOTHER ON FEEDING

Assess Child's Appetite

All children aged 6 months or more with **SEVERE ACUTE MALNUTRITION** (oedema of both feet or WFH/L less than -3 z-scores or MUAC less than 115 mm) and no medical complication should be assessed for appetite.

Appetite is assessed on the initial visit and at each follow-up visit to the health facility. Arrange a quiet corner where the child and mother can take their time to get accustomed to eating the RUTF. Usually the child eats the RUTF portion in 30 minutes.

Explain to the mother:

- The purpose of assessing the child's appetite.
- What is ready-to-use-therapeutic food (RUTF).
- How to give RUTF:
 - Wash hands before giving the RUTF.
 - Sit with the child on the lap and gently offer the child RUTF to eat.
 - Encourage the child to eat the RUTF without feeding by force.
 - Offer plenty of clean water to drink from a cup when the child is eating the RUTF.

Offer appropriate amount of RUTF to the child to eat:

- After 30 minutes check if the child was able to finish or not able to finish the amount of RUTF given and decide:
 - Child **ABLE** to finish at least one-third of a packet of RUTF portion (92 g) or 3 teaspoons from a pot within 30 minutes.
 - Child **NOT ABLE** to eat one-third of a packet of RUTF portion (92 g) or 3 teaspoons from a pot within 30 minutes.

COUNSEL

COUNSEL MOTHER ON FEEDING

Assess Child's Feeding

Assess feeding if child is Less Than 2 Years Old, Has MODERATE ACUTE MALNUTRITION, ANAEMIA. Ask questions about the child's usual feeding and feeding during this illness. Compare the mother's answers to the ***Feeding Recommendations*** for the child's age.

ASK - How are you feeding your child?

■ **If the child is receiving *any* breast milk, ASK:**

- How many times during the day?
- Do you also breastfeed during the night?

■ **Does the child take any other food or fluids?**

- What food or fluids?
- How many times per day?
- What do you use to feed the child?

■ **If MODERATE ACUTE MALNUTRITION or if a child with CONFIRMED HIV INFECTION fails to gain weight or loses weight between monthly measurements, ASK:**

- How large are servings?
- Does the child receive his own serving?
- Who feeds the child and how?
- What foods are available in the home?

■ **During this illness, has the child's feeding changed?**

- If yes, how?

COUNSEL

COUNSEL MOTHER ON FEEDING

Feeding Recommendations During Sickness and Health

NOTE: These feeding recommendations should be followed for infants of HIV negative mother. Mothers with unknown status should be encouraged to breastfeed but also be tested for HIV in order to make an informed choice.

Up to 6 months	6 up to 9 months	9 months up 12 months	12 months up to 2 years	2 years up to 5 years
				
■ Immediately after birth, put your baby in skin to skin contact with you. ■ Allow the baby to take the breast within the first hour. Give your baby colostrum the first yellowish, thick milk. It protects the baby from many illnesses. ■ Breastfeed as often as the child wants, day and night, at least 8 times in 24 hours. wake the baby to breastfeed every 3 hours. ■ Do not give other foods or fluids not even water. Monitor the child's growth at the nearest health facility.	■ Breastfeed as often as the child wants, at least 8 times per 24 hours ■ if the child is not breast feeding give in addition 1-2 cups of milk per day and two extra meals per day ■ Introduce complementary foods gradually with one item at first. Start giving thick enriched porridge and mashed foods ■ Give very small quantities (4 times per day) after breastfeeding. ■ Give: - Orange, Lemon or Tomato juice after dilution with very small quantity of water and sugar. ■ Custard, Rice <u>OR</u> Potato or carrot mashed , banana with milk ■ add a teaspoon of oil ■ Legumes (Broad, beans, Lentils,) add one or two drops of lemon or tomato juice ■ Vegetable soup. ■ Mashed fruits. Monitor the child's growth at the nearest health facility.	■ Breastfeed as often as the child wants. ■ Give adequate servings of: Assida, Gorassa, Bread, Kissra, Rice <u>WITH</u> ■ mashed vegetables or fruits <u>WITH</u> ■ Minced meat, chicken, fish <u>OR</u> ■ Broad beans, Lentils or any Legumes . ■ Give small frequent meals 5-6 times per day. * ■ Add one or two tea spoon of oil to the child food. Monitor the child's growth at the nearest health facility	■ .Breastfeed as often as the child wants. ■ Give adequate servings of: Assida, <u>WITH</u> ■ mashed vegetables or fruits <u>WITH</u> ■ Milk, milk products <u>OR</u> ■ Eggs, <u>OR</u> ■ Minced meat, chicken, fish <u>OR</u> ■ Broad beans, Lentils or any Legumes . <u>OR</u> Family foods free from spices Give small frequent meals 5-6 times per day. * Add one or two tea spoon of oil to the child food. Monitor the growth of your child at the nearest health facility.  Monitor the child's growth at the nearest health facility	■ Give family foods at 3 meals each day. Also, twice daily, give nutritious food between meals, such as: ■ Milk and milk products ■ Fruits or vegetables  Monitor the child's growth at the nearest health facility

* A good daily diet should be adequate in quantity and include an energy-rich food(for example, thick cereal with added oil), meat, fish, eggs, or pulses, and fruits and vegetables.

COUNSEL

COUNSEL MOTHER ON FEEDING

Feeding Recommendations for Children Who are Not breastfed

NOTE: These feeding recommendations should be followed for infant who is not been breastfed due to any acceptable reason such as: orphan or mother too sick to breastfeed her infant.

Note: HIV infection is not a recommendation for not to breastfeed the infants. HIV positive mothers should be encouraged to breastfeed as usual.

Up to 6 months	6 months up to 9 months	9 months up to 12 months	12 months up to 2 years														
																	
If AFASS (see "AFASS" criteria for giving replacement if Formula feed exclusively no breast milk at all) ■ Give formula feed as often as the child wants, day and night ■ Feed at least 6-8 times in 24 hours ■ Other foods or fluids are not necessary ■ Prepare correct strength and amount just before use ■ Use milk within an hour and discard any left over ■ Cup feeding is safer than bottle feeding ■ Clean the cup and utensils with soap and water ■ Give these amounts of formula 6-8 times per day <table><tr><th>Age months and times</th><th>Approx. amount per day</th></tr><tr><td>0 up to 1</td><td>60 ml x 8</td></tr><tr><td>1 up to 2</td><td>90 ml x 7</td></tr><tr><td>2 up to 3</td><td>120 ml x 6</td></tr><tr><td>3 up to 4</td><td>120 ml x 6</td></tr><tr><td>4 up to 5</td><td>150 ml x 6</td></tr><tr><td>5 up to 6</td><td>150 ml x 6</td></tr></table> 	Age months and times	Approx. amount per day	0 up to 1	60 ml x 8	1 up to 2	90 ml x 7	2 up to 3	120 ml x 6	3 up to 4	120 ml x 6	4 up to 5	150 ml x 6	5 up to 6	150 ml x 6	■ If the child was on exclusive replacement feeding advise the mother to continue feeding, as per formula milk instruction. ■ Give about 1-2 cups (500 ml) of full cream milk or infant formula per day ■ Give milk with a cup, not a bottle. ■ Start to give thick enriched porridge and mashed foods ■ Initially give 2-3 table spoons 2 times/day ■ From 7 months increase amounts gradually to 2/3 of a 250 ml cup at each meal 3 times per day, feed at least 10 times in 24 hours ■ If possible, give an additional animal-source food, such as liver or meat If no milk is available, give 4-5 feeds per day one cup=250 ml Food examples include: ■ Potatoes bananas, rice porridge, vegetables, minced meat, fish, beans groundnuts and other legumes. ■ Fruits like pawpaw bananas and avocados ■ Add a teaspoonful of oil per meal ■ Use iodized salt 	■ Give 3 adequate servings of nutritious complementary foods plus one snack per day between meals (mashed fruit and vegetables). Each meal should be 3/4 cup*. If possible, give an additional animal-source food, such as liver or meat to include protein ■ Give about 1-2 cups (500 ml) of full cream milk or infant formula per day ■ Give milk with a cup, not a bottle ■ If no milk is available, give 4-5 feeds per day one cup = 250 ml Food examples include: ■ Potatoes, bananas, rice porridge, vegetables, minced meat, fish, beans, groundnuts, and other legumes. ■ Fruits like pawpaw, bananas, and avocados ■ Add a teaspoonful of oil per meal ■ Use iodized salt 	■ Give 3 adequate nutritious feeds plus 2 snacks per day (each meal should be 1 cup). If possible, give an additional animal-source food, such as liver or meat. Also give an egg if available ■ Give fruit or vegetables twice every day ■ Give about cups (500 ml) of full cream milk or infant formula per day. If no milk is available, give 4-5 feeds per day Feed actively with own plate and spoon Food examples include: ■ Potatoes bananas, rice porridge, vegetables, minced meat, fish, beans groundnuts and other legumes. ■ Fruits like pawpaw bananas and avocados ■ Add a teaspoonful of oil per meal ■ Use iodized salt 
Age months and times	Approx. amount per day																
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2 up to 3	120 ml x 6																
3 up to 4	120 ml x 6																
4 up to 5	150 ml x 6																
5 up to 6	150 ml x 6																

* Make sure the fruits are always carefully washed

COUNSEL

COUNSEL MOTHER ON FEEDING

Feeding Recommendations For a Child Who Has PERSISTENT DIARRHOEA

- If still breastfeeding, give more frequent, longer breastfeeds, day and night.
- If taking other milk:
 - replace with increased breastfeeding OR
 - replace with fermented milk products, such as yoghurt OR
 - replace half the milk with nutrient-rich semisolid food.
- For other foods, follow feeding recommendations for the child's age.

Feeding Recommendations For Stunted Child

- Continue feeding as per feeding recommendations for age.
- Give extra meals rich in animal proteins, like eggs, milk, fish, beef, chicken meat.

SPECIAL FEEDING ASSESSMENT AND ADVISE

Assess Feeding if Child Has ANAEMIA, MODERATE ACUTE MALNUTRITION, HIV Infection, HIV Exposed or is Less Than 2 Years Old

Ask questions about the child's usual feeding and feeding during this illness. Compare the mother's answers to the **Feeding Recommendations** for the child's age in the box below:

ASK:

- Do you breast feed your child?
 - ◊ How many times during the day?
 - ◊ Do you also breastfeed during the night?
- Does the child take any other food or fluids?
 - ◊ What food or fluids?
 - ◊ How many times per day?
 - ◊ What do you use to feed the child?

If very low weight for age, ASK:

- How large are servings?
 - ◊ Does the child receive his own serving?
 - ◊ Who feeds the child and how?
- What foods are available in the home?
- During this illness, has the child's feeding changed? If yes, how?

If HIV positive mother has opted not to breastfeed

ASK:

- What milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How are you preparing the milk?
 - ◊ Let mother demonstrate or explain how a feed is prepared, and how it is given to the infant.
- Are you giving any breast milk at all?
- What foods and fluids in addition to replacement feeds is given?
- How is the milk being given? Cup or bottle?
- How are you cleaning the feeding utensils?

Practice Good Hygiene and Proper Food Handling

- Wash hands before food preparations, before and after eating.
- Serve food immediately after preparation.
- Use clean utensils to prepare and serve foods.
- Make sure fruits are properly washed.

SPECIAL FEEDING ASSESSMENT AND ADVISE

Safe Preparation of Formula Milk

- Always use a marked cup or glass and spoon to measure water and the scoop to measure the formula powder.
- Wash your hands before preparing a feed.
- Bring the water to boil and then let it cool. Keep it covered while it cools.
- Measure the formula powder into a marked cup or glass. Make the scoops level. Put in one scoop for every 25 ml of water.
- Add a small amount of the cooled boiled water and stir. Fill the cup or glass to the mark with the water. Stir well.
- Feed the infant using a cup.
- Wash the utensils.

IMPORTANT: Cows milk is not safe for children and is not recommended for infants below six months.

Teach the Mother How to Feed by a Cup

- Hold the infant sitting upright or semi-upright on your lap.
- Hold a small cup of milk to the infant's lips:
 - tip the cup so the milk just touches the infant's lips,
 - the cup rests gently on the infant's lower lip and the edges of the cup, and
 - touch the outer part of the infant's upper lip,
 - the infant becomes alert and opens his mouth and eyes.
- Do not pour the milk into the infant's mouth. Just hold the cup to his lips and let her/ him take it himself.
- When the infant has had enough he closes his mouth and will not take any more.
- When the baby takes enough and refuses put him or her to the shoulder and burp her/him rubbing the back.

Feeding Advice for the Mother of a Child with HIV Infection

- The child with confirmed HIV infection should be encouraged to breastfeed as s/he is already HIV infected but need the benefits of breastfeeding.
- The child should be fed according to the feeding recommendations for his age.
- These children often suffer from poor appetite and mouth sores - give appropriate advice.
- If the child is being fed with a bottle encourage the mother to use a cup as this is more hygienic and will reduce episodes of diarrhoea.
- Inform the mother about the importance of hygiene when preparing food because her child can easily get sick. She should wash her hands after going to the toilet and before preparing food.
- If the child is not gaining weight well, the child can be given an extra meal each day and the mother can encourage him to eat more by offering him snacks that he likes if these are available.
- Advise her about her own nutrition and the importance of a well balanced diet to keep herself healthy.
- Encourage her to plant vegetables to feed her family.

SPECIAL FEEDING ASSESSMENT AND ADVISE

"AFASS" Criteria for Formula Milk Feeding to Eligible Infants

Acceptable: Mother perceives no problem in replacement feeding.

Feasible: Mother has adequate time, knowledge, skills, resources, and support to correctly mix formula or milk and feed the infant up to 12 times in 24 hours.

Affordable: Mother and family, with community can pay the cost of purchasing, producing, preparing and using replacement feeding without harming the health and nutrition of the family.

Sustainable: Availability of a continuous supply of all ingredients needed for safe replacement feeding as long as the infant needs it for up to one year of age or longer.

Safe: Replacement foods are correctly and hygienically prepared, stored and fed in nutritionally adequate quantities.



SPECIAL FEEDING ASSESSMENT AND ADVISE

Counsel the Mother About Feeding Problems

If the child is not being fed as described in the above recommendations, counsel the mother accordingly. In addition:



- **If the mother reports difficulty with breastfeeding, assess breastfeeding (See *YOUNG INFANT* chart) as needed, show the mother correct positioning and attachment for breastfeeding.**
- **If the child is less than 6 months old and is taking other milk or foods:**
 - Build mother's confidence that she can produce all the breast milk that the child needs.
 - Suggest giving more frequent, longer breastfeeds day or night, and gradually reducing other milk or foods.
- **If other milk needs to be continued, counsel the mother to:**
 - Breastfeed as much as possible, including at night.
 - Make sure that other milk is a locally appropriate breast milk substitute.
 - Make sure other milk is correctly and hygienically prepared and given in adequate amounts.
 - Finish prepared milk within an hour.
- **If the mother is HIV positive and is mix feeding:**
 - Counsel the mother on appropriate feeding (avoid mixed feeding as it increases the risk of HIV transmission)
- **If the mother is using a bottle to feed the child:**
 - Recommend substituting a cup for bottle.
 - Show the mother how to feed the child with a cup.
- **If the child is not feeding well during illness, counsel the mother to:**
 - Breastfeed more frequently and for longer period if possible.
 - Use soft, varied, appetizing, favourite foods to encourage the child to eat as much as possible, and offer frequent small feedings.
 - Clear a blocked nose if it interferes with feeding.
 - Avoid spicy, salty or acid food if the child has oral thrush or mouth ulcers
 - Expect that appetite will improve as child gets better.
- **If an infant is 6 months or older and the mother has decided to stop breastfeeding, counsel the mother to:**
 - Continue breastfeeding until the child is at least one year old
 - Breastfeeding the child early in the morning and in the evening if the mother has to work outside the home.
- **If the complementary food is inadequate, counsel the mother to:**
 - Give the child adequate servings of nutritious complementary food such as thick, enriched porridge, mixed foods containing milk and mashed food (According to the box "Feeding Recommendations during Sickness and Health").
 - Add a spoonful of extra oil to the child's food.
 - Add greens and fruits.
- **Follow-up any feeding problem in 5 days.**

COUNSEL ON FLUID

Advise the Mother to Increase Fluid During Illness

- **FOR ANY SICK CHILD:**
 - For breastfeeding children: Breastfeed more frequently and for longer at each feed.
 - For children older than 6 months increase other fluids. For example, give soup, rice water, yoghurt drinks or clean water.
- **FOR A CHILD WITH DIARRHOEA:**
 - Giving extra fluid can be lifesaving. Give fluid according to Plan A or Plan B **TREAT THE CHILD** chart.

COUNSEL FOR WHEN TO RETURN

Advise the Mother When to Return to the Health Worker

FOLLOW-UP VISIT:

- Advise the mother to come for follow-up at the earliest time listed for the child's problems.

If the child has:	Return for follow-up in:
- PNEUMONIA - DYSENTERY	2 days
MEASLES WITH EYE OR MOUTH COMPLICATIONS UNCOMPLICATED MALARIA, if fever persists	3 days
- PERSISTENT DIARRHOEA - ACUTE EAR INFECTION - CHRONIC EAR INFECTION - FEEDING PROBLEM - COUGH OR COLD, if not improving	5 days
GUM OR MOUTH ULCERS	7 days
- ANAEMIA - HIV INFECTION - UNCOMPLICATED SEVERE ACUTE MALNUTRITION - HIV EXPOSED: POSSIBLE HIV INFECTION	14 days
- MEASLES - MODERATE MALNUTRITION	30 days

NEXT WELL-CHILD VISIT: Advise the mother when to return for next immunization, Vitamin A supplementation and for deworming according to the schedule.



WHEN TO RETURN IMMEDIATELY

Advise mother to return immediately if the child has any of these signs:

Any sick child	- Not able to drink or breastfeed - Becomes sicker - Develops a fever
If child has NO PNEUMONIA: COUGH OR COLD, also return if:	- Fast breathing - Difficult breathing
If child has diarrhoea, also return if:	- Blood in stool - Drinking poorly

Counsel the Mother about Her Own Health

- If the mother is sick, provide care for her, or refer her for help.
- If she has a breast problem (such as engorgement, sore nipples, breast infection), provide care for her or refer her for help.
- Advise her to eat well to keep up her own strength and health. If the mother is breastfeeding advise her to take two extra meals daily.
- Ask the mother to show her Tetanus Toxoid (TT) card. Check the mother's immunization status and give her tetanus toxoid if needed.
- Make sure she has access to:
 - Family planning
 - Counselling on Sexually Transmitted Infections and Reproductive Tract Infections (STI/RTI) and AIDS prevention.
- Encourage the mother to ensure that she knows her HIV status and to seek HIV testing if she does not know her status or is concerned about the possibility of HIV infection in herself or in her family.

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

- Care for the child who returns for follow-up using all the boxes that match the child's previous classifications.
- If the child has any new problem, assess, classify and treat the new problem as on the **ASSESS AND CLASSIFY** chart.

PNEUMONIA

After 3 days:

Check the child for general danger signs.
Assess the child for cough or difficult breathing.
Ask:

- Is the child breathing slower?
- Is there a chest indrawing?
- Is there less fever?
- Is the child eating better?

} See **ASSESS & CLASSIFY** chart.

Treatment:

- If **any general danger sign or stridor**, refer **URGENTLY** to hospital.
- If **chest indrawing and/or breathing rate, fever and eating are the same or worse**, refer **URGENTLY** to hospital.
- If **breathing slower, no chest indrawing, less fever, and eating better**, complete the 5 days of antibiotic.

PERSISTENT DIARRHOEA

After 5 days:

Ask:

- Has the diarrhoea stopped?
- How many loose stools is the child having per day?

Treatment:

- If **the diarrhoea has not stopped** (child is still having 3 or more loose stools per day), do a full reassessment of the child. Treat for dehydration if present. Then refer to hospital.
- If **the diarrhoea has stopped** (child having less than 3 loose stools per day), tell the mother to follow the usual feeding recommendations for the child's age.

DYSENTERY

After 3 days:

Assess the child for diarrhoea. > See **ASSESS & CLASSIFY** chart.

Ask:

- Are there fewer stools?
- Is there less blood in the stool?
- Is there less fever?
- Is there less abdominal pain?
- Is the child eating better?

Treatment:

- If the child is **dehydrated**, treat dehydration.
- If **number of stools, amount of blood in stools, fever, abdominal pain, or eating are worse or the same**:
 - Change to second-line oral antibiotic recommended for dysentery in your area. Give it for 5 days. Advise the mother to return in 3 days. If you do not have the second line antibiotic, **REFER** to hospital.

Exceptions - if the child:

- is less than 12 months old, or
 - was dehydrated on the first visit, or
 - if he had measles within the last 3 months
- } **REFER** to hospital.

- If **fewer stools, less blood in the stools, less fever, less abdominal pain, and eating better**, continue giving ciprofloxacin until finished.

Ensure that mother understands the oral rehydration method fully and that she also understands the need for an extra meal each day for a week.

MALARIA

If fever persists after 3 days:

Do a full reassessment of the child. > See **ASSESS & CLASSIFY** chart.

DO NOT REPEAT the Rapid Diagnostic Test if it was positive on the initial visit.

Treatment:

- If the child has **any general danger sign or stiff neck**, treat as **VERY SEVERE FEBRILE DISEASE**.
- If the child has any **other cause of fever other than malaria**, provide appropriate treatment.
- If there is **no other apparent cause of fever**:
 - If fever has been present for 7 days, refer for assessment.
 - Do microscopy to look for malaria parasites. If parasites are present and the child has finished a full course of the first line antimalarial, give the second-line antimalarial, if available, or refer the child to a hospital.
 - If there is no other apparent cause of fever and you do not have a microscopy to check for parasites, refer the child to a hospital.

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

FEVER: NO MALARIA

If fever persists after 3 days:

Do a full reassessment of the child. > See ASSESS & CLASSIFY chart.

Repeat the malaria test.

Treatment:

- If the child has **any general danger sign or stiff neck**, treat as VERY SEVERE FEBRILE DISEASE.
- If a child has a **positive malaria test**, give first-line oral antimalarial. Advise the mother to return in 3 days if the fever persists.
- If the child has any **other cause of fever other than malaria**, provide treatment.
- If there is **no other apparent cause** of fever:
 - If the fever has been present for 7 days, refer for assessment.

MEASLES WITH EYE OR MOUTH COMPLICATIONS, GUM OR MOUTH ULCERS, OR THRUSH

After 3 days:

Look for red eyes and pus draining from the eyes.

Look at mouth ulcers or white patches in the mouth (thrush).

Smell the mouth.

Treatment for eye infection:

- If **pus is draining from the eye**, ask the mother to describe how she has treated the eye infection. If treatment has been correct, refer to hospital. If treatment has not been correct, teach mother correct treatment.
- If **the pus is gone but redness remains**, continue the treatment.
- If **no pus or redness**, stop the treatment.

Treatment for mouth ulcers:

- If **mouth ulcers are worse, or there is a very foul smell from the mouth**, refer to hospital.
- If **mouth ulcers are the same or better**, continue using half-strength gentian violet for a total of 5 days.

Treatment for thrush:

- If **thrush is worse** check that treatment is being given correctly.
- If the child has **problems with swallowing**, refer to hospital.
- If **thrush is the same or better**, and the child is feeding well, continue nystatine for a total of 7 days.

EAR INFECTION

After 5 days:

Reassess for ear problem. > See ASSESS & CLASSIFY chart.

Measure the child's temperature.

Treatment:

- If there is **tender swelling behind the ear or high fever (38.5°C or above)**, refer URGENTLY to hospital.
- **Acute ear infection:**
 - If **ear pain or discharge** persists, treat with 5 more days of the same antibiotic. Continue wicking to dry the ear. Follow-up in 5 days.
 - If **no ear pain or discharge**, praise the mother for her careful treatment. If she has not yet finished the 5 days of antibiotic, tell her to use all of it before stopping.
- **Chronic ear infection:**
 - Check that the mother is wicking the ear correctly and giving quinolone drops three times a day. Encourage her to continue.

FEEDING PROBLEM

After 7 days:

Reassess feeding. > See questions in the COUNSEL THE MOTHER chart.

Ask about any feeding problems found on the initial visit.

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the child back again.
- If the child is classified as MODERATE ACUTE MALNUTRITION, ask the mother to return 30 days after the initial visit to measure the child's WFH/L, MUAC.

ANAEMIA

After 14 days:

- Give iron. Advise mother to return in 14 days for more iron.
- Continue giving iron every 14 days for 2 months.
- If the child has palmar pallor after 2 months, refer for assessment.

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

UNCOMPLICATED SEVERE ACUTE MALNUTRITION

After 14 days or during regular follow up:

Do a full reassessment of the child. > See *ASSESS & CLASSIFY* chart.

Assess child with the same measurements (WFH/L, MUAC) as on the initial visit.

Check for oedema of both feet.

Check the child's appetite by offering ready-to use therapeutic food if the child is 6 months or older.

Treatment:

- If the child has **COMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or MUAC is less than 115 mm or oedema of both feet AND has developed a medical complication or oedema, or fails the appetite test), refer **URGENTLY** to hospital.
- If the child has **UNCOMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or MUAC is less than 115 mm or oedema of both feet but NO medical complication and passes appetite test), counsel the mother and encourage her to continue with appropriate RUTF feeding. Ask mother to return again in 14 days.
- If the child has **MODERATE ACUTE MALNUTRITION** (WFH/L between -3 and -2 z-scores or MUAC between 115 and 125 mm), advise the mother to continue RUTF. Counsel her to start other foods according to the age appropriate feeding recommendations (see *COUNSEL THE MOTHER* chart). Tell her to return again in 14 days. Continue to see the child every 14 days until the child's WFH/L is -2 z-scores or more, and/or MUAC is 125 mm or more.
- If the child has **NO ACUTE MALNUTRITION** (WFH/L is -2 z-scores or more, or MUAC is 125 mm or more), praise the mother, STOP RUTF and counsel her about the age appropriate feeding recommendations (see *COUNSEL THE MOTHER* chart).

MODERATE ACUTE MALNUTRITION

After 30 days:

Assess the child using the same measurement (WFH/L or MUAC) used on the initial visit:

- If WFH/L, weigh the child, measure height or length and determine if WFH/L.
- If MUAC, measure using MUAC tape.
- Check the child for oedema of both feet.

Reassess feeding. See questions in the COUNSEL THE MOTHER chart.

Treatment:

- If the child is no longer classified as **MODERATE ACUTE MALNUTRITION** praise the mother and encourage her to continue.
- If the child is still classified as **MODERATE ACUTE MALNUTRITION** counsel the mother about any feeding problem found. Ask the mother to return again in one month. Continue to see the child monthly until the child is feeding well and gaining weight regularly or his or her WFH/L is -2 z-scores or more or MUAC is 125 mm. or more.

Exception:

If you do not think that feeding will improve, or if the child has lost weight or his or her MUAC has diminished, refer the child.

GIVE FOLLOW-UP CARE FOR HIV EXPOSED AND INFECTED CHILD

HIV EXPOSED

Follow up regularly as per national guidelines.

At each follow-up visit follow these instructions:

- Ask the mother: Does the child have any problems?
- Do a full assessment including checking for mouth or gum problems, treat, counsel and follow up any new problem
- Provide routine child health care: Vitamin A, deworming, immunization, and feeding assessment and counselling
- Continue cotrimoxazole prophylaxis
- Continue ARV prophylaxis if ARV drugs and breastfeeding are recommended; check adherence: How often, if ever, does the child/mother miss a dose?
- Ask about the mother's health. Provide HIV counselling and testing and referral if necessary
- Plan for the next follow-up visit

HIV testing:

- If new HIV test result became available since the last visit, reclassify the child for HIV according to the test result.
- Recheck child's HIV status six weeks after cessation of breastfeeding. Reclassify the child according to the test result.

If child is confirmed HIV infected

- Start on ART and enrol in chronic HIV care.
- Continue follow-up as for CONFIRMED HIV INFECTION ON ART

If child is confirmed uninfected

- Continue with co-trimoxazole prophylaxis if breastfeeding or stop if the test results are after 6 weeks of cessation of breastfeeding.
- Counsel mother on preventing HIV infection through breastfeeding and about her own health

CONFIRMED HIV INFECTION NOT ON ART

Follow up regularly as per national guidelines.

At each follow-up visit follow these instructions:

- Ask the mother: Does the child have any problems?
- Do a full assessment including checking for mouth or gum problems, treat, counsel and follow up any new problem
- Counsel and check if mother able or willing now to initiate ART for the child.
- Provide routine child health care: Vitamin A, deworming, immunization, and feeding assessment and counselling
- Continue cotrimoxazole prophylaxis if indicated.
- Initiate or continue isoniazid preventive therapy if indicated.
- If no acute illness and mother is willing, initiate ART (See Box Steps when Initiating ART in children)
- Monitor CD4 count and percentage.
- Ask about the mother's health, provide HIV counselling and testing.
- Home care:
 - Counsel the mother about any new or continuing problems
 - If appropriate, put the family in touch with organizations or people who could provide support
 - Advise the mother about hygiene in the home, in particular when preparing food
- Plan for the next follow-up visit

GIVE FOLLOW-UP CARE FOR HIV EXPOSED AND INFECTED CHILD

CONFIRMED HIV INFECTION ON ART: THE FOUR STEPS OF FOLLOW-UP CARE

Follow up regularly as per national guidelines.

STEP 1: ASSESS AND CLASSIFY

- **ASK:** Does the child have any problems?

Has the child received care at another health facility since the last visit?

- **CHECK: for general danger signs** - If present, complete assessment, give pre-referral treatment, **REFER URGENTLY**.
- **ASSESS, CLASSIFY, TREAT** and **COUNSEL** any sick child as appropriate.
- **CHECK** for ART severe side effects

- Severe skin rash
- Difficulty breathing and severe abdominal pain
- Yellow eyes
- Fever, vomiting, rash (only if on Abacavir)

If present, give any pre-referral treatment, **REFER URGENTLY**

- Check for other ART side effects

STEP 2: MONITOR PROGRESS ON ART

- **IF ANY OF FOLLOWING PRESENT, REFER NON-URGENTLY:**

- **Record the Child's weight and height**
- **Assess adherence**
 - Ask about adherence: how often, if ever, does the child miss a dose? Record your assessment.
- **Assess and record clinical stage**
 - Assess clinical stage. Compare with the child's stage at previous visits.
- **Monitor laboratory results**
 - Record results of tests that have been sent.

If any of these present, refer **NON-URGENTLY:**

- Not gaining weight for 3 months
- Loss of milestones
- Poor adherence
- Stage worse than before
- CD4 count lower than before
- LDL higher than 3.5 mmol/L
- TG higher than 5.6 mmol/L

- **Manage side effects**
- **Send tests that are due**

STEP 3: PROVIDE ART, COTRIMOXAZOLE AND ROUTINE TREATMENTS

- **If child is stable:** continue with the ART regimen and cotrimoxazole doses.
- **Check for appropriate doses:** remember these will need to increase as the child grows
- **Give routine care:** Vitamin A supplementation, deworming, and immunization as needed

STEP 4: COUNSEL THE MOTHER OR CAREGIVER

Use every visit to educate and provide support to the mother or caregiver

- **Key issues to discuss include:**

How the child is progressing, feeding, adherence, side-effects and correct management, disclosure (to others and the child), support for the caregiver

- **Remember to check that the mother and other family members are receiving the care that they need**
- **Set a follow-up visit:** if well, follow-up as per national guidelines. If problems, follow-up as indicated.

Assess, classify and treat the sick young infant aged up to 2 months



ASSESS AND CLASSIFY

ASSESS

CLASSIFY

IDENTIFY TREATMENT

DO A RAPID APPRAISAL OF ALL WAITING INFANTS

ASK THE MOTHER WHAT THE YOUNG INFANT'S PROBLEMS ARE

- Determine if this is an initial or follow-up visit for this problem.
 - if follow-up visit, use the follow-up instructions.
 - if initial visit, assess the child as follows:

USE ALL BOXES THAT MATCH THE INFANT'S SYMPTOMS AND PROBLEMS TO CLASSIFY THE ILLNESS

URGENT PRE-REFERRAL TREATMENTS ARE IN BOLD PRINT***

CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION, VERY SEVERE DISEASE, PNEUMONIA AND LOCAL BACTERIAL INFECTION

ASK:

- Has the infant had convulsions?
- Is the infant having difficulty feeding?
 - Is the infant not feeding at all or not feeding well?
- Has the mother had tuberculosis infection two weeks before delivery?(smear +ve)

LOOK, LISTEN, FEEL:

- Look if the infant has convulsions.

- Count the breaths in one minute. Repeat the count if elevated.
- Look for severe chest indrawing.

YOUNG INFANT MUST BE CALM

- Look at the umbilicus. Is it red or draining pus?
- Measure axillary temperature (or feel for fever or low body temperature).
- Look for skin pustules.
- Look at the young infant's movements.
- Does the infant move only when stimulated?
- Does the infant not move even when stimulated?

ALL YOUNG INFANTS

- Not feeding at all or
- Convulsions or
- Severe chest indrawing or
- Fever (38°C* or above or feels hot) or
- Low body temperature (less than 35.5°C*) or
- Young infant does not move or moves only when stimulated
- Fast breathing (60 breaths per minute or more) in infants less than 7 days old.

Pink:
POSSIBLE SERIOUS BACTERIAL INFECTION or VERY SEVERE DISEASE

- If less than 1 month treat convulsions with phenobarbitone intramuscular
- If 1 month or older, treat current convulsion with diazepam rectal.
- Give first dose of intramuscular antibiotics.
- Treat to prevent low blood sugar.
- Treat low body temperature(less than 35.5°C)
- Treat high fever (38.5°C or above)
- Advise mother how to keep the infant warm on the way to the hospital
- Refer **URGENTLY** to hospital. **OR**
- If referral is **REFUSED** or **NOT FEASIBLE**, treat at the clinic until referral is feasible.*

- Fast breathing (60 breaths per minute or more) in infants 7 - 59 days old.

Yellow:
PNEUMONIA

- Give oral antibiotic which is amoxicillin for 7 days.
- If the mother has TB, refer the infant for tuberculosis (TB) assessment and isoniazid (INH) preventive therapy (ITP).
- Advise mother to give home care for the young infant
- Follow up in 3 days.

- Umbilicus red or draining pus or
- Skin pustules

Yellow:
LOCAL BACTERIAL INFECTION

- Give an appropriate oral antibiotic which is amoxicillin for 5 days***
- Teach the mother to treat local infections at home
- If the mother has TB, refer the infant for tuberculosis (TB) assessment and isoniazid (INH) preventive therapy (ITP).
- Advise mother to give home care for the young infant
- Follow up in 2 days.

- None of the signs of very severe disease or bacterial infection

Green:
INFECTION UNLIKELY

- If the mother has TB, refer the infant to nearest health facility for Screening of active tuberculosis.
- Advise mother to give home care.

If the young infant is:

Fast breathing is:

From birth up to 2 months

60 breaths per minute or more

* These thresholds are based on axillary temperature. The thresholds for rectal temperature readings are approximately 0.5°C higher.

** If **referral is not possible**, re-classify the illness for Possible Serious Bacterial Infection (PSBI) see the Treat the young infant chart page 49 for classification and page 46 for treatment options and dosages.

*** If the infant has any other severe classification necessitating **referral** and if **referral is not possible** give full course of the antibiotic as outpatient.

THEN ASK: Does the young infant have diarrhoea*?

IF YES,ASK:

- For how long?
- Is there blood in stool?

Look and Feel

- Look at the young infant's general condition:
 - Does the infant move only when stimulated?
 - Does the infant not move even when stimulated?
- Is the infant restless and irritable?
- Look for sunken eyes.
- Pinch the skin of the abdomen. Does it go back:
 - Very slowly (longer than 2 seconds)?
 - or slowly?

Classify DIARRHOEA for DEHYDRATION

Two of the following signs: • Young infant does not move or moves only when stimulated • Sunken eyes • Skin pinch goes back very slowly.	Pink: SEVERE DEHYDRATION	■ If infant has no other severe classification: ◦ Give fluid for severe dehydration (Plan C) OR ■ If infant also has another severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding ■ If young infant has diarrhoea lasting 7 days or more refer for assessment ■ If infant present with blood in stool refer URGENTLY for assessment
Two of the following signs: • Restless and irritable • Sunken eyes • Skin pinch goes back slowly.	Yellow: SOME DEHYDRATION	■ Give fluid and continue breast feeding for some dehydration (Plan B) ■ If infant has any severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding ■ If young infant also has diarrhoea lasting 7 days or more refer for assessment ■ If infant also presents with blood in stool refer for assessment ■ Advise mother when to return immediately ■ Follow up in 2 days if not improving
• No enough signs to classify as some or severe dehydration.	Green: NO DEHYDRATION	■ Give fluids and breastmilk (Plan A) ■ Advise mother when to return immediately ■ Follow-up in 2 days if not improving ■ Advise mother on home care ■ If young infant has diarrhoea lasting 7 days or more refer for assessment ■ If infant presents with blood in stool refer for assessment

* What is diarrhoea in a young infant?

A young infant has diarrhoea if the stools have changed from usual pattern and are many and watery (more water than fecal matter).

The normally frequent or semi-solid stools of a breastfed baby are not diarrhoea.

CHECK FOR JAUNDICE

ASK:

- Does the infant have yellow colouration of skin or eyes?
- If yes, when did it appear first:
 - Before 24 hours from birth?
 - After 24 hours from birth?

LOOK AND FEEL:

- Look at the skin on the face and eyes is it yellow?
- Look at palms and soles. Are they yellow?
- Look for jaundice in any other parts of the body?

Classify JAUNDICE

• Yellow palms and soles if started at age >24 hours <u>or</u> • Jaundice at any other part if start at age less than 24 hours.	Pink: SEVERE JAUNDICE	■ Treat to prevent low blood sugar. ■ Refer URGENTLY to hospital. ■ Advise mother how to keep the infant warm on the way to the hospital.
• Only yellow eyes and skin if started at age >24 hours • Jaundice at any other part if started at age more than 24 hours.	Yellow: JAUNDICE	■ Advise the mother to breastfeed as often and for as long as infant wants, day and night. ■ Advise mother when to return immediately. ■ Follow-up in 1 day. ■ If jaundice persists for more than 14 days refer for assessment.
• No signs suggestive of jaundice	Green: NO JAUNDICE	■ Advise the mother to give home care for the young infant

CHECK FOR EYE PROBLEM

LOOK:

- Look for pus draining from the eyes.
 - Is the draining profuse?
- Are the eyes swollen?

Classify EYE INFECTION

• Eyes profusely discharging pus with or without swelling.	Pink: SEVERE EYE INFECTION	■ Give first dose of intramuscular antibiotics ■ Apply first dose of local antibiotics ■ Treat to prevent low blood sugar ■ Advise the mother to keep the infant warm on the way to hospital ■ Refer URGENTLY to hospital*
• Eyes draining pus.	Yellow: EYE INFECTION	■ Teach the mother to treat eye infection at home ■ Advise mother to give home care for young infant ■ Follow-up in 2 days
• No pus draining.	Green: NO EYE INFECTION	■ Advise mother to give home care for young infant

THEN CHECK YOUNG INFANT FOR HIV INFECTION?

ASK or NOTE:

- Has the mother tested for HIV?
- Has the infant tested for HIV by PCR Or Antibody test?
- Is the HIV status for mother or infant unknown?*

The infant's HIV status:	Mother's HIV status is:
• Infant has PCR test positive	• Mother is HIV positive
• Infant is seropositive	• Mother is HIV negative
• Infant is seronegative	

- If the mother is HIV positive and the infant does NOT have a positive virological test. ASK:
 - Is the infant breastfeeding now?
 - Was the young infant breastfeeding at the time of the test or before it?
 - Is the mother and or infant on antiretroviral prophylaxis?

Classify HIV INFECTION by test results

• Infant has positive virological test.	Yellow: CONFIRMED HIV INFECTION	■ Give cotrimoxazole prophylaxis at age 6 weeks. ■ Refer to Care and Treatment Centres (CTC) for ART initiation. ■ Refer the child for tuberculosis (TB) assessment and isoniazid (INH) preventive therapy (ITP). ■ Assess feeding and counsel according to the Food Box in the COUNSEL THE MOTHER chart. ■ Advise the mother on home care. ■ Follow-up in 14 days, then after 1 month.
One or both of the following: • Infant has positive serological test or • Mother HIV positive AND infant is breastfeeding or stopped less than 6 weeks ago has a negative virological test or • Mother has seropositive and infant not yet tested.	Yellow: HIV EXPOSED: POSSIBLE HIV INFECTION	■ Give cotrimoxazole prophylaxis at age 6 weeks. ■ Refer for ARV prophylaxis according to risk assessment. ■ Assess the young infant's feeding and give appropriate feeding advice according to the Food Box in the COUNSEL THE MOTHER chart. ■ Confirm HIV status as soon possible with best available test.. ■ Advise the mother on home care for the young infant. ■ Follow-up in 14 days, then after 1 month.
• HIV test not done for mother or infant.	Yellow: UNKNOWN HIV STATUS	■ Offer PITC to mother and child and refer for a HIV test. ■ Treat, counsel and follow up existing infections ■ Advise the mother about feeding and about her own health
• Negative HIV test in mother and infant.	Green: HIV INFECTION UNLIKELY	■ Treat, counsel and follow up existing infections. ■ Advise the mother about feeding and about her own health.

*Unknown includes those who do not have a test result for confirmation. Do a PITC for HIV before classifying the illness. if PITC is not possible decide HIV status is unknown.

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE OR WASTING IN BREASTFEEDING INFANTS

- If the young infant has no indication to be referred to hospital.
- If the infant has indication for referral do not check for feeding problem or low weight, continue with the next assessment.

ASK: ● Is the infant breastfed? If yes, how many times in 24 hours? ● Does the infant usually receive any other foods or drinks? ◦ If yes, how often? ◦ If yes, what do you use to feed the infant?	LOOK: ● Determine the weight for age. ◦ Weight less than 2 kg ◦ Low weight (<-2SD) ◦ Not low (>-2SD) ● Look for ulcers or white patches in the mouth (thrush).
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IF AN INFANT:

- Is less than 7 days old or
- Is breastfeeding less than 10 times in 24 hours, or
- Is taking any other foods or drinks, or
- Is low weight for age

ASSESS BREASTFEEDING:

- Has the infant breastfed in the previous hour?

If the infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

(If the infant was fed during the last hour, ask the mother if she can wait and tell you when the infant is willing to feed again.)

- Is the infant able to attach?
 - not well attached good attachment
- **TO CHECK ATTACHMENT, LOOK FOR:**
 - Chin touching breast
 - Mouth wide open
 - Lower lip turned outwards
 - More areola visible above than below the mouth

(All of these signs should be present if the attachment is good.)
- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
 - not suckling effectively suckling effectively

Clear a blocked nose if it interferes with breastfeeding.

Classify **FEEDING**

● Weight < 2kg in infants less than 7 days.	Pink: VERY LOW WEIGHT FOR AGE	■ REFER to hospital for Kangaroo Mother Care. ■ Treat to prevent low blood sugar. ■ Advise the mother on keeping the young infant warm on the way to hospital.
● Not well attached to breast <u>or</u> ● Not suckling effectively <u>or</u> ● Less than 10 breastfeeds in 24 hours <u>or</u> ● Receives other foods or drinks <u>or</u> ● Low weight for age <u>or</u> ● Thrush (ulcers or white patches in mouth).	Yellow: FEEDING PROBLEM OR LOW WEIGHT	■ Advise the mother to breastfeed as often and for as long as the infant wants, day and night ◦ If not well attached or not suckling effectively, teach correct positioning and attachment ◦ If breastfeeding less than 10 times in 24 hours, advise to increase frequency of feeding. ■ Advise the mother to breastfeed as often and as long as the infant wants, day and night ■ If low weight and still not able to attach well teach mother to express breast milk and feed by cup ■ If receiving other foods or drinks, counsel the mother about breastfeeding more, reducing other foods or drinks, and using a cup ■ If not breastfeeding at all refer for breastfeeding counselling and possible relactation ■ If thrush, teach the mother to treat thrush at home ■ Advise mother to give home care for the young infant ■ Follow-up any FEEDING PROBLEM or thrush in 2 days ■ Follow-up LOW WEIGHT FOR AGE in 14 days.
● Not low weight for age and no other signs of inadequate feeding.	Green: NO FEEDING PROBLEM	■ Advise mother to give home care for the young infant ■ Praise the mother for feeding the infant well

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT OR WASTING IN INFANTS NOT RECEIVING BREAST MILK

(Use this chart when a HIV positive mother has chosen not to breastfeed)

ASK: - What milk are you giving? - How many times during the day and night? - How much is given at each feed? - How are you preparing the milk? - Let mother demonstrate or explain how a feed is prepared. - Are you giving any breast milk at all? - What foods and fluids in addition to replacement feeds is given? - How is the milk being given? Cup or bottle? - How are cleaning the feeding utensils? LOOK, LISTEN, FEEL - Determine the weight for age. - Weight less than 2 kg - Low weight (<-2SD) - Not low (>-2SD) - Look for ulcers or white patches in the mouth.	Classify FEEDING	Weight < 2 kg in less than 7 days	Pink: FEEDING PROBLEM AND OR LOW WEIGHT FOR AGE	- REFER to hospital for Kangaroo Mother Care. - Treat to prevent low blood sugar. - Advise the mother on keeping the young infant warm on the way to hospital.
		- Milk incorrectly or unhygienically prepared or - Giving inappropriate replacement milk or other foods/fluids or - Giving insufficient replacement feeds or - A HIV positive mother mixing breast milk and other feeds or - Bottle feeding or - Low weight for age or - Thrush.	Yellow: FEEDING PROBLEM OR LOW WEIGHT	- Counsel mother according to the recommendations in the <i>COUNSEL THE MOTHER</i> chart for the mother who is HIV positive - Explain the guidelines for safe replacement feeding - Identify concern of mother and family about feeding - Help mother to withdraw other foods or fluids - If mother is using a bottle, teach cup feeding - Follow up FEEDING PROBLEM or oral thrush in 2 days - Follow up LOW WEIGHT in 14 days - Give Vitamin A at 6 weeks - Treat oral thrush - Advise to continue feeding and ensure good hygiene.
		Not low weight for age, no wasting and no other signs of inadequate feeding.	Green: NO FEEDING PROBLEM	- Advise mother to give home care for the young infant - Praise the mother for feeding the infant - Advise mother to continue feeding and ensure good hygiene

ASSESS AND CLASSIFY FOR BIRTH WEIGHT AND GESTATIONAL AGE IF YOUNG INFANT <7 days old

ASK or NOTE:

- For the gestational age at delivery ____ Weeks?
- For the birth weight ____ gm?

LOOK:

- Look for the birth weight on the child health passport book or weigh the baby*

Classify

**BIRTH WEIGHT
and
GESTATIONAL
AGE**

• Weight less than 1500 gm or gestational age less than 32 weeks	Pink: VERY PRE-TERM AND/OR VERY LOW BIRTH WEIGHT	▪ Treat to prevent low blood sugar ▪ Advise mother how to keep the infant warm on the way to the hospital ▪ Refer URGENTLY with mother to hospital.^*
• Weight 1500 gm up to 2500 gm or gestational age 32-36 weeks	Yellow: PRE-TERM AND/OR LOW BIRTH WEIGHT	▪ Advise mother on home care for the young infant ▪ Counsel the mother on care of pre-term or low birth weight young infant ▪ Follow-up in 14 days ▪ Give vitamin K
• Weight 2500 gm or more or gestational age 37 weeks or more	Green: TERM AND NORMAL BIRTH WEIGHT	▪ Advise mother on home care of the young infant

* For those young infants whose birth weight is not known, the measured weight of that day should be regarded as representing birth weight.

** If **referral is not possible** , Please remember: Always all young infants with birth weight of less than 1.500gm **MUST** be referred to hospital.

THEN CHECK THE YOUNG INFANT'S IMMUNIZATION AND VITAMIN A STATUS:

IMMUNIZATION SCHEDULE

AGE	VACCINE	ROUTE OR SITE OF INJECTION	DOSE
Birth	BCG*	Intradermal, Right shoulder	0.05ml
	OPV-0**	Oral	2 drops
6 weeks	OPV 1	Oral	2 drops
	Pentavalent 1	Intramuscular(i.m), Left thigh(outer)	0.5ml

** If an infant is less than 12 months old and did not receive BCG, the vaccine can be given at any time the child comes for the initial visit. Young infants who are HIV positive or of unknown HIV status with symptoms consistent with HIV infection should not be given BCG vaccine.*

*** Do not give OPV 0 to an infant who is more than 14 days.*

IMPORTANT: Give Penta1, and OPV1 at the age of six weeks. Keep an interval of 4 weeks between the subsequent vaccines. immunize sick infants, unless they are being referred. Advise the caretaker when to return for the next dose.

■ VITAMIN A SUPPLEMENTATION

<i>If mother is breastfeeding give:</i>	<i>200 000 IU to the mother within 6 weeks of delivery</i>
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THEN CHECK AND IMMUNIZE MOTHER FOR TETANUS

- Immunise all women of child bearing age against tetanus to prevent the neonatal tetanus
- Give intramuscular injection of 0.5ml on the shoulder, follow the following schedule;

VACCINE	AGE
Tetanus Toxoid 1	15-49 years at any contact
Tetanus Toxoid 2	4 months from the 1st dose
Tetanus Toxoid 3	6 months from the 2nd dose
Tetanus Toxoid 4	1 years from the 3rd dose
Tetanus Toxoid 5	1 year from the 4th dose

ASSESS OTHER PROBLEMS

ASSESS MOTHER'S OWN HEALTH

TREAT THE SICK YOUNG INFANT AND COUNSEL THE MOTHER

TREAT THE SICK YOUNG INFANT

GIVE THESE TREATMENTS IN THE CLINIC ONLY

Give First Dose of Intramuscular Gentamicin and Ampicilin or Benzyl-penicillin.

- **FOR YOUNG INFANTS BEING REFERRED URGENTLY FOR POSSIBLE SERIOUS BACTERIAL INFECTION or VERY SEVERE DISEASE**
 - Give first dose of Both of these; Benzyl penicilin (50 mg/kg per day) or Ampicillin (50 mg/kg per day) and Gentamicin (5 mg/kg per day) intramuscularly and refer the child urgently to hospital.
- **IF REFERRAL IS REFUSED OR NOT POSSIBLE**, re-classify POSSIBLE SERIOUS BACTERIAL INFECTION or VERY SEVERE DISEASE (see page) and treat as follows. For
 - ALL Young infants with birthweight of less than 1.500gm (low birth weight) **MUST** be referred to hospital by all means, should not be treated as outpatient
 - **New borns age 0 - 6 days** if has only fast breathing, has **Severe Pneumonia*** need referral, but if not accepted give oral Amoxycilin twice daily for 7 days.
 - **Young infants age 0 - 59days** if has signs of **clinical severe infection**** give oral Amoxycilin twice daily for 7 days PLUS injectable gentamicin once daily for 7 days.
 - **Young infants age 0 - 59 days** and has any signs of **critical illness*****, you **MUST** give this young infant Pre-referral treatment and **MUST** be referred to hospital. But if REFERRAL IS NOT POSSIBLE regardless of efforts to reinforce, then treat at the health facility with once daily injectable gentamicin and twice daily injectable ampicilin for 7 days.

	GENTAMICIN*** 5mg/kg	BENZYL PENICILLIN 50,000 units/kg		AMPICILIN 50mg/kg
WEIGHT	Undiluted 2 ml vial containing 20 mg = 2 ml at 10 mg/ml OR Add 6 mls sterile water to 2 ml vial containing 80 mg* = 8 ml at 10 mg/ml	Add 2.1 ml sterile water to a vial of 600mg (1,000,000 units) to make 2.5ml of 40,000units/ml.	Add 3.6ml of water for injection to a vial of 600mg(1,000,000 units) to make 4.0ml of 250,000 units/ml.	Add 1.3 ml of sterile water to 250mg vial to make 1.5ml of 250mg
1.0 -< 1.5kg	0.5ml	0.1ml	0.2ml	0.3ml
1.5 -< 2.5kg	1.0ml	0.2ml	0.4ml	0.6ml
2.5 -< 3.5kg	1.5ml	0.4ml	0.6ml	0.9ml
3.5 -< 4.5kg	2.0ml	0.5ml	0.8ml	1.2ml
4.5 -< 5.5kg	2.5ml	0.6ml	1.0ml	1.5ml

* Severe Pneumonia sign: Fast breathing in infants aged less than 7 days.

** Clinical severe infection signs are; not feeding well on observation, fever, low body temperature, severe chest in-drawing and movement only when stimulated.

*** Critical illness signs are; not ble to feed at all, no movement on stimulation..

**** Avoid using undiluted 40 mg/ml gentamicin the dose is 1/4 of that listed.

TREAT THE SICK YOUNG INFANT

Treat a Convulsing Young Infant Less Than 1 Month with Phenobarbitone Intramuscularly

Manage the Airway

- Turn the child to his/her side to avoid aspiration.
- Do not insert anything in the mouth.
- If the child is blue (cyanosis), open the mouth and make sure the airway is clear
- If neccessary, remove secretions from the throat.

If High Fever

Undress and fan the child to lower the fever.

GIVE INTRAMUSCULAR PHERNOBARBITONE

- Select an appropriate vial of phenobarbitone concetration before giving the medicine.

WEIGHT	PHERNOBARBITONE
	200mg/ml
	Give at a dose of 15mg/kg
1.5-<2.5kg	0.2ml
2.5-<4.0kg	0.3ml
4.0-<6.0kg	0.4ml

To Treat to Prevent Low Blood Sugar

- If the young infant is able to breastfeed:
 - Ask the mother to breastfeed the young infant.
- If the young infant is not able to breastfeed but is able to swallow:
 - Give 20 - 50 ml (10 ml/kg body weight) of expressed breastmilk before departure. If expressed breastmilk cannot be given, give 20 - 50 ml of sugar water.(Tomake sugar water: Dissolve 4 level teaspoons of sugar (20 gm) in a 200 ml cup of clean water.)
- If the young infant is not able to swallow:
 - Give 20 - 50 ml (10 ml/kg body weight) of expressed breastmilk or sugar water by nasogastric tube.

Treat Young Infant for Low Body Temperature(temperature less than 35.5°C)

- Dry the young infant if wet, and remove any soiled or wet clothing.
- Wrap the young infant with dry clean and warm cloth and cover with a blanket.
- Keep the young infant close to mother.
- If pre-term or low birth weight use Kangaroo Mother Care (KMC) *see COUNSEL THE MOTHER chart: page 57 of the chartbook*
 - Provide skin to skin contact with and infant.

TREAT THE SICK YOUNG INFANT

Treat Young Infant for Fever(temperature 38.5°C or above)

- If necessary to lower temperature undress the child and the temperature will be lowered.
Note: *Young infant should not be given antipyretic for the risk of permanent liver damage.*

Teach the Mother How to Keep the Young Infant Warm on the Way to the Hospital

- Hold the infant in skin to skin contact
OR
- Keep the young infant clothed or covered as much as possible all the time. Dress the young infant with extra clothing including hat, gloves, socks and wrap the infant in a soft dry cloth and cover with a blanket.

Give Vitamin K for PRE-TERM AND/OR LOW BIRTH WEIGHT Babies

- Give single dose Vitamin K to the young infant who is Pre-term or low birth weight

WEIGHT	DOSE
<1.5kg	0.5mg
1.5 - 2.5kg	1.0mg

REFER URGENTLY

- Write a referral note for the mother to take to the hospital (See Annex 3)
- If the infant also has SOME DEHYDRATION OR SEVERE DEHYDRATION and is able to drink:
 - Give the mother some prepared ORS, and ask her to give frequent sips of ORS on the way to the hospital.
 - Advise the mother to continue breastfeeding.

TREAT THE SICK YOUNG INFANT

IF REFERRAL IS REFUSED OR NOT POSSIBLE, further assess and classify the sick young infant with POSSIBLE SERIOUS BACTERIAL INFECTION or VERY SEVERE DISEASE

SIGNS	CLASSIFY	IDENTIFY TREATMENT
The sick young infant has any one of the following: ■ Convulsions ■ Not able to feed at all ■ No movement on stimulation ■ Weight is < 2kg	CRITICAL ILLNESS	■ Reinforce URGENT referral, Explain to the caregiver that the infant is very sick and MUST be urgently referred for hospital care ■ If referral is still not feasible, give once daily intramuscular gentamicin and twice daily intramuscular ampicillin until referral is feasible or for 7 days if referral is still not possible. (for dosages see TREAT YOUNG INFANT CHARTS Give THESE TREATMENTS IN THE CLINIC ONLY and GIVE APPROPRIATE ORAL ANTIBIOTIC page 46). ■ Treat to prevent low blood sugar. ■ Teach the mother how to keep the young infant warm at home. ■ Advise mother to return daily for the injections. ■ Treat any other classification of illness in the young infant. ■ Reassess the young infant at each visit.
The sick young infant has any one of the following: ■ Not feeding well on observation ■ Temperature 38°C or more ■ Temperature less than 35.5°C ■ Severe chest indrawing ■ Movement only when stimulated.	CLINICAL SEVERE INFECTION	■ Give once daily intramuscular gentamicin and oral amoxicillin for 7 days. (for dosages see TREAT YOUNG INFANT CHARTS Give THESE TREATMENTS IN THE CLINIC ONLY and GIVE APPROPRIATE ORAL ANTIBIOTIC page 46). ■ Treat to prevent low blood sugar. ■ Teach the mother how to keep the young infant warm at home. ■ Advise the mother to return for the next injection the following day. ■ Treat any other classifications of illness the young infant has. ■ Reassess the young infant at each visit.
The sick young infant has: ■ Fast breathing (60 breaths per minute or more) in infants less than 7 days old.	SEVERE PNEUMONIA	■ Give oral amoxicillin for 7 days. ■ Teach the mother how to give oral amoxicillin twice daily. ■ Treat any other classification of illness in the young infant. ■ Advise the mother to return for follow up in 3 days.

TREAT THE SICK YOUNG INFANT

Follow the instructions for every oral drug to be given at home. also follow the instructions listed with each drug's dosage table.

- Determine the appropriate drugs and dosage for the young infant's age or weight.
- Tell the mother the reason for giving the drug to the young infant.
- Demonstrate how to measure a dose.
- Watch the mother practise measuring a dose by herself.
- Ask the mother to give the first dose to her young infant.
- Explain carefully how to give the drug, then label and package the drug.
- If more than one drug will be given, collect, count and package each drug separately.
- Explain that all the oral drug tablets or syrups must be used to finish the course of treatment, even if the infant gets better.
- Check the mother's understanding before she leaves the clinic.

Give an Appropriate Oral Antibiotic for PNEUMONIA and LOCAL BACTERIAL INFECTION

- First-line antibiotic: Amoxycilin
- Second-line antibiotic: Ampicillin+Cloxacilin

AGE or WEIGHT	AMOXICILLIN Give 2 times daily for 5 days			Ampicillin+Cloxacillin 125mg/5ml
	Dispersible Tablet (250 mg)	Dispersible Tablet (125 mg)	Syrup 125 mg in 5 ml	Give 50mg/kg twice daily for 5 days
< 3.0 kg	1/2	1	2.25 ml	2.5ml
3.0 - 4.0 kg	1/2	1	5 ml	5.0ml
4.0 - 5.9 kg	1	2	10 ml	

Give Appropriate Oral Antibiotic for Infants with HIV INFECTION and HIV EXPOSED

- Give cotrimoxazole for PCP prophylaxis from 6 weeks

AGE or WEIGHT	COTRIMOXAZOLE (Trimethoprim + Sulphamexoxazole) Give once daily		
	ADULT TABLET (80/400mg)	PAEDIATRIC TABLET (20/100mg)	SYRUP (40/200mg/5ml)
6 weeks up to 2 months (3.0 - < 6.0 kg)	1/4	1	2.5 ml

*Avoid giving cotrimoxazole to a young infant who is less than 1 month of age, premature or jaundiced.

To Treat Diarrhoea, See TREAT THE CHILD Chart: Page 26.

Teach the Mother to Treat Local Infections, Eye Infection and Thrush at Home

- Explain how the treatment is given.
- Watch her as she does the first treatment in the clinic.
- She should return to the clinic if the infection worsens.

To Treat Skin Pustules or Umbilical Infection	To Treat Thrush (ulcers or white patches in mouth) with Nystatin or Gentian Violet	Treat Eye Infection
The mother should do the treatment twice daily for 5 days: ▪ Wash hands ▪ Gently wash off pus and crusts with soap and water ▪ Dry the area ▪ Paint the skin or umbilicus/cord with full strength gentian violet (0.5%) ▪ Wash hands	The mother should do the treatment four times daily for 7 days: ▪ Wash hands ▪ Wash mouth with clean soft cloth wrapped around the finger and wet with salt water ▪ Give nystatin 1ml 4 times a day or paint the mouth with half-strength gentian violet (0.25%) ▪ Wash hands	▪ Do the following 6-8 times daily: • Wet clean cloth with boiled and cooled water • Use the wet cloth to gently wash off pus from the babies eyes ▪ Apply 1% tetracycline eye ointment in each eye 3 times daily

Immunize Every Sick Young Infant and Give Vitamin A as Described in the ASSESS AND CLASSIFY part: Page 10.

COUNSEL THE MOTHER

Teach Correct Positioning and Attachment for Breastfeeding

- Show the mother how to hold her infant
 - with the infant's head and body straight
 - facing the breast, with infant's nose opposite her nipple
 - with infant's body close to her body
 - supporting infant whole body, not just neck and shoulders
- Show her how to help infant to attach. She should:
 - Touch her infant's lips with her nipple
 - Wait until her infant mouth is open wide open
 - Move her infant quickly on her breast aiming infant's mouth to the nipple
- Look for signs of good attachment and effective suckling. If the attachment or suckling is not good, try again.
- If mother is HIV positive: Counsel her as described in the feeding recommendations for children classified as HIV EXPOSED.

Advise the Mother to Give Home Care for the Young Infant

1. EXCLUSIVELY BREASTFEED THE YOUNG INFANT (For breastfeeding mothers).

- Give only breastmilk to the young infant.
- Breastfeed frequently, as often and for as long as the infant wants, day and night, during sickness and in health.

2. MAKE SURE THAT THE YOUNG INFANT IS KEPT WARM AT ALL TIMES.

- In cool weather, cover the infant's head and feet, and add extra clothing.

3. KNOW WHEN TO RETURN

■ WHEN TO RETURN FOR FOLLOW UP VISITS

If the infant has:	Return for follow-up in:
■ JAUNDICE	1 days
• LOCAL BACTERIAL INFECTION • ANY FEEDING PROBLEM • THRUSH • EYE INFECTION	2 days
■ PNEUMONIA ■ SEVERE PNEUMONIA when referral is refused or not feasible	3 days
■ PRE-TERM AND OR LOW BIRTH WEIGHT ■ LOW WEIGHT FOR AGE in an infant not receiving breastmilk	7 days
■ LOW WEIGHT FOR AGE in ■ CONFIRMED HIV INFECTION ■ HIV EXPOSED: POSSIBLE HIV INFECTION	14 days

WHEN TO RETURN IMMEDIATELY

Advise the mother to return immediately if the young infant has any of these signs:

- Breastfeeding or drinking poorly.
- Infant moves only when stimulated or does not move at all.
- Convulsions.
- Becomes sicker.
- Develops a fever.
- Feels unusually cold .
- Fast breathing.
- Difficult breathing.
- Blood in stool.
- Palms and soles are yellow.

■ ESSENTIAL NEW BORN CARE PACKAGE

Counsel the mother on:

- **Ensuring warmth for the baby:** In cool weather, cover the infants head and feet and dress the infant with extra clothing
- **Breastfeeding.** Ensure optimal breastfeeding emphasize on proper positioning and attachment
- **Cord care:** Keep cord clean and dry, do not put anything on the umbilicus
- **Eye care:** Clean baby's eyes immediately after birth and instill ointment for prophylaxis
- **Routine immunization:** Get the baby immunized with all recommended EPI vaccines on time

CARE OF PRE-TERM OR LOW BIRTH WEIGHT YOUNG INFANT

Kangaroo Mother Care (KMC)

There are three components of Kangaroo Mother Care:

1. Continuous skin to skin contact between the babies front and mothers chest.
2. Continue exclusive breastfeeding: the cloth that wraps around the mother and the baby is loosened to breastfeed.
3. Support to the mother from the health worker and family: To continue to do what she normally does while providing Kangaroo Mother Care.

How to wrap the baby and mother: Mother and baby should be chest to chest with baby's head turned to one side.

- Place the centre of a long cloth over the baby's head turned to one side.
- Wrap both ends of the cloth firmly around the mother, under her arms to her back. The wrap should not be so tight that it constricts the baby. Leave room for the baby to breathe normally.
- Cross the cloth ends behind the mother and tie the ends of the cloth in a secure knot.
- If the cloth is long, bring both ends of the cloth to front and tie the ends of the cloth in a knot under the baby.
- The wrap should be tight enough so that the baby does not slip out when the mother stands.
- Support the baby's head by pulling the wrap up to just under the baby's ear. The wrap can be loosened for breastfeeding.
- Have the mother put on her blouse or dress. Be sure to use clothing that is loose and that has an adequate opening in the front so as not to cover the baby's face and so that breastfeeding will be easy.

Tips to Help the Mother Breastfeed Her Low Birth Weight Baby

- Express a few drops of milk on the baby's lips to help the baby start suckling.
- Give the baby short rests during breast feeding: Feeding is hard work for LBW baby.
- If the baby coughs, gags or spits up when he or she starts to breastfeed, the milk may be getting down too fast for the little baby. Tell the mother to take the baby off the breast if this happens.
- Hold the baby against her chest until the baby can breathe well again, then put it back to the breast.
- If the LBW baby does not have enough energy to suck for long or strong enough suckling reflex: Teach the mother to express breast milk and feed it by a cup.

How to Express Breastmilk

Expressing breastfeeding can take 20-30 minutes or longer in the beginning

- Wash hand with soap and water.
- Prepare a cleaned and boiled cup or container with a wide opening.
- Sit comfortably and lean slightly toward the container.
- Hold the breast in a "C-hold".

A. Place the finger and thumb on the areola and press inward towards the chest wall.

B. Press the areola behind the nipple between the finger and thumb.

C. Press from the sides to express milk from the other segments of the breast.

TIPS for storing and using stored breastmilk

- Fresh breastmilk has the highest quality. If the breastmilk must be saved, advise the mother and family to:
 - Use either a glass or hard plastic container with a large opening and a tight lid to store breastmilk.
 - Use a clean container and lid.
 - Explore with mother how to distinguish the time the milk is expressed (morning, mid day or afternoon).
 - Empty the breast and store the milk in the coolest place possible.
 - Milk can be stored 8-10 hours at room temperature in a cool place and 72 hours in the refrigerator.
 - Mother or caregiver gives infant expressed breastmilk from a cup. Bottles are unsafe to use because they are difficult to wash and can be easily contaminated.

Quantity to feed by cup (in ml) every 2-3 hours from birth

(Use calibrated vessel to measure the required quantity each time you want to feed the young infant)

Weight (kg)	Day 0	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1.5-1.9	15	17	19	21	23	25	27	27
2.0-2.4	20	22	25	27	30	32	35	35

SAFE PREPARATION OF INFANT FORMULA

- Everytime use cup or glass with marker to measure water and scoop to measure powdered formula milk
- Wash hands before preparing milk feed
- Boil water and leave to cool while covered
- Measure cooled water in a cup or glass with marker
- Measure formula milk using a scoop, level the milk in the scoop
- Put "scoop of formula milk" in water according to manufacturer's advice or recommendations
- Add little amount boiled and cooled water then stir
- Fill the cup or glass up to the marker with boiled and cooled water, then stir appropriately
- Feed the child with cup or glass
- Wash utensils

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

ASSESS EVERY YOUNG INFANT FOR "POSSIBLE SERIOUS BACTERIAL INFECTION or VERY SEVERE DISEASE" DURING FOLLOW-UP VISIT	
	LOCAL BACTERIAL INFECTION After 2 days: Look at the umbilicus. Is it red or draining pus? Look at the skin pustules.
CRITICAL ILLNESS WHEN REFERRAL WAS REFUSED OR NOT FEASIBLE At each contact for injection of antibiotics (every day): Explain again to the caregiver that the infant is very sick and should urgently be referred for hospital care. Reassess the young infant as described in the chart IF REFERRAL WAS REFUSED OR NOT FEASIBLE page 49. Treat any new problem. if referral is still not feasible, continue giving once daily intramuscular gentamicin and twice daily intramuscular ampicillin until referral is feasible or for 7 days.	Treatment: If umbilical pus or redness remains same or is worse, refer to hospital. If pus and redness are improved, tell the mother to continue giving the 5 days of antibiotic and continue treating the local infection at home.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

PNEUMONIA or SEVERE PNEUMONIA

After 3 days

Reassess the young infant for POSSIBLE SERIOUS BACTERIAL INFECTION or PNEUMONIA or LOCAL BACTERIAL INFECTION as described in the assess and classify sick young infants charts.

Treatment

Refer urgently to hospital if:

- The infant **becomes worse** or
- Any new sign of **POSSIBLE SERIOUS BACTERIAL INFECTION** or **VERY SEVERE DISEASE** appears while on treatment.

If the young infant is improving, ask the mother to continue giving the oral amoxicillin twice daily until all the tablets are finished.

Ask the mother to bring the young infant back in more days.

CLINICAL SEVERE INFECTION WHEN REFERRAL WAS REFUSED OR NOT FEASIBLE

At each contact for injection (**every day**):

Reassess the young infant as described in the chart IF REFERRAL IS REFUSED OR NOT FEASIBLE in page 49.

If the young infant is improving, complete the 7 days of treatment with intramuscular gentamicin. Ask the mother to continue giving the oral amoxicillin twice daily until all tablets are finished.

Refer the young infant urgently to hospital if:

- The infant shows any sign of CRITICAL ILLNESS or
- Any new sign of CLINICAL SEVERE INFECTION appear while on treatment or
- There is no improvement on day 4 after 3 full days of treatment or
- Any sign of CLINICAL SEVERE INFECTION is still present at the 7th intramuscular injection of gentamicin.

DIARRHOEA

After 2 days:

ASK: Has the diarrhoea stopped?

- If the diarrhoea has **not stopped**, assess, classify and treat the young infant for diarrhoea (see page 18 and 39)
- if diarrhoea has **stopped**, tell the mother to continue exclusive breastfeeding.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

JAUNDICE

After 1 day:

Reassess infant for the jaundice.

- If the infant **has yellow palms and soles**, classify the infant as having SEVERE JAUNDICE and refer the infant urgently to hospital.
- If the infant **does not have yellow palms and soles** but the **jaundice has not decreased compared to the initial visit**, continue to follow up in 2 days until the jaundice starts decreasing.
- If the jaundice has **started decreasing**, reassure the mother and ask her to continue home care. Ask her to return for follow-up at 2 weeks of age.
- If an infant continues to have **jaundice beyond 2 weeks of age**, refer the infant to a hospital for further assessment.

EYE INFECTION

After 2 days:

Look for pus draining from the eye.

- If **eye discharge is worse**, refer.
- If **eye discharge is the same or better**, continue with 1% tetracycline ointment for a total of 5 days.
- Reassess after 2 days.
- Remind the mother when to return immediately.

FEEDING PROBLEM

After 2 days:

Reassess feeding. See "Then Check for Feeding Problem or Low Weight or Wasting". Ask about any feeding problems found on the initial visit.

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the young infant back again.
- If the young infant is low weight for age or wasted, ask the mother to return 14 days of this follow up visit and measure weight and length. Continue follow-up until the infant is gaining weight and length well.

Exception:

- If you do not think that feeding will improve, or if the young infant has **lost weight**, refer the child.

PRE-TERM or LOW BIRTH WEIGHT

After 7 days

- Check weight and determine if the infant is gaining weight.
- Re-assess KMC.
- Re-assess feeding.
- If the infant is gaining weight praise the mother and encourage her to continue with optimal feeding. Ask mother to come back after 1 month or according to immunization schedule.
- If the infant weight is the same and is feeding well encourage the mother to continue with optimal breastfeeding. Ask the mother to return in 7 days.
- If the infant is losing weight refer to hospital.
- If she has difficulty with KMC, review KMC steps and assist accordingly.

LOW WEIGHT FOR AGE

After 14 days:

Weigh the young infant and determine if the infant is still low weight for age.

Reassess feeding: See "Then Check for Feeding Problem or Low Weight."

- If the infant is **no longer low weight for age**, praise the mother and encourage her to continue.
- If the infant is **still low weight for age, but is feeding well**, praise the mother. Ask her to have her infant weighed again within a month or when she returns for immunization, whichever is the earlier.
- If the infant is **still low weight for age and still has a feeding problem**, counsel the mother about the feeding problem. Ask the mother to return again in 14 days (or when she returns for immunization, if this is within 14 days). Continue to see the young infant every few weeks until the infant is feeding well and gaining weight regularly and is no longer low weight for age.

Exception:

- If you think that feeding will not improve, or if the young infant has **lost weight**, refer to hospital.

ORAL THRUSH

After 2 days:

Look for ulcers or white patches in the mouth (thrush).

Reassess feeding: See "Then Check for Feeding Problem or Low Weight" above.

- If **thrush is worse**, or the infant has **problems with attachment or suckling**, refer to hospital.
- If **thrush is the same or better**, and if the infant is **feeding well**, continue half-strength gentian violet for a total of 5 days.

Give Follow-up Care for CONFIRMED HIV INFECTION or HIV EXPOSED: POSSIBLE HIV INFECTION as in Older Child

Annex 1: Tables of Other Causes of Fever

OTHER CAUSES OF FEVER IN CHILDREN WHO HAVE NEGATIVE MALARIA TEST

SIGNS	CLASSIFICATION	TREAT	MORE INFORMATION
Runny Nose	COLD	- Give paracetamol for high fever(38.5° or more. - Give extra fluids.	Cold is caused by viral infection which there is no need of antibiotics to treat.
- Sore throat for older child - Pain or difficulty during swallowing - painful swollen neck glands	TONSILITIS/PHARYNGITIS	- Give Amoxycillin for 5 days - Give paracetamol for high fever(38.5°C or more.	Use a torch and spatula to look at the child's throat so as to see if there is redness, pus or swelling.
- Pain on passing urine - Growth faltering - Lower abdominal pain - Increased frequency to micturition - Bed wetting to a child who does not have the habit.	URINARY TRACT INFECTION(UTI)	- Give Amoxycillin for 5 days - Give paracetamol for high fever(38.5°C or more.	- Do urinalysis if feasible - WBC count >5/HPF indicates there is urinary tract infection
- Skin pustules - Boils - Cellulitis	LOCAL BACTERIAL INFECTION(SKIN)	- Give Ampicloxacillin for 5 days - Give paracetamol for high fever(38.5°C or more. - Do incision and drainage of abscess or - Clean wounds using antiseptics.	
- Fever - Vomiting - Neck stiffness - Meningitidis spots (rose spots)	MENINGITIS	- Treat to prevent low blood sugar - Give paracetamol for high fever(38.5°C or more. - Refer URGENTLY to Hospital	At hospital Cerebral spinal fluid will be taken for diagnostic test.

Annex 2: Dosages For RUFT in Children with acute malnutrition.

DOSAGE FOR RUTF FOR CHILDREN WITH ACUTE MALNUTRITION

HOW TO GIVE READY TO USE THERAPEUTIC FOOD (RUTF) or PLUMPY NUTS

Table below shows the amount of RUTF to give per day/per week according to child's weight:

Weight (kg)	Plumpy'nut sachets (1 packet of plumpy' nut weighs 92 gm)	
	Per day (Sachets)	Per week (Sachets)
3.0 – 3.4	1¼	8
3.5 – 3.9	1½	11
4.0 – 5.4	2	14
5.5 – 6.9	2½	18
7.0 – 8.4	3	21
8.5 – 9.4	3½	25
9.5 – 10.4	4	28
10.5 - 14.9	4½	32
15.5 - 19.9	5	35

Annex 2: Dosages For RUFT in Children with acute malnutrition.

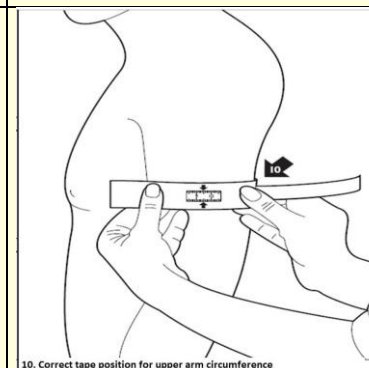
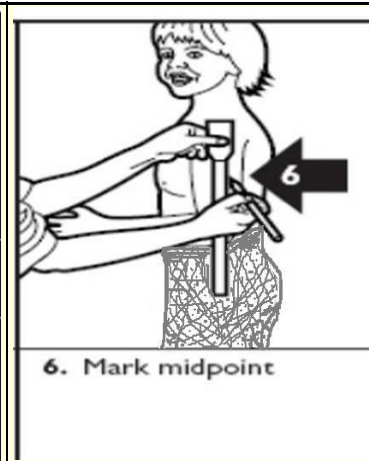
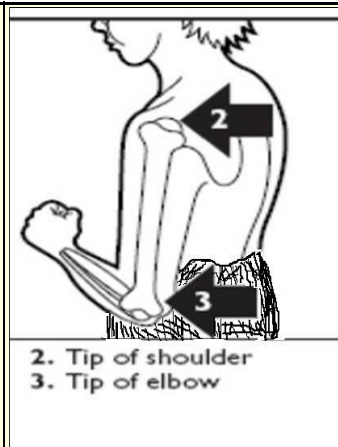
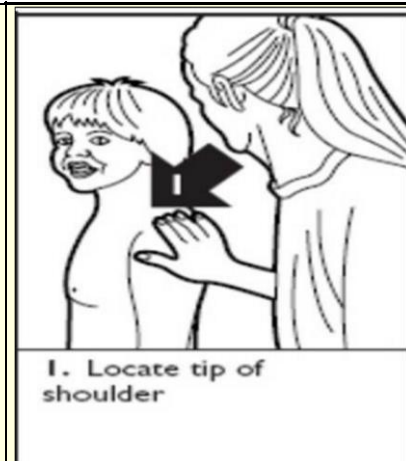
HOW TO MEASURE MID UPPER ARM CIRCUMFERENCE(MUAC)

To measure Mid upper arm circumference (MUAC)

- MUAC: MUAC is the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow (olecranon process and the acromion). In children, MUAC is useful for the assessment of nutritional status.
- This measurement is not significant for children aged less than 6 months.

How to measure Mid Upper Arm Circumference for children

- There is a special tool called Arm circumference insertion tape, however a normal tape measure can function similarly.
 - Make sure the child has undressed the whole of left arm.
 - Flex the child's arm to lie on his or her abdomen to make an angle of 90°.
 - Locate the tip of the shoulder and the elbow.
 - Measure the length from the tip of the shoulder to the tip of the elbow.
 - Look for place on the upper arm where way half of the distance of the measured length and put a mark. Then remove the tape.
 - Let the child extend the arm straight before using the tape for measurement.
 - Encircle the tape around the arm at the part where you put the mark.
 - Make sure the tape is not very tight or not very loose on the child's.
 - Read the measurement on the tape at the corresponding point.
 - Record the measurement in centimetres(cms) in single decimal places.
- Look at the following pictures in the steps for easy understanding.



Annex 3: REFERRAL NOTE FOR THE SICK YOUNG INFANT

REFERRAL NOTE FOR THE SICK YOUNG INFANT

Infant's name:	Family name:
Caregiver's name:	Age of infants: Temperature:
Address or village:	
Tick the signs present that are reason for referral of the young infant.	

POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE ☐ Unable to feed at all or not feeding well ☐ Convulsions.. ☐ Severe chest indwng ☐ temperature 38°C or above ☐ Temperature 35.5°C or less ☐ No movement at all ☐ Fast breathing (60 breaths per minute or more) in infants less than 7 days old SEVERE DEHYDRATION ☐ Sunken eyes ☐ Skin pinch goes back very slowly SEVERE JAUNDICE ☐ Any Jaundice in infant aged less than 24 hours ☐ Yellow palms or soles at any age SEVERE EYE INFECTION ☐ Eyes profusely discharging pus with or without swelling VERY LOW WEIGHT FOR AGE ☐ Weight less than 2.0 kg VERY PRE-TERM AND/OR VERY LOW BIRTH WEIGHT ☐ Weight less than 1500 gm or gestational age less than 32 weeks Prereferral treatments given: 	REASONS FOR REFERRAL
--	------------------------------------

Comments:

.....

.....

.....

.....

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Date of referral:	Time of referral:
Name of Referring Health Worker:	Name of facility:

MANAGEMENT OF THE SICK CHILD AGED 2 MONTHS UP TO 5 YEARS

Name: _____ Age: _____ (Mos) Weight _____ (kg) Height/Length _____ (cm) Temperature _____ (°C)
 Ask: What are the child's problems? _____ Initial Visit? _____ Follow-up Visit _____

ASSESS (Circle all signs present)

CLASSIFY

CHECK FOR GENERAL DANGER SIGN • NOT ABLE TO DRINK OR BREASTFEED • VOMITS EVERYTHING • CONVULSIONS • LETHARGIC OR UNCONSCIOUS • CONVULSING NOW	General danger sign present? Yes ____ No ____ Remember to use Danger sign when selecting classifications
DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? Yes ____ No ____ • For how long? ____ Days • Count the breaths in one minute: ____ breaths per minute. Fast breathing? • Look for chest indrawing • Look and listen for stridor • Look and listen for wheezing	
DOES THE CHILD HAVE DIARRHOEA? Yes ____ No ____ • For how long? ____ Days • Is there blood in the stool? • Look at the child's general condition. Is the child: ◦ Lethargic or unconscious? Restless and irritable? • Look for sunken eyes. • Offer the child fluid. Is the child: ◦ Not able to drink or drinking poorly? Drinking eagerly, thirsty? • Pinch the skin of the abdomen. Does it go back: ◦ Very slowly (longer than 2 seconds)? Slowly?	
DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5°C or above) Yes ____ No ____ Decide malaria risk: High ____ Low ____ No ____ • For how long? ____ Days • If more than 7 days, has fever been present every day? • Has child had measles within the last 3 months? Do a malaria test, if NO general danger sign or severe classification, in all cases in high malaria risk or NO obvious cause of fever in low malaria risk: Test POSITIVE? _____ NEGATIVE? _____ • Look or feel for stiff neck • Look for runny nose • Look for signs of MEASLES: ◦ Generalized rash and ◦ One of these: cough, runny nose, or red eyes • Look for any other cause of fever.	
If the child has measles now or within the last 3 months: • Look for mouth ulcers. If yes, are they deep and extensive? • Look for pus draining from the eye. • Look for clouding of the cornea.	
DOES THE CHILD HAVE AN EAR PROBLEM? Yes ____ No ____ • Is there ear pain? • Is there ear discharge? If Yes, for how long? ____ Days • Look for pus draining from the ear • Feel for tender swelling behind the ear	
THEN CHECK FOR ACUTE MALNUTRITION • Look for oedema of both feet. • Determine WFH/L z-score: ◦ Less than -3? Between -3 and -2? -2 or more? • Child 6 months or older measure MUAC ____ mm. If child has MUAC less than 115 mm or WFH/L less than -3 Z scores: • Is there any medical complication: ◦ General danger sign? ◦ Any severe classification? ◦ Pneumonia with chest indrawing? • Child 6 months or older: Offer RUTF to eat. Is the child: ◦ Not able to finish? Able to finish? • Child less than 6 months: Is there a breastfeeding problem?	
CHECK FOR ANAEMIA: • Look for palmar pallor. ◦ Severe palmar pallor? ◦ Some palmar pallor? ◦ No palmar pallor?	
CHECK FOR HIV INFECTION • Note mother's and/or child's HIV status ◦ Mother's HIV test: NEGATIVE POSITIVE NOT DONE/KNOWN ◦ Child's virological test: NEGATIVE POSITIVE NOT DONE ◦ Child's serological test: NEGATIVE POSITIVE NOT DONE • If mother is HIV-positive and NO positive virological test in child: ◦ Is the child breastfeeding now? ◦ Was the child breastfeeding at the time of test or 6 weeks before it? ◦ If breastfeeding: Is the mother and child on ARV prophylaxis?	
CHECK FOR TUBERCULOSIS • If child has household/other contact with a known case of TB. • Determine if child has cough for more than 14 days. • Determine if the child has unexplained or prolonged fever for more than 7 days. • unexplained fatigue, reduced playfulness, less active. • Does the child have Growth faltering or UNCOMPLICATED SEVERE ACUTE MALNUTRITION or MODERATE ACUTE MALNUTRITION? • Look for generalized lymphadenopathy. ◦ Are there any enlarged lymph glands in two or more of the following sites: neck, armpit, or groin?	
ASSESS MOUTH AND GUM CONDITIONS (For children on ART or HIV EXPOSED, HIV INFECTION OR HIV EXPOSED: POSSIBLE HIV INFECTION) • Does the child has mouth or gum ulcers? • Is the child not able to eat due to painful mouth ulcers? • Look for mouth or gum ulcers? • Are they deep or extensive?	
CHECK THE CHILD'S IMMUNIZATION STATUS (Circle immunizations needed today) BCG _____ OPV-1 _____ OPV-2 _____ OPV-3 _____ Measles1 _____ Measles 2 _____ Vitamin A _____ OPV-0 _____ Penta 1 _____ Penta 2 _____ Penta-3 _____ IPV _____ Mebendazole or Albendazole _____	Return for next immunization on: _____ (Date)
ASSESS FEEDING if the child is less than 2 years old, has MODERATE ACUTE MALNUTRITION, ANAEMIA, CONFIRMED HIV INFECTION or is HIV EXPOSED • Do you breastfeed your child? Yes ____ No ____ ◦ If yes, how many times in 24 hours? ____ times. Do you breastfeed during the night? Yes ____ No ____ • Does the child take any other foods or fluids? Yes ____ No ____ ◦ If Yes, what food or fluids? ◦ How many times per day? ____ times. What do you use to feed the child? ◦ If very low weight for age: How large are servings? ◦ Does the child receive his own serving? ____ Who feeds the child and how? • During this illness, has the child's feeding changed? Yes ____ No ____ ◦ If Yes, how?	FEEDING PROBLEMS
ASSESS OTHER PROBLEMS: Ask about mother's own health	

TREAT

[illegible]

MANAGEMENT OF THE SICK YOUNG INFANT AGED UP TO 2 MONTHS



Name:..... Age:.....(Days/weeks) Weight :.....(kg) Temperature:..... (°C)
 Ask: What are the infant's problems?..... Initial Visit?..... Follow-up Visit?.....
ASSESS (Circle all signs present) **CLASSIFY**

CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE or PNEUMONIA or LOCAL BACTERIAL INFECTION - Has the infant had convulsions? - Is the infant not able to feed or breast feed at all? - Has the mother had tuberculosis infection two weeks before delivery?(smear +ve) - Look for convulsions? - Count the breaths in one minute. ____ breaths per minute Repeat if elevated: ____ Fast breathing? - Look for severe chest indrawing. - Look and listen for grunting. - Look at the umbilicus. Is it red or draining pus? - Fever (temperature 37.5°C or above feels hot) or low body temperature (below 35.5°C or feels cool) - Look for skin pustules. - Look for young infants movements - movements only when stimulated - no movement even when stimulated		
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes ____ No ____ - For how long? -----days - Is there blood in stool? - Look at the young infant's general condition. Does the infant: - move only when stimulated? - not move even when stimulated? - Is the infant restless and irritable? - Look for sunken eyes. - Pinch the skin of the abdomen. Does it go back: - Very slowly (> 2 seconds)? - Slowly?		
THEN CHECK FOR JAUNDICE - Does the baby have yellow colouration of skin or eyes? yes ____ No ____ - If yes, ask when did it start? (If no, check for jaundice). - Before 24 hours after birth. 24 hours from birth. - Look for jaundice - yellow palms and soles. - yellow eyes and skin of the face. - yellow at any part of the body.		
CHECK FOR EYE PROBLEM - Look at the infant's eyes - Are they profusely discharging pus?. - Are they draining pus?. - Are they swollen?		
HAS THE MOTHER OR INFANT HAD HIV TEST DONE? - Has the mother tested for HIV? Yes.....No..... - Has the infant tested for HIV by PCR Or Antibody test? - Is the HIV status of mother or infant Unknown? - Check the mother and infant HIV status - Infant PCR test positive - Infant seropositive - Mother HIV positive - Both mother and baby are HIV negative		
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT IN BREASTFED INFANTS - Is the infant breastfed? Yes ____ No ____ If yes, how many times in 24 hours? ____ times - Does the infant usually receive any other foods or drinks? Yes ____ No ____ If yes, how often? - What do you use to feed the child? - Determine the weight for age. - Low weight (<-2SD) - Not low (>-2SD)		
ASSESS BREASTFEEDING: If the infant is < 7 days old, or is breast feeding < 10 times in 24 hours, or is taking any other foods or drinks or is low weight for age or wasting AND has no indications to refer urgently to hospital:? Ask: - Has the infant breastfed in the previous hour? If the infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes. - Is the infant able to attach? To check attachment, look for: - Chin touching breast: Yes ____ No ____ - Mouth wide open: Yes ____ No ____ - Lower lip turned outward: Yes ____ No ____ - More areola above than below the mouth: Yes ____ No ____ - not well attached good attachment - Is the infant sucking effectively (that is, slow deep sucks, sometimes pausing)? - not sucking sucking effectively - effectively - Look for ulcers or white patches in the mouth(thrush)		
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR NON BREASTFED INFANTS ASK: - What milk are you giving?..... How many times in 24hrs ____ - How much is given at each feed ____ - How are you preparing the milk? - Are you giving any breast milk? Yes ____ No ____ - What other foods/fluids are given? ____ - Is the child fed by cup or bottle? - How is cleaning the utensils done? Appropriate / Not appropriate - How much is given at each feed? - Is the replacement milk: - Correctly prepared? Yes ____ No ____ - Hygienically prepared? Yes ____ No ____ - Appropriate? Yes ____ No ____ - Sufficient? Yes ____ No ____ - Look for ulcers or white patches in the mouth (thrush) - Determine the weight for age. - Low weight (<-2SD) - Not low (>-2SD)		
CHECK FOR BIRTH WEIGHT AND GESTATIONAL AGE (In Infants < 7 days old) - What was the gestational age at birth? ____ weeks - What was the birth weight? ____ kg - Measure weight? - Weight <1500 gm or gestational age < 32 weeks - Weight 1500 gm to 2500 gm or gestational age 32 to 36 week - Weight ≥ 2500 gm for gestational age ≥ 37 weeks		
CHECK THE CHILD'S IMMUNIZATION STATUS (Circle immunizations needed today) Vitamin A (for mother if infant is breastfed) BCG OPV0 Penta1 OPV1		Return for next immunization on: _____ (Date)
ASSESS OTHER PROBLEMS: ASSESS MOTHER'S OWN HEALTH		

TREAT

[illegible]

Return for follow-up in:

Give any immunizations needed today:

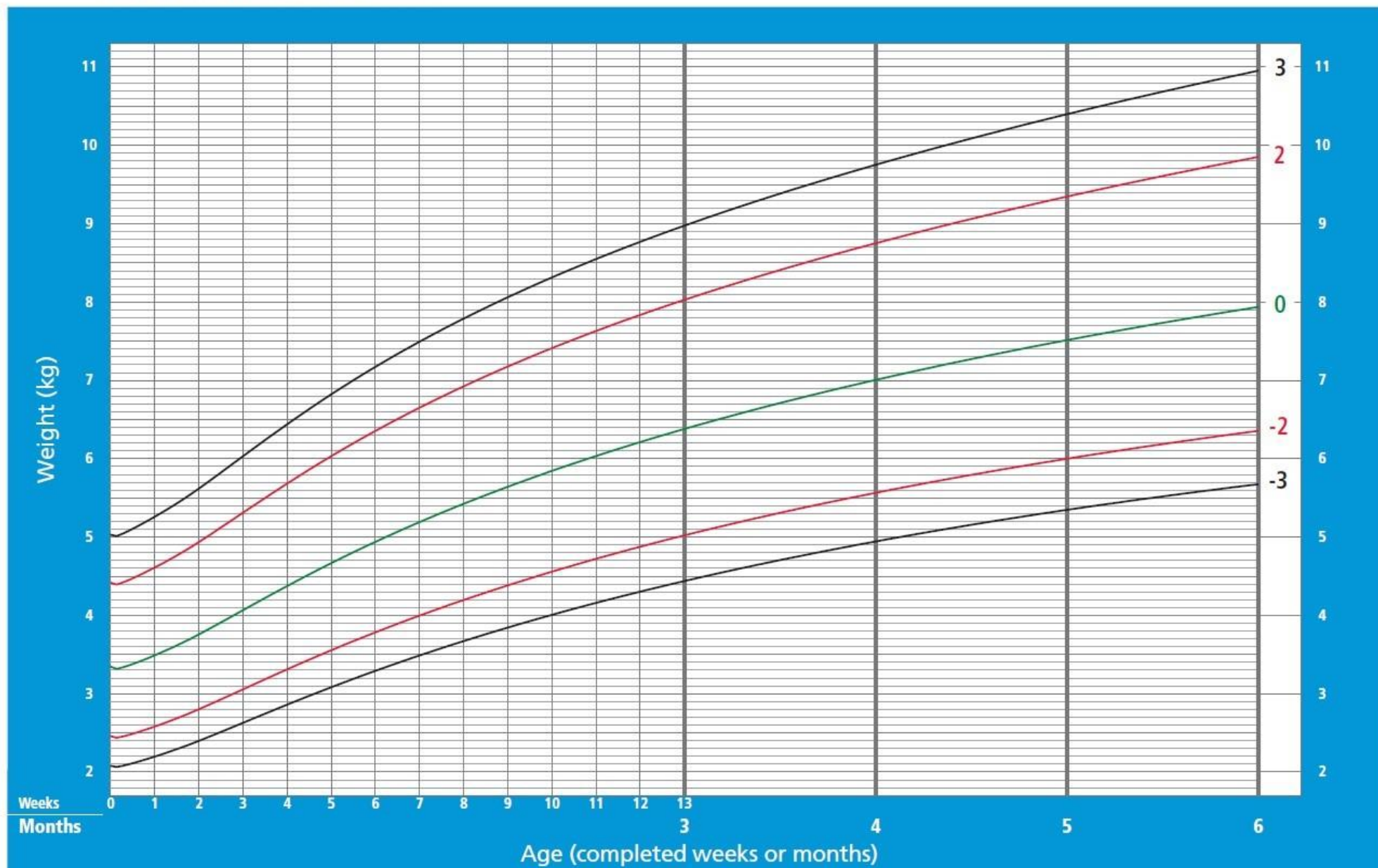
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Advise

given:.....
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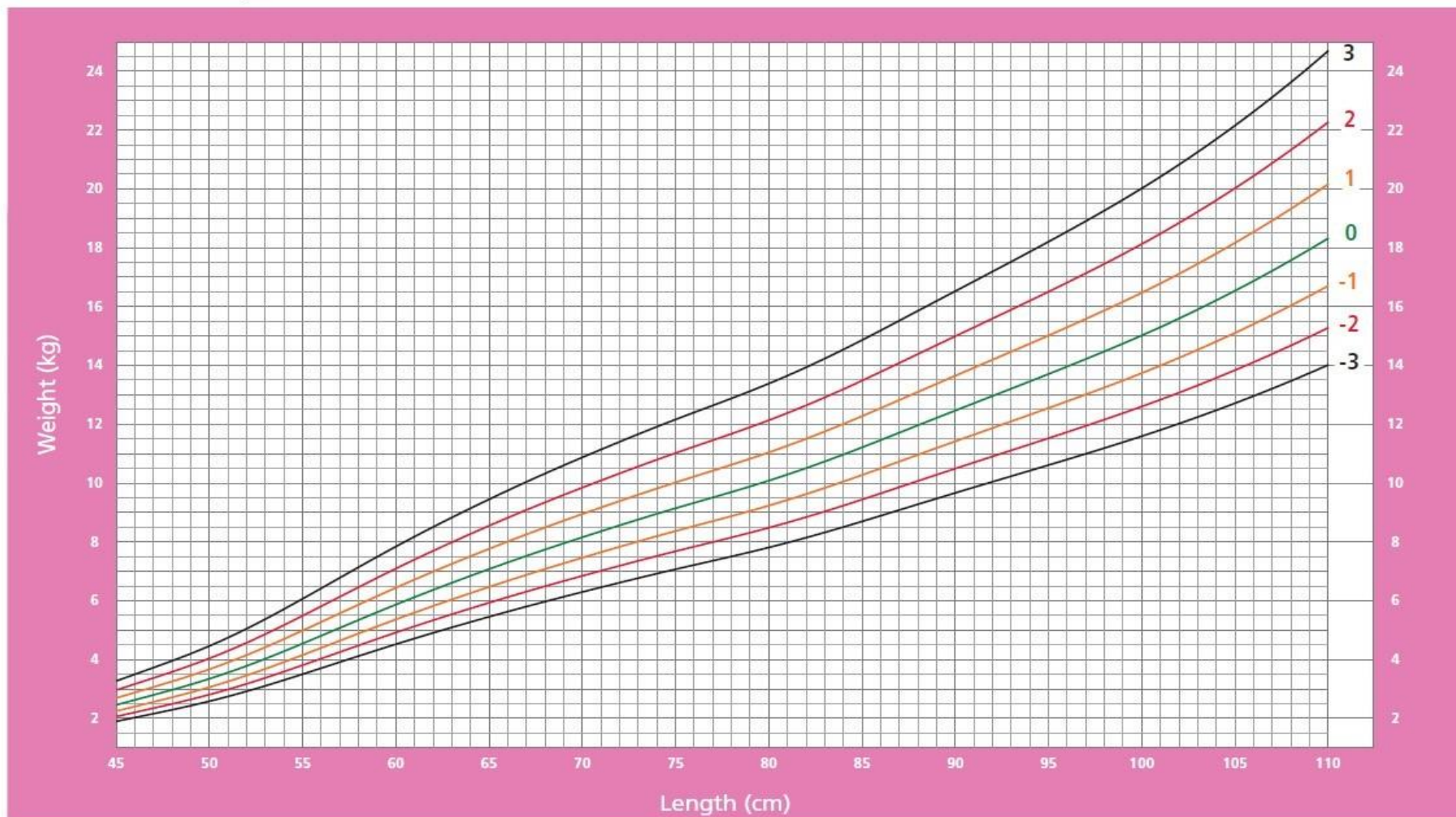
Weight-for-age BOYS

Birth to 6 months (z-scores)



Weight-for-length GIRLS

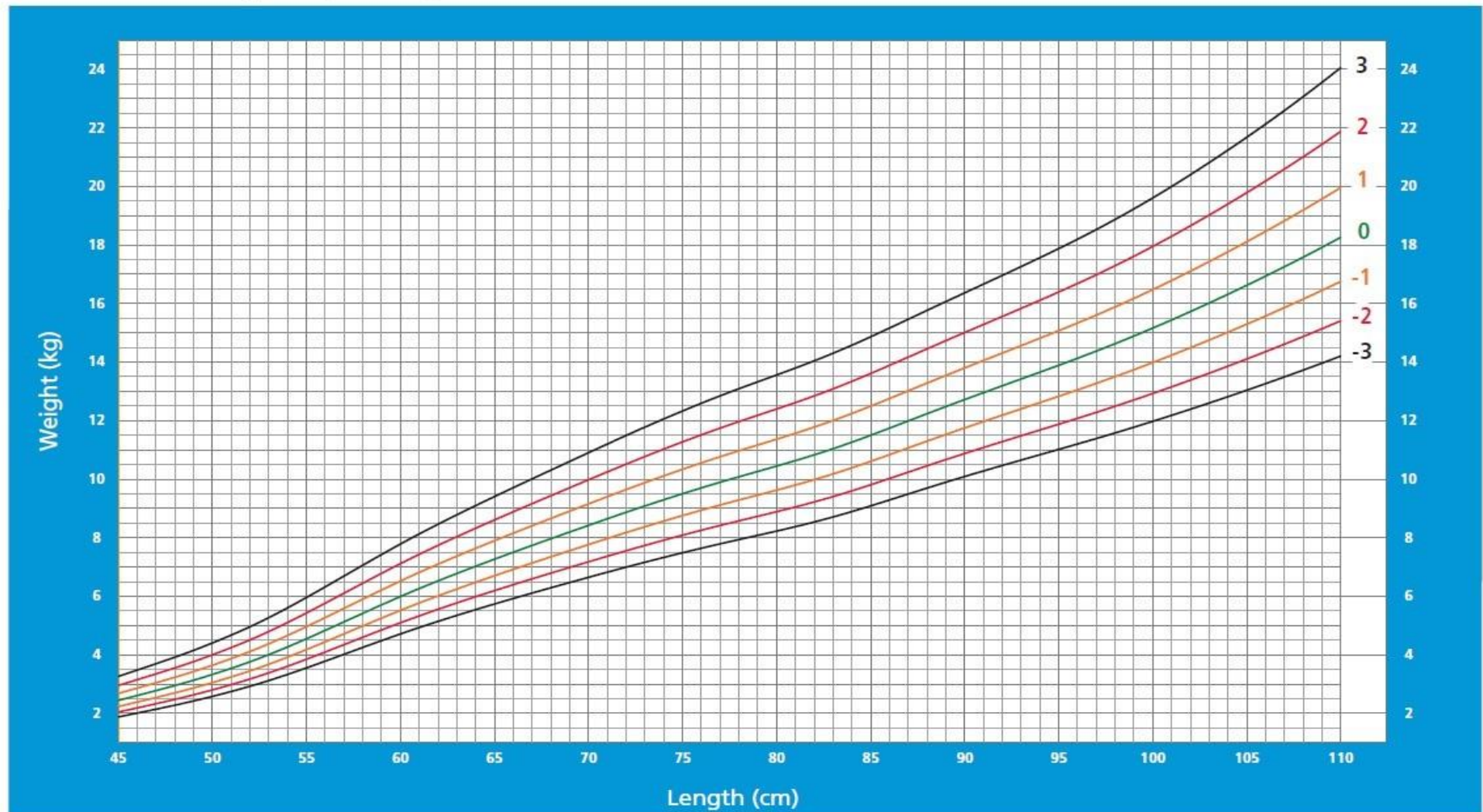
Birth to 2 years (z-scores)



WHO Child Growth Standards

Weight-for-length BOYS

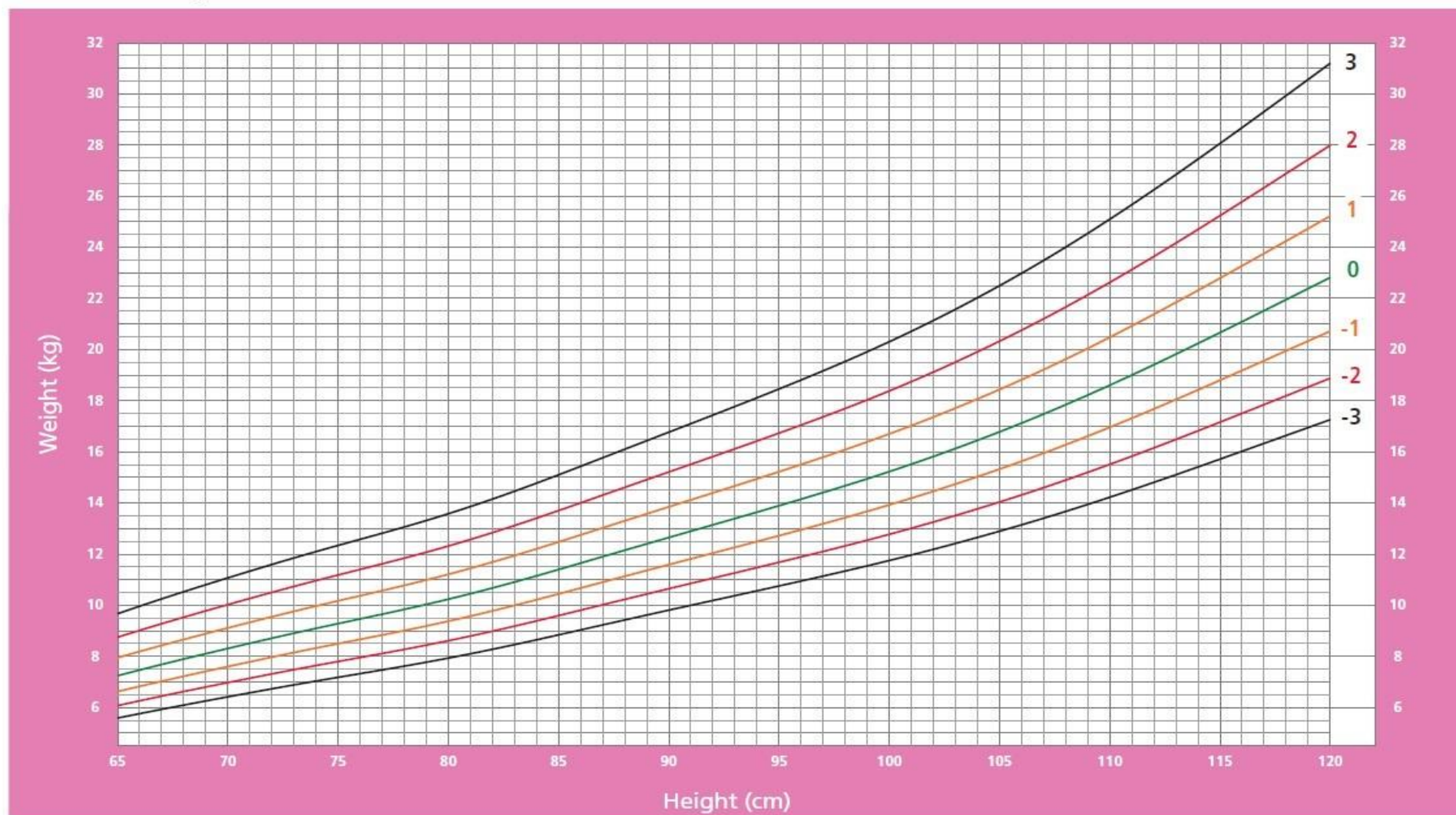
Birth to 2 years (z-scores)



WHO Child Growth Standards

Weight-for-Height GIRLS

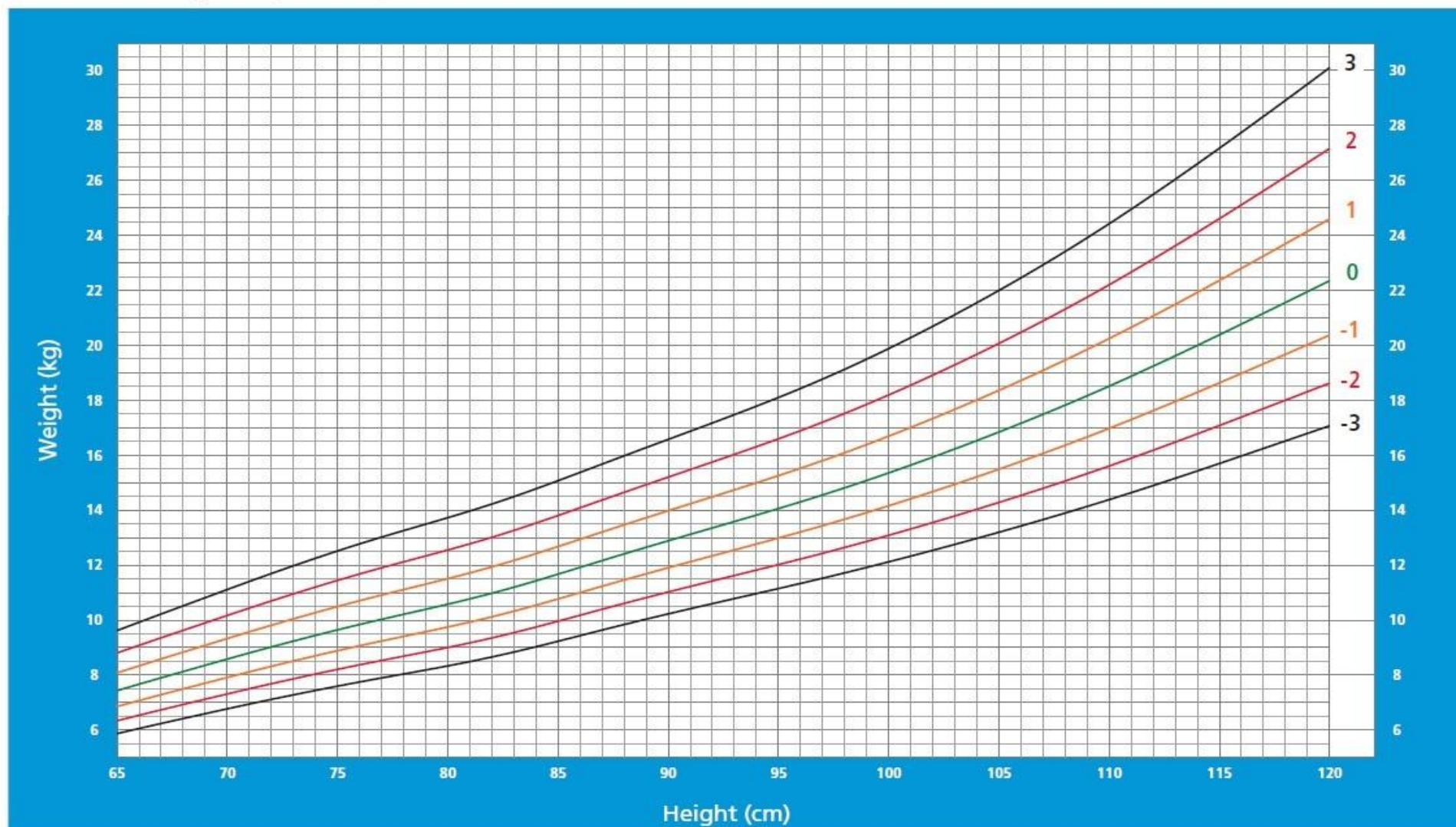
2 to 5 years (z-scores)



WHO Child Growth Standards

Weight-for-height BOYS

2 to 5 years (z-scores)



WHO Child Growth Standards

PRINCIPLES OF THE INTEGRATED CLINICAL CASE MANAGEMENT

IMNCI clinical guidelines are based on the following principles:

- ① **Examining all sick children aged up to five years** of age for **general danger signs** and all young infants for signs of **very severe disease**. These signs indicate severe illness and the need for immediate referral or admission to hospital.
- ② The children and infants are then **assessed for main symptoms**:
 - ◆ In older children the main symptoms include:
 - Cough or difficulty breathing,
 - Diarrhoea,
 - Fever, and
 - Ear infection.
 - ◆ In young infants, the main symptoms include:
 - Local bacterial infection,
 - Diarrhoea,
 - Jaundice, and
 - Eye problem
- ③ Then in addition, all sick children are **routinely checked** for:
 - Nutritional and immunization status,
 - HIV status in high HIV settings, and
 - Other potential problems.

- ④ Only a **limited number of clinical signs** are used, selected on the basis of their sensitivity and specificity to detect disease through classification.

A combination of individual signs leads to a **child's classification** within one or more symptom groups rather than a diagnosis. The classification of illness is based on a colour-coded triage system:

- ◆ **"PINK"** indicates urgent hospital referral or admission,
- ◆ **"YELLOW"** indicates initiation of specific outpatient treatment,
- ◆ **"GREEN"** indicates supportive home care.

- ⑤ IMNCI management procedures use **a limited number of essential drugs** and encourage active participation of caregivers in the treatment of their children.
- ⑥ An essential component of IMNCI is the **counselling of caregivers** regarding home care:
 - ◆ Appropriate feeding and fluids,
 - ◆ When to return to the clinic immediately, and
 - ◆ When to return for follow-up

IMNCI Chart Booklet

This IMNCI chart booklet is for use by nurses, clinicians and other health professionals who see young infants and children less than five years old. It facilitates the use of the IMNCI case management process and the charts describe the sequence of all the case management steps. The chart booklet should be used by all health professionals providing care to sick children to help them apply the IMNCI case management guidelines. Health professionals should always use the chart booklet for easy reference during the process of clinical care.

The chart booklet is divided into two main parts because clinical signs in sick young infants and older children are somewhat different and the case management procedures also differ between these age groups:

- **SICK CHILD AGED 2 MONTHS TO 5 YEARS.** This part contains all the necessary clinical algorithms, information and instructions on how to provide care to sick children aged 2 months to 5 years.
 - **SICK YOUNG INFANT AGED UP TO 2 MONTHS.** This part includes case management clinical algorithms for the care of a young infant aged up to 2 months
- and

Each of these parts contains IMNCI charts corresponding to the main steps of the IMNCI case management process.