INTEGRATED MANAGEMENT OF NEONATAL & CHILDHOOD ILLNESS

CHART BOOKLET

2019

World Health Organization

Ministry of National Health Services,
Regulation And Coordination, Government

unicef

Generic Integrated Management of Neonatal & Childhood Illness was prepared by the World Health Organization's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR), now the Department of Child and Adolescent Health and Development (CAH), and UNICEF through a contract with ACT International, Atlanta, Georgia, USA. This was adapted for Pakistan by the IMNCI Adaptation Group, Ministry of Health, Pakistan with the collaboration of WHO and UNICEF in 1998.

Acknowledgements

World Health Organization acknowledges the support and valuable contribution of all child health experts who supported updating the IMNCI material & development of abridged course, edition and adaptation. Complete list of contributors to IMNCI in Pakistan, since its inception, is placed at the end of this document.

Previous version of IMNCI document was edited by Liaquat University of Medical & Health Sciences (LUMHS), Jamshoro in 2014 with technical guidance and support of World Health Organization.

Update of IMNCI guidelines and 6-day abridged course has been developed by Child Survival Program, Department of Health, Government of Sindh with technical support from World Health Organization in collaboration with UNICEF and Aga Khan University in 2017.

Updated National IMNCI guidelines have been edited by Dr. Abdul Rehman Pirzado in 2019

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Integrated Management of Neonatal & Childhood Illness

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SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

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ASSESS AND CLASSIFY THE SICK CHILD
AGE 2 MONTHS UP TO 5 YEARS

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 FOLLOW UP chart
  - if initial visit, assess the child as follows:

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

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	**VERY SEVERE DISEASE**	▪ **Give diazepam if convulsing now** ▪ **Quickly complete the assessment** ▪ **Give any prereferral 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:	***Fast breathing is:***
2 months up to 12 months	**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.	**SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	▸ **Give first dose of an appropriate antibiotic** ▸ **Refer URGENTLY to hospital****
• Chest indrawing **or** • Fast breathing.	**PNEUMONIA**	▸ **Give oral Amoxicillin for 5 days***** ▸ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days**** ▸ If coughing for more than 14 days or recurrent wheeze, refer for possible TB or asthma assessment ▸ Advise mother when to return immediately ▸ Follow-up in 3 days
• No signs of pneumonia or very severe disease.	**NO PNEUMONIA: 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, refer for possible TB or asthma assessment ▸ 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, manage the child as described in the pneumonia section of the guidelines.*

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

***** 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 diarrhea?

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?

* If referral is not possible manage the child as described in Module 2
ANNEX: Where Referral Is Not Possible

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.	**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.	**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 the mother to continue breastfeeding** ▸ Advise mother when to return immediately ▸ Follow-up in 5 days if not improving
	Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	▸ Give fluid, zinc supplements, and food to treat diarrhea at home (Plan A) ▸ Advise mother when to return immediately ▸ Follow-up in 5 days if not improving
And If diarrhea 14daysor more	Dehydration present.	**SEVERE PERSISTENT DIARRHOEA**	▸ Treat dehydration before referral unless the child has another severe classification ▸ Refer to hospital
	No Dehydration present.	**PERSISTENT DIARRHOEA**	▸ Advise the mother on feeding a child who has PERSISTENT DIARRHOEA ▸ Give multivitamins and minerals (including zinc) for 14 days ▸ Follow-up in 5 days
and if blood in stool	Blood in the stool	**DYSENTERY**	▸ **Give ciprofloxacin for 3 days** ▸ Follow-up in 3 days

Does the child have fever?

by history or feels hot or temperature **37.5^{0}C or above***

If yes:
Decide Malaria Risk: high or low

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 severe classification***

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

Decide Dengue Rik: High or Low

Then Ask for:

- Headache
- Myalgia
- Rash
- Retro-orbital pain/ ocular pain
- Hemorrhagic manifestations (e.g. positive tourniquet test, purpura/ ecchymosis, epistaxis, gum bleeding)

……

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.

CLASSIFY FEVER	▪ Any general danger sign or ▪ Stiff neck.	**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^{0}C or above)** ▸ **Refer URGENTLY to hospital**
High or Low malaria Risk	Malaria test POSITIVE.	**MALARIA**	▸ **Give one dose of Paracetamol in clinic for high fever (38.8^{0}C or above)** ▸ Give appropriate antibiotic treatment for an identified bacteri5l 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
	▪ Malaria test NEGATIVE ▪ Other cause of fever PRESENT.	**FEVER: NO MALARIA**	▸ **Give recommended first line oral antimalarial** ▸ **Give one dose of Paracetamol in clinic for high fever (38.8^{0}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
No Malaria Risk and No travel to malaria Risk area	▪ Any general danger sign or ▪ Stiff neck.	**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^{0}C or above).** ▸ **Refer URGENTLY to hospital.**
	▪ No general danger signs ▪ No stiff neck.	**FEVER**	▸ **Give one dose of Paracetamol in clinic for high fever (38.5^{0}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
Measles now or within 3 months	▪ Any general danger sign or ▪ Clouding of cornea or ▪ Deep or extensive mouth ulcers.	**SEVERE COMPLICATED MEASLES******	▸ **Give Vitamin A treatment** ▸ **Give first dose of an appropriate antibiotic** ▸ **If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment Refer URGENTLY to hospital**
	▪ Pus draining from the eye or ▪ Mouth ulcers.	**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 3 days
	▪ Measles now or ▪ within the last 3 months.	**MEASLES**	▸ **Give Vitamin A treatment**
Dengue	▪ Bleeding from the nose or gums ▪ Bleeding in the stool or vomits ▪ Black stool or vomitus ▪ Skin petechiae ▪ Slow capillary refill (more than 3 seconds) ▪ Persistent abdominal; pain ▪ Persistent vomiting ▪ Positive tourniquet test	**SEVERE DENGUE HEMORRHAGIC FEVER**	▸ ***If skin petechiae, peritent abdominal pain, persistent vomiting or positive tourniquet test are the only positive signs, then give ORS.*** ▸ ***If any other sign of bleeding is positive, give fluids rpidly as in Plan C.*** ▸ ***Treat the child to prevent low blood sugar.*** ▸ ***Refer URGENTLY to hospital.*** ▸ ***Do not give Aspirin.***
	▪ No sign of Dengue hemorrhagic fever	**FEVER ONLY: DENGUE HEMORRHAGIC FEVER UNLIKELY**	▸ Advise mother when to return immediately. ▸ **Follow up in 2 days if the fever persists or if the child shows signs of bleeding** ▸ **Do not give aspirin**

- **These temperatures are based on axillary temperatures.**

** 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:	*Look and feel:*
• Is there ear pain? Is • there ear discharge? If yes, for how long?	• Look for pus draining from the ear. • Feel for tender swelling behind the ear.

Classify EAR PROBLEM

• Tender swelling behind the ear.	**MASTOIDITIS**	▪ **Give first dose of an appropriate antibiotic** ▪ **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.	**ACUTE EAR INFECTION**	▪ **Give an 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.	**CHRONIC EAR INFECTION**	▪ Dry the ear by wicking ▪ Treat with topical quinolone eardrops for 14 ▪ days Follow-up in 5 days
• No ear pain and No pus seen draining from the ear.	**NO EAR INFECTION**	▪ No treatment

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:**
  - **Child is 6 months or older, offer RUTF*** to eat. Is the child:**

    Not able to finish RUTF portion?

    Able to finish RUTF portion?
  - **Child is less than 6 months, assess breastfeeding:**

    Does the child have a breastfeeding problem?

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 or ◦ Breastfeeding problem.	***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 hospital**
• 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** ■ 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**	■ Assess the child's feeding and counsel the mother on the feeding recommendations ■ 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 malanutrition.

THEN CHECK FOR ANAEMIA

Check for anaemia

- Look for palmar pallor. Is it:
  - Severe palmar pallor*?
  - Some palmar pallor?

Classify ANAEMIA

• Severe palmar pallor	**SEVERE ANAEMIA**	▪ **Refer URGENTLY to hospital**
• Some pallor	**ANAEMIA**	▪ Give iron** ▪ Give mebendazole if child is 1 year or older and has not had a dose in the previous 6 ▪ months ▪ Advise mother when to return immediately Follow-up in 14 days
• No palmar pallor	**NO ANAEMIA**	If child is less than 2 years old, assess the child's feeding and counsel the mother according to the feeding recommendations If feeding problem, follow-up in 5 days

*Assess for sickle cell anaemia if common in your area.

**If child has severe acute malnutrition and is receiving RUTF, DO NOT give iron because there is already adequate amount of iron in RUTF.

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

IMMUNIZATION SCHEDULE:

AGE	VACCINE			
Birth	BCG	OPV 0	Hep B 0	
6 weeks	Pentavalent* 1	OPV 1	Pnemococcal 1	Rota 1
10 weeks	Pentavalent 2	OPV 2	Pnemococcal 2	Rota 2
14 weeks	Pentavalent 3	OPV 3	Pnemococcal 3	IPV
9 months	Measles 1			
15 months	Measles 2			

* DPT + Hep B + Hib

Note: space between two doses of multiple dose vaccines is at least 4 weeks.

Never repeat the earlier dose of vaccine irrespective of the duration.

Vitamin AUPPLEMENTATION

- Give every child a dose of Vitamin A every six months from the age of 6 month.
- Record the dose in child's chart.

ROUTINE WORM TREATMENT

- Give every child pyrantel pamoate every 6 months form one year of age.
- Record the dose in child's chart.

ASSESS OTHER PROBLEMS:

MAKE SURE CHILD WITH ANY GENERAL DANGER SIGN IS REFERRED after first dose of an appropriate antibiotic and other urgent treatments. Treat all children with a general danger sign to prevent low blood sugar.

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 below 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 practice 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.**

FOR PNEUMONIA, ACUTE EAR INFECTION:

FIRST-LINE ANTIBIOTIC: Oral Amoxicillin

AGE or WEIGHT	**AMOXICILLIN*** *Give two times daily for 5 days*	
	TABLET 250 mg	**SYRUP** 250mg/5 ml
2 months up to 12 months (4 - <10 kg)	1	5 ml
12 months up to 3 years (10 - <14 kg)	2	10 ml
3 years up to 5 years (14-19 kg)	3	15 ml

** Amoxicillin is the recommended first-line drug of choice in the treatment of pneumonia due to its efficacy and increasing high resistance to cotrimoxazole*

FOR DYSENTERY

FIRST-LINE ANTIBIOTIC: Oral Ciprofloxacine

AGE	**CIPROFLOXACINE** Give 15mg/kg two times daily for 3 days	
	250 mg tablet	500 mg tablet
Less than 6 months	1/2	1/4
6 months up to 5 years	1	1/2

FOR: CHOLERA

FIRST-LINE ANTIBIOTIC FOR CHOLERA: Ciprofloxacine
SECOND-LINE ANTIBIOTIC FOR CHOLERA: as under:

AGE or WEIGHT	**ERYTHROMYCIN** *Give four times daily for 3 days*	**TETRACYCLINE** *Give four times daily for 3 days*
	TABLET 250 mg	**TABLET** 250 mg
2 years up to 5 years (10 - 19 kg)	1	1

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

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

Give Inhaled Salbutamol for Wheezing

USE OF A SPACER*

A spacer is a way of delivering the bronchodilator drugs effectively into the lungs. No child under 5 years should be given an inhaler without a spacer. A spacer works as well as a nebulizer if correctly used.

- From salbutamol metered dose inhaler (100 microgram/puff) give 2 puffs
- Repeat up to 3 times every 15 minutes before classifying pneumonia.

Spacers can be made in the following way:

- Use a 500ml drink bottle or similar.
- Cut a hole in the bottle base in the same shape as the mouthpiece of the inhaler.
- This can be done using a sharp knife.
- Cut the bottle between the upper quarter and the lower 3/4 and disregard the upper quarter of the bottle.
- Cut a small V in the border of the large open part of the bottle to fit to the child's nose and be used as a mask.
- Flame the edge of the cut bottle with a candle or a lighter to soften it.
- In a small baby, a mask can be made by making a similar hole in a plastic (not polystyrene) cup.
- Alternatively, commercial spacers can be used if available.

To use an inhaler with a spacer:

- Remove the inhaler cap. Shake the inhaler well.
- Insert mouthpiece of the inhaler through the hole in the bottle or plastic cup
- The child should put the opening of the bottle into his mouth and breath in and out through the mouth.
- A carer then presses down the inhaler and sprays into the bottle while the child continues to breathnormally.
- Wait for three to four breaths and repeat.
- For younger children place the cup over the child's mouth and use as a spacer in the same way.

** If a spacer is being used for the first time, it should be primed by 4-5 extra puffs from the inhaler.*

Give Paracetamol for High Fever (>38.5^{0}C or more) or Ear pain

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

AGE or WEIGHT	PARACETAMOL	
	TABLET (100 mg)	**TABLET** (500 mg)
2 months up to 3 years (4 - <14 kg)	1	¼
3 years up to 5 years (14 - <19 kg)	1 ½	½

Give Oral Antimalarial for MALARIA

- Give the first dose of artemether-lumefantrine in the clinic and observe for one hour.
- If the child vomits within an hour repeat the dose.
- Give second dose at home after 8 hours.
- Then twice daily for further two days as shown below.
- Artemether-lumefantrine should be taken with food.

UNCOMPLICATED PLASMODIUM FALCIPARUM MALARIA

Artemether-Lumefantrine tablets
(20 mg artemether and 120 mg lumefantrine)
Give two times daily for 3 days

WEIGHT (age)	Day 1	Day 2	Day 3
5 - <10 kg (2 months up to 12 months)	1	1	1
10 - <14 kg (12 months up to 3 years)	1	1	1
14 - <19 kg (3 years up to 5 years)	2	2	2

Artisunate – Sulfadoxine-pyrimethamine tablets
(50 mg artisunate and 500 mg sulphadoxine+25mg pyrimethamine)
Give two times daily for 3 days

AGE	Day 1		Day 2	Day 3
	SP	ARTISUMATE	ARTISUMATE	ARTISUMATE
5 months up to 11 months)	½	½	½	½
12 months up to 6 years)	1	1	1	1

UNCOMPLICATED PLASMODIUM VIVAX MALARIA

WEIGHT (age)	CHLOROQUINE					
	TABLETS 150 mg base (250 mg salt)			SYRUP 50 mg base per 5 ml teaspoon full (TSF)		
	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3
5 - <10 kg (2 months up to 12 months)	¼	¼	¼	¾ TSF	¾ TSF	¾ TSF
10 - <14 kg (12 months up to 3 years)	1	1	1	¾ TSF	¾ TSF	¾ TSF

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Follow the instructions below for every oral drug to be given at home.

Also follow the instructions listed with each drug's dosage table

*Give Iron**

- Give one dose daily for 14 days.

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

* Children with severe acute malnutrition who are receiving ready-to-use therapeutic food (RUTF) should not be given Iron

GIVE VITAMIN A AND MEBENDAZOLE IN CLINIC

Explain to the mother why the drug is given

Determine the dose appropriate for the child's weight (or age)

Measure the dose accurately

Give Vitamin A Supplementation and Treatment

VITAMIN A SUPPLEMENTATION:

- Give first dose any time after 6 months of age to ALL CHILDREN
- Thereafter vitamin A **every six months** to ALL CHILDREN

VITAMIN A TREATMENT:

- Give an extra dose of Vitamin A (same dose as for supplementation) for ***treatment*** if the child has MEASLES or PERSISTENT DIARRHOEA. If the child has had a dose of vitamin A within the past month or is on RUTF for treatment of severe acute malnutrition, DO NOT GIVE VITAMIN A.
- Always record the dose of Vitamin A given on the child's card.

AGE or WEIGHT	
6 up to 12 months	100 000 IU
One year and older	200 000 IU

Give Pyrantel Pamoate

- FOR TREATMENT OF ANEMIA AND STOOL POSITIVE FOR WORMS
  - If the child is 2 years of age or older, and has not had a dose in the previous 6 months OR
  - If the child is 4 months of age or older and has evidence of worm infestation
- **GIVE PYRANTEL PAMOATE AS A SINGLE DOSE IN CLINIC**

AGE or WEIGHT	TABLET (125 mg)	TABLET (220 mg)
4 months up to 9 moths (6 - <8 kg)	½	¼
9 months up to 1 year (8 - <10 kg)	¾	½
1 year up to 3 years (10 - <14 kg)	1	½
3 years up to 5 years (14 – 19 kg)	1 ½	¾

Give Multivitamin / Mineral supplement

- For persistent diarrhea give 5 ml (one tea spoon full) once a day for 2 weeks

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 mothers understanding before she leaves the clinic.**

Soothe the Throat, Relieve the Cough with a Safe Remedy

- **Safe remedies to recommend:**
  - Breast milk for a breastfed infant.

  _____
  _____
- **Harmful remedies to discourage:**

  _____
  _____
  _____

Treat Eye Infection with Tetracycline Eye Ointment

- **Clean both eyes 4 times daily**.
  - Wash hands.
  - Use clean cloth and water to gently wipe away pus.
- **Then apply tetracycline eye ointment in both eyes 4 times daily.**
  - Squirt a small amount of ointment on the inside of the lower lid.
  - Wash hands again.
- **Treat until there is no pus discharge.**
- **Do not 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 or soft, strong tissue paper 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.
  - Instill quinolone eardrops after dry wicking three times daily for two weeks.

** Quinolone eardrops may include ciprofloxacin, norfloxacin, or ofloxacin.*

Treat for Mouth Ulcers with Gentian Violet (GV)

- **Treat for mouth ulcers twice daily.**
  - Wash hands.
  - Wash the child's mouth with clean soft cloth wrapped around the finger and wet with salt water.
  - Paint the mouth with half-strength gentian violet (0.25% dilution).
  - Wash hands again.
  - Continue using GV for 48 hours after the ulcers have been cured.
  - Give paracetamol for pain relief.

Treat Thrush with Nystatin

Treat thrush four times daily for 7 days

- Wash hands
- Wet a clean soft cloth with salt water and use it to wash the child's mouth
- Instill nystatin 1ml four times a day
- Avoid feeding for 20 minutes after medication
- If breastfed check mother's breasts for thrush. If present treat with nystatin
- Advise mother to wash breasts after feeds. If bottle fed advise change to cup and spoon
- Give paracetamol if needed for pain

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 Intramuscular Antibiotics

GIVE TO CHILDREN BEING REFERRED URGENTLY

- Give Ampicillin (50 mg/kg) and Gentamicin (7.5 mg/kg).

AMPICILLIN

- Dilute 500mg vial with 2.1ml of sterile water (500mg/2.5ml).
- IF REFERRAL IS NOT POSSIBLE OR DELAYED, repeat the ampicillin injection every 6 hours.
- **Where there is a strong suspicion of meningitis, the dose of ampicillin can be increased 4 times.**

GENTAMICIN

- 7.5 mg/kg/day once daily

AGE or WEIGHT	AMPICILLIN 500 mg vial	GENTAMICIN 2ml/40 mg/ml vial
2 up to 4 months (4 - <6 kg)	1 m	0.5-1.0 ml
4 up to 12 months (6 - <10 kg)	2 ml	1.1-1.8 ml
12 months up to 3 years (10 - <14 kg)	3 ml	1.9-2.7 ml
3 years up to 5 years (14 - 19 kg)	5 m	2.8-3.5 ml

Give Diazepam to Stop Convulsions

- Turn the child to his/her side and clear the airway. Avoid putting things in the mouth.
- Give 0.5mg/kg diazepam injection solution per rectum using a small syringe without a needle (like a tuberculin syringe) or using a catheter.
- Check for low blood sugar, then treat or prevent.
- Give oxygen and REFER
- If convulsions have not stopped after 10 minutes repeat diazepam dose

AGE or WEIGHT	DIAZEPAM 10mg/2mls
2 months up to 6 months (5 - 7 kg)	0.5 ml
6 months up to 12months (7 - <10 kg)	1.0 ml
12 months up to 3 years (10 - <14 kg)	1.5 ml
3 years up to 5 years (14-19 kg)	2.0 ml

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).
- 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 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 antimlarial as soon as the child is able to take orally.

  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 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.

  If low risk of malaria, do not give quinine to a child less than 4 months of age.

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)	300 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*

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 a breast-milk substitute.
  - If neither of these is available, give sugar water*.
  - Give 30 - 50 ml of milk or sugar water* before departure.
- **If the child is not able to swallow:**
  - Give 50 ml of milk or sugar water* by nasogastric tube.
  - If no nasogastric tube available, give 1 teaspoon of sugar moistened with 1-2 drops of water sublingually and repeat doses every 20 minutes to prevent relapse.
  - * *To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water.*

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

PLAN A: TREAT DIARRHOEA AT HOME

Counsel the mother on the 3 Rules of Home Treatment:
Give Extra Fluids, Continue Feeding, 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 breastmilk.
  - If the child is not exclusively breastfed, give one or more of the following: ORS , 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 young infant has been treated with Plan B or Plan C during this visit.*
- *the young infant cannot return to a clinic if the diarrhea 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 infant vomits, wait 10 minutes. Then continue, but more slowly.
- Continue giving extra fluid until the diarrhea stops.

1. ***GIVE EXTRA FLUID***
2. ***CONTINUE FEEDING***
3. ***WHEN TO RETURN***

See COUNSIL THE MOTHER chart

PLAN B: TREAT SOME DEHYDRATION WITH ORS

In the clinic, give recommended amount of ORS over 4-hour period
DETERMINE AMOUNT OF ORS TO GIVE DURING FIRST 4 HOURS

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

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

- If the child wants more ORS than shown, give more.
- For young infants who are not breastfed, also give 100 - 200 ml clean water during this period if you use standard ORS. This is not needed if you use new low osmolarity ORS.

SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.

- Give frequent small sips from a cup.
- If the child vomits, wait 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 3 Rules of Home Treatment:

4. ***GIVE EXTRA FLUID***
5. ***CONTINUE FEEDING***
6. ***WHEN TO RETURN***

See Plan A for recommended fluids
And
See COUNSIL THE MOTHER chart

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

(see food advise in COUNSIL THE MOTHER chart)

PLAN C: TREAT SEVERE DEHYDRATION QUICKLY

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

Can you give intravenous (IV) fluid immediately? — YES

START HERE

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.

NO

Is IV treatment available nearby (within 30 minutes)? — YES

- **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 nasogastric tube.

NO

Are you trained to use a nasogastric (NG) tube for rehydration? — YES

- **Start rehydration 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.

NO

Can the child drink? — YES

NO

Refer URGENTLY to hospital for IV or NG 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.

GIVE VITAMIN A SUPPLEMENTAION AS NEEDED

GIVE MEBENDAZOLE AS NEEDED

IMMUNIZE EVERY CHILD AS NEEDED

GIVE READY-TO-USE THERAPEUTIC FOOD

Give Ready-to-Use Therapeutic Food for SEVERE ACUTE MALNUTRITION

- Wash hands before giving the ready-to-use therapeutic food (RUTF).
- Sit with the child on the lap and gently offer the ready-to-use therapeutic food.
- Encourage the child to eat the RUTF without forced feeding.
- Give small regular meals of RUTF and encourage child to often eat 5-6 meals per day
- If still breastfeeding, continue by offering breast milk first before every RUTF feed.
- Give only the RUTF for at least two weeks, if breastfeeding continue to breast and gradually introduce foods recommended for the age (See Feeding recommendations in *COUNSEL THE MOTHER* chart).
- When introducing recommended foods, ensure that the child completes his daily ration of RUTF before giving other foods.
  Offer plenty of clean water, to drink from a cup, when the child is eating the ready-to-use therapeutic food**.**

Recommended Amounts of Ready-to-Use Therapeutic Food

CHILD'S WEIGHT (kg)	**Packets per day** (92 g Packets Containing 500 kcal)	**Packets per Week Supply**
4.0-4.9 kg	2.0	14
5.0-6.9 kg	2.5	18
7.0-8.4 kg	3.0	21
8.5-9.4 kg	3.5	25
9.5-10.4 kg	4.0	28
10.5-11.9 kg	4.5	32
>12.0 kg	5.0	35

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 tree 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 edema of both feet AND has developed a medical complication or edema, 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 edema 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 child every 14 days until 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.

COUNSEL THE MOTHER

FEEDING COUNSELLING

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**

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?

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FEEDIMG RECOMMENDTIONS DURING ILLNESS AND HEALTH

Up to 6 Months of Age

Breast feed as often as the child wants day and night at least 8 times in 24 hours.

Breast feed at least for 10 minutes on each breast every time

Do not give other foods water.

Do not use bottles or pacifiers

6 Months up to 12 Months

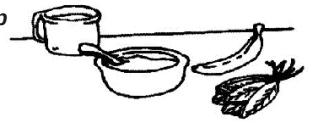
Breast feed as often as the child wants

Give adequate servings of:

Khichri* ,Rice (Bhatt)* with seasonal vegetables (Carrot, Spinach ,Potatoes etc.), or Minced Meat. Rice Kheer, Suji ka Halwa or Kheer*, Dalia*, Vermicellis'*, Choori*, Mashed Potato or vegetables* ,Egg, Banana

And others Seasonal fruits (upto 9 months food should be mashed)

- ***3 times per day if breastfed;***
- ***5 times per day if not breastfed.***
- ***Each serving should be equivalent to 1/2-3/4 or a cup***



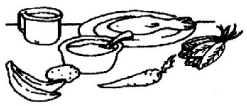
12 Months up to 2 Years

Breast feed as often as the child wants

Give adequate servings of:

Roti, Parattha, Khichri or Rice, Curry, Minced Meat, Chicken ,Egg, Seasonal Vegetables, Choori, Vermicellis', and/or any foods listed for 6-12 months child

Give food at least 3 times per day AND Give also snacks 2 times per day between meals such as seasonal fruit (Banana, Apple, Mango, Orange etc.) Biscuit ,home made Pakora or Samosa, Lassi, Yoghurt ,Bread with Egg, Halwa etc.



2 Years and Older

Give family foods at Least 3 meals each day. ***Also, twice daily, give nutritious food between meals, such as: Seasonal fruit (Banana, Apple, Mango, Orange etc.) Biscuit ,Rusk, Chips, Pakora, Samosa, Lassi, Yoghurt ,Bread with Eggs, Halwa etc.***

Wash your hands before preparing the child's food and use clean cooking utensils.

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

Feeding Recommendations For a Child Who Has PERSISTENT DIARRHOEA

If still breast feeding ,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 COUNSELLING

Stopping Breastfeeding

STOPPING BREASTFEEDING means changing from all breast milk to no breast milk.

This should happen gradually over one month. Plan in advance for a safe transition.

1. **HELP MOTHER PREPARE**:
   - Mother should discuss and plan in advance with her family, if possible
   - Express milk and give by cup
   - Find a regular supply or formula or other milk
   - Learn how to prepare a store milk safely at home
2. **HELP MOTHER MAKE TRANSITION:**
   - Teach mother to cup feed (See chart booklet Counsel part in Assess, classify and treat the sick young infant aged up to 2 months)
   - Clean all utensils with soap and water
   - Start giving formula or cow's milk once baby takes all the feeds by cup

STOP BREASTFEEDING COMPLETELY:

- Express and discard enough breast milk to keep comfortable until lactation stops

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.

EXTRA FLUIDS AND MOTHER'S HEALTH

Advise the Mother to Increase Fluid During Illness

FOR ANY SICK CHILD:

- Breastfeed more frequently and for longer at each feed. If child is taking breast-milk substitutes, increase the amount of milk given.
- Increase other fluids. For example, give soup, rice water, yoghurt drinks or clean water.

FOR CHILD WITH DIARRHOEA:

- Giving extra fluid can be lifesaving.
- Give fluid according to Plan A or Plan B on *TREAT THE CHILD* chart.

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.
- Check the mother's immunization status and give her tetanus toxoid if needed.

  Make sure she has access to:

  - Family planning
  - Counselling on STD and AIDS prevention.

WHEN TO RETURN

Advise the Mother When to Return to 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 ▪ MALARIA, if fever persists ▪ FEVER: NO MALARIA, if fever persists ▪ MEASLES WITH EYE OR MOUTH ▪ COMPLICATIONS ▪ MOUTH OR GUM ULCERS OR THRUSH	3 days after treatment
▪ PERSISTENT DIARRHOEA ▪ ACUTE EAR INFECTION ▪ CHRONIC EAR INFECTION ▪ COUGH OR COLD, if not improving	5 days after treatment
▪ UNCOMPLICATED SEVERE ACUTE MALNUTRITION ▪ FEEDING PROBLEM	14 days after treatment
▪ ANAEMIA	14 days after treatment
▪ MODERATE ACUTE MALNUTRITION	30 days after treatment
NEXT WELL-CHILD VISIT: Advise the mother to return for next immunization according to immunization schedule	

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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 COUGH OR COLD, also return if:	▪ Fast breathing ▪ Difficult breathing
If child has diarrhea, also return if:	▪ Blood in stool Drinking poorly

ASSESS, CLASSIFY AND TREAT THE SICK YOUNG INFANT AGE UP TO 2 MONTHS

DO A RAPID APRAISAL 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 young infant as follows:

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

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

ASK:

- Is the infant having difficulty in feeding?
- Has the infant had convulsions (fits)?

LOOK AND FEEL:

- Count the breaths in one minute.
  Repeat the count if 60 or more breaths per minute.
  } YOUNG INFANT MUST BE CALM
- Look for severe chest indrawing
- Measure axillary temperature.
- Look at the young infant's movements. *If infant is sleeping, ask the mother to wake him/her*.
  - Does the infant move on his/her own? *If the infant is not moving, gently stimulate him/her*.
  - Does the infant move only when stimulated but then stops?
  - Does the infant not move at all?
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules.

Classify ALL YOUNG INFANTS

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
Any one or more of the following signs: • Not able to feed since birth, stopped feeding well or not feeding at all or • Convulsions or • Severe chest indrawing or • Fever (38°C* or above) or • Low body temperature (less than 35.5°C*) or • Movement only when stimulated or no movement at all, or • Fast breathing (60 breaths per minute or more) in infants less than 7 days old	**POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE**	➢ ***Give first dose of intramuscular antibiotic.*** ➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.***** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.*** ➢ ***If referral is refused or not possible, further assess and classify the young infant (as on page 39) and treat accordingly.***
• Fast breathing (60 breaths per minute or more) in infants 7 to 59 days old	**PNEUMONIA**	➢ Give amoxicillin for 7 days. ➢ Advise mother to give home care for the young infant. ➢ Follow up on day 4 of treatment. ➢ Also treat per any other
• Umbilicus red or draining pus • Skin pustules	**LOCAL INFECTION**	➢ Give amoxicillin for 5 days. ➢ Teach mother to treat local infections at home. ➢ Advise mother to give home care for the young infant. ➢ Follow up on day 3.
• No signs of bacterial infection or very severe disease	**SEVERE DISEASE OR INFECTION UNLIKELY**	➢ Advise mother to give home care for the young infant.

* *These thresholds are based on axillary temperature.*
** *If referral is refused or not possible, see page 12.*

THEN CHECK FOR JAUNDICE

ASK:

- When did jaundice first appear?

LOOK AND FEEL:

- Look for jaundice (yellow skin).
- Look at the young infant's palms and soles. Are they yellow?

Classify JAUNDICE

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
• Any jaundice if age less than 24 hours or • Yellow palms or soles at any age	**SEVERE JAUNDICE**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.***
• Jaundice appearing after 24 hours of age and • Palms or soles not yellow	**JAUNDICE**	➢ Advise the mother to give home care for the young infant. ➢ Advise mother to return immediately if palms or soles appear yellow. ➢ If the young infant is older than 3 weeks, refer to a hospital for assessment. ➢ Follow-up on day 2.
• No jaundice	**NO JAUNDICE**	➢ Advise the mother to give home care for the young infant.

THEN ASK: Does the young infant have diarrhoea*?

IF YES, LOOK AND FEEL:

- Look at the young infant's general condition:

  Infant's movements
  - Does the infant move on his/her own?
  - Does the infant move only when stimulated but then stops?
  - Does the infant not move at all?

  - 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

SIGNS	CLASSIFY	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
Two of the following signs: • Movement only when stimulated or no movement at all • Sunken eyes • Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	➢ ***If infant has no other severe classification:*** ***- Follow Plan C to treat severe dehydration quickly. Start IV fluid immediately, or refer urgently for IV fluid. If that is not possible, start rehydration by NG tube.*** OR ➢ ***If infant also has another severe classification:*** ***- Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way.*** ***- Advise mother to continue breastfeeding.*** ➢ ***Teach the mother how to keep the infant warm on the way to the hospital.***
Two of the following signs: • Restless and irritable • Sunken eyes • Skin pinch goes back slowly.	**SOME DEHYDRATION**	➢ Give fluid and breast milk for some dehydration (Plan B). OR ➢ ***If infant also has another severe classification:*** ***- Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way.*** ***- Advise mother to continue breastfeeding.*** ➢ Advise mother when to return immediately ➢ Follow-up on day 3 if not improving
• Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	➢ Give fluids and breastmilk to treat for diarrhoea at home (Plan A) ➢ Advise mother when to return immediately

* ***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.

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN BREASTFED INFANTS

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 AND FEEL:

- Determine weight for age.
  - Weight less than 1.5 kg?
  - Weight for age less than -3 Z score?
- Look for ulcers or white patches in the mouth (thrush).

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 well attached?

not well attached *good attachment*

TO CHECK ATTACHMENT, LOOK FOR:

- *More areola seen above infant's top lip than below bottom lip*
- *Mouth wide open*
- *Lower lip turned outwards*
- *Chin touching breast*

(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

SIGNS	CLASSIFY	IDENTIFY TREATMENT
• Weight < 1.5 kg, or • Weight < -3 Z score	**VERY LOW WEIGHT**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother to keep the young infant warm on the way to hospital.***
• Not well attached to breast or • Not suckling effectively, or • Less than 8 breastfeeds in 24 hours, or • Receives other foods or drinks, or • Low weight for age, or • Thrush (ulcers or white patches in mouth)	**FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	➢ If not well attached or not suckling effectively, teach correct positioning and attachment. • If not able to attach well immediately, teach the mother to express breast milk and feed by a cup ➢ If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Advise her to breastfeed as often and for as long as the infant wants, day and night. ➢ If receiving other foods or drinks, counsel 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. - Advise about correctly preparing breast-milk substitutes and using a cup. ➢ Advise the mother how to feed and keep the low weight infant warm at home ➢ If thrush, teach the mother to treat thrush at home. ➢ Advise mother to give home care for the young infant. ➢ Follow up FEEDING PROBLEM or thrush on day 3. ➢ Follow up LOW WEIGHT FOR AGE on day 14.
• Not low weight for age and no other signs of inadequate feeding	**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 FOR AGE IN INFANTS RECEIVING NO BREASTMILK

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.
- How is the milk being given? Cup or bottle?
- How are you cleaning the feeding utensils?
- Are you giving any breastmilk at all?
- What foods and fluids in addition to replacement feeds are given?

LOOK, LISTEN, FEEL:

- Determine the weight for age.
  - Weight less than 1.5 kg?
  - Weight for age less than -3 Z score?
- Look for ulcers or white patches in the mouth (thrush).

Classify FEEDING

SIGNS	CLASSIFY	IDENTIFY TREATMENT
• Weight < 1.5 kg, or • Weight < –3 Z score	**VERY LOW WEIGHT**	➢ ***Treat to prevent low blood sugar.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***Teach the mother to keep the young infant warm on the way to the hospital.***
• Giving inappropriate replacement feeds, or • Giving insufficient replacement feeds, or • Milk incorrectly or unhygienically prepared, or • Using a feeding bottle, or • An HIV positive mother mixing breastmilk and other feeds before 6 months, or • Low weight for age, or • Thrush	**FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	➢ Counsel about feeding ➢ Explain the guidelines for safe replacement feeding ➢ Identify concerns of mother and family about feeding. ➢ If mother is using a bottle, teach cup feeding. ➢ If thrush, teach the mother to treat it at home. ➢ Follow-up FEEDING PROBLEM or thrush on day 3. ➢ Follow up LOW WEIGHT FOR AGE on day 7.
• Not low weight for age and no other signs of inadequate feeding	**NO FEEDING PROBLEM**	➢ Advise mother to continue feeding, and ensure good hygiene ➢ Praise the mother for feeding the infant well

THEN CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS:

	AGE	VACCINES*			
IMMUNIZATION SCHEDULE:	**Birth**	BCG** Hep B0	OPV0		
	6 weeks	DPT+HIB-1+Hep B1	OPV-1	Rotavirus-1	Pneumococcal conjugate vaccine (PCV) 1
	10 weeks	DPT+HIB-2+Hep B2	OPV-2	Rotavirus-2	Pneumococcal conjugate vaccine (PCV) 2

* Vaccines should be provided in line with the national immunization policy
** Young infants who are HIV positive or unknown HIV status with symptoms consistent with HIV should not be given BCG

- **Give all missed doses on this visit.**
- Immunize sick infants unless being referred.
- Advise the caretaker when to return for the next dose.

ASSESS OTHER PROBLEMS

TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

IF THE YOUNG INFANT IS CLASSIFIED AS POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE, GIVE PRE-REFERRAL TREATMENTS AND REFER URGENTLY

1. Give First Doses of Intramuscular Gentamicin and Oral Amoxicillin

Gentamicin: Desired range is 5–7.5 mg/kg/day in once daily injection. In low birth weight infants, give 3–4 mg/kg/day in once daily injection. To prepare the injection**:** From a 2 ml vial containing 40 mg/ml, remove 1 ml gentamicin from the vial and add 1 ml distilled water to make the required strength of 20 mg/ml.

Amoxicillin: Desired range is 75 to 100 mg/kg/day divided into 2 oral doses. Give first dose pre-referral if young infant can swallow.

WEIGHT	**Gentamicin** (strength 20 mg/ml) Per dose	**Amoxicillin** Dispersible tablet (250 mg) Per dose	**Amoxicillin** Dispersible tablet (125 mg) per dose	**Amoxicillin** Syrup (125 mg in 5 ml) Per dose
1.5 to 2.4 kg	**0.4 ml**	**1/2 tablet**	**1 tablet**	**5 ml**
2.5 to 3.9 kg	**0.8ml**	**1/2 tablet**	**1 tablet**	**5 ml**
4.0 to 5.9 kg	**1.2 ml**	**1 tablet**	**2 tablets**	**10 ml**

2. Treat the Young Infant 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) expressed breastmilk before departure. If not possible to give expressed breastmilk, give 20–50 ml (10 ml/kg) sugar water. ***(To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water.)***
- ***If the young infant is not able to swallow:***
  Give 20–50 ml (10 ml/kg) of expressed breastmilk or sugar water by nasogastric tube.

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

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

4. Refer Urgently

- **Write a referral note for the mother to take to the hospital.**
- ***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.

  Advise mother to continue breastfeeding.

TREAT THE YOUNG INFANT WITH SEVERE DEHYDRATION QUICKLY WITH PLAN C

Follow the arrows. If answer is Yes, go across. If No, go down.

Can you give intravenous (IV) fluid immediately?

YES →

- **Start IV fluid immediately.**
- If the young infant 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

- **Reassess the young infant 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 young infant can drink: usually after 3–4 hours.
- Reassess a young infant after 6 hours. Classify dehydration. Then choose the appropriate plan (A, B or C) to continue treatment.

NO ↓

Is IV treatment available nearby (within 30 minutes)?

YES →

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

NO ↓

Are you trained to use a nasogastric (NG) tube for rehydration?

YES →

NO ↓

Can the young infant drink?

YES →

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

NO ↓

Refer URGENTLY to hospital for IV or NG treatment.

NOTE:

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

WHERE REFERRAL IS REFUSED OR NOT POSSIBLE, FURTHER ASSESS AND CLASSIFY THE SICK YOUNG INFANT WITH POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE

Asses	Classify	Identify Treatment
Young infant has any one of the following: • Convulsions • Unable to feed at all • No movement on stimulation • Unable to cry • Bulging fontanelle • Cyanosis	**CRITICAL ILLNESS**	➢ ***Give first dose of both ampicillin and gentamicin intramuscularly.*** ➢ ***Explain to the caregiver that the infant is very sick and needs urgent referral for hospital care.*** ➢ ***Treat to prevent low blood sugar.*** ➢ ***Teach the mother how to keep the young infant warm on the way to the hospital.*** ➢ ***Refer URGENTLY to hospital.*** ➢ ***If referral is still not possible, continue treatment with daily IM gentamicin and twice-daily IM ampicillin until referral is possible (up to 7 days).***

Young infant has any one of the following:
• Not feeding well on observation
• Temperature 38ºC or more
• Temperature less than 35.5º C
• Severe chest indrawing
• Movement only when stimulated
	CLINICAL SEVERE INFECTION	➢ ***Explain to the caregiver that the infant is very sick and needs urgent referral for hospital care.***
		➢ ***Treat to prevent low blood sugar.***
		➢ ***Teach the mother how to keep the young infant warm on the way to the hospital.***
		➢ ***Refer URGENTLY to hospital.***
		➢ ***If referral still is not possible,***
		  ➢ Treat at outpatient clinic with daily intramuscular gentamicin*.
		  ➢ Give oral amoxicillin for 7 days.
		  ➢ Teach the mother how to give the oral amoxicillin twice daily.
		  ➢ Advise mother to return for the next injection tomorrow.
		  ➢ Treat also for any other classifications that the young infant has.
		  ➢ Reassess the young infant at each visit (see Follow-up Care, p. 22).

Young infant has: • Fast breathing (60 breaths per minute or more) in infants <u>less than 7 days old</u>**	**SEVERE PNEUMONIA**	➢ Give oral amoxicillin for 7 days. ➢ Teach the mother how to give the oral amoxicillin twice daily. ➢ Treat also for any other classifications that the young infant has. ➢ Advise the mother to return for follow up on day 4.

*Countries may decide to treat with IM gentamicin for 7 days or 2 days. If a country chooses 2 days, then there is a mandatory follow-up visit on day 4.

**Note that a young infant <u>7-59 days old</u> having fast breathing (60 breaths per minute or more) does NOT need to be referred; treat at outpatient clinic with oral amoxicillin.

WHERE REFERRAL IS REFUSED OR NOT POSSIBLE, TREAT THE YOUNG INFANT WHO HAS CLINICAL SEVERE INFECTION WITH IM GENTAMICIN AND ORAL AMOXICILLIN

➢ *Give Intramuscular Gentamicin to Young Infants with CLINICAL SEVERE INFECTION where Referral is Refused or Not Possible*

- Desired range is 5–7.5 mg/kg/day in once daily injection. In low birth weight infants, give 3–4 mg/kg/day in once daily injection.
- **Option 1:** Treat for 7 days. **Option 2:** Treat for 2 days. Option to be decided in the process of country adaptation.
- **Preparation**: From a 2 ml vial containing 40mg/ml, remove 1 ml gentamicin from the vial and add 1 ml distilled water to make the required strength of 20 mg/ml.

	GENTAMICIN (Strength 20 mg/ml)
WEIGHT	**Amount per dose**
1.5 to 2.4 kg	**0.4 ml**
2.5 to 3.9 kg	**0.8 ml**
4.0 to 5.9 kg	**1.2 ml**

➢ Ask the mother to bring back the young infant for the next injection tomorrow.

➢ *Give Oral Amoxicillin where Referral is Refused or Not Possible*

- **To young infants with CLINICAL SEVERE INFECTION**
- **To young infants <u>less than 7 days old</u> with SEVERE PNEUMONIA (fast breathing alone)**

	AMOXICILLIN Desired range is 75 to 100 mg/kg/day divided into 2 daily oral doses **Give twice daily for 7 days**		
WEIGHT	**Dispersible tablet (250 mg) Per dose**	**Dispersible tablet (125 mg) per dose**	**Syrup (125 mg in 5 ml) Per dose**
1.5 to 2.4 kg	**1/2 tablet**	**1 tablet**	**5 ml**
2.5 to 3.9 kg	**1/2 tablet**	**1 tablet**	**5 ml**
4.0 to 5.9 kg	**1 tablet**	**2 tablets**	**10 ml**

➢ Teach the mother how to give oral medicines at home (page 15).

GIVE PRE-REFERRAL TREATMENT TO THE YOUNG INFANT WHO HAS CRITICAL ILLNESS AND REFER URGENTLY TO HOSPITAL

➢ *Give First Doses of IM Gentamicin and IM Ampicillin to Young Infants with CRITICAL ILLNESS and Refer Urgently to Hospital**

GENTAMICIN: Desired range is 5–7.5 mg/kg/day in once daily injection. In low birth weight infants, give 3–4 mg/kg/day in once daily injection.

- **Preparation**: From a 2 ml vial containing 40 mg/ml, remove 1 ml gentamicin from the vial and add 1 ml distilled water to make the required strength of 20 mg/ml.

AMPICILLIN: Desired dose is 50 mg per kg given twice daily.

- **Preparation**: To a vial of 250 mg, add 1.3 ml sterile water = 250 mg/1.5 ml.

	GENTAMICIN (Strength 20 mg/ml)	**AMPICILLIN** (Strength 250 mg/1.5 ml)
WEIGHT	**Amount per dose**	**Amount per dose**
1.5 to 2.4 kg	**0.4 ml**	**0.8 ml**
2.5 to 3.9 kg	**0.8 ml**	**1.2 ml**
4.0 to 5.9 kg	**1.2 ml**	**1.5 ml**

* If after additional counselling and problem solving, referral is still not possible, administer intramuscular gentamicin once daily AND intramuscular ampicillin twice daily until referral becomes possible, up to 7 days.

TREAT THE YOUNG INFANT

➢ *Teach the Mother to Give Oral Medicines at Home*

Follow the instructions below to teach the mother about each oral medicine to be given at home. Also follow the instructions listed with each medicine's dosage table.

- Determine the appropriate medicines and dosage for the infant's age or weight.
- Tell the mother the reason for giving the medicine to the infant.
- Demonstrate how to measure a dose.
- Watch the mother practice measuring a dose by herself.
- Ask the mother to give the first dose to her infant.
- Explain carefully how to give the medicine, then label and package the medicine.
- If more than one medicine will be given, collect, count and package each medicine separately.
- Explain that all the 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 Oral Amoxicillin*

- **Local Infection:** Give oral amoxicillin twice daily for 5 days
- **Pneumonia (fast breathing alone) in infant 7–59 days old:** Give oral amoxicillin twice daily for 7 days

	AMOXICILLIN Desired range is 75 to 100 mg/kg/day divided into 2 daily oral doses **Give twice daily**		
WEIGHT	**Dispersible Tablet (250 mg) Per dose**	**Dispersible Tablet (125 mg) Per dose**	**Syrup (125 mg in 5 ml) Per dose**
1.5 to 2.4 kg	**1/2 tablet**	**1 tablet**	**5 ml**
2.5 to 3.9 kg	**1/2 tablet**	**1 tablet**	**5 ml**
4.0 to 5.9 kg	**1 tablet**	**2 tablets**	**10 ml**

TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

➢ *Teach the Mother How to Treat Local Infections at Home*

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

To Treat Skin Pustules or Umbilical 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 again

To Treat Thrush (ulcers or white patches in mouth)

The mother should do the treatment 4 times daily for 7 days:

- Wash hands
- Paint the mouth with half-strength gentian violet (0.25%) using a clean soft cloth wrapped around the finger
- Wash hands again

➢ *Immunize Every Sick Young Infant, as needed.*

TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

➢ *To Treat the Young Infant with Diarrhoea, Give Extra Fluids and Continue Feeding*

If the young infant has NO DEHYDRATION, use Plan A. If the young infant has SOME DEHYDRATION, use Plan B.

PLAN A: TREAT DIARRHOEA AT HOME

Counsel the mother on the Rules of Home Treatment for Young Infant:

1. Give Extra Fluids
2. When to Return

1. ***GIVE EXTRA FLUID*** **(as much as the young infant will take)**

TELL THE MOTHER:

- **Breastfeed frequently and for longer at each feed.**
- Also give ORS or clean water in addition to breastmilk.

It is especially important to give ORS at home when:

- *the young infant has been treated with Plan B or Plan C during this visit.*
- *the young infant 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

Tell the mother to:

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

2. WHEN TO RETURN

PLAN B: TREAT SOME DEHYDRATION WITH ORS

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**
AGE*	**Up to 4 months**
ORS	200 – 450 ml

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

- If the young infant wants more ORS than shown, give more.
- For young infants who are not breastfed, also give 100 - 200 ml clean water during this period if you use standard ORS. This is not needed if you use new low osmolarity ORS.

SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.

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

AFTER 4 HOURS:

- Reassess the young infant and classify the infant for dehydration.
- Select the appropriate plan to continue treatment.
- **Begin breastfeeding the young infant 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 Rules of Home Treatment for Young Infant:

1. GIVE EXTRA FLUIDS. Breastfeed frequently and for longer at each feed.
2. WHEN TO RETURN

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 in line
  - with the infant approaching breast with nose opposite to the nipple
  - with the infant held close to the mother's body
  - with the infant's whole body supported, not just neck and shoulders.
- Show her how to help the infant to attach. She should:
  - touch her infant's lips with her nipple
  - wait until her infant's mouth is opening wide
  - move her infant quickly onto her breast, aiming the infant's lower lip well below the nipple.
- Look for signs of good attachment and effective suckling. If the attachment or suckling is not good, try again.

➢ *Teach the Mother How to Feed by a Cup*

- Put a cloth on the infant's front to protect his clothes as some milk can spill
- Hold the infant semi-upright on the lap.
- Put a measured amount of milk in the cup.
- Hold the cup so that it rests lightly on the infant's lower lip.
- Tip the cup so that the milk just reaches the infant's lips.
- Allow the infant to take the milk himself. DO NOT pour the milk into the infant's mouth.

Teach the Mother How to Express Breastmilk

Ask the mother to:

- Wash her hands thoroughly.
- Make herself comfortable.
- Hold a wide necked container under her nipple and areola.
- Place her thumb on top of the breast and the first finger on the underside of the breast so they are opposite each other (at least 4 cm from the tip of the nipple).
- Compress and release the breast tissue between her finger and thumb a few times.
- If the milk does not appear, she should re-position her thumb and finger closer to the nipple and compress and release the breast as before.
- Compress and release all the way around the breast, keeping her fingers the same distance from the nipple. Be careful not to squeeze the nipple or to rub the skin or move her thumb or finger on the skin.
- Express one breast until the milk just drips, then express the other breast until the milk just drips.
- Alternate between breasts 5 or 6 times, for at least 20 to 30 minutes.
- Stop expressing when the milk no longer flows but drips from the start.

COUNSEL THE MOTHER

➢ *Teach the Mother How to Keep the Low Weight Infant Warm at Home*

- Keep the young infant in the same bed with the mother.
- Keep the room warm (at least 25°C) with home heating device and make sure that there is no draught of cold air.
- Avoid bathing the low weight infant. When washing or bathing, do it in a very warm room with warm water, dry immediately and thoroughly after bathing and clothe the young infant immediately.
- Change clothes (e.g. nappies) whenever they are wet.
- Provide skin to skin contact as much as possible, day and night. For skin to skin contact:
  - Dress the infant in a warm shirt open at the front, a nappy, hat and socks.
  - Place the infant in skin to skin contact on the mother's chest between the mother's breasts. Keep the infant's head turned to one side.
  - Cover the infant with mother's clothes (and an additional warm blanket in cold weather).
- When not in skin to skin contact, keep the young infant clothed or covered as much as possible at all times. Dress the young infant with extra clothing including hat and socks, loosely wrap the young infant in a soft dry cloth and cover with a blanket.
- Check frequently if the hands and feet are warm. If cold, re-warm the baby using skin to skin contact.
- Breastfeed the infant frequently (or give expressed breastmilk by cup).

COUNSEL THE MOTHER

➢ Advise the Mother to Give Home Care for the Young Infant

1. **EXCLUSIVELY BREASTFEED THE YOUNG INFANT (for breastfeeding mothers)**
   - Give only breastfeeds to the young infant.
   - Breastfeed frequently, as often and for as long as the infant wants, day or night, during sickness and 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 dress the infant with extra clothing.
3. **WHEN TO RETURN:**

Follow up visit	
If the infant has:	**Return for first follow-up on:**
• JAUNDICE	Day 2 of treatment
• DIARRHOEA • FEEDING PROBLEM • THRUSH • LOCAL INFECTION	Day 3 of treatment
• PNEUMONIA • SEVERE PNEUMONIA where referral is refused or not possible	Day 4 of treatment
• LOW WEIGHT FOR AGE in infant receiving no breastmilk	Day 7 of treatment
• LOW WEIGHT FOR AGE in breastfed infant	Day 14 of treatment

WHEN TO RETURN IMMEDIATELY:

Advise the caretaker to return immediately if the young infant has any of these signs:
➢ Breastfeeding poorly ➢ Reduced activity ➢ Becomes sicker ➢ Develops a fever ➢ Feels unusually cold ➢ Develops fast breathing ➢ Develops difficult breathing ➢ Palms or soles appear yellow

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

➢ *CLINICAL SEVERE INFECTION where REFERRAL WAS REFUSED OR NOT POSSIBLE*

- ➢ Follow up at the next contact for injection (day 2) and on day 4 of treatment.
- ➢ At each contact, reassess the young infant as on page 12.
- ➢ ***Refer*** young infant if:
  - Infant **becomes worse** after treatment is started or
  - Any **new sign of CLINICAL SEVERE INFECTION appears** while on treatment or
  - Any **sign of CLINICAL SEVERE INFECTION is still present** after day 8 of treatment or
  - If **no improvement on day 4** after 3 full days of treatment.
- ➢ If the young infant is improving, complete the 2 days treatment with IM gentamicin. Ask the mother to continue giving the oral amoxicillin twice daily until all the tablets are finished.

➢ *PNEUMONIA or SEVERE PNEUMONIA*

- ➢ Follow up on day 4 of treatment.
- ➢ Reassess the young infant for POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE, PNEUMONIA AND LOCAL INFECTION as on page 2.
- ➢ ***Refer*** young infant if:
  - Infant **becomes worse** after treatment is started or
  - Any **new sign of 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 4 more days.
- ➢ Young infants with fast breathing alone should be checked as often as possible but it is mandatory to do so on day 4 of treatment.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

➢ *LOCAL INFECTION*

On day 3 of treatment:

- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules.

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.
- If skin pustules are ***same or worse***, refer to hospital. If ***improved***, tell the mother to continue giving the 5 days of antibiotic and continue treating the local infection at home.

➢ *JAUNDICE*

On day 2: LOOK for jaundice. Are palms or soles yellow?

- If **palms or soles are yellow**, refer to hospital.
- If palms or soles are not yellow, but jaundice **has not decreased**, advise the mother about home care and ask her to return for follow up again tomorrow.
- If jaundice has **started decreasing**, reassure the mother and ask her to continue home care. Ask her to return for follow up at 3 weeks of age.

After 3 weeks of age: If **jaundice continues beyond 3 weeks age**, refer the young infant to hospital for further assessment.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

➢ *DIARRHOEA*

On day 3, ASK: Has the diarrhea stopped?

- If the diarrhea has **not stopped**, assess and treat the young infant for diarrhea (see page 4)
- If the diarrhea has **stopped**, tell the mother to continue exclusive breastfeeding.

➢ *FEEDING PROBLEM*

On day 3:

Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" above (page 6 or 7).
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, ask the mother to return 14 days after the initial visit to measure the young infant's weight gain.

Exception:
If you do not think that feeding will improve, or if the young infant has ***lost weight***, refer to HOSPITAL.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

➢ *LOW WEIGHT FOR AGE*

On day 14 (or on day 7 if the infant is receiving no breastmilk):

Weigh the young infant and determine if the infant is still low weight for age.
Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" on page 6 or 7.

- 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.
- 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 or is no longer low weight for age.

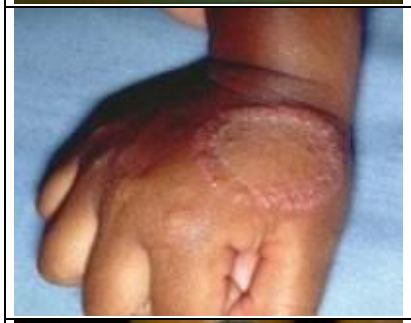
Exception:
If you do not think that feeding will improve, or if the young infant has ***lost weight***, refer to hospital.

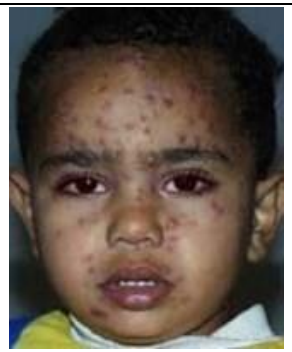
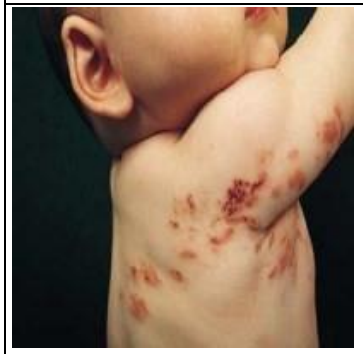
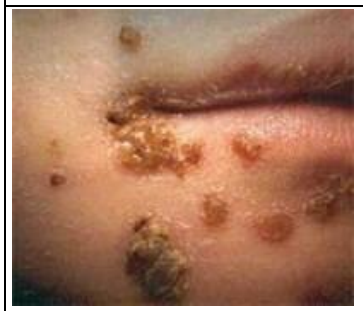
➢ *THRUSH*

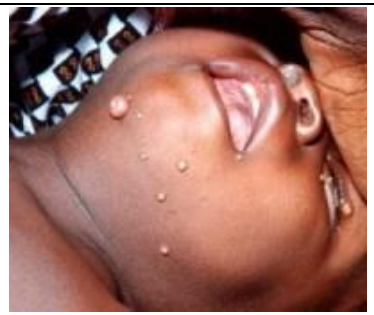
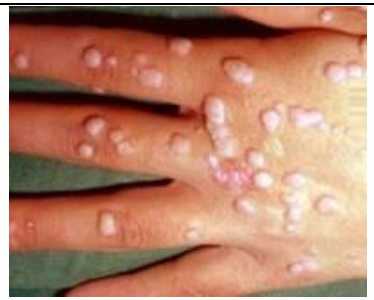
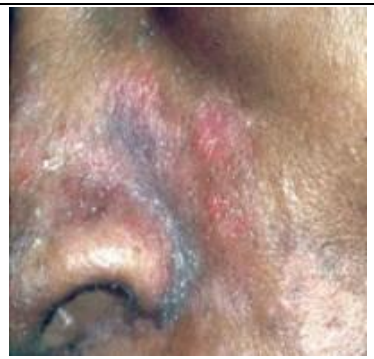
On day 3 of treatment:
Look for ulcers or white patches in the mouth (thrush).
Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" (page 6 or 7).

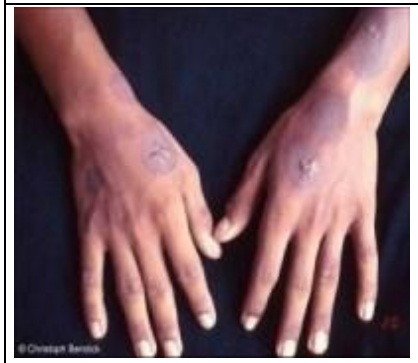
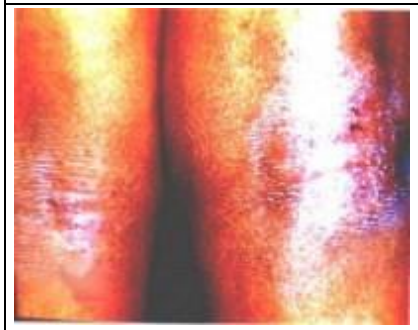
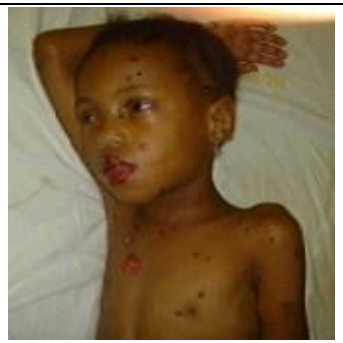
- If ***thrush is worse***, or the infant has ***problems with attachment or suckling***, refer to hospital.
- If ***thrush is the same or better***, and if the infant is ***feeding well***, continue half-strength gentian violet for a total of 7 days.

Annex: IDENTIFY SKIN PROBLEM

IF SKIN IS ITCHING	SIGNS	CLASSIFY AS:	TREATMENT	UNIQUE FEATURES IN HIV
	Itching rash with small papules and scratch marks. Dark spots with pale centres	**PAPULAR ITCHING RASH (PRURIGO)**	**Treat itching:** ■ Calamine lotion ■ Antihistamine oral ■ If not improves 1% hydrocortisone Can be early sign of HIV and needs assessment for HIV	**Is a clinical stage 2 defining case**
	An itchy circular lesion with a raised edge and fine scaly area in the centre with loss of hair. May also be found on body or web on feet	**RINGWORM (TINEA)**	Whitfield ointment or other antifungal cream if few patches If extensive refer, if not give: Ketoconazole for 2 up to 12 months(6-10 kg) 40mg per ■ day for 12 months up to 5 years give 60 mg per ■ day or give griseofulvin 10mg/kg/day if in hair shave hair treat itching as above	Extensive: There is a high incidence of co existing nail infection which has to be treated adequately to prevent recurrence of tinea infections of skin. **Fungal nail infection is a clinical stage 2 defining disease**
	Rash and excoriations on torso; burrows in web space and wrists. face spared	**SCABIES**	Treat itching as above manage with anti scabies: 25% topical Benzyl Benzoate at night, repeat for 3 days after washing and or 1% lindane cream or lotion once wash off after 12 hours	In HIV positive individuals scabies may manifest as crust scabies. Crusted scabies presents as extensive areas of crusting mainly on the scalp, face back and feet. Patients may not complain of itching. The scales will teeming with mites

IF SKIN HAS BLISTERS/SORES/PUSTULES	**SIGNS**	**CLASSIFY AS:**	**TREATMENT**	**UNIQUE FEATURES IN HIV**
	Vesicles over body. Vesicles appear progressively over days and form scabs after they rupture	**CHIKEN POX**	Treat itching as above Refer URGENTLY if pneumonia or jaundice appear	Presentation atypical only if child is immunocompromised Duration of disease longer Complications more frequent Chronic infection with continued appearance of new lesions for >1 month; typical vesicles evolve into nonhealing ulcers that become necrotic, crusted, and hyperkeratotic.
	Vesicles in one area on one side of body with intense pain or scars plus shooting pain. Herpes zoster is uncommon in children except where they are immuno-compromised, for example if infected with HIV	**HERPES ZOSTER**	▪ Keep lesions clean and dry. Use local antiseptic ▪ If eye involved give acyclovir 20 mg /kg 4 times daily for 5 days ▪ Give pain relief ▪ Follow-up in 7 days	Duration of disease longer Haemorrhagic vesicles, necrotic ulceration Rarely recurrent, disseminated or multi-dermatomal **Is a Clinical stage 2 defining disease**
	Red, tender, warm crusts or small lesions	**IMPETIGO OR FOLLICULITIS**	Clean sores with antiseptic Drain pus if fluctuant Start cloxacillin if size >4cm or red streaks or tender nodes or multiple abscesses for 5 days (25-50 mg/kg every 6 hours) Refer URGENTLY if child has fever and / or if infection extends to the muscle.	

NON-ITCHY	**SIGNS**	**CLASSIFY AS:**	**TREATMENT**	**UNIQUE FEATURES IN HIV**
	Skin coloured pearly white papules with a central umblication. It is most commonly seen on the face and trunk in children.	**MOLLUSCUM CONTAGIOSUM**	Can be treated by various modalities: Leave them alone unless superinfected Use of phenol: Pricking each lesion with a needle or sharpened orange stick and dabbing the lesion with phenol Electrodesiccation Liquid nitrogen application (using orange stick) Curettage	Incidence is higher Giant molluscum (>1cm in size), or coalescent Pouble or triple lesions may be seen More than 100 lesions may be seen. Lesions often chronic and difficult to eradicate Extensive molluscum contagiosum is a Clinical stage 2 defining disease
	The common wart appears as papules or nodules with a rough (verrucous) surface	**WARTS**	Treatment: Topical salicylic acid preparations (eg. Duofilm) Liquid nitrogen cryotherapy. Electrocautery	Lesions more numerous and recalcitrant to therapy Extensive viral warts is a Clinical stage 2 defining disease
	Greasy scales and redness on central face, body folds	**SEBBHORREA**	Ketoconazole shampoo If severe, refer or provide tropical steroids For seborrheic dermatitis: 1% hydrocortisone cream X 2 daily If severe, refer	Seborrheic dermatitis may be severe in HIV infection. Secondary infection may be common

DRUG AND ALLERGIC REACTIONS	**SIGNS**	**CLASSIFY AS:**	**TREATMENT**	**UNIQUE FEATURES IN HIV**
	Generalized red, wide spread with small bumps or blisters; or one or more dark skin areas (fixed drug reactions)	**FIXED DRUG REACTIONS**	Stop medications give oral antihistamines, if pealing rash refer	Could be a sign of reactions to ARVs
	Wet, oozing sores or excoriated, thick patches	**ECZEMA**	Soak sores with clean water to remove crusts(no soap) Dry skin gently Short time use of topical steroid cream not on face. Treat itching	
	Severe reaction due to cotrimoxazole or NVP involving the skin as well as the eyes and the mouth. Might cause difficulty in breathing	**STEVEN JOHNSON SYNDROME**	Stop medication refer urgently	**The most lethal reaction to NVP, Cotrimoxazole or even Efavirens**

IMNCI Case Recording Form: MANAGEMENT OF THE SICK YOUNG INFANT -- BIRTH UP TO AGE 2 MONTHS

ID No._____

Name: _____ Age (days): _____ Sex: ____ Weight (kgs): _____ Temperature: ____°C ____^{0}F

ASK: What are the infant's problems? _____ Initial visit? ___ Follow-up Visit? ___

ASSESS (Circle all signs present)	**CLASSIFY**
CHECK FOR POSSIBLE VERY SEVERE DISEASE and LOCAL INFECTION - Is the infant having difficulty feeding? - Has the infant had convulsions? · Count the breaths in one minute. _____breaths per minute Repeat if (≥ 60) elevated _____ Fast breathing? · Look for severe chest indrawing · Fever (temperature ≥ 38°C) or body temperature below 35.5°C · Look at young infant's movements. Does the infant move on his/her own? Does the infant move only when stimulated? Does the infant not move at all? · Look at umbilicus. Is it red or draining pus? · Look for skin pustules.	
CHECK FOR JAUNDICE - When did the jaundice appear first? · Is skin yellow? · Are the palms or soles yellow?	
DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes __ No ____ If yes, ASK: · For how long? _____ Days ·Look at the young infant's general condition. Does the infant move only when stimulated? Does the infant not move at all? 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)? / Slowly?	
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE - Is the infant breastfed? Yes _____ No _____ - If Yes, how many times in 24 hrs? _____ times - Does the infant receive any other foods or drinks? Yes ___ No ___ If Yes, how often? _____ times - If yes, what do you use to feed the infant? - Determine weight for age. - Very low weight for age (< 1.5 kg or < -3 Z score) ___ Low weight for age____ NOT low weight for age ____ - Look for ulcers or white patches in the mouth (thrush)	
If the infant has **any difficulty feeding,** is **feeding < 8 times in 24 hours,** is **taking any other food or drinks,** or is **low weight for age, AND has no indications to refer urgently to hospital: ASSESS BREASTFEEDING**: - Has the infant breastfed in the previous hour? - If 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? To check attachment, look for: - More areola seen above than below the mouth Yes ___ No ___ - Mouth wide open Yes ___ No ___ - Lower lip turned outward Yes ___ No ___ - Chin touching breast Yes ___ No ___ *Good attachment_____ Poor attachment_____ No attachment at all ____* - Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? *Suckling effectively____ not suckling effectively_____ not suckling at all____*	
CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS: Circle immunizations needed today. BCG Hep B-0 OPV-0 Pentavalent-1 OPV-1 Rotavirus-1 PCV-1	Return for next immunization on:
ASSESS OTHER PROBLEMS:	
COUNSEL THE MOTHER ABOUT HER OWN HEALTH	

TREAT

Remember to refer any child who has a danger sign and no other severe classification

IMNCI Case Recording Form: MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ID No._____

Name_____Age(months)_____Weight(Kg) _____Length/Height (cm)_____ Temperature_____^{o}_C_____^{o}F

ASK What are the child's problems?_____Initial visit?_____Follow up visit?_____

ASSESS (Circle all signs present) | **CLASSIFY**

CHECK FOR GENERAL DANGER SIGNS

LETHARGIC OR UNCONSCIOUS
NOT ABLE TO DRINK OR BREASTFEED
CONVULSIONS

CONVULSING NOW
VOMITS EVERYTHING
ANY GENERAL DANGER SIGN PRESENT YES___ NO___
(remember to use when selecting classification)

DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? YES____ NO____

For how long? ____ Days
Look and listen for stridor
Look and listen for wheeze

Count the breaths in one minute. (child must be calm) _____ breaths per minute.
Fast breathing? YES____ NO____

DOES THE CHILD HAVE DIARRHOEA? YES____ NO____

For how long? ____ Days
Is there blood in the stools? YES____ NO____
Pinch the skin of the abdomen. Does it go back:
Very slowly (longer than 2 seconds)
Slowly

Look at the child's general condition. Is the child:
Lethargic or unconscious
Restless or irritable
Offer the child fluid. Is the child:
Not able to drink or drinking poorly?
Drinking eagerly, thirsty?

DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5C or above) YES____ 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

Decide malaria risk High____ Low____ No____
Malaria transmission in the area = YES____ NO____
Transmission season = YES____ NO____
In non or low endemic areas
travel history within the last 15-days to an area
where malaria transmission occurs =YES____ NO ____

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 causes of fever
Look for signs and symptoms of DENGUE FEVER; if suspected do tourniquet test
(if yes, use the relevant treatment instructions)

Do a malaria test, if No general danger sign in all cases in
High malaria risk or No obvious causes of fever in low
Malaria risk:
Test POSITIVE? P. falciporium P. vlvax NEGATIVE?

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 cornea

DOES THE CHILD HAVE AN EAR PROBLEM? YES____ NO____

Is there severe 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 AND ANAEMIA

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
Look for palmar pallor:
Severe palmar pallor Some palmar pallor No palmar pallor

If child has MUAC less than 115 mm or WFH/L less than -3 z-score

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 THE CHILD'S IMMUNIZATION, VITAMIN-A AND DEWORMING STATUS

BCG OPV0	OPV-I *Pentavalent–I Pneumococcal – I Rota 1	OPV-II *Pentavalent–II Pneumococcal – II Rota 2	OPV-III *Pentavalent–III Pneumococcal – III IPV	Measles-I	Measles-II**	Vitamin A Mebendazole

*Pentavalent: DPT+HepB+Hib ^If the child is seen b/w 12-15 months of age,
**2nd dose of measles can be given if one month passed since the Measles 1st dose is given

Return for next immunization on:

_____
(DATE)

ASSESS THE CHILD'S FEEDING if the child is less than 2 years old, has **MODERATE ACUTE MALNUTRITION, ANAEMIA.**

Do you breastfeed your child? YES____ NO____ If YES how many times in 24 hours? ____times. Do you breastfeed during the night?
Does the child take any other foods or fluids? YES____ NO____
If YES what foods or fluids?
How many times per day? ____times What do you use to feed the child?
If MODERATE ACUTE MALNUTRITION: How large are the servings?
Does the child receive his own serving? YES____ NO____ 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?

FOLLOW UP:

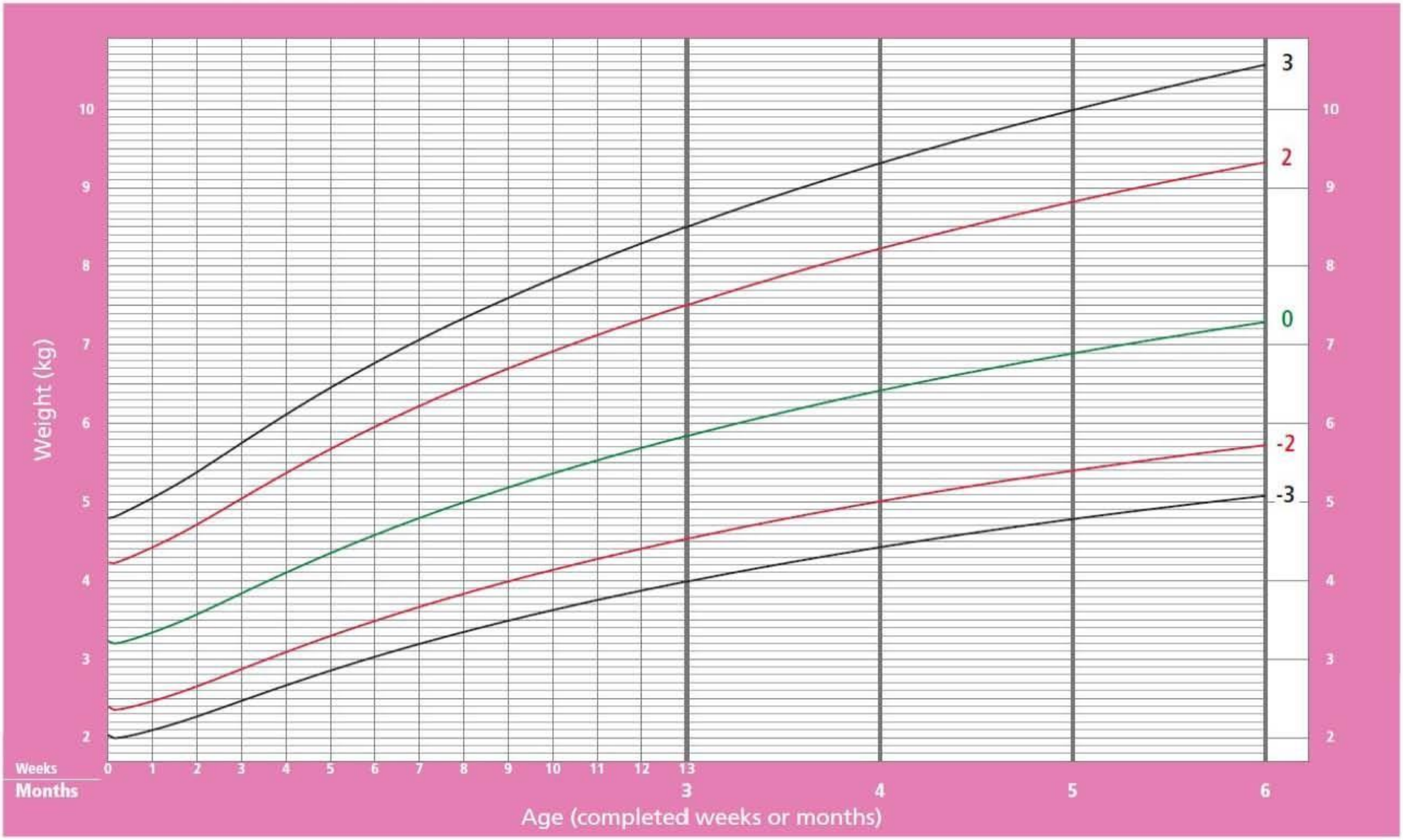
TREAT

Remember to refer any child who has a danger sign and no other severe classification

Weight-for-age GIRLS

Birth to 6 months (z-scores)

World Health Organization

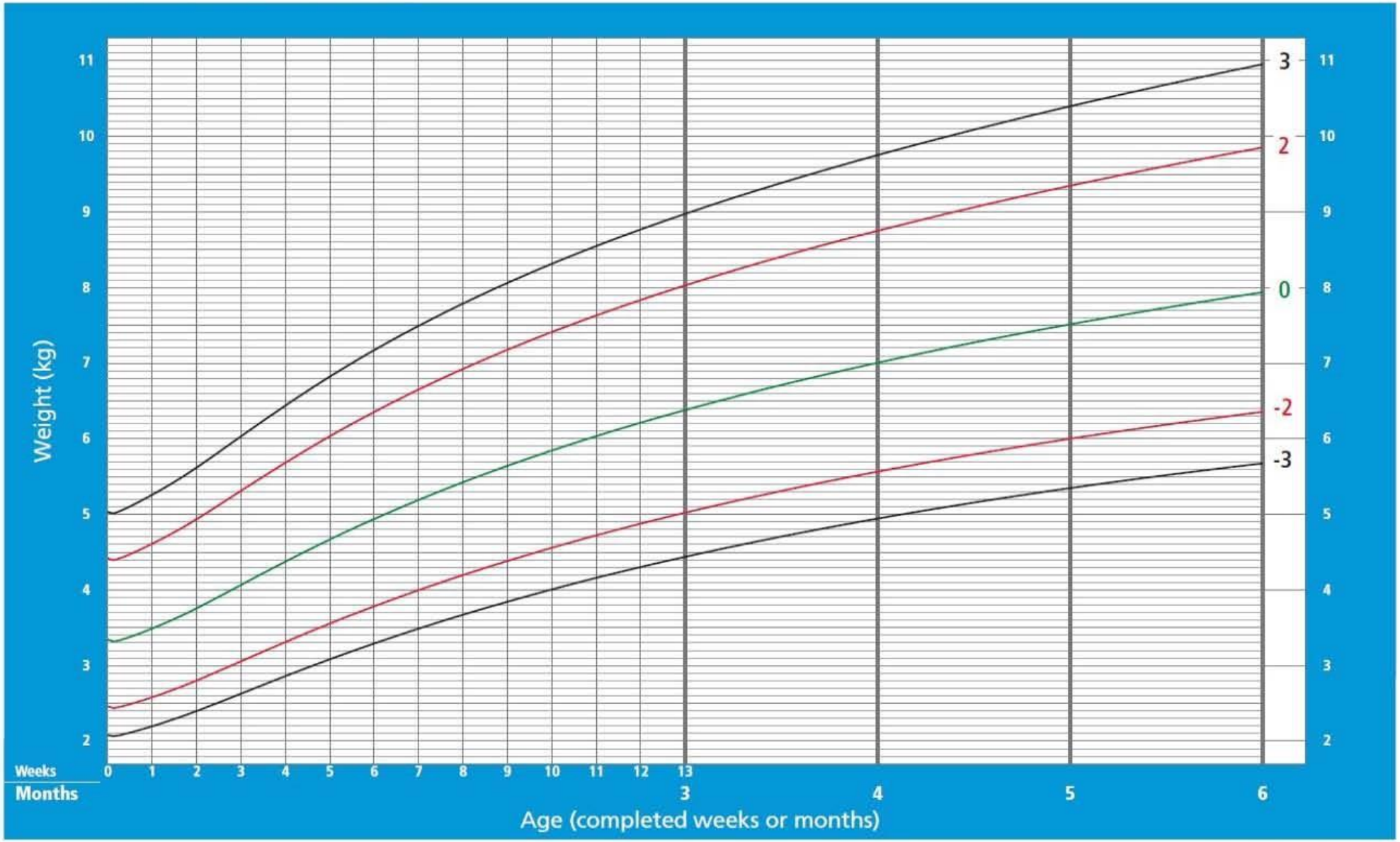


WHO Child Growth Standards

Weight-for-age BOYS

Birth to 6 months (z-scores)

World Health Organization

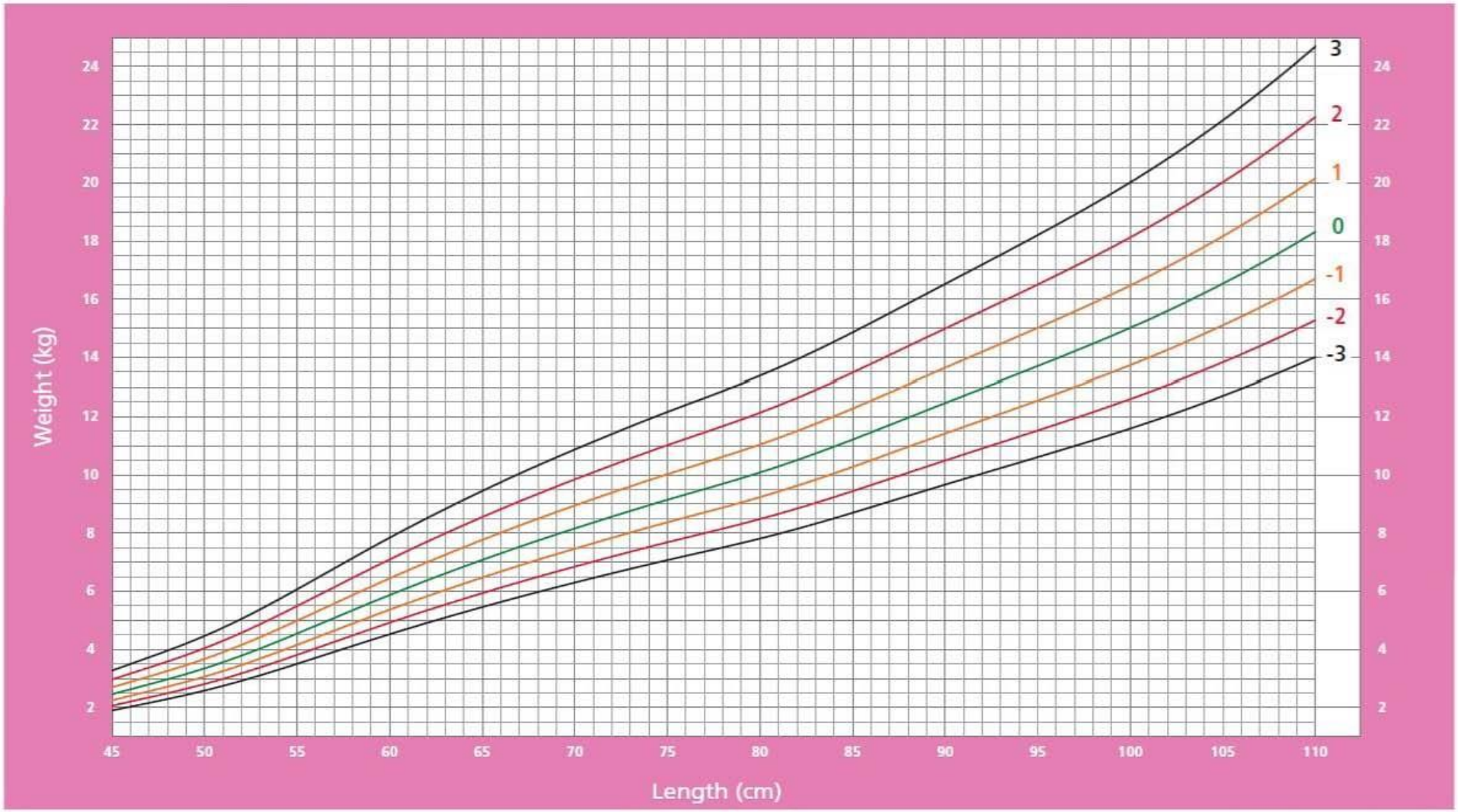


WHO Child Growth Standards

Weight-for-length GIRLS

Birth to 2 years (z-scores)

World Health Organization

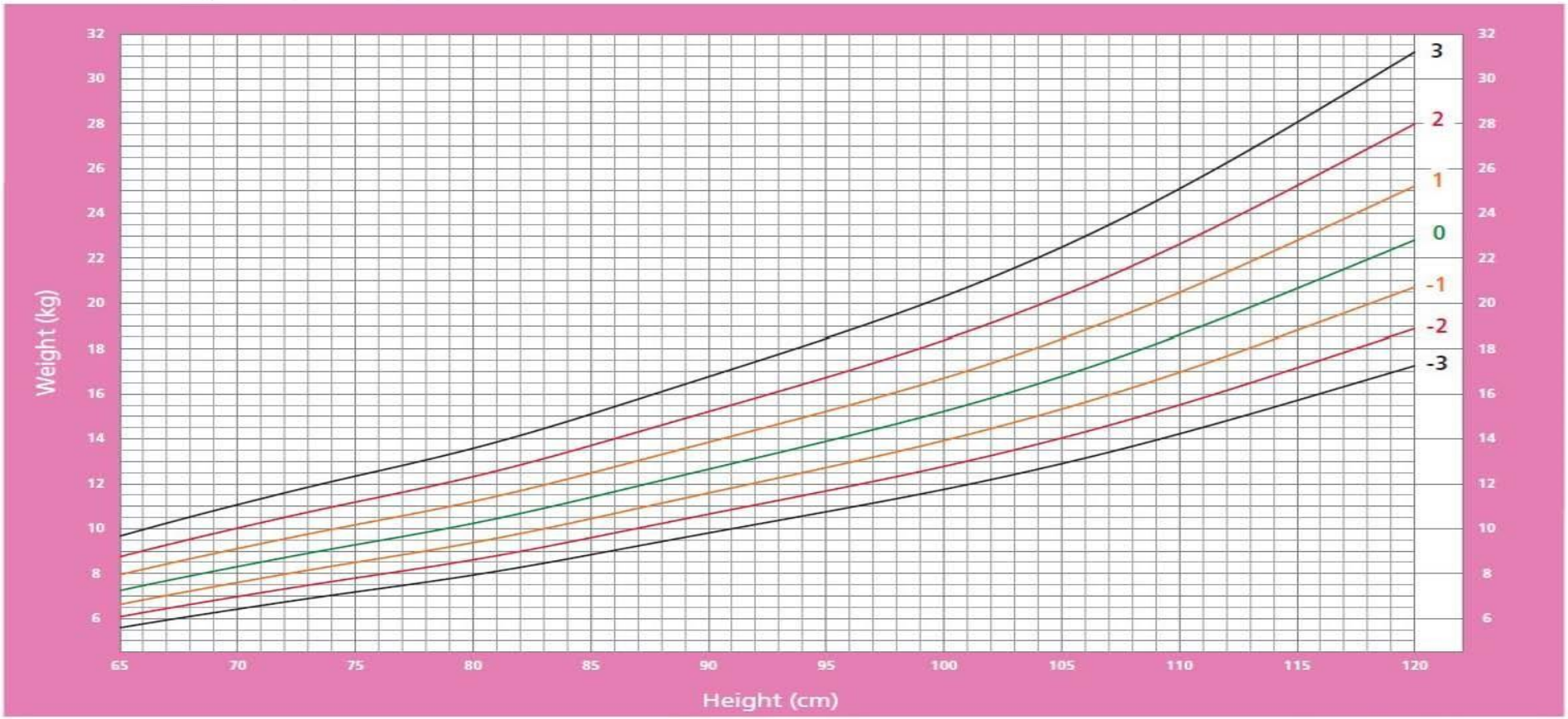


WHO Child Growth Standards

Weight-for-Height GIRLS

2 to 5 years (z-scores)

World Health Organization

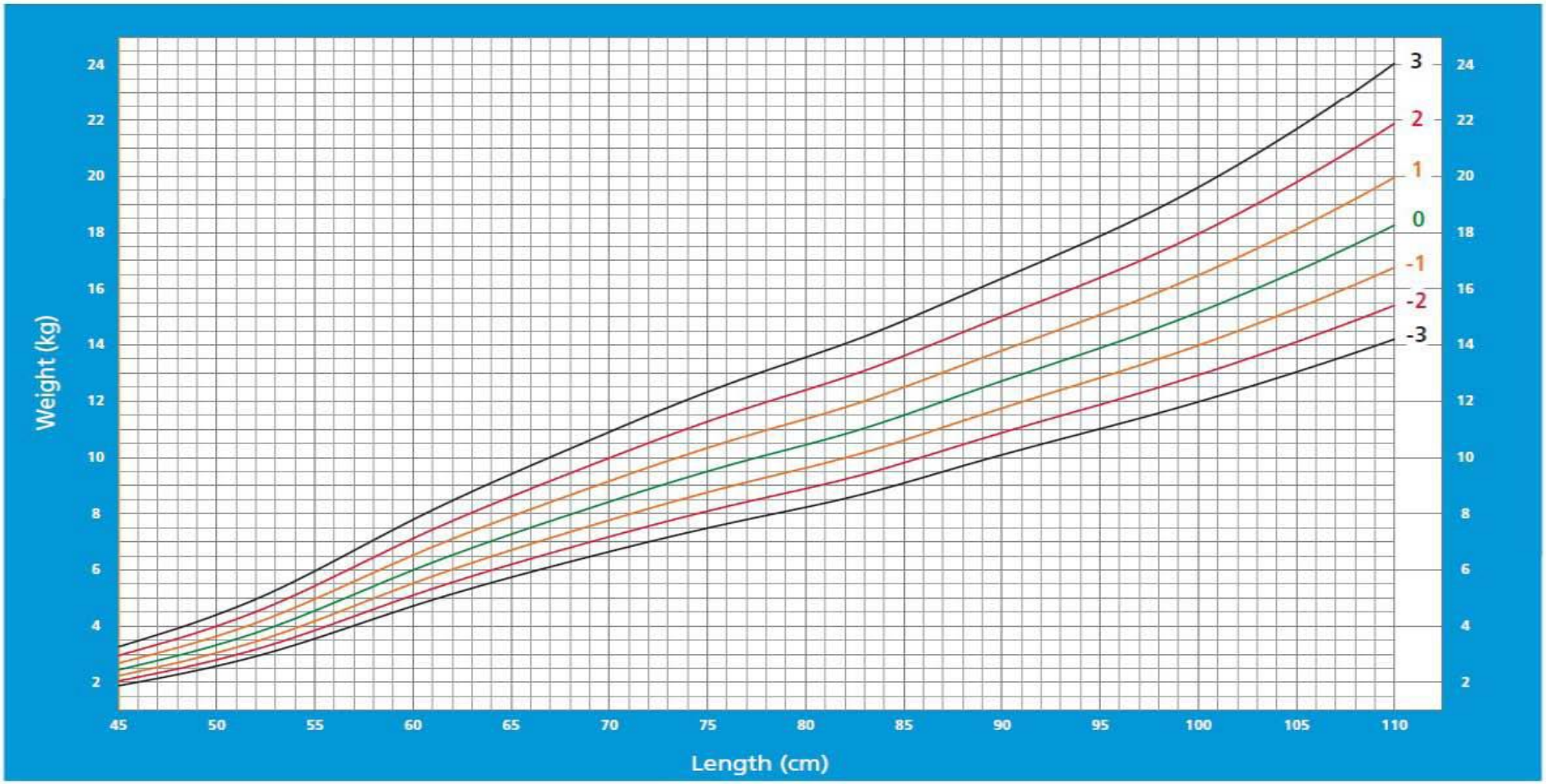


WHO Child Growth Standards

Weight-for-length BOYS

Birth to 2 years (z-scores)

World Health Organization

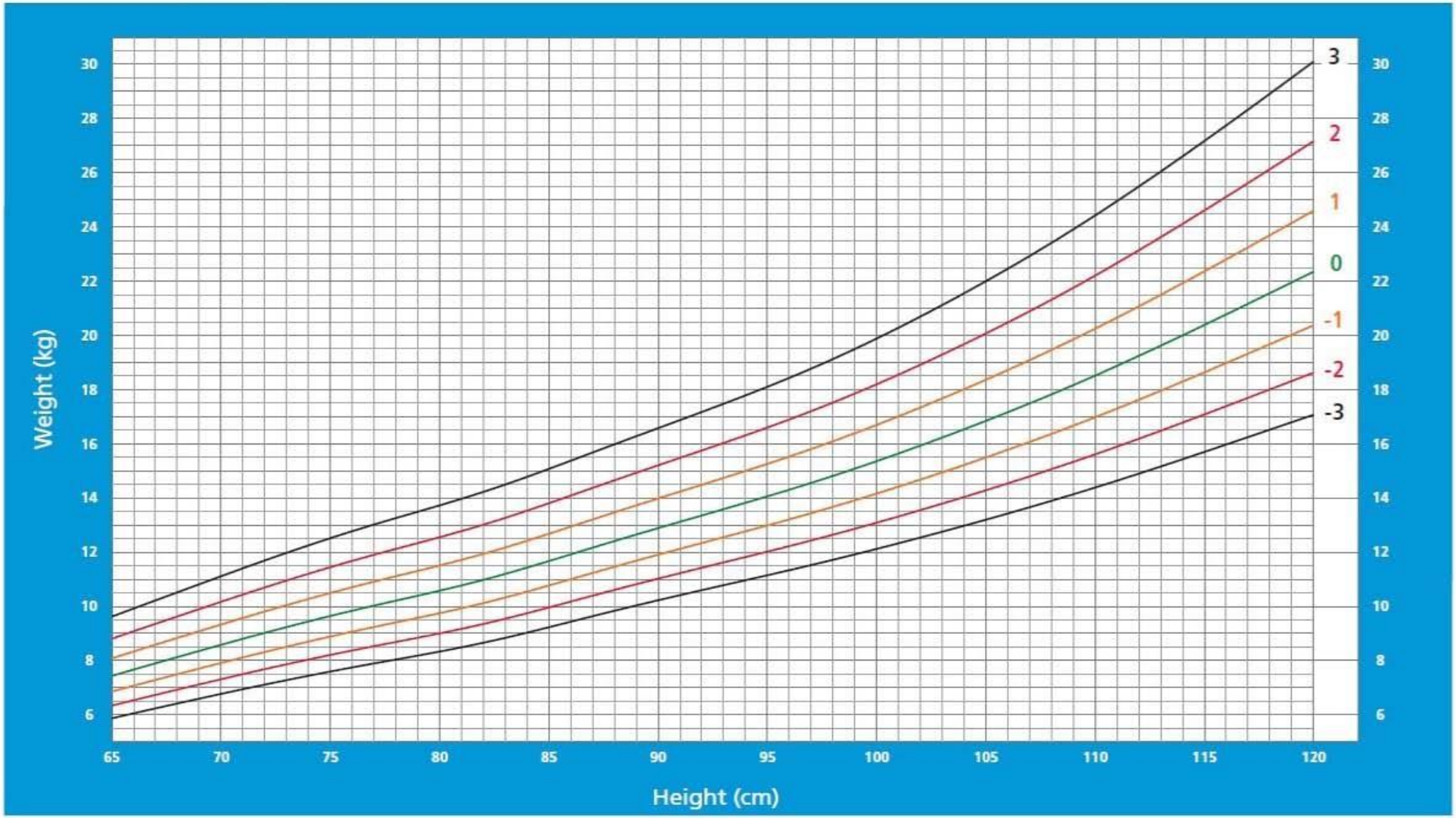


WHO Child Growth Standards

Weight-for-height BOYS

World Health Organization

2 to 5 years (z-scores)



WHO Child Growth Standards

WHEN TO RETURN IMMEDIATELY

BRING ANY SICK CHILD IF

- Not able to drink or breastfeed

- Becomes sicker

- Develops fever

BRING CHILD WITH COUGH IF

- Fast breathing

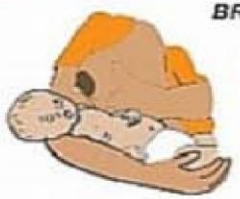
- Difficult breathing

BRING CHILD WITH DIARRHOEA IF

- Blood in stool

- Drinking poorly

BRING YOUNG INFANT TO CLINIC IF ANY OF ABOVE SIGNS OR



- Breastfeeding poorly

- Feels unusually cold

- Palms and soles appear yellow

GIVE GOOD HOME CARE FOR YOUR CHILD

FOR ANY SICK CHILD :

- If child is breastfed, breastfeed more frequently and for longer at each feed.
- If child is taking breastmilk substitutes, increase the amount of milk given
- Increase other fluids. You may give soup, rice water, yoghurt drinks or clean water.
  Give these fluids as much as the child will take. Give frequent small sips from a cup.
- If the child vomits, wait 10 minutes then continue – but more slowly

EXCLUSIVELY BREASTFEED THE YOUNG INFANT

- Give only breastfeeds to the young infant
- Breastfeed frequently, as often and for as long as the infant wants

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

- In cool weather cover the infant's head and feet and dress the infant with extra clothing

FOR CHILD WITH DIARRHOEA:

- Breastfeed frequently and for longer at each feed
- Give fluids:
  - ☐ ORS
  - ☐ Food based fluids, such as soup, rice water, yogurt drinks
  - ☐ Clean water
- Give zinc supplement, if the child aged more than 2 months and if zinc is given
- Continue giving extra fluid until the diarrhoea stops

PRINCIPLES OF THE INTEGRATED CLINICAL CASE MANAGEMENT

IMCI 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, and
     - Jaundice.

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. IMCI 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 IMCI 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