REPUBLIC OF BOTSWANA
Ministry of Health

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

GUIDELINES FOR HEALTH CARE WORKERS

Sick child age 0 up to 5 years

Revised: September 2024

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ASSESS AND CLASSIFY THE SICK CHILD

TREAT THE CHILD

FOLLOW-UP

COUNSEL THE CARETAKER

SICK YOUNG INFANT AGE UP TO 2 MONTHS

ASSESS AND CLASSIFY THE SICK YOUNG INFANT

TREAT AND COUNSEL

FOLLOW-UP

Annex:

Skin Problems

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ASSESS AND CLASSIFY THE SICK CHILD

ASSESS

CLASSIFY

IDENTIFY TREATMENT

ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE

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

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

CHECK FOR GENERAL DANGER SIGNS

Ask:	***Look:***
• Is the child able to drink or breastfeed? • Does the child vomit everything? • Has the child had convulsions* with the present illness?	• See if the child is lethargic or unconscious. • Is the child convulsing* now?

URGENT attention

• Any general danger sign	***Pink:*** **VERY SEVERE DISEASE**	■ **Give diazepam if convulsing now** ■ **Quickly complete the assessment** ■ **Give any pre-referal 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.

*Any convulsions in children aged less than 6 months. Or More than one episode of convulsions during the present illness or convulsions lasting more than 15 mnutes in children aged 6 months or more.

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. 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 or • Chest indrawing	***Pink:*** **SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	■ Give oxygen and treat for wheeze/stridor if present ■ If stridor is present treat nebulize with Adrenaline ■ Give first dose of an appropriate antibiotic ■ Refer URGENTLY to hospital**
• Fast breathing.	***Yellow:*** **PNEUMONIA**	■ Give oral Amoxicillin for 5 days ■ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days ■ Soothe the throat and relieve the cough with a safe remedy ■ If coughing for more than 14 days or recurrent wheeze, asses for possible TB or asthma disease*** ■ Advise mother when to return immediately ■ Follow-up in 3 days
• No signs of pneumonia or very severe disease.	***Green:*** **COUGH OR COLD**	■ If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days ■ Soothe the throat and relieve the cough with a safe remedy ■ If coughing for more than 14 days or recurrent wheezing, 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 national referral guidelines or as in WHO Pocket Book for hospital care for children..*

****Cough of any duration in HIV+ or exposed child asess for TB.*

Does the child have diarrhoea?

If yes, ask:

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

Look and feel:

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

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. • Tachycardic • Bradycardic • Weak, thread, impalpable pulse • No tears • Capillary refill prolonged • Extremeties cool, mottled, cyanotic	***Pink:*** **SEVERE DEHYDRATION**	■ If child has no other severe classification: ○ Give fluid for severe dehydration (Plan C) OR **If child also has another severe classification:** ○ **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** ○ **Advise the mother to continue breastfeeding** ■ **If child is 2 years or older and there is cholera in your area, give antibiotic for cholera**
	Two of the following signs: • Restless, irritable • Slightly sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly.	***Yellow:*** **SOME DEHYDRATION**	■ Give fluid, zinc supplements, and food for some dehydration (Plan B) ■ **If child also has a severe classification:** ○ **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** ○ **Advise the mother to continue breastfeeding** ■ Advise mother when to return immediately ■ Follow-up in 3 days
	Not enough signs to classify as some or severe dehydration.	***Green:*** **NO DEHYDRATION**	■ **Give fluid, zinc supplements, and food to treat diarrhoea at home (Plan A) ■ Advise mother when to return immediately ■ Follow-up in 3 days
and if diarrhoea 14 days or more	• Dehydration present. • No dehydration.	***Pink:*** **SEVERE PERSISTENT DIARRHOEA**	■ Treat dehydration ■ Refer to hospital
		Pink:	
and if blood in stool	• Blood in the stool.	***Yellow:*** **DYSENTERY**	■ **Give Nalidixic Acid for 5 days** ■ Follow-up in 3 days

**** For a child with severe malnutrition don't give ORS instead give Resomal.***

*****Every child with diarrhoea should be rehydrated and observed for tolerance/retaining of ORS for 1 hour in the clinic.***

Does the child have fever?

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

If yes:

Decide Malaria Risk: high or low

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

Malaria risk stratification using attack rate per 1000 of population

High	Low	Insignificant
Zone A	Zone B	Zone C
Okavango	Ngami, Chobe, Boteti, Tutume, Bobirwa	Gaborone, Lobatse, Southern, Kweneng East, Kweneng West, Gantsi, Kgatleng, Kgalagadi north, Kgalagadi South, South East, Goodhope, Serowe, Palapye, Mahalapye, Francistown, North-East

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

High or Low Malaria Risk

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

No Malaria Risk and No Travel to Malaria Risk Area

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

If MEASLES now or within last 3 months, Classify

• Any general danger sign or • Clouding of cornea or • Deep or extensive mouth ulcers.	***Pink:*** **SEVERE COMPLICATED MEASLES****	■ **Give Vitamin A treatment** ■ **Give first dose of an appropriate antibiotic** ■ **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.	***Yellow:*** **MEASLES WITH EYE OR MOUTH COMPLICATIONS****	■ **Give Vitamin A treatment** ■ **If pus draining from the eye, treat eye infection with tetracycline eye ointment** ■ If mouth ulcers, treat with gentian violet ■ Follow-up in 3 days
• Measles now or within the last 3 months.	***Green:*** **MEASLES**	■ **Give Vitamin A treatment**

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

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

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

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

Does the child have an ear problem?

If yes, ask:

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

Look and feel:

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

Classify EAR PROBLEM

• Tender swelling behind the ear.	***Pink:*** **MASTOIDITIS**	■ **Give first dose of an appropriate antibiotic** ■ **Give first dose of paracetamol for pain** ■ **Refer URGENTLY to hospital**
• Pus is seen draining from the ear and discharge is reported for less than 14 days, or • Ear pain.	***Yellow:*** **ACUTE EAR INFECTION**	■ **Give an antibiotic for 5 days** ■ **Give paracetamol for pain** ■ Dry the ear by wicking ■ Follow-up in 5 days
• Pus is seen draining from the ear and discharge is reported for 14 days or more.	***Yellow:*** **CHRONIC EAR INFECTION**	■ Dry the ear by wicking ■ Treat with topical quinolone eardrops for 7 days ■ Follow-up in 5 days
• No ear pain and No pus seen draining from the ear.	***Green:*** **NO EAR INFECTION**	■ No treatment

Hearing Loss

• Baby 6 months - 18 months; Baby cannot turn to sound from rubbing of fingers • Child 18 months - 5 years Chlid cannot point to familliar objects/body parts in response to whisper command or normal soft voice command?	***Yellow:*** **HEARING LOSS**	REFER FOR ASSESSMENT

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
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-
* Look for oedema of both feet
* Determine Weight for Age z-score
* assess breastfeeding or formula feeding:

Does the child have a breastfeeding/ formula feeding 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 **Children less than 6 months** • Oedema **OR** • Weight for Age less than -3 z score **OR** • Breastfeeding or formula feeding problem	*Pink:* **COMPLICATED SEVERE ACUTE MALNUTRITION** I I I **SEVERE UNDERWEIGHT**	• **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-touse 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. **Children less than 6 months** • Weight for Age between -3 z score and -2z score	**Yellow:** **MODERATE ACUTE MALNUTRITION** I **MODERTE UNDERWEIGHT**	• 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 14 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, followup in 7 days

THEN CHECK FOR ANAEMIA

Check for anaemia

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

- Do a malaria test
- If in high malaria risk and some palmor present

Classify ANAEMIA

• Severe palmar pallor	***Pink:*** **SEVERE ANAEMIA**	■ **Refer URGENTLY to hopsital**
• Some pallor	***Yellow:*** **ANAEMIA**	■ Give iron*** ■ Give antimalarial if malaria test is positive ■ 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	***Green:*** **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

*If pallor in high Malaria setting do a malaria test

**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 FOR HIV INFECTION

***ANY CHILD CLASSFIED AS TB DISEASE AND CONFIRMED HIV INFECTION SHOULD BE CLASSIFIED AS TB-HIV CO-INFECTION AND SHOULD BE REFFERED UGENTLY**

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

ASK

Has the mother or child had an HIV test?

IF YES:

Decide HIV status:

- Mother: POSITIVE or NEGATIVE *
- Child:
  - Virological test POSITIVE or NEGATIVE
  - Serological test POSITIVE or NEGATIVE

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

- Was the child breastfeeding at the time or 3 months before the test?
- Is the child breastfeeding now?
- If breastfeeding ASK: Is the mother and child on ARV prophylaxis?

IF NO, THEN TEST:

- Mother and child status unknown: TEST mother.
- Mother HIV positive and child status unknown: TEST child.

Classify HIV status

• Positive virological test in child OR • Positive serological test in a child 18 months or older	***Yellow:*** **CONFIRMED HIV INFECTION**	■ **Do a verification test before initiation**** ■ **Initiate ART treatment and HIV care** ■ **Give cotrimoxazole prophylaxis***** ■ Assess the child's feeding and provide appropriate counselling to the mother ■ Advise the mother on home care ■ Asess or refer for TB assessment and INH preventive therapy ■ Follow-up regularly as per national guidelines
• Mother HIV-positive AND negative virological test in a breastfeeding child or only stopped less than 6 weeks ago OR • Mother HIV-positive, child not yet tested OR • Positive serological test in a child less than 18 months old	***Yellow:*** **HIV EXPOSED**	■ **Give cotrimoxazole prophylaxis** ■ **Start or continue ARV prophylaxis as recommended** ■ Do virological test to confirm HIV status***** ■ Assess the child's feeding and provide appropriate counselling to the mother ■ Advise the mother on home care ■ Follow-up regularly as per national guidelines
HIV test not done for mother or infant	***Yellow:*** **HIV INFECTION STATUS UNKNOWN**	■ Inititate HIV testing and counselling. ■ Conduct HIV test for the mother and if positive, a virological test for the infant. ■ conduct virological test for the infant if thew mother is not available.
• Negative HIV test in mother or child	***Green:*** **HIV INFECTION UNLIKELY**	■ Treat, counsel and follow-up existing infections

*If the mother/caretaker not available, child 's test results not available, follow the mother/caretaker and perform the test/s

**If verification results are positive initiate ART treatment, if negative reclassify and counsel the caretaker.

*** Give cotrimoxazole prophylaxis to all HIV infected and HIV-exposed children utill confirmed negative after cessation of breastfeeding.

*****If virological test is negative, repeat test 3 months after the breatfeeding has stopped.

THEN CHECK FOR ACTIVE TB

***ANY CHILD CLASSFIED AS NEW TB DISEASE AND CONFIRMED HIV INFECTION SHOULD BE CLASSIFIED AS TB-HIV CO-INFECTION AND SHOULD BE REFFERED UGENTLY**

ASK ABOUT FEATURES OF TB INFECTION

- Any close TB contact
- Persistant non remitting cough for more than 2 weeks
- History of loss of weight
- Fatigue/reduced playfulness
- Fever every day for 7 days or more
- loss of appetite
- Shortness of breath
- coughing out blood
- Night sweats

LOOK FOR FEATURES OF TB INFECTION

- Feel for any enlarged lymph node
- Look documented lose of weight or unsatisfactory weight gain during the past 3 months (especially) if not responding to deworming together with food and or micronutrients supplementation

Classify TB

• Positive sputum/stool microscopy • Positive Xpert MTB/RIF test • Chest x-ray suggesting TB	***Yellow:*** • **TB DISEASE ***	▪ Treat for TB, as per National TB Guidelines ▪ Record in TB register ▪ Trace contacts and manage according to TB guidelines ▪ Counsel and test for HIV if HIV status unknown ▪ Advice when to return immediately ▪ Follow-up monthly to review progress
• A close TB contact and/or features of TB	***Yellow:*** • **PROBABLE TB**	▪ Do gene x-pert ▪ Do Tuberculin Skin Test(TST) ▪ Advise when to return immediately ▪ Follow up in 3 days
• close TB contact with no features of TB	***Yellow:*** • **TB EXPOSURE**	▪ Do Tuberculin Skin Test(TST) ▪ Treat with INH for 6 months ▪ Trace other contacts ▪ Advise when to return immediately ▪ Follow-up monthly
• No close contact • No features of TB • Tuberculin Test Negative(TST)	***Green:*** **TB UNLIKELY**	▪ Treat, counsel and follow-up existing infections ▪ Advise when to return immediately

THEN CHECK FOR DEVELOPMENTAL MILESTONES

Assessment box

0-2 MONTHS
- Social smile (baby smiles back)
- Baby follows a colourful object dangled before their eyes

2-4 MONTHS
- Holds the head upright
- Follows the object or face with their eyes
- Turns the head or responds in any other way to sound smiles back

4-6 MONHS
- Rolls over
- Reaches for and grasps objctes with a hand
- Takes an object to themouth
- Babbles makes sounds

6-9 MONTHS
- Sits without support
- Moves object from onehand to the other
- Repeats syllables (bababa,mamama)
- Plays peek-a-boo (hide and seek)
- Takes steps with support
- Picks up small object or string with 2 fingers
- Says 2-3 words
- Imitates simple gestures (claps hands, bye)

12-18 MONTHS
- Walks without support
- Drinks from a cup
- Says 7 to 10 words
- Points to some body parts on request

18-24 MONTHS
- Kicks a ball
- Builds a tower with 3 blocks or small boxes
- Points at a picture on request
- Speaks in short sentences

24 MONTHS AND OLDER
- Jumps
- Undresses or dressesthemselves
- Says first name, tell shortstory
- Interested in playing with other children

CLASSIFY FOR DEVELOPMENTAL MILESTONES **Classification arrow**

Abscence of one or more milestones from current age group OR • Abscence of one or more milestones from earlier age group OR • Regression of milestones	***Yellow:*** **DEVELOPMENTAL MILESTONE/S DELAY**	■ Counsel the caregiver appropriately ■ Refer for psychomtor evaluation ■ Screen for caretaker's health needs and risk factors and other possible causes including Malnutrition, TB disease and hyperthyroidism
• Abscence of one or more milestones from current age group	***Yellow:*** **DEVELOPMENTAL MILESTONE/S ALERT**	■ Praise caregiver on milestones achieved ■ Counsel caregiver on play & communication activities to do at home (refer to Care for Child Development card) ■ Advise to return for follow up in 30 days ■ Screen for possible TB disease
• All milestones for the current age group are present	***Green:*** **DEVELOPMENTAL MILESTONE/S NORMAL**	■ Praise caregiver on milestones achieved ■ Encourage caregiver to give more challenging activities for the next age group(refer to Care for Child Development card) ■ Advice to continue with follow uo consultations

CHECK FOR INTERACTION, COMMUNICATION AND RESPONSIVENESS

ASK

- How do you play with your child? (Ask the caregiver to demonstrate)
- How do you talk with your child? (Ask the caregiver to demonstrate)
- How do you get your child to smile? (Ask the caregiver to demonstrate)
- How do you think your child is learning? (Ask for 6 months and older)

LOOK, LISTEN (Health care provider looks and listens as the caregiver plays and communicates with the child.)

- Is the caregiver aware of child's movements?
- Does the caregiver play with child?
- Does the caregiver talk to child?
- Does the caregiver smile with the child?

Classification **CLASSIFY FOR INTERACTION, COMMUNICATION AND RESPONSIVENESS**

General signs for all children • Does not move/play with the child, or controls child's movements • Is not able to comfort child, and child does not look to caregiver for comfort • Scolds the child **AGE < 6 Months** • Does not play with baby • Does not talk to baby • Tries to force smile or is not responsive to baby **AGE: 6 Months & Older** • Does not play with child • Does not talk, or talks harshly to child • Says child is slow to learn	**Yellow: POOR INTERACTION AND /OR COMMUNICATION AND RESPONSIVENESS**	**For All Children:** • Ask caregiver to copy child's movements and to follow child's lead • Help caregiver look into child's eyes while gently talking and holding child • Help caregiver distract child from unwanted actions by giving alternative toys or activities **AGE < 6 Months** • Discuss ways in which to help baby see, hear, feel and move appropriate for their age • Ask the caregiver to look into baby's eyes while talking to the baby • Ask caregiver to make large gestures and cooing sounds and/or copy baby's sounds and gestures, and see baby's response **AGE: 6 Months & Older** • Ask caregiver to do play or communication activity, appropriate for age • Help caregiver interpret what child is doing and thinking, while observing child's response and smile • Counsel the caregiver on appropriate activity to do together with the child • Encourage more activity with the child, check hearing and seeing. • Refer child with difficulties (See the counsel the mother card on recommendation for care for Child's Development) **Follow up in 14 days**
General signs for all Children • Caregiver moves towards the child, talks to or makes sounds with child • Caregiver tries to force smile or is not responsive to child • Caregiver looks into child's eyes while talking softly to them, gently touches child or holds them closely. • Caregiver distracts child from unwanted actions with appropriate toys. **AGE< 6 Months** • Moves the baby's arms and legs while gently stroking the baby. • Gets baby's attention with shaker or other ways • Looks into baby's eyes while talking softly to baby • Responds to baby's sounds and gestures to get baby to smile **AGE :6 Months & older** • Plays word games or with toys • Looks into child's eyes and talks softly to child • Draws smile out from the child • Says the child is learning well	**Green: GOOD INTERACTION AND/OR COMMUNICATION AND RESPONSIVENESS**	• Praise caregiver and encourage to continue age appropriate play and communi- cation (See the counsel the mother card on recommendation for care for Child's Development)

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

IMMUNIZATION SCHEDULE: Follow national guidelines

AGE	VACCINE				
Birth	BCG*		Hep B		
2 months	Penta 1	OPV-1	RTV1****	PCV1	
3 months	Penta 2	OPV-2	RTV2****	PCV2	
4 months	Penta 3	OPV-3	RTV3	PCV3	IPV-1
9 months	Measles Rubella **	IPV-2			
18 months	Measles Rubella**	OPV Booster	DT		

VITAMIN A SUPPLEMENTATION

Give every child a dose of Vitamin A every six months from the age of 6 months. Record the dose on the child's chart. ***

Given in May and November.

ROUTINE WORM TREATMENT

Give every child Albendazole every 12 months from the age of one year. Record the dose on the child's card.

Given in November.

**Children who are HIV positive or unknown HIV status with symptoms consistent with HIV should not be vaccinated.*

*** Measles Rubella vaccine may be given at any opportunistic moment during periodic supplementary immunization activities as early as one month following the previous dose.*

****If child is on RUFT do not give vitamin A*

***** Emphasis should be made on catch up for children up to two years.*

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.

HIV TESTING ALGORYTHM

Perform testing with the first rapid test (T1) for HIV screening.

1. If negative, recommend annual HIV testing (or appropriate HIV testing intervals based upon risk exposure as per National HTC guidelines) and refer to the appropriate HIV services
2. If positive, repeat with a second rapid HIV test (T2).
3. If the second rapid HIV test is positive, this is diagnostic for HIV infection and the patient must be immediately reffered and tracked to ART initiation site.
4. If the second rapid HIV test is negative (i.e. T1 and T2 are discodent) re-test the client as folllows

- Repeat HIV test 1 and 2 in parrallel
- If both reapet test are negative, the patient is diagnosed HIV negative and recommend annual testing.
- If both repeat test are positive, this sis a diagnostic for HIV infection and the patient must be immediately refered and tracked for ARV innitiation .
- If the repeat tests remain discordant(one positive and one negative):
- If in a government facility;send a blood soeciemen for ELISA testing and further investigation at the HIV Reference Laboratory and ask the patient to return in 2 weeks for the results.
- If in an approved Routine Testing Center(i.e. NGOs);use a tie-breaker(T3).If (after repeat of T1 andT2)T3 is negative the client is reported as negative for HIV infection .Recommend annual HIV testing ,etc.(as outlined in step #2).
- if (after repeat of T1 and T2 in parallel)Test3 is positive consider this results as inconclusive.Send a blood speciemen for ELISA testing and further investigation at HIV Reference Laboratory and ask patient to return in 2weeks for results.
- However if tie-breaker is not available;send a blood speciemen for ELISA testing and further investigation at the HIV Reference Laboratory and ask the patient to return in 2 weeks for results.

HIV TESTING VERIFICATION

FOR PATIENTS WHO PRESENT FOR ART INTIATION WITH A POSITIVE HIV DIAGNOSIS;

Perform verfication of HIV diagnosis as follows:

1.Perform verification using two rapid HIV test T1 and T2 in parallel.

2.If both verification tests are negative,the patient is diagnosed as HIV negative.Recommend annual HIV testing,etc.(as outline in step#2 above).

3.If both verification tests are positive,proceed with ART intiation.

4.If verification tests are discordant(one positive and one negative)send blood speciemen for ELiSA testing and further investigation at the HIV Reference Laboratory and ask the patient to return in 2 weeks for the result.

<u>Patients<18 months of age</u>

ALL HIV EXPOSED BABIES MUST COMPLETE DNA PCR TESTING BY 6 WEEKS OF AGE.DRIED BLOOD SPOT (DBS) IS THE PREFERRED SPECIEMEN COLLECTION METHOD.

Immediately refer any infant,who is found to be positive for ART initiation,without waiting for a confirmatory DNA PCR test rsults.

All children identified sa negative by 6 weeks,who donot breastfeed,must undergo rapid HIV testing(as outlined above) at 18 months.

All children identified as ngative by 6 weeks ,who are breastfeed should have repeat HIV testing 6 weeks after ceassation of breast feeding(if <18 months use DNA PCR -DBS,if 18months or more than 18 months use rapid tests as outlined above).

HIVexposed babies should be clinically evaluated monthly at child welfare clinic to detect the development of opportunistic infections or other HIV related illness.

Discuss any HIV exposed babies with WHO clinical stage 2,3,or 4 conditions with a peadiatric HIV specialist for consideration for ART.

If DNA test results have not returned within one month call the lab and track results.

HIV TESTING AND INTERPRENTING RESULTS

HIV testing is RECOMMENDED for:

- All children with unknown HIV status especially those born to HIVpositive mothers. (If you do not know the mother's status, test the mother first, if possible)

Types of HIV Tests		
	What does the test detect?	**How to interpret the test?**
SEROLOGICAL TESTS (Including rapid tests)	These tests **detect antibodies made by immune cells in response to HIV**. They do not detect the HIV virus itself.	HIV antibodies pass from the mother to the child. Most antibodies have gone by 12 months of age, but in some instances they do not disappear until the child is 18 months of age. This means that a positive serological test in children less than 18 months is **NOT** a reliable way to check for infection of the child, threrefore it should not be used.
VIROLOGICAL TESTS (Including DNA or RNA PCR)	These tests **directly detect the presence of the HIV virus** or products of the virus in the blood.	Positive virological (PCR) tests reliably detect HIV infection at any age, even before the child is 18 months old. If the tests are negative and the child has been breastfeeding, this does not rule out infection. The baby may have just become infected. Tests should be done six weeks or more after breastfeeding has completely stopped—only then do the tests reliably rule out infection.

For HIV exposed children 18 months or older, a positive HIV antibody test result means the child is infected.

For HIV exposed children less than 18 months of age:

- If PCR or other virological test is available, test from 6-8 weeks of age.
  - A positive result means the child is infected. Always do a confirmatory test immediately after receiving positive results.
  - A negative result means the child is not infected, but could become infected if they are still breast feeding.
- If PCR or other virological test is not available, use HIV antibody test. A positive result is consistent with the fact that the child has been exposed to HIV, but does not tell us if the child is definitely infected.

Interpreting the HIV Antibody Test Results in a Child less than 18 Months of Age		
Breastfeeding status	POSITIVE (+) test	NEGATIVE (-) test
NOT BREASTFEEDING, and has not in last 6 weeks	Do a confirmatory test	Repeat PCR at 9 months ans Serology test at 18 months
BREASTFEEDING	Do a confirmatory test once breastfeeding has been discontinued for more than 6 weeks.	Child can still be infected by breastfeeding. Repeat test once breastfeeding has been discontinued for more than 6 weeks.

WHO PAEDIATRIC STAGING FOR HIV INFECTION

This is used for monitoring children during follow up to determine clinical response to ARV treatment. Determine the clinical stage by assessing the child's signs and symptoms. Look at the classification for each stage. Decide what is the highest stage applicable to the child where one or more of the child's symptoms are represented.

	Stage 1 **Asymptomatic**	**Stage 2** **Mild Disease**	**Stage 3** **Moderate Disease**	**Stage 4** **Severe Disease (AIDS)**
	-	-	Unexplained severe acute malnutrition not responding to standard therapy	Severe unexplained wasting/stunting/severe acute malnutrition not responding to standard therapy

Symptoms/Signs	No symptoms, or only:
	Persistent generalized lymphadenopathy (PGL)
		• Enlarged liver and/or spleen
		• Enlarged parotid
		• Skin conditions (prurigo, seborraic dermatitis, extensive molluscum contagiosum or warts, fungal nail infection herpes zoster)
		• Mouth conditions recurrent mouth ulcerations, linea gingival Erythema)
		• Recurrent or chronic upper respiratory tract infections (sinusitis, ear infection, tonsilitis, ortorrhea)
			• Oral thrush (outside neonatal period).
			• Oral hairy leukoplakia.
			• Unexplained and unresponsive to standard therapy:
			  ○ Diarhoea for over 14 days
			  ○ Fever for over 1 month
			  ○ Thrombocytopenia*(under 50,000/mm3 for 1month
			  ○ Neutropenia* (under 500/mm3 for 1 month)
			  ○ Anaemia for over 1 month (haemoglobin under 8 gm)*
			• Recurrent severe bacterial pneumonia
			• Pulmonary TB
			• Lymp node TB
			• Symptomatic lymphoid interstitial pneumonitis (LIP)*
			• Acute necrotising ulcerative gingivitis/periodontitis
			• Chronic HIV associated lung diseses including bronchiectasis*
				• Oesophageal thrush
				• More than one month of herpes simplex ulcerations.
				• Severe multiple or recurrent bacteria infections > 2 episodes in a year (not including pneumonia) pneumocystis pneumonia (PCP)*
				• Kaposi's sarcoma.
				• Extrapulmonary tuberculosis.
				• Toxoplasma brain abscess*
				• Cryptococcal meningitis*
				• Acquired HIVassociated rectal fistula
				• HIV encephalopathy*

*Conditions requiring diagnosis by a doctor or medical officer - should be referred for appropriate diagnosis and treatment.

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

Give an Appropriate Oral Antibiotic

- **FOR PNEUMONIA, ACUTE EAR INFECTION:**

FIRST-LINE ANTIBIOTIC: Oral Amoxicillin SECOND LINE ANTIBIOTIC: Oral Erythromycin

AGE or WEIGHT	**AMOXICILLIN*** *Give three times daily for 5 days*	
	TABLET 250 mg	**SYRUP** 125mg/5 ml
2 months up to 12 months (4 - <10 kg)	1/2	5 ml
12 months up to 3 years (10 - <14 kg)	2	10 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 PROPHYLAXIS IN HIV CONFIRMED OR EXPOSED CHILD:**

ANTIBIOTIC FOR PROPHYLAXIS: Oral Cotrimoxazole

AGE	**COTRIMOXAZOLE** (trimethoprim + sulfamethoxazole) Give once a day starting at 4-6 weeks of age		
	Syrup (40/200 mg/5ml)	Paediatric tablet (Single strength 20/100 mg)	Adult tablet (Single strength 80/400 mg)
Less than 6 months	2.5 ml	1	-
6 months up to 5 years	5 ml	2	1/2

- **FOR DYSENTERY give Nalidixic acid**

FIRST-LINE ANTIBIOTIC: Oral Nalidixic acid

AGE	**NALIDIXIC ACID** Give 4 times daily for 5 days	
	250 mg/ 5ml syrup	500 mg tablet
Less than 12 months	2.5 mls	1/4
12 months up to 5 years	5 mls	1/2

- **FOR CHOLERA , PNEUMONIA:**

FIRST-LINE ANTIBIOTIC FOR CHOLERA: _____

SECOND-LINE ANTIBIOTIC FOR PNEUMONIA: _____

AGE or WEIGHT	**ERYTHROMYCIN** *Give four times daily for 3 days for Cholera and 5 days for Pneumonia*
	SYRUP 125 mg per 5 ml
2 months up to 4 months (4 - <6 kg)	2.5 ml
4 Months uo to 12 months (6-<10 kg)	5 ml
12 months up to 5 years (10-19 kg)	10 ml

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 nebuliser if correctly used.

- From salbutamol metered dose inhaler (100 µg/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 breath normally.
- 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 Adrenaline per nebulizer

1. Nebulize with Adrenaline 0.5ml/kg of 1:1000(1 mg/ml vial) Adrenaline(Maximum dose of 5 ml of Adrenaline) diluted in 3 mls of Normal Saline.
2. Continue giving O2
3. Avoid irritating the baby. Give them a rest. (Irritating the baby worsens the croup)
4. Refer Urgently to the hospital

N.B For kids 10 kg and above use strictly 5 mls of Adrenaline. Dilute with 3 mls of normal saline.

Give Oral Antimalarial for MALARIA

- **If Artemether-Lumefantrine (AL)**
  - 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.
- **If Artesunate Amodiaquine (AS+AQ)**
  - Give first dose in the clinic and observe for an hour, if a child vomits within an hour repeat the dose.
  - Then daily for two days as per table below using the fixed dose combination.

WEIGHT (age)	**Artemether-Lumefantrine tablets** (20 mg artemether and 120 mg lumefantrine) Give two times daily for 3 days			**Artesunate plus Amodiaquine tablets** Give Once a day for 3 days					
				(25 mg AS/67.5 mg AQ)			(50 mg AS/135 mg AQ)		
	Day 1	Day 2	day 3	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3
5 - <10 kg (2 months up to 12 months)	1	1	1	1	1	1	-	-	-
10 - <14 kg (12 months up to 3 years)	1	1	1	-	-	-	1	1	1
14 - <19 kg (3 years up to 5 years)	2	2	2	-	-	-	1	1	1

- Give **Primaquine** 0.25 mg/kg stat dose along with first dose of AL for all P.falciparum cases except for children less than 6 months of age

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

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

AGE or WEIGHT	**PARACETAMOL**	
	TABLET (125 mg/5 mls)	**TABLET** (500 mg)
2 months up to 3 years (4 - <14 kg)	5 mls	1/4
3 years up to 5 years (14 - <19 kg)	10 mls	1/2

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 µg 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 Oral Drugs for TB

INH preventive therapy for TB EXPOSURE or TB infection

- **Crush the tablet (s) and dissolve in water**
- **Treatment must be given for 6 months**
- **Follow-up children each month to check adherence and progress, and to provide medication**

WEIGHT	Isoniazid (INH) 100 mg once daily	
	Tablet	mg
2 - < 3.5 kg	¼	25
3.5 - < 7 kg	½	50
7- <10 kg	1	100
10- < 15 kg	1 ½	150
15 - < 20 kg	2	200
20 -<25 kg	2 ½	250
25 - <30	3	300

Treat for TB

- **Use regimen in the national Tb guidelines for treating uncomplicated TB - see table below**
- **Children with complicated TB (smear positive or cavitatory TB) use appropriate regimen indicated below**
- **Do not change the regimen of children reffered from the hospital or TB clinic withot consulting the reffering doctor**
- **Follow-up children each month to check to check adherence and progress.**

REGIMEN	INTENSIVE PHASE TWO MONTHS once daily	Ethambutol 400mg * (Do not use if < 4Kg ¼ tab if wt 47.4 Kg ½ tab if wt 7.511.9 Kg)	CONTINUATION PHASE FOUR MONTHS once daily
	$R_{60}H_{30}Z_{150}$tablet		3FDC tablet
WEIGHT	Daily dose	Daily dose	Daily dose
2-2.9 kg	1/2 tab	*	½ tab
3-5.9 kg	1 tab	*	1 tab
6-8.9 kg	1 ½ tab	*	1 ½ tab
9-11.9 Kg	2 ½ tab	*	2 ½ tabs
12-14.9 Kg	3 tabs	¾ tab	3 tabs
15-19.9 Kg	4 tabs	1 tab	4 tabs
20-24.9 Kg	5 tabs	1 tab	5 tabs
25-29.9 Kg	6 tabs	1½ tab	6 tabs

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. Warm fluids

- **Harmful remedies to discourage:**

Alcohol, chlorpheniramine, Promethazine, Codeine containing cough mixtures etc

Treat Eye Infection with Tetracycline Eye Ointment

- **Clean both eyes 3 times daily**.
  - Wash hands.
  - Use clean cloth and water to gently wipe away pus.
- **Then apply tetracycline eye ointment in both eyes 3 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 or Miconazole oral gel

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 or Miconazole 5 mls four times a day for 5 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 VITAMIN A, MULTIVITAMIN, ALBENDAZOLE IN CLINIC AND ZINC SULPHATE

- **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 3 doses of Vitamin A for ***treatment*** if the child has MEASLES. ;(first dose in clinic, then give the caretaker 2 doses to take home-one due the next day and the third dose in day 14.) 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	VITAMIN A DOSE
6 up to 12 months	100 000 IU
One year and older	200 000 IU

Give Multivitamin

- Supplementation for persistant diarrhoea

  -Give 5 mls daily for 14 days.

Give Albendazole

- Give albendazole as a single dose in clinic :
- For the child 1-2 years give 200mg
- For the child 2-5 years give 400mg

GIVE VITAMIN A, MULTIVITAMIN, ALBENDAZOLE IN CLINIC AND ZINC SULPHATE

Give Zinc Sulphate

Give all children with diarrhoea Zinc sulphate for 2 weeks

- Infants less than 6 months give 10mg elemental Zinc as a daily dose
- Children more than 6 months give 20mg elemental Zinc as a daily dose

Show the caretaker how to give Zinc sulphate

Infants : Dissolve the tablet in a small amount of expressed breast milk, ORS or clean water, in a small cup or spoon

Older children: Tablet can be chewed or dissolved in a small amount of clean water in a cup or spoon.

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 ml	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 ml	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*

*** Artesunate is the first line drug for all severe malaria cases and Quinine is an alternative*

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

NB. The word "Mother" refers to Caretaker in the abscence of the Mother

PLAN A: TREAT DIARRHOEA AT HOME

Admit to DECAM corner for one hour and give ORS 10ml/kg to assess if the child is able todrink and tolerate the ORS.

If tolerating send home and counsel the mother on the 4 Rules of Home Treatment:

1. Give ORS and Extra Fluid
2. Give Zinc Supplements
3. Continue Feeding
4. When to Return.

1. ***GIVE ORS AND 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 or formula fed, give ORS or clean boiled water in addition to milk.
     - If the child is not exclusively breastfed, give one or more of the following: ORS solution, food-based fluids (such as soup, rice water, and yoghurt drinks), or clean boiled water.
   - **It is especially important to give ORS at home when:**
     - *the child has been treated with Plan B or Plan C during this visit.*
     - *the child cannot return to a clinic if the diarrhoea gets worse.*
   - **TEACH THE MOTHER HOW TO PREPARE AND GIVE ORS. GIVE THE MOTHER 4 PACKETS OF ORS TO USE AT HOME.**
   - **SHOW THE MOTHER HOW MUCH FLUID TO GIVE IN ADDITION TO THE USUAL FLUID INTAKE:**

***Use the child's age only when you don't know the weight**. The appropriate amount of ORS required in (mls) can be calculated by multiplying the child 's weight in (kg) times 10* **(i.e 10mls/kg) OR :**

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

Tell the mother to:

- Give frequent small sips from a cup.
- If the child vomits, wait 10 minutes. Then continue, but more slowly.
- Continue giving extra fluid until the diarrhoea stops.
- ***GIVE ZINC***
  - **TELL THE MOTHER HOW MUCH ZINC TO GIVE (20 mg tab):**

0 months up to 6 months	1/2 tablet daily for 14 days
6 months or more	1 tablet daily for 14 days

  - **SHOW THE MOTHER HOW TO GIVE ZINC SUPPLEMENTS**
    - Infants - dissolve tablet in a small amount of expressed breast milk, ORS or clean boiled water in a cup.
    - Older children - tablets can be chewed or dissolved in a small amount of water.
- ***CONTINUE FEEDING***
- ***WHEN TO RETURN***
  - ***Advice when to return immediately back to the nearest clinic***
  - ***Follow up in 3 days (Exact date of review)***

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**	**6 - <10 kg**	**10 - <12 kg**	**12 - 19 kg**
AGE*	**Up to 4 months**	**4 months up to 12 months**	**12 months up to 2 years**	**2 years up to 5 years**
In ml	200 - 450	450 - 800	800 - 960	960 - 1600

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

  - If the child wants more ORS than shown, give more.
- SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.
  - Give frequent small sips from a cup.
  - Give an additional 10ml/kg per loose stool or vomitus during rehydration
  - If the child vomits, wait 10 minutes. Then continue, but more slowly. If vomiting continues refer the child.
  - 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.
  - IF child has improved, send patient home as per **Plan A**
  - IF minimal/ no improvement/ vomiting everything continue management as per **Plan C**
  - Introduce/continue feeds before discharge.
- **IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:**
  - Show her how to prepare ORS solution at home.
  - Show her how much ORS to give to finish 4-hour treatment at home.
  - Give her enough ORS packets to complete rehydration. Also give her 2 packets as recommended in **Plan A**.
  - Explain the 4 Rules of Home Treatment:
    1. **GIVE ORS AND EXTRA FLUID**
    2. **GIVE ZINC (age 2 months up to 5 years)**
    3. **CONTINUE FEEDING**
    4. **WHEN TO RETURN**
       - Advice when to return immediately back to the nearest clinic
       - Follow up in 3 days (Exact date of review)

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

PLAN C: TREAT SEVERE DEHYDRATION QUICKLY

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

START HERE

Intravenous (IV) line secured? YES→

- **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, 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 times 1 if no improvement.

- **Reassess the child every 1-2 hours.**
- 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 ↓

Insert Naso-gastric (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.

NO ↓

Refer URGENTLY to hospital

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.

TREATMENT OF SEVERE DEHYDRATION WITH SEVERE MALNUTRITION

1. COUNSCIOUS/NOT IN SHOCK (Sunken eyes, not able to drink or drinking poorly, skin pinch goes back very slowly) N.B History of fluid losses will be a better option.

Do not give IV fluids

For all children:

- Give ReSomal 5ml/kg every 30 minutes for the first 2 hours
- Then 5-10 ml/kg/hour for the next 4-10 hours
- Give more ReSomal if the child wants more orlarge stools or vomiting
- Check blood glucose
- Treat if <3 mol/l

2. LETHARGIC OR UNCONSCIOUS WITH OTHER FEATURES OF SHOCK. (rapid pulse, cold peripheries, delayed capillary refil)

- Insert an IV line(and draw blood for emergency laboratory investigations)
- Weigh the child(or estimate weight) to calculatethe volume of the fluid to be given
- Give the IV fluid 15 ml/kg over 1 hour. Use one of the following solutions(in order of preference) according to availability:
-

-Give Half Darrow's solution - if not available GIVE:

-Ringer' s lactate with 5% glucose(dextrose); or

Weight	Volume*
4 kg	60 ml
6 kg	90 ml
8 kg	120 ml
10 kg	150 ml
12 kg	180 ml
14 kg	210 ml
16 kg	240 ml
18 kg	270 ml

*GIVE EACH AMOUNT OVER 1 HOUR (15 ML/KG)

- Measure the pulse and breathing rate at the start and every 5 -10 minutes.

If there are signs of no improvement:

-give repeat IV 15 ml/kg over 1 hour;then

-switch to oral or nasogastric rehydratoin with ReSomal, 10 ml/kg/h up to 10 hours;then

-initiate refeeding with starter F-75.

A CHILD WITH SEVERE ACUTE MALNUTRITION SHOULD NOT BE GIVEN ORS.

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 the child to eat often 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

MANAGEMENT OF A CHILD PRESENTING WITH ACUTE DIARRHOEA (AGE 2-59MONTHS)

Acute Diarrhoea

Look for other associated symptoms e.g history of bloody stools, signs of malnutrition, fever, cough, pallor

MALNUTRITION

See malnutrition protocol

Assessment of dehydration

Assessment	Minimal/None	Mild to moderate (2 or more)	Severe (2 or more)
Mental status	Well, alert	Normal/fatigued/restless/irritable	Apathic, lethargic, unconscious
Thirst	Drinks normally	Thirsty: eager to drink	Drinks poorly, unable to drink
Skin fold	Instant recoil	Recoil in <2 seconds	Recoil in >2 seconds
Eyes	Normal	Slightly sunken	Deeply sunken
Heart Rate	Normal	Normal to increased	Tachycardic, bradycardic in severe cases
Quality of pulses	Normal	Normal to increased	Weak, thread, impalpable
Breathing	Normal	Normal; fast	Deep
Tears	Present	Decreased	Absent
Mouth and tongue	Moist	Dry	Very dry, parched
Capillary Refill	Normal	Prolonged	Prolonged
Extremities	Warm	Cool	Cool, mottled, cyanotic
Urine output	Normal/decreased	Decreased	Minimal
Management	A	B	C

PLAN A:MINIMAL/NONE

- Admit to DECAM corner and give ORS 10ml/kg
- If tolerating, s end home with 4 packets of ORS
- Continue feeding including breastfeeding
- Give zinc supplement for 14 days
  - 10mg: 0 to < 6months
  - 20mg: > 6months
- Follow -up in 3days
- Advice when to return immediately
- If not tolerating ORS or vomiting everything, refer to hospital as per PLAN C

PLAN B: SOME DEHYDRATION

- Give ORS at 75ml/kg over 4 hours

WT (kg)	< 6kg	6 - <10kg	10 - <12kg	>12kg
Age (mnths)	0 - 4	4 - 12	12-24	24-59
ml	200-450	450-800	800-960	960-1600

- Continue feeding whenever the child wants
- Give an additional 10ml/kg per loose stool or vomitus during rehydration
- After 4 hours reassess and classify the child
- If child has improved, send patient home as per Plan A
- If minimal/no improvement/vomiting everything continue management as per Plan C

PLAN C: SEVERE DEHYDRATION

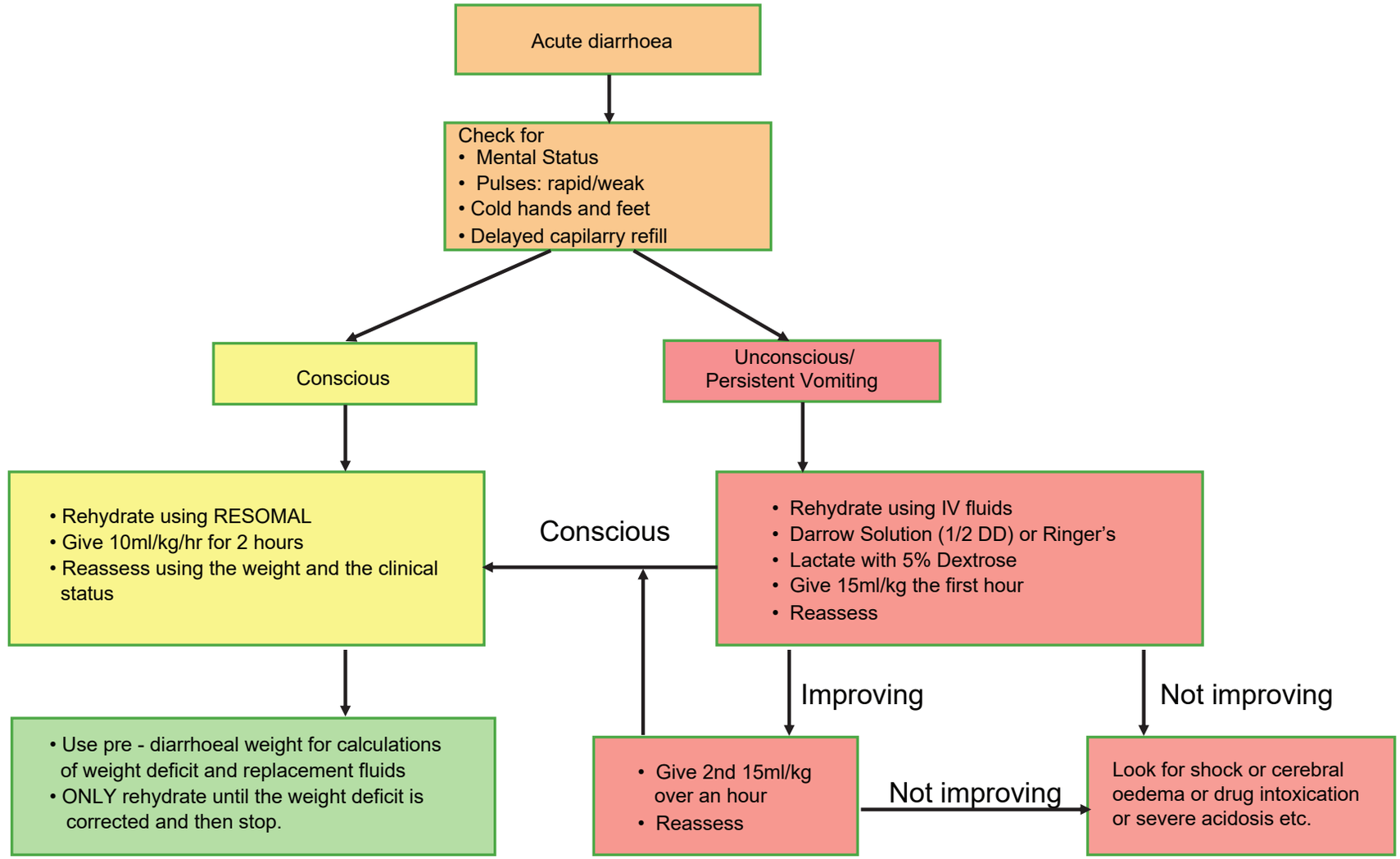
- Start IV fluids immediately using Ringer's Lactate or Normal Saline

AGE	1st give 30ml/kg	Then give 70ml/kg
Infants (< 12mnths)	1 hour	5 hours
Children (1 -5yrs)	30 mins	2.5hrs

- Repeat if radial pulse is still very weak or not palpable or if there is no improvement
- If IV drip is not available within 5 minutes, insert NGT and start oral rehydration
  - Give ORS 20ml/kg/hour for 6 hours (total 120ml/kg)
- Reassess the child every 1 -2 hours while waiting for transfer
- If there is vomiting, give ORS more slowly
- Transfer patient to hospital for further management

* All children presenting with diarrhoea and/vomiting under 2 months of age should be referred to the hospital for further assesmment
* Stool sample is not routinely indicated except in cases of bloody diarrhoea or surveillance purposes

MANAGEMENT OF ACUTE DIARRHOEA IN MALNORISHED CHILDREN (UNDERNUTRITION)



*All children with malnutrition (known or new diagnosis) who present with diarrhoea should be referred to hospital for further management

TREAT THE HIV INFECTED CHILD

Steps when Initiating ART in Children

All children less than 5 years who are HIV infected should be initiated on ART irrespective of CD4 count or clinical stage.

Remember that if a child has any general danger sign or a severe classification, he or she needs URGENT REFERRAL. ART initiation is not urgent, and the child should be stabilized first.

REFER TO HIV GUIDELINES PAGE 39 to 41

Refer to Social Worker for further counselling.

Manage Side Effects of ARV Drugs

SIGNS or SYMPTOMS	APPROPRIATE CARE RESPONSE
Yellow eyes (jaundice) or abdominal pain	Stop drugs and REFER URGENTLY
Rash	If on **abacavir**, assess carefully. Is it a dry or wet lesion? Call for advice. If the rash is severe, generalized, or peeling, involves the mucosa or is associated with fever or vomiting: stop drugs and REFER URGENTLY
Nausea	Advise that the drug should be given with food. If persists for more than 2 weeks or worsens, call for advice or refer.
Vomiting	Children may commonly vomit medication. Repeat the dose if the medication is seen in the vomitus, or if vomiting occurred 30 minutes of the dose being given. **If vomiting persists**, the caregiver should bring the child to clinic for evaluation. **If vomiting everything, or vomiting associated with severe abdominal pain or difficulty breathing, REFER URGENTLY.**
Diarrhoea	Assess, classify, and treat using diarrhoea charts. Reassure mother that if due to ARV, it will improve in a few weeks. Follow-up as per chart booklet. If not improved after two weeks, call for advice or refer.
Fever	Assess, classify, and treat using feve chart.
Headache	Give paracetamol. If on efavirenz, reassure that this is common and usually self-limiting. If persists for more than 2 weeks or worsens, call for advice or refer.
Sleep disturbances, nightmares, anxiety	This may be due to **efavirenz**. Give at night and take on an empty stomach with low-fat foods. If persists for more than 2 weeks or worsens, call for advice or refer.
Tingling, numb or painful feet or legs	If new or worse on treatment, call for advice or refer.
Changes in fat distribution	Consider switching from stavudine to abacavir, consider to viral load. Refer if needed.

IMMUNIZE EVERY SICK CHILD AS NEEDED

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

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

PNEUMONIA

After 3 days:

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

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

} See *ASSESS & CLASSIFY* chart.

Treatment:

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

DIARRHOEA

After 3 days:

Check for General Danger Signs

Assess the child for diarrheoa
Ask:

- Has the diarrhoea stopped?
- How many loose stools is the child having per day?
- Is there blood in stool?

Then Assess and classify for diarrhoea

Treatment:

- If ***any General Danger Sign or Severe Dehydration refer the child to the hospital Urgently***
- If ***Some Dehydration choose Plan B***
- ***If No Dehydration choose Plan A***

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.

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 and refer to the hospital.
- 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.

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

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).

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***, complete 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 ciprofloxacin drops tree times a day. Encourage her to continue.
  - Do a pus swab then refer for further management

FEEDING PROBLEM

After 7 days:
Reassess feeding. > See questions in the *COUNSEL THE CARETAKER* chart.
Ask about any feeding problems found on the initial visit.

- Counsel the caretaker about any new or continuing feeding problems. If you counsel the caretaker 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 caretaker to return every 14 days until the child is -2Z score and above.

ANAEMIA

After 14 days:
- Give iron. Advise mother to return in 14 days for more iron.
- Repeat FBC
- Continue giving iron every 14 days for 1 month.
- If the child has palmar pallor after 1 months, refer for assessment.

UNCOMPLICATED SEVERE ACUTE MALNUTRITION

After 7 days or during regular follow up:
Do a full reassessment of the child. > See *ASSESS & CLASSIFY* chart.
Assess child with the same measurements (WFH/L, MUAC) as on the initial visit.
Check for oedema of both feet.
Check the child's appetite by offering ready-to use therapeutic food if the child is 6 months or older.

Treatment:
- If the child has **COMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or MUAC is less than 115 mm or oedema of both feet AND has developed a medical complication or oedema, or fails the appetite test), refer URGENTLY to hospital.
- If the child has **UNCOMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or MUAC is less than 115 mm 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 7 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 7 days. Continue to see the child every 7 days until the child's WFH/L is 2 z scores or more, and/or MUAC is 125 mm or more.
- If the child has **NO ACUTE MALNUTRITION** (WFH/L is -2 z-scores or more, or MUAC is 125 mm or more), praise the mother, STOP RUTF and counsel her about the age appropriate feeding recommendations (see COUNSEL THE MOTHER chart).

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

MODERATE ACUTE MALNUTRITION

After 14 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 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 14 days. Continue to see the child every 14 days until the child is feeding well and gaining weight regularly or his or her WFH/L is -2 z-scores or more or MUAC is 125 mm. or more.

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

GIVE FOLLOW-UP CARE FOR HIV EXPOSED AND INFECTED CHILD

HIV EXPOSED

Follow up regularly as per national guidelines.

At each follow-up visit follow these instructions:

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

HIV testing:

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

If child is confirmed HIV infected

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

If child is confirmed uninfected

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

CONFIRMED HIV INFECTION NOT ON ART

Follow up regularly as per national guidelines.

At each follow-up visit follow these instructions:

- Ask the mother: Does the child have any problems?
- Do a full assessment including checking for mouth or gum problems, treat, counsel and follow up any new problem
- Counsel and check if mother able or willing now to initiate ART for the child.
- Provide routine child health care: Vitamin A, deworming, immunization, and feeding assessment and counselling
- Continue cotrimoxazole prophylaxis if indicated.
- Initiate or continue isoniazid preventive therapy if indicated.
- If no acute illness and mother is willing, initiate ART (See Box Steps when Initiating ART in children)
- Monitor CD4 count and percentage.
- Ask about the mother's health, provide HIV counselling and testing.

Home care:

- Counsel the mother about any new or continuing problems
- If appropriate, put the family in touch with organizations or people who could provide support
- Advise the mother about hygiene in the home, in particular when preparing food

- Plan for the next follow-up visit

GIVE FOLLOW-UP CARE FOR HIV EXPOSED AND INFECTED CHILD

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

Follow up regularly as per national guidelines.

STEP 1: ASSESS AND CLASSIFY

ASK: Does the child have any problems?

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

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

- Severe skin rash
- Difficulty breathing and severe abdominal pain Yellow eyes
- Fever, vomiting, rash (only if on Abacavir)
- Check for other ART side effects

} If present, give any prereferral treatment, REFER URGENTLY

STEP 2: MONITOR PROGRESS ON ART

IF ANY OF FOLLOWING PRESENT, REFER NON-URGENTLY:

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

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

If any of these present, refer NONURGENTLY:

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

STEP 3: PROVIDE ART, COTRIMOXAZOLE AND ROUTINE TREATMENTS

If child is stable: continue with the ART regimen and cotrimoxazole doses.

Check for appropriate doses: remember these will need to increase as the child grows

Give routine care: Vitamin A supplementation, deworming, and immunization as needed

STEP 4: COUNSEL THE MOTHER OR CAREGIVER

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

- **Key issues to discuss include:** How the child is progressing, feeding, adherence, side-effects and correct management, disclosure (to others and the child), support for the caregiver

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

COUNSEL THE CARETAKER

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 ta customed 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.

FEEDING COUNSELLING

Assess Child's Feeding

Assess feeding if child is Less Than 2 Years Old, Has MODERATE ACUTE MALNUTRITION, ANAEMIA, CONFIRMED HIV INFECTION, or is HIV EXPOSED. 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?

In addition, for HIV EXPOSED child:

- **If mother and child are on ARV treatment or prophylaxis and child breastfeeding, ASK:**
  - **Do you take ARV drugs? Do you take all doses, miss doses, do not take medication?**
  - **Does the child take ARV drugs (The policy is to take ARV prophylaxis until 28 days after birth). Does he or she take all doses, missed doses, does not take medication?**
- **If child not breastfeeding, 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 the mother demonstrate or explain how a feed is prepared, and how it is given to the infant.**
  - **Are you giving any breast milk at all?**
  - **Are you able to get new supplies of milk before you run out?**
  - **How is the milk being given? Cup or bottle?**
  - **How are you cleaning the feeding utensils?**

FEEDING COUNSELLING

Feeding Recommendations During Sickness and Health

Feeding recommendations FOR ALL CHILDREN during sickness and health, and including HIV EXPOSED children on ARV prophylaxis

Newborn, birth up to 1 week	1 week up to 6 months	6 up to 9 months	9 up to 12 months	12 months up to 2 years	2 years and older
					
■ Immediately after birth, put your baby in skin to skin contact with you. ■ Allow your baby to take the breast within the first hour. Give your baby colostrum, the first yellowish, thick milk. It protects the baby from many Illnesses. ■ Breastfeed day and night, as often as your baby wants, at least 8 times In 24 hours. Frequent feeding produces more milk. ■ If your baby is small (low birth weight), feed at least every 2 to 3 hours. Wake the baby for feeding after 3 hours, if baby does not wake self. ■ DO NOT give other foods or fluids. Breast milk is all your baby needs. This is especially important for infants of HIV-positive mothers. Mixed feeding increases the risk of HIV mother-to-child transmission when compared to exclusive breastfeeding.	■ Breastfeed as often as your child wants. Look for signs of hunger, such as beginning to fuss, sucking fingers, or moving lips. ■ Breastfeed day and night whenever your baby wants, at least 8 times in 24 hours. Frequent feeding produces more milk. ■ Do not give other foods or fluids. Breast milk is all your baby needs.	■ Breastfeed as often as your child wants. ■ Also give thick porridge or well-mashed foods, including animal-source foods and vitamin A-rich fruits and vegetables. ■ Start by giving 2 to 3 tablespoons of food. Gradually increase to 1/2 cups (1 cup = 250 ml). ■ Give 2 to 3 meals each day. ■ Offer 1 or 2 snacks each day between meals when the child seems hungry.	■ Breastfeed as often as your child wants. ■ Also give a variety of mashed or finely chopped family food, including animal-source foods and vitamin A-rich fruits and vegetables. ■ Give 1/2 cup at each meal(1 cup = 250 ml). ■ Give 3 to 4 meals each day. ■ Offer 1 or 2 snacks between meals. The child will eat if hungry. ■ For snacks, give small chewable items that the child can hold. Let your child try to eat the snack, but provide help if needed.	■ Breastfeed as often as your child wants. ■ Also give a variety of mashed or finely chopped family food, including animal-source foods and vitamin A-rich fruits and vegetables. ■ Give 3/4 cup at each meal (1 cup = 250 ml). ■ Give 3 to 4 meals each day. ■ Offer 1 to 2 snacks between meals. ■ Continue to feed your child slowly, patiently. Encourage —but do not force— your child to eat.	■ Give a variety of family foods to your child, including animal-source foods and vitamin A-rich fruits and vegetables. ■ Give at least 1 full cup (250 ml) at each meal. ■ Give 3 to 4 meals each day. ■ Offer 1 or 2 snacks between meals. ■ If your child refuses a new food, offer "tastes" several times. Show that you like the food. Be patient. ■ Talk with your child during a meal, and keep eye contact.

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

FEEDING COUNSELLING

Feeding Recommendations for HIV EXPOSED Child on Infant Formula Only

These feeding recommendations are for HIV EXPOSED children in setting where the national authorities recommend to avoid all breastfeeding or when the mother has chosen formula feeding.

PMTCT: If the baby is on AZT for prophylaxis, continue until 4 to 6 weeks of age.

Up to 6 months

- **FORMULA FEED exclusively. Do not give any breast milk. Other foods or fluids are not necessary.**
- **Prepare correct strength and amount just before use. Use milk within two hours. Discard any left over—a fridge can store formula for 24 hours.**
- **Cup feeding is safer than bottle feeding. Clean the cup and utensils with hot soapy water.**

Give the following amounts of formula 8 to 6 times per day:

Age in months	Approx. amount and times per day
0 up to 1	60 ml x 8
1 up to 2	90 ml x 7
2 up to 4	120 ml x 6
4 up to 6	150 ml x 6

6 up to 12 monts

- **Give 1-2 cups (250 - 500 ml) of infant formula or boiled, then cooled, full cream milk. Give milk with a cup, not a bottle.**
- **Give:**

_____

_____

_____

_____ *

- **Start by giving 2-3 tablespoons of food 2 - 3 times a day. Gradually increase to 1/2 cup (1 cup = 250 ml) at each meal and to giving meals 3-4 times a day.**
- **Offer 1-2 snacks each day when the child seems hungry.**
- **For snacks give small chewable items that the child can hold. Let your child try to eat the snack, but provide help if needed.**

12 months up to 2 years

- **Give 1-2 cups (250 - 500 ml) of boiled, then cooled, full cream milk or infant formula.**
- **Give milk with a cup, not a bottle.**
- **Give:**

_____

_____

_____

_____ *

or family foods 3 or 4 times per day. Give 3/4 cup (1 cup = 250 ml) at each meal.

- **Offer 1-2 snacks between meals.**
- **Continue to feed your child slowly, patiently.**
- **Encourage - but do not force - your child to eat.**

Safe preparation of replacement feeding

Infant formula

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

Cow's milk

- **Cow' s or other animal milks are not suitable for infants below 6 months of age (even modified).**
- **For a child between 6 and 12 month of age: boil the milk and let it cool (even if pasteurized).**
- **Feed the baby using a cup.**

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

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 (e.g. full cream cow's 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 only formula or cow's milk once baby takes all feeds by cup

3. 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, madila 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 HIV/AIDS prevention.

Give additional counselling if the mother is HIV-positive

- Reassure her that with regular followup, much can be done to prevent serious illness, and maintain her and the child's health
- Emphasize good hygiene, and early treatment of illnesses

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
■ PERSISTENT DIARRHOEA ■ ACUTE EAR INFECTION ■ CHRONIC EAR INFECTION ■ COUGH OR COLD, if not improving	5 days
■ UNCOMPLICATED SEVERE ACUTE MALNUTRITION ■ FEEDING PROBLEM	14 days
■ ANAEMIA	14 days
■ MODERATE ACUTE MALNUTRITION	30 days
■ CONFIRMED HIV INFECTION ■ HIV EXPOSED	According to national recommendations

NEXT WELL-CHILD VISIT: Advise the mother to return for next immunization according to immunization schedule.

WHEN TO RETURN IMMEDIATELY

Advise mother to return immediately if the child has any of these signs:	
Any sick child	■ Not able to drink or breastfeed ■ Becomes sicker ■ Develops a fever
If child has COUGH OR COLD, also return if:	■ Fast breathing ■ Difficult breathing
If child has diarrhoea, also return if:	■ Blood in stool ■ Drinking poorly

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

CHILD DEVELOPMENT

- Children become more capable as they grow older. They learn to talk, walk, and run.They learn to think and solve problems. These changes are examples of the child's development.
- This learning helps them to do well in school and, when they grow up, to contribute to their families and communities.
- The recommendations in the counselling card provide ideas for activities families can do to help their children learn.
- The play and communication activities are for all children.
- They describe what mothers and fathers, and others who care for the young child, can do.
- Feeding, dressing, and other daily tasks provide many opportunities for adults to play and communicate with their children.
- The activities also help children grow. For this reason, the recommendations are especially important for low weight babies and undernourished children.
- Studies have found that extra attention through play and communication, as well as through responsive feeding, stimulates the growth of low weight babies and poorly nourished children.
    - Low weight babies and children who are poorly nourished also have difficulty learning. They may be timid and easily upset, harder to feed, and less likely to play and communicate.
    - Since these children are less active, they may be less able to get the attention of the adults who care for them. As a result over time, mothers and other caregivers are less likely to feed, play with, or communicate frequently with them. They may also need help to understand how their children communicate their hunger, discomfort, interests, and other needs.
- Poorly nourished, sick, and disabled children all have special needs for care.
    - Play and communication can also help caregivers. After giving birth, for example, some mothers find it difficult to become active and involved in caring for their young babies. They may be sick or overwhelmed with their responsibilities. They appear sad and tired. They are uninterested in other people and do not join other family activities.
    - Paying close attention to their babies, playing with them, and seeing how their babies respond to the attention will help these caregivers become more active and happier. They will feel more important in the lives of their young children and more confident in their caring role. The activities help both the child and the caregiver.

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

How children learn

Each child is unique at birth, and the differences among children affect how they learn. Their early care also affects their learning. Experiences during the first years with their families and other caregivers affect the kind of adults children will become.

Families give their children special care for development by giving them love, attention, and many opportunities to learn. By playing and communicating with their children, families help their children grow healthier and stronger. Children learn to communicate their needs, solve problems, and help others. From a very young age, children learn important skills that will prepare them for life.
Much of what children learn, they learn when they are very young
The brain develops most rapidly before birth and during the first two years of life.
· Hearing and sight areas of the brain develop most rapidly during the first 3 and 4 months of life.
· Language areas develop most rapidly between age 6 months and 2 years.
· The areas of the brain for thinking and solving problems begin to develop at birth and reach the peak for the most rapid change at age 12 months.

Good nutrition and good health are especially important when these abilities develop in the early years. Breast milk has a special role in providing the nutrients for the development of the brain. Breast milk also helps young children stay free from illness so that they are strong and can explore and learn from early experiences. Poor nutrition during the early years will limit the child's potential for development for life.
Children can see and hear at birth. Starting when they are very young, children need opportunities to use their eyes and ears, in addition to good nutrition. For their brains to develop well, children also need to move, to have things to touch and explore, and to play with others. Children also need love and affection. All these experiences stimulate the brain to develop.

Children need a safe environment as they learn.Children are always exploring new things while they are learning new skills. They need a clean, safe, protected physical environment to be safe from injuries and accidents while they are playing and learning. Children also should be protected from violence and strong anger at them and around them. Adults need to protect young children from physical harm and harsh criticism, in order to help children gain confidence to explore and learn. When children are young, they often explore by putting things into their sensitive mouths. With their mouths, as well as with their hands, children learn what is soft and hard, hot and cold, dry and moist, and rough and smooth. Families must be sure that the things that young children put into their mouths are large enough so that they cannot swallow them. Also, they should not let children put long, thin, or sharp objects into their mouths.

Any object a child plays with should be clean. Putting the child on a clean blanket or mat helps to keep playthings clean.
When a child wants to play with something that is not safe or not clean, the caregiver may have to gently say "no". While the child is learning, it is helpful to exchange the object for something that is safe and clean. Children can be easily distracted from things they should not do by drawing their interest towards other activities. Children learn by putting things into their sensitive mouths

To feel safe, young children need to have a special relationship with at least one person who can give them love and attention. The sense that they belong to a family will help them get along well with others. It will also give them confidence to learn. Children naturally want to communicate with another person from birth. They become especially close to the caregivers who feed them, spend time communicating with them, and give them love and affection.
Children need consistent loving attention from at least one person. During breastfeeding, a baby and mother are very close. They communicate by responding to the slightest movement and sound, even smell, of the other person. This special responsiveness is like a dance. The baby becomes "attached" to the person who consistently responds to her, holds her, loves her, and helps her feel safe. This connection or bond lasts a lifetime.
Sometimes the mother and baby have difficulty developing this special connection. You can help mothers and other caregivers be sensitive to what their babies are trying to do as they begin to communicate, and help the caregiver respond appropriately. You can help caregivers encourage the efforts of their children to learn. Adults can encourage their children by responding to their children's words, actions, and interests with sounds, gestures, gentle touches, and words. Adults can help their children develop into happy, healthy persons by looking at and talking about the attempts of young children to do new things, to make sounds and to talk, even when children are not yet able to speak.

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

How children learn...continued

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Children need consistent loving attention from at least one person

Children learn by playing and trying things out, and by observing and copying what others do

Children learn by experimenting and solving problems.

Children are curious. They want to find out how they can affect people and things around them, even from the first months of age.

Play is children’s “work”. Play gives children many opportunities to think, test ideas, and solve problems. Children are the first scientists.

Children learn by experimenting and solving problems.

Children can learn by playing with pots and pans, cups and spoons, and other clean household items. They learn by banging, dropping, and putting things in and taking things out of containers. Children learn by stacking things up and watching things fall, and testing the sounds of different objects by hitting them together. Children learn a lot from doing things themselves.

Children learn by playing with simple household items.

Children also learn by imitating what others do. For example, a mother who wants her child to eat a different food shows the child by eating the food herself. To learn a new word, a child must hear it many times. For a child to learn to be polite and respectful, caretaker needs to be polite and respectful to his child.

Children also learn how to react to things by how others react.

Children also learn by imitating what others do.

What children learn from play and communication with others.

The counselling card identifies play and communication activities to encourage and stimulate the child’s physical, social, emotional, and intellectual development.

Some examples of new skills are:

· Physical (or motor)—learning to reach and grab for an object, and to stand and walk.

· Cognitive skills—learning to think and solve problems, to compare sizes and shapes, and to recognize people and things.

· Social—learning to communicate what she needs and use words to talk to another person.

Emotional—learning to calm himself when upset, be patient when learning a new skill, be happy, and make others happy.

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

Prevent Illness , wash hands effectively

Frequent illness in childhood weakens the child. The child in an impoverished environment is at risk of dying each time he faces illness. Some children are sick with diarrhoea and other childhood illnesses 8 or more times a year.

Illness affects the child's growth. Failure to grow, identified on the child's growth curve, often relates to the child's future bouts of illness and possible death.

Illness also affects the child's development. Compared to a healthy child, a child who is frequently sick is less curious. He has less energy to experiment and explore the world around him. Children who are frequently sick, like undernourished children, are often developmentally delayed.

The goal for the community is not just to help a child survive illness, but help to prevent illness. The child needs a healthy life in order to grow and develop well.

The four family practices that help prevent childhood illness and common injuries include:

· Breastfeed the child.

· Vaccinate the child.

· Wash hands.

· Use an insecticidetreated bednet.

· Prevent injury.

Wash hands effectively

Diarrhoea, common colds, pneumonia, and other illnesses can pass from person to person by unclean hands. The community health worker can encourage families to wash their hands during each home visit. Advise the family on the importance of hand washing. The regular practice of hand washing with soap and clean water in the home can help all family members prevent illness. Especially important, it can help prevent major childhood illnesses—pneumonia and diarrhoea, which are the most common killers of children under 5.

Advise the family when to wash hands

Family members should wash their hands:

· After using the latrine or toilet.

· After changing the child's nappies.

· Before preparing and serving food.

· Before feeding children.

· Before eating.

These practices help to prevent illness from spreading among all members of the family. Where there are sick family members, every member should wash their hands also before playing with a child.

Help the family identify a convenient place to wash hands Advise the family on how to wash hands.

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

Use of bednets, Prevent Injury and Respond to illness

Use an insecticide-treated bednets

In an area where malaria is common, children under 5 years (and pregnant women) are particularly at risk of malaria. The mosquitoes that carry the malaria parasite come out to bite at night. Without the protection of bednets, children will get malaria repeatedly. They are at great risk of dying. They should sleep under a bednet that has been treated with an insecticide to repel and kill mosquitoes.

Further, malaria is a major cause of anaemia in young children. Anaemia makes a child very weak and tired. It is more difficult for the child to learn.

Children and pregnant women should sleep under ITN

Help families get a bednet
Advise caregivers on using a bednet for their young children. If the family does not have a bednet, provide information on where to get a bednet. Often the national malaria programme distributes free bednets or bednets at a reduced cost.

Advise families on how to use and maintain a bednet
Unfortunately, many families who have a bednet do not use it correctly. They do not hang the net correctly over the sleeping area. Or they do not tuck it in. They may wash the insecticide out of the net. They may not replace a damaged or torn net

Prevent injury

Curiosity helps a child explore the environment and learn. It also can lead the child into harm. Common dangers that kill or injure small children can often be prevented. Adults need to be aware of whether the child is moving, and what the child touches. They must respond quickly to prevent the child's approach to danger.

Injuries can often be prevented by removing the conditions in the environment that might hurt the child. Adults can:
· Put barriers around fires and hot stoves to prevent burns.
· Lock or put out of reach dangerous objects, including sharp knives, medicine, cleaning supplies, insecticides, and kerosene.
· Drain standing water or put up fences to prevent children from wandering into water holes.
· Fence yards and play grounds to prevent children from running into roads.

Respond to illness

Even when families try to prevent illness in their household, children can become sick many times a year. Poor environments and illness in the community contribute to conditions that are difficult for families to control.

As a result, children often have cough, diarrhoea, or other signs of illness. Where the community health worker has been trained to assess and treat signs of illness, families should bring their sick children to the community health worker as the first stop in seeking care. Otherwise they should take their sick children directly to the health facility.

Responding to illness requires, first, recognizing that the child is sick. Children who are sick may be less active, refuse to eat, or be irritable or fussy. They may have cough, diarrhoea, or other signs that they are ill.

Adults who are sensitive to the early signs of illness can begin to provide good home care—offer more fluids and continue responsive feeding. They can keep the child warm and comfort the child. If the child does not quickly improve, they should take the child to the health facility for care.

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

Children learn by putting things in their sensitive month

How children learn

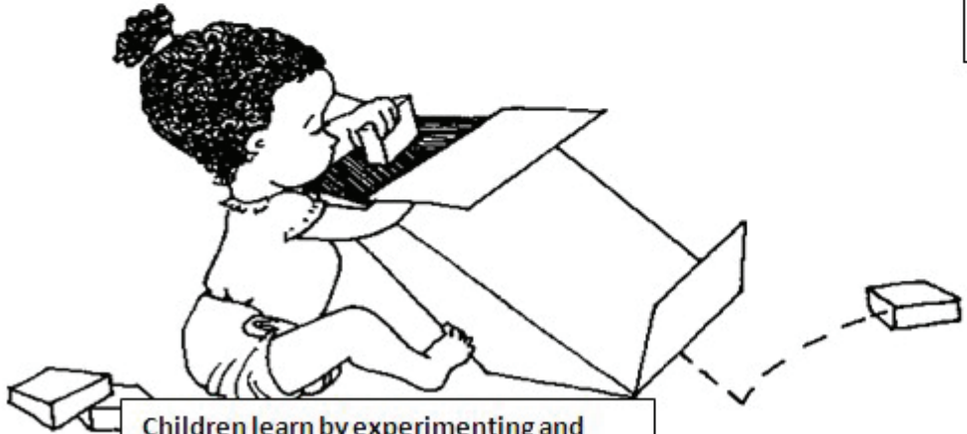
Children need consistent attention from at least one person

COUNSEL THE CAREGIVER ON CARING FOR CHILD 'S HEALTHY GROWTH AND DEVELOPMENT

HOW CHILDREN LEARN

Children also learn by imitating what others do

Children learn by playing with simple house hold items



Children learn by experimenting and solving problems

SICK YOUNG INFANT AGE UP TO 2 MONTHS

ASSESS AND CLASSIFY THE SICK YOUNG INFANT

ASSESS

<u>DO A RAPID APRAISAL OF ALL WAITING INFANTS</u>
ASK THE MOTHER WHAT THE YOUNG INFANT'S PROBLEMS ARE

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

CLASSIFY

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

IDENTIFY TREATMENT

CHECK FOR VERY SEVERE DISEASE AND LOCAL BACTERIAL INFECTION

ASK:

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

LOOK, LISTEN, FEEL:

Check blood sugar (Hypoglyceamia < 3 mmol/l and Hyperglycaemia > 12 mmol/l)

- Count the breaths in one minute. Repeat the count if more than 60 breaths per minute.
- Low respirations < 20 breaths/minute
- Look for severe chest indrawing.
- Grunting
- Oxygen saturation (SPO2) < 90 %

YOUNG INFANT MUST BE CALM

- Measure axillary temperature.
- Look at the umbilicus. Is it red or draining pus?
- Look for few or severe skin pustules.
- Bulging fontanelle
- 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 young infant is not moving, gently stimulate him/her.

  - Does the infant not move at all?

Classify ALL YOUNG INFANTS

Any one of the following signs • Check blood sugar (Hypoglyceamia < 3 mmol/l and Hyperglycaemia > 12 mmol/l) • Not able to feed at all or not feeding well or • Convulsions or • Fast breathing (60 breaths per minute or more) in infants or • Low respirations < 20 breaths/minute or • Severe chest indrawing or • Grunting or • Oxygen saturation (SPO2) < 90 % or • High body temperature (37.5°C* or above) or • Low body temperature (less than 35.5°C*) or • Movement only when stimulated or no movement at all. • Umbilicus red or draining pus • Severe skin pustules • Bulging fontanelle	***Pink:*** **VERY SEVERE DISEASE**	■ **Give first dose of intramuscular antibiotics** ■ **Treat to prevent low blood sugar** ■ **Refer URGENTLY to hospital **** ■ **Advise mother how to keep the infant warm on the way to the hospital**
• Few skin pustules	***Yellow:*** **LOCAL BACTERIAL INFECTION**	■ **Give an appropriate oral antibiotic for 5 days** ■ Teach the mother to treat local infections at home ■ Advice the mother on when to return immediately. ■ Advise mother to give home care for the young infant ■ Follow up in 2 days
• None of the signs of very severe disease or local bacterial infection	***Green:*** **SEVERE DISEASE OR LOCAL INFECTION UNLIKELY**	■ Advise mother to give home care.

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

*** If referral not possible, manage the sick young infant as described in the national referral care guidelines or WHO Pocket Book for hospital care for children, Page 63 of the chartbooklet*

CHECK FOR JAUNDICE

If jaundice present, ASK:

- When did the jaundice appear first?

LOOK AND FEEL:

- Look for jaundice (yellow eyes or skin)
- Look at the young infant's palms and soles. Are they yellow?
- Jaundice with abnormal vital signs

CLASSIFY **JAUNDICE**

• Any jaundice if age less than 24 hours or • Yellow palms and soles at any age. • Jaundice with abnormal vital signs. • Jaundice in young infant who is older than 14 days	***Pink:*** **SEVERE JAUNDICE**	▪ **Increase feeding** ▪ **Treat to prevent low blood sugar** ▪ ***Refer URGENTLY to hospital*** ▪ ***Advise mother how to keep the infant warm on the way to the hospital***
• Jaundice appearing after 24 hours of age and • Palms and soles **not** yellow	***Yellow:*** **JAUNDICE**	▪ Advise the mother to give home care for the young infant and increase feeding ▪ Advise mother to return immediately if palms and soles appear yellow. ▪ Follow-up in 2 day
• No jaundice	***Green:*** **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 when stimulated and 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?
- Check capillary refil time
- Count the breaths in 1 minute
- Feel the extremeties- are they cold?

Classify DIARRHOEA

for DEHYDRATION

One of the following signs: • Not able to feed at all or not feeding well • Movement only when stimulated or no movement at all • Sunken eyes • Skin pinch goes back very slowly. • Restless and irritable • Check capillary refil time (more than 3 seconds) • Fast breathing (60 breaths per minute or more) • Cold extremeties?	***Pink:*** **SEVERE DEHYDRATION**	■ If infant has no other severe classification: ○ Give fluid for severe dehydration (Plan C) OR ***If infant also has another severe classification:*** ○ ***Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** ***Advise the mother to continue breastfeeding*** ■ **Keep the child warm on way to the hospital**
• Not enough signs to classify as severe dehydration.	***Yellow:*** **SOME DEHYDRATION**	■ Give fluid and breast milk for some dehydration (Plan B) ■ Encourage frequent feeding ■ ***If infant has any severe classification:*** ○ ***Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** ○ ***Advise the mother to continue breastfeeding*** ○ ***Advice the mother on how to keep the infant warm on the way to the hospital*** ■ Advise mother when to return immediately ■ Follow-up in 1 day
• Child meets Plan B requirements/actions	***Green:*** **NO DEHYDRATION**	■ Give fluids to treat diarrhoea at Home and continue breastfeeding (Plan A) ■ Advice the caretaker on when to return immediately ■ Follow up in 2 days

IF BLOOD IN STOOL

• blood in stool	***Pink:*** **BLOOD IN STOOL**	■ Give first dose of IM antibiotics ■ Refer URGENTLY to the hospital ■ Advice the mother to continue breastfeeding ■ Keep the baby warm

*** 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 faecal matter).

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

THEN,CHECK THE YOUNG INFANT FOR HIV INFECTION (Use this chart if the child is not enrolled in HIV care)

Assessment box

ASK:

-Has the mother had an HIV test?

If yes:

- Mother POSITIVE or NEGATIVE?
- Has the infant had an HIV test?

If yes :

-Virolgical test POSITIVE or NEGATIVE?

If no:

-Mother or infant HIV test not done

If mother is HIV Positive and the infant does NOT have a positive virological test, ASK:

-Is the infant breastfeeding now?

-Was the young infant breastfeeding at the time of the test or before it?

-Is the mother on treatment and the infant on antiretroviral prophylaxis or ART treatment?

CLASIFY HIV INFECTION by test results.

• Infant has positive virological test	***Yellow:*** **CONFIRMED HIV INFECTION**	■ Give cotrimoxazole prophylaxis* from age 4-6 weeks. ■ refer or give antiretroviral treatment and HIV CARE. ■ Refer or start the mother on antiretrovirals if not on treatment. ■ advise the mother on home care. ■ follow-up as per national guidlines.
• Mother is HIV positive AND infant who is breastfeeding or stopped less than 3 months ago has negative virological test or • Mother is HIV positive, and young infant not yet tested.	***Yellow:*** **HIV EXPOSED: POSSIBLE INFECTION**	■ Give Cotrimoxazole prophylaxis* from age 4-6 weeks. ■ Start or contnue antiretroviral prophylaxis according to risk assessment. ■ Conduct a virological test : 1. Test the high risk infant at birth and if negative repeat at 6-8 weeks 2. Test the low risk infant at age 4-6 weeks and repeat 3 momths after the child stops breastfeeding.** ■ Refer or start the mother on antireretrovirals if not on treatment. ■ Advise the mother on home care. ■ Follow up regularly as per national guidlines.
HIV test not done for mother or infant	***Yellow:*** **HIV INFECTION STATUS UNKNOWN**	■ Inititate HIV testing and counselling. ■ Conduct HIV test for the mother and if positive, a virological test for the infant. ■ conduct virological test for the infant if thew mother is not available.
• Negative HIV test fro the mother or Negative virological test for infant.	***Green:*** **HIV INFECTION UNLIKELY**	■ Treat, counsel and follow up any infections. ■ Advise the mother about feeding and about her own health. ■ Advise breastfeeding mother to test every three months.

*** Do not give Cotrimoxazole to the child less than 1 month,jaundiced or prematurity.**

****All HIV exposed high risk infants should be tested at the initial visit.**

NB - Only do serological test in abandoned babies to determine HIV exposure status.

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

Use this table to assess feeding of all young infants except HIV-exposed young infants not breastfed. For HIV-exposed non-breastfed young infants see chart "THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN NON-BREASTFED INFANTS"

If an infant has no indications to refer urgently to hospital:

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, LISTEN, FEEL:

- Determine weight for age.
- weight less than 2 KG?
- Weight for age less than -2 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?
  - Good attachment poor *attachement No attachement at all*
- **TO CHECK ATTACHMENT, LOOK FOR:**
  - *Chin touching breast*
  - *Mouth wide open*
  - *Lower lip turned outwards*
  - *More areola visible above than below the mouth*

  (All of these signs should be present if the attachment is good.)
- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?

  Suckling effectively Not suckling effectively Not suckling at all

Clear a blocked nose if it interferes with breastfeeding.

Classify FEEDING

• Weight <2 kg in infants in 7 days*	***Pink:*** **VERY LOW WEIGHT**	■ **Refer URGENTLY to hospital.** ■ **Treat to prevent low blood sugar.** ■ **Advise the mother on keeping the young infant warm om the way to the 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 • Weight for age less than -2 Z score. or • Thrush or Ulcers in mouth	***Yellow:*** **FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	■ If not well attached or not suckling effectively teach correct positioning and attachement. ■ If not able to attach well immediately, teach the mother to express breast milk and feed by cup. ■ If breastfeeding less than 8 times in 24 hours , advise to increase frequency of feeding. advise the mother to breastfeed as often and as long as the infant wants, day and night. ■ If not breastfeeding at all: ■ Refer for breastfeeding counselling and possible relactation. ■ Advise about correctly preparing breast milk substitues and using cup. ■ advise the mother how to feed and keep the low weight infant warm at home. ■ If trush, teach the mother to treat trush at home ■ Advise mothr to give home carefor the young infant. ■ Follow up any feeding problem or trush in 2 days. ■ Follow up low weight for age in 7 days.
• Not low weight for age and no other signs of inadequate feeding.	***Green:*** **NO FEEDING PROBLEM**	■ Advise mother to give home care for the young infant ■ Praise the mother for feeding the infant well.

* This excludes infants born with weight less than 2 kg and gained weight

* This applies to children born at home, less than 2kg or born at clinics with maternity and not introduced to KMC (Kangaroo Mother Care) needs to be refered.

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

Use this chart for HIV EXPOSED infants not breastfeeding AND the infant has no indications to refer urgently to hospital:

Ask:

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

LOOK, LISTEN, FEEL:

- Determine weight for age.
- Weight less that 2kg
- Look for ulcers or white patches in the mouth (thrush).

Classify FEEDING

Weight <2 kg in infants in 7 days*	***Pink:*** **VERY LOW WEIGHT**	■ Refer URGENTLY to hospital. ■ Treat to prevent low blood sugar. ■ Advise the mother on keeping the young infant warm om the way to the hospital.
• Milk incorrectly or unhygienically prepared or Giving inappropriate replacement feeds or Giving insufficient replacement feeds or • An HIV positive mother mixing breast and other feeds before 6 months or • Using a feeding bottle or • Weight for age less than -2 Z score or • Thrush (ulcers or white patches in mouth).	***Yellow:*** **FEEDING PROBLEM OR LOW WEIGHT**	■ 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 ■ 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 any feeding problem or thrush in 1 day ■ Follow-up low weight for age in 7 days
• Not low weight for age and no other signs of inadequate feeding.	***Green:*** **NO FEEDING PROBLEM**	■ Advise mother to give home care for the young infant ■ Praise the mother for feeding the infant well. ■ Ensure good hygiene.

THEN CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS:

IMMUNIZATION SCHEDULE:	AGE	VACCINE	
	Birth	BCG*	Hep B

- *Young infants who are HIV Positive or of unknown HIV status with symptoms consistent of HIV Infection should not be given BCG
- *Young infants born to mothers with TB infection must not be given BCG until the child test negative for PTB, meanwhile give TB prophylaxis(INH)

- **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

ASSESS THE MOTHER'S HEALTH NEEDS

Nutritional status and anaemia, contraception. Check hygienic practices.

TREAT AND COUNSEL

TREAT THE YOUNG INFANT

GIVE FIRST DOSE OF INTRAMUSCULAR ANTIBIOTICS

- Give first dose of both ampicillin and gentamicin intramuscularly.

WEIGHT	AMPICILLIN Dose: 50 mg per kg To a vial of 250 mg	GENTAMICIN
	Dose : 50 mg per kg	5 mg per kg

** Use manufacuture' s recommendation on reconstitution*

- Referral is the best option for a young infant classified with VERY SEVERE DISEASE. If referral is not possible, continue to give ampicillin and gentamicin for at least 5 days. Give ampicillin two times daily to infants less than one week of age and 3 times daily to infants one week or older. Give gentamicin once daily.

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 10 ml/kg expressed breast milk before departure. If not possible to give expressed breast milk, give 10 ml/kg sugar water ***(To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean boiled water)***.
- ***If the young infant is not able to swallow:***

  Give 10 ml/kg of expressed breast milk or sugar water by nasogastric tube.

IF IV LINE IS IN SITU, A BOLUS OF DEXTROSE 10% AT 2 ml/kg

TEACH THE MOTHER HOW TO KEEP THE YOUNG INFANT WARM ON THE WAY TO THE HOSPITAL

- Provide skin to skin contact (kangaroo mother care/KMC)

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

TREAT THE YOUNG INFANT

GIVE AN APPROPRIATE ORAL ANTIBIOTIC FOR LOCAL BACTERIAL INFECTION

- First-line antibiotic: _____
- Second-line antibiotic:_____

AGE or WEIGHT	AMOXICILLIN FOR 5 DAYS	
	Tablet 250 mg	Syrup 125 mg in 5 ml
Birth up to 1 month (<4 kg) *	1/4	2.5 ml **(TWICE DAILY)**
1 month up to 2 months (4-<6 kg)	1/2	5 ml **(THREE TIMES DAILY)**

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TEACH THE MOTHER 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

The mother should do the treatment twice daily for 5 days:

- Wash hands
- Gently wash the affected area with soap and water
- Dry the area
- Wash hands

To Treat Mouth Ulcers or Thrush with Micinazole or Nystatin

- The mother should do the treatment four times daily for 7 days:
  - Wash hands
- Give Nystatin suspension 0.5 ml orally four times a day for 7 days or Miconazole oral gel 1.25 mls orally 4 times a day

To Treat Diarrhoea, See TREAT THE CHILD Chart.

Immunize Every Sick Young Infant, as Needed

TREAT THE YOUNG INFANT

GIVE ARV FOR PMTCT PROPHYLAXIS

Give ARV prophylaxis to prevent transmission of HIV to all newborns of HIV infected mothers. According to the national policy, the prophylaxis may be given from birth up to 4-6 weeks of age or from birth until one week after the breastfeeding has stopped. Regarless of whether or not the mother recieved any ART during pregnancy or delivery:

LOW RISK INFANTS-{these are infants born from mothers with suppressed viral load(recorded and valid) OR started ART atleast 12 weeks prior to delivery}.

- Have no evidence of poor adherence to ART in pregnancy
- Have no evidence of detectable viral load in the third trimester

They are given a Short course AZT as soon as possible within 72 hours of delivery. Also continue infant feeding counselling.

Retest all HIV Exposed babies at 9 months and 18 months.

HIGH RISK INFANTS -These are those infants at high risk for mother to child transmission of HIV and include th following:

- BBA(born before arrival) seen within 72 hours of delivery
- Infants whose mothers :
  - Sero-converted during pregnancy and have no documentation of achieving virologic suppression.
  - Have detectable viral load (.200 copies/ml) during the third trimester
  - No record of viral load or invalid viral load(more than 3 months).
  - Took ART for less than 12 weeks from delivery.
  - Have difficulties with adherence/ defaulted ART.
  - Abandoned babies whose maternal HIV status is unknown

Retest all HIV Exposed babies at 9 months and 18 months.

HIGH RISK INFANTS PROPHYLAXIS:

- Begin full ARTfor infantsAZT/3TC/NVP for 4 weeks immediately after delivery, within 72 hours
  - Test the high risk infants at birth to determine their HIV status. If negative repeat PCR at 6-8 weeks
  - Continue prophylaxis while awaiting results
  - For infants testing positive, switch from prophylaxis to treatment (ABC/3TC/DTG) if the baby weighs more than 3 kg.
- Diligently monitor and report all adverse birth outcomes of HIV positive women regardless of their ART regimens.

The HIV positive mother should also get ARV drugs for treatment if she needs it or to prevent HIV transmission to her child.

Give Cotrimoxazole prophylaxis from the age of 4-6 weeks to prevent opportunistic infections to all HIV exposed or infected young infants.

TREAT THE YOUNG INFANT

GIVE ARV FOR PMTCT PROPHYLAXIS

DOSES					
Medication	Term	Preterm			
			30 weeks	31-34 weeks	35-36 weeks
AZT (for low risk and high risk HEI)	4mg/kg PO BDx4 weeks	0 - 2 WEEKS	2mg/kg PO BD	2mg/kg PO BD	4mg/kg PO BD
		2- 4 WEEKS	2mg/kg PO BD	3mg/kg PO BD	4mg/kg PO BD
sd- NVP	6mg/kg PO stat only	>32 - <37 weeks			
		2mg/kg stat only			
3TC (for high risk HEI)	4mg/kg PO BD x 4 weeks	0 – 4 weeks	>34- < 37		
			2mg/kg BD		
NVP (for high risk HEI)	6mg/kg PO BD x 4 weeks	0-4 weeks	6mg/kg PO BD		
NB: Call the Doctor for premature infants: <30 weeks needing AZT, <32 weeks needing NVP, <34 weeks needing 3TC					

TREAT THE YOUNG INFANT

IF REFERRAL IS NOT FEASIBLE OR DELAYED

Further assess and classify young infant with very severe disease

SIGNS	CLASSIFY	IDENTIFY TREATMENT
The sick young infant has any one of the following ■ Convulsion ■ Not able to feed at all ■ No movement on stimulation ■ Weight <2kg	**CRITICAL ILLINESS**	■ **Reinforce Urgent referral. Explain to the caregiver that the infant is very sick and must be urgently referred.** ■ **If referral is still not feasible* or delayed*, give once daily intramuscular gentamycin and twice daily intramuscular ampicillin until referral is feasible.** ■ **Treat to prevent low blood sugar.** ■ Teach the mother how to keep the young infant warm at all times. ■ Advise the mother to return daily for injections. ■ Treat any other classification of illness in the young infant. ■ Reassess the young infant at each visit. ■ Keep calling for help
The sick young infant has any one of the following: ■ Not feeding well on observation. ■ Temperature 37.5 degrees celsius or more ■ Temperature less than 35.5 degrees celsius. ■ Severe chest indrawing. ■ Movement only when stimulated. ■ Fast breathing(60 breaths per minute or more). ■ Bradypnea (Respiration < 20 breaths ?minutes ■ SPO2 < 90 % ■ Grunting ■ Bulging fontanelle	**CLINICAL SEVERE INFECTION**	■ **give once-daily intramuscular gentamycin and ampiicillin twice daily until refferal is feasible.** ■ **Treat to prevent low blood sugar.** ■ Teach the mother how to keep the young infant warm all time. ■ Treat any other classification of illness in the young infant. ■ Reassess the young infant 1 to 2 hours ■ Keep calling for help. ■ Keep on reassessing the child.

* Involve other stakeholders to enable referral.

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 EXPRESS AND STORE BREAST MILK

EXPRESSING 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 under side 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.

STORING BREASTMILK:

- Room temperature 25 to 27 degrees celcious for up to 4 hours
- Refrigerator- store uo to 3 to 5 days
- Freezer - up to 12 months

Frozen milk **MUST not be re-frozen after being thawed**

Frozen milk can be warmed gradually by placing the storage container in warm water for 30 minutes

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 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 her breasts. Keep the infat'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 breast milk by cup).

COUNSEL THE MOTHER

ADVISE THE MOTHER TO GIVE HOME CARE FOR THE YOUNG INFANT

1. **EXCLUSIVELY BREASTFEED THE YOUNG INFANT**
   Give only breastfeeds to the young infant. Breastfeed frequently, as often and for as long as the infant wants.
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 in:**
▪ JAUNDICE	1 day
▪ LOCAL BACTERIAL INFECTION ▪ FEEDING PROBLEM ▪ THRUSH ▪ DIARRHOEA	1 day 1 day 2 days 1 day
▪ LOW WEIGHT FOR AGE	7 days
▪ CONFIRMED HIV INFECTION ▪ HIV EXPOSED	According to national recommendations

WHEN TO RETURN IMMEDIATELY:

Advise the mother to return immediately if the young infant has any of these signs:
▪ Breastfeeding poorly ▪ Reduced activity ▪ Becomes sicker ▪ Develops a fever ▪ Feels unusually cold ▪ Fast breathing ▪ Difficult breathing ▪ Palms and soles appear yellow ▪ Vomits everything ▪ Convulsions ▪ More than 6 diarrheal stools in 24 hours

COUNSEL THE CARETAKER FOR HIV POSITIVE MOTHER WHO IS NOT BREASTFEEDING

- The mother should have received full counselling before making the decision not to breastfeed.
- Ensure that the mother or caretaker has an adequate supply of appropriate breastmilk substitute.
- Ensure that the mother or caretaker knows how to prepare the milk correctly and hygenically and has the facilities and resources to do so.
- Demonstrate how to feed with a cup and spoon rather than a bottle.
- Make sure that the mother or caretaker understand that prepared feed must be finished within 1 hour of preparation.
- Make sure that the mother or the caretaker understands that mixing breastfeeding and replacement feeding may increase the risk of HIV infection and should not be done.

HOW TO PREPARE COMMERCIAL FORMULA MILK

- Wash your hand before preparing the formula.
- Follow the instructions on the container for making each feed and how frequently to give it every 24 hours.
- always use the marked cup or glass to measure water and the scoop to measure the formula powder.
- Measure the exact amount of powder that you will need for one feed.
- Boil enough water.
- Add the hot water to the powdered formula.
- Only make enough formula for one feed at a time. Do not keep milk milk in a thermo flask, because it will quickly become contaminated.
- Feed the baby from a cup,Discard any unused formula, give it to an older child , or drink it yourself.
- Wash the utensils.

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

ASSESS EVERY YOUNG INFANT FOR "VERY SEVERE DISEASE" DURING FOLLOW-UP VISIT

LOCAL BACTERIAL INFECTION

After 2 days:

- Look at the skin pustules.

Treatment:

- 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.
- Review post treatment (Day 5).

DIARRHOEA

After 1 day:

Ask: Has the diarrhoea stopped?

Treatment

- If the diarrhoea has not stopped, assess and treat the young infant for diarrhoea. >SEE "Does the Young Infant Have Diarrhoea?"
- If the diarrhoea has stopped, tell the mother to continue exclusive breastfeeding.

JAUNDICE

After 1 day:

- Look for jaundice. Are palms and soles yellow?

Treatment:

- If palms and soles are yellow, refer to hospital.
- If palms and soles are not yellow, but jaundice has not decreased, advise the mother home care and ask her to return for follow up in 1 day.
- If jaundice has started decreasing, reassure the mother and ask her to continue home care. Ask her to return for follow up at 7 days of age. If jaundice continues beyond 7 days of age, refer the young infant to a hospital for further assessment.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

FEEDING PROBLEM

After 2 days:
Reassess feeding. > See "Then Check for Feeding Problem or Low Weight".
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 7 days of this follow up visit. Continue follow-up until the infant is gaining weight well.

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

LOW WEIGHT FOR AGE

After 7 days:

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

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

- If the infant is ***no longer low weight for age***, praise the mother and encourage her to continue.
- If the infant is ***still low weight for age, but is feeding well***, praise the mother. Ask her to have her infant weighed again within 7 days or when she returns for immunization, whichever is the earlier.
- If the infant is ***still low weight for age and still has a feeding problem***, counsel the mother about the feeding problem. Ask the mother to return again in 7 days (or when she returns for immunization, if this is within 7 days). Continue to see the young infant every few weeks until the infant is feeding well and gaining weight regularly and is no longer low weight for age.

Exception:

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

THRUSH

After 2 days:

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

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

- If ***thrush is worse*** check that treatment is being given correctly.
- If 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 Miconazole oral gel or Nystatin oral suspension for a total of 7 days.

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

CONFIRMED HIV INFECTION OR HIV EXPOSED

A young infant classified as CONFIRMED HIV INFECTION or HIV EXPOSED should return for follow-up visits regularly as per national guidelines.

Follow the instructions for follow-up care for child aged 2 months up to 5 years.

CRITICAL ILLNESSS WHEN REFERRAL WAS NOT FEASIBLE

At each contact for injection of antibiotics:

- Explain again to the caregiver that the infant is very sick and should urgently be referred for hospital care.
- Reassess the young infant as described on page 63.
- Treat any new problem.
- If referral is still not feasible, continue giving once-daily intramuscular gentamicin and twice-daily intramuscular ampicillin until referral is feasible or for 7 days.

*CLINICAL SEVERE INFECTION WHEN REFERRAL WAS NOT FEASIBLE**

At each contact for injection:

- Reassess the young infant daily.
- After 1 day: If the young infant is improving, complete the 2 days of treatment with intramuscular gentamicin. Ask the mother to continue giving the oral amoxicillin twice daily until all the syrups are finished.
- Ask the mother to bring the young infant back on day 4 of treatment (3 days after the initial visit).

If a 7-day gentamicin/ampicillin regimen is used:

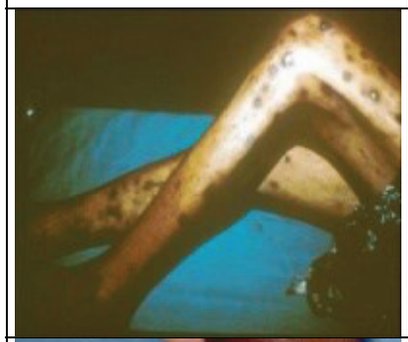
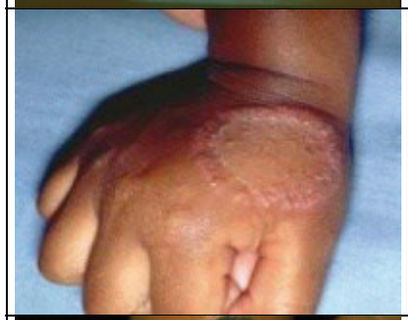
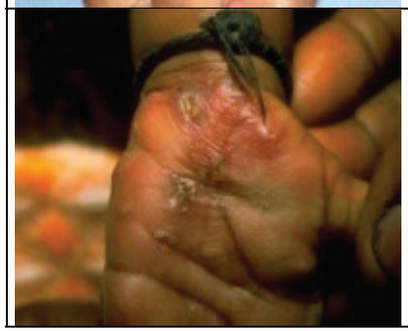
- At each contact for injection:
- Reassess the young infant
- If the young infant is improving, complete the 7 days treatment with intramuscular gentamicin. Ask the mother to continue giving the oral amoxicillin twice daily until all the syrups are finished.
- Refer the young infant urgently to hospital if:
  - The infant shows any sign of CRITICAL ILLNESS or
  - Any new sign of CLINICAL SEVERE INFECTION appears while on treatment or
  - There is no improvement on day 4 after 3 full days of treatment or
  - Any sign of CLINICAL SEVERE INFECTION is still present at the contact for the 7th intramuscular injection of gentamicin.

*Depending on whether the national policy is for 2 or 7 days of intramuscular gentamicin.

Annex:
Skin Problems

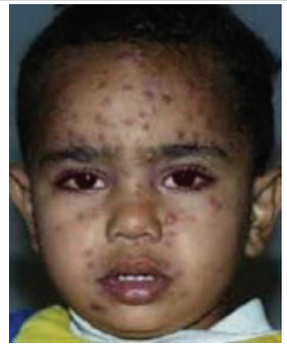
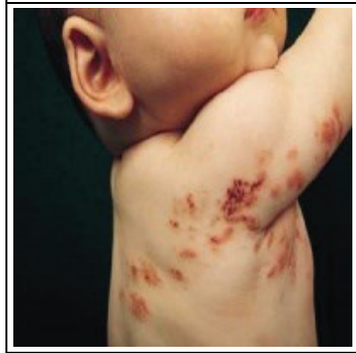
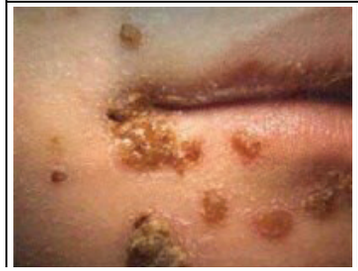
IDENTIFY SKIN PROBLEM

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	**RING WORM (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

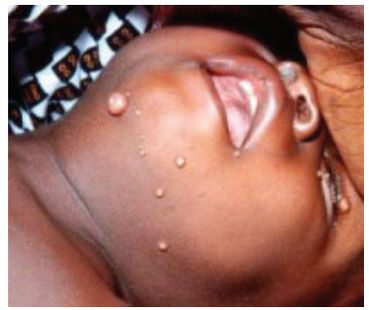
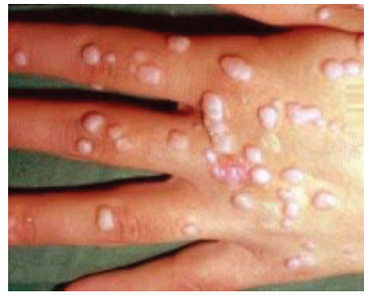
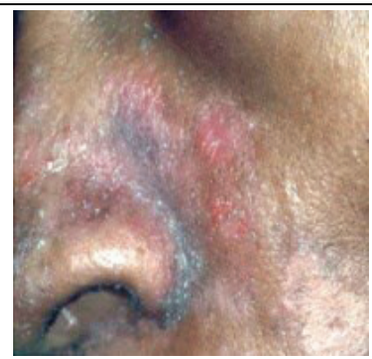
IDENTIFY SKIN PROBLEM

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.	
				

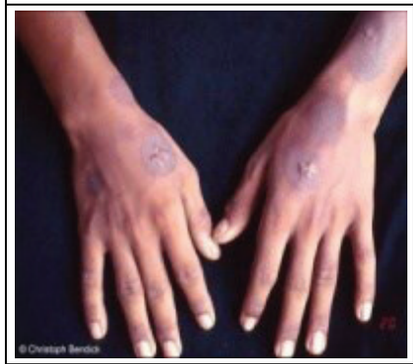
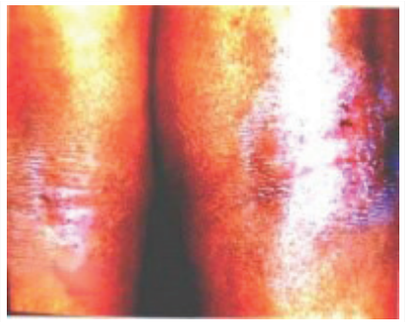
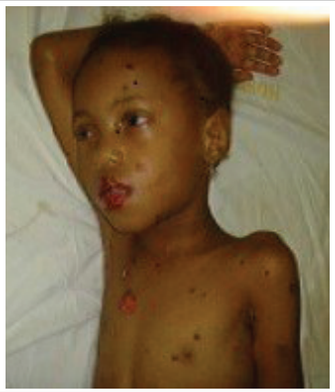
IDENTIFY SKIN PROBLEM

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

CLINICAL REACTION TO DRUGS

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**

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

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

ASSESS (Circle all signs present)	**CLASSIFY**
CHECK FOR GENERAL DANGER SIGN • NOT ABLE TO DRINK OR BREASTFEED • VOMITS EVERYTHING • CONVULSIONS • LERTHAGIC OR UNCONSCIOUS General Danger sign present? • CONVULSING NOW Yes___ No ____	..... Remember to use danger signs when selecting classification
DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? Yes __ No __ • For how long? ___ Days • Count the breaths in one minute: ___ breaths per minute. Fast breathing? • Look for chest indrawing • Look and listen for stridor • Look and listen for wheezing	
DOES THE CHILD HAVE DIARRHOEA? Yes __ No __ • For how long? ___ Days • Is there blood in the stool? • Look at the childs 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 then 2 seconds)? Slowly?	
DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5°C or above) Yes __ No __ Decide malaria risk: High ___ Low ___ No___ • For how long? ___ Days • If more than 7 days, has fever been present every day? • Has child had measles within the last 3 months? Do a malaria test, if NO general danger sign in all cases in high malaria risk or NO obvious cause of fever in low malaria risk: Test POSITIVE? P. falciparum P. vivax *NEGATIVE?* • Look or feel for stiff neck • Look for runny nose • Look for signs of MEASLES: ○ Generalized rash and ○ One of these: cough, runny nose, or red eyes • Look for any other cause of fever.	
If the child has measles now or within the last 3 months: • Look for mouth ulcers. If yes, are they deep and extensive? • Look for pus draining from the eye. • Look for clouding of the cornea.	
DOES THE CHILD HAVE AN EAR PROBLEM? Yes __ No __ • Is there ear pain? • Is there ear discharge? If Yes, for how long? ___ Days • Is there hearing loss? • Look for pus draining from the ear • Feel for tender swelling behind the ear • 6-18 months; look for response to finger rubbing • 18 months and above ; respond to verbal command	
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?	
If child has MUAC less than 115 mm or WFH/L less than -3 Z scores: • Is there any medical complication: General danger sign? Any severe classification? Pneumonia with chest indrawing? • Child 6 months or older: Offer RUTF to eat. Is the child: ○ Not able to finish? Able to finish? • Child less than 6 months: Is there a breastfeeding problem?	
CHECK FOR HIV INFECTION • Note mother's and/or child's HIV status ○ Mother's HIV test: NEGATIVE POSITIVE NOT DONE/KNOWN ○ Child's virological test: NEGATIVE POSITIVE NOT DONE ○ Child's serological test: NEGATIVE POSITIVE NOT DONE • If mother is HIV-positive and NO positive virological test in child: ○ Is the child breastfeeding now? ○ Was the child breastfeeding at the time of test or 6 weeks before it? ○ If breastfeeding: Is the mother and child on ARV prophylaxis?	
CHECK FOR TB DISEASE Does the child have a close TB contact, OR Cough for than two weeks or Fever for more than seven days OR NOT GROWING WELL? IF YES: Ask and look for features of TB infection • Contact with a known MDR TB patient; • Feel for elarged lymp node • Persistent, non-remitting cough or wheeze for more than 2 weeks • Documented loss of weight or unsatisfactory weight gain during the past 3 months (especially if not responding to deworming together with food and/or micronutrients supplementation • Fatigue/reduced playfulness • Fever every day for 7 days or more • Sputum positive or gene Xpert / RIF test +ve • Chest x-ray suggesting TB;	
CHECK FOR CHILD'S DEVELOPMENTAL MILESTONES • Ascence of one or more milestones from current age group • Ascence of one or more milestones from earlier age group • Regression of milsestone/s	
CHECK FOR INTERACTION,COMMUNICATION AND RESPONSIVENESS • How do you play with the child? • How do you talk with the child? • How do you get your child to smile? • How do you think your child is learning? LOOK & LISTEN • Caregiver aware of child's movements? • Does caregiver play with the child? • Does the caregiver talk to the child? • Does the caregiver smile with the child?	
CHECK THE CHILD'S IMMUNIZATION STATUS (Circle immunizations needed today) BCG, Hep B, Penta-1, OPV-1, RTV-1, PCV-1, Penta-2, OPV-2, RTV-2, PCV-2, Penta-3, OPV-3, RTV-3, PCV-3, IPV-1, Measles Rubella-1, IPV-2, Measles Rubella-2, DT booster, OPV booster, Vitamin A, Albendazole	Return for next immunization on: _____ (Date)
ASSESS FEEDING if the child is less than 2 years old, has MODERATE ACUTE MALNUTRITION, ANAEMIA, or is HIV exposed or infected • Do you breastfeed your child? Yes ___ No ___ ○ If yes, how many times in 24 hours? ___ times. Do you breastfeed during the night? Yes ___ No ___ • Does the child take any other foods or fluids? Yes ___ No ___ ○ If Yes, what food or fluids? ○ How many times per day? ___ times. What do you use to feed the child? ○ If MODERATE ACUTE MALNUTRITION: How large are servings? ○ Does the child receive his own serving? ___ Who feeds the child and how? • During this illness, has the child's feeding changed? Yes ___ No ___ ○ If Yes, how?	FEEDING PROBLEMS
ASSESS OTHER PROBLEMS:	
ASK ABOUT MOTHER' S OWN HEALTH	

TREAT

Return for follow-up in ... days. Advise mother when to return immediately. Give any immunization and feeding advice needed today.

MANAGEMENT OF THE SICK YOUNG INFANT AGED UP TO 2 MONTHS

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

CHECK FOR SEVERE DISEASE AND LOCAL BACTERIAL INFECTION

- Is the infant having difficulty in feeding?
- Has the infant had convulsions?
- Check blood sugar (Hypoglyceamia < 3 mmol/l and Hyperglycaemia > 12 mmol/l)
- Count the breaths in one minute. ___ breaths per minute
  Repeat if elevated: ___ Fast breathing?
- Low Respiration < 20 breaths per minute
- Look for severe chest indrawing.
- Oxygen saturation < 90%
- Look and listen for grunting.
- Look at the umbicilus. Is it red or draining pus?
- Fever (temperature 38°C or above fells hot) or
  low body temperature (below 35.5°C or feels cool)
- Look for skin pustules. Are there many or fewer pustules?
- Movement only when stimulated or no movement even when stimulated?
- Bulging fontanelle

THEN CHECK FOR JAUNDICE

- When did the jaundice appear first?
- Look for jaundice (yellow eyes or skin)
- Look at the young infant's palms and soles. Are they yellow?

DOES THE YOUNG INFANT HAVE DIARRHOEA? Yes ___ No ___

- Is there blood in stool?
- Look at the young infant's general condition. Does the infant:
  - move only when stimulated?
  - not move even when stimulated?

  Is the infant restless and irritable?
- Look for sunken eyes.
- Pinch the skin of the abdomen. Does it go back:
  - Very slowly?
  - Slowly?

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT

If the infant has no indication to refer urgently to hospital

- Is there any difficulty feeding? Yes ___ No ___
- Is the infant breastfed? Yes ___ No ___
  If yes, how many times in 24 hours? ___ times
- Does the infant usually receive any other foods or drinks? Yes ___ No ___
  If yes, how often?
- What do you use to feed the child?
- Determine weight for age. Low ___ Not low ___
- Look for ulcers or white patches in the mouth (thrush).

CHECK FOR HIV INFECTION

- Note mother's and/or child's HIV status:
  - Mother's HIV test: NEGATIVE POSITIVE NOT DONE/KNOWN
  - Child's virological test: NEGATIVE POSITIVE NOT DONE
  - Child's serological test: NEGATIVE POSITIVE NOT DONE
- If mother is HIV positive and and NO positive virological test in young infant:
  - Is the infant breastfeeding now?
  - Was the infant breastfeeding at the time of test or 6 weeks before it?
  - If breastfeeding: Is the mother and infant on ARV prophylaxis?

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.

- Is the infant able to attach? To check attachment, look for:
  - Chin touching breast: Yes ___ No ___
  - Mouth wide open: Yes ___ No ___
  - Lower lip turned outward: Yes ___ No ___
  - More areola above than below the mouth: Yes ___ No ___

  not well attached *good attachment*
- Is the infant sucking effectively (that is, slow deep sucks, sometimes pausing)?

  not sucking effectively *sucking effectively*

CHECK THE CHILD S IMMUNISATION STATUS (circle immunisations needed today)

BCG Hep B

Return for next immunisation on:
_____
(date)

ASSESS OTHER PROBLEMS(Including PNC review notes):

ASK ABOUT MOTHERS OWN HEALTH (Including PNC) :

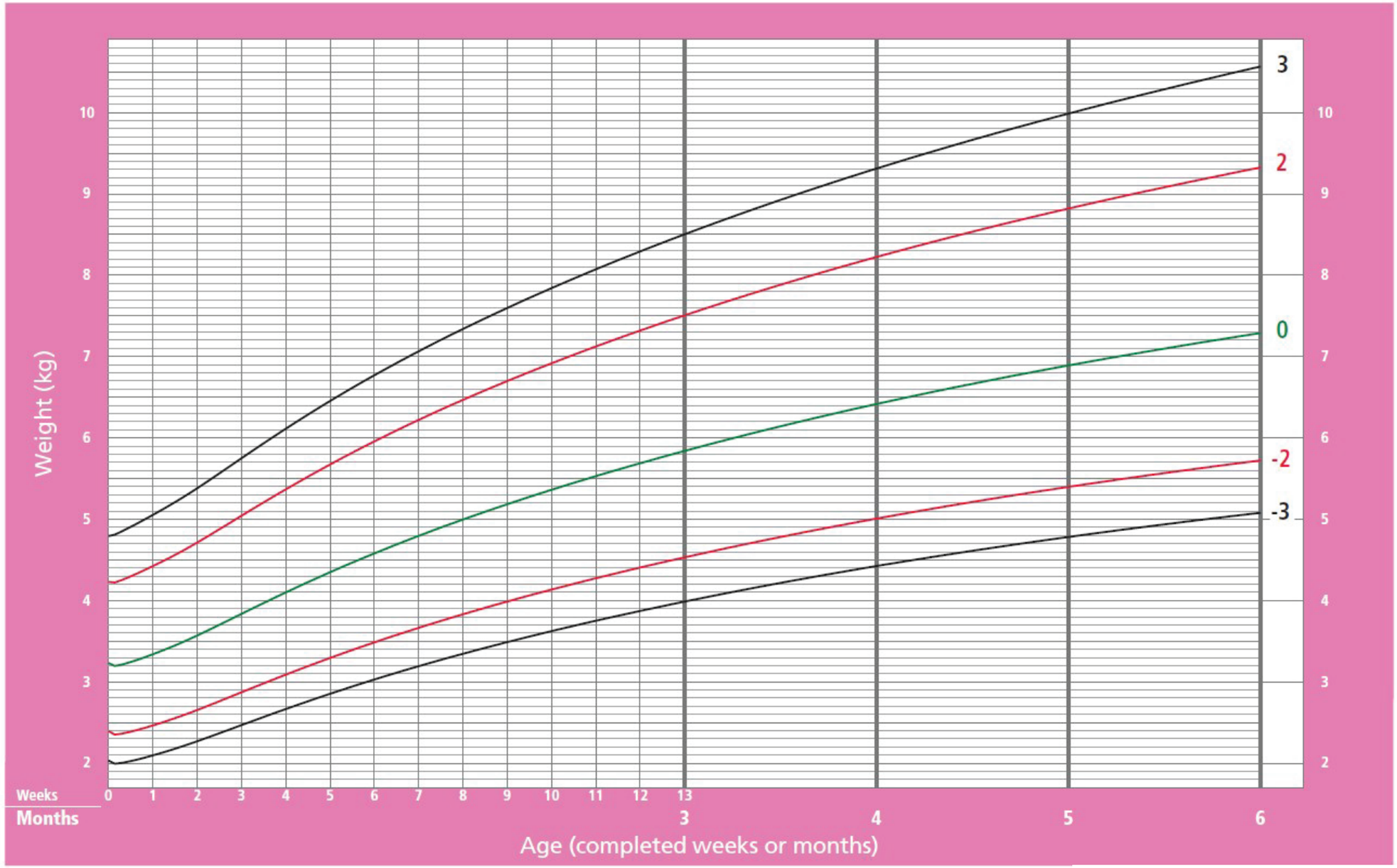
TREAT

Return for follow-up in ... days. Advise mother when to return immediately. Give any immunization and feeding advice needed today.

Weight-for-age GIRLS

Birth to 6 months (z-scores)

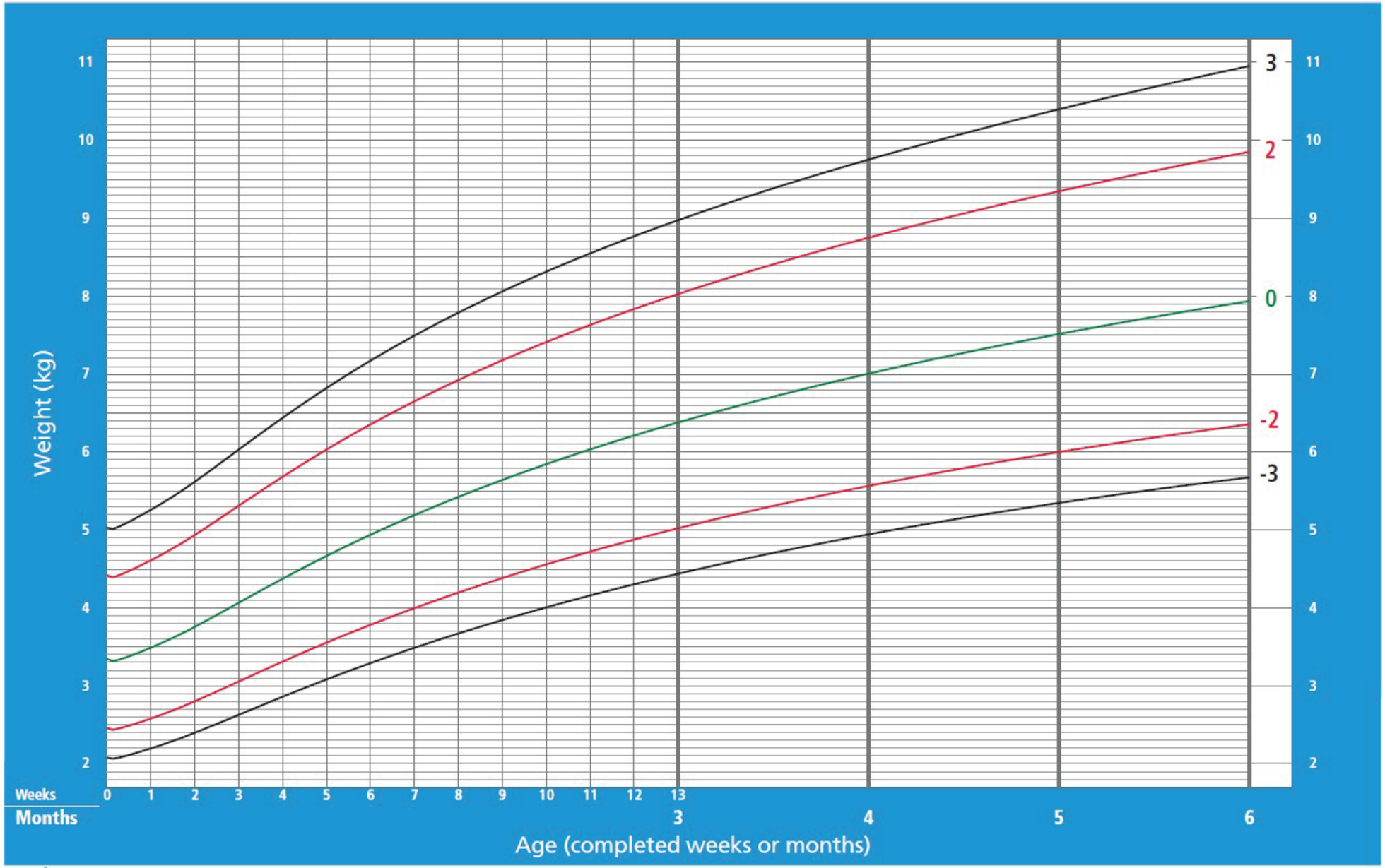
World Health Organization



Weight-for-age BOYS

Birth to 6 months (z-scores)

World Health Organization

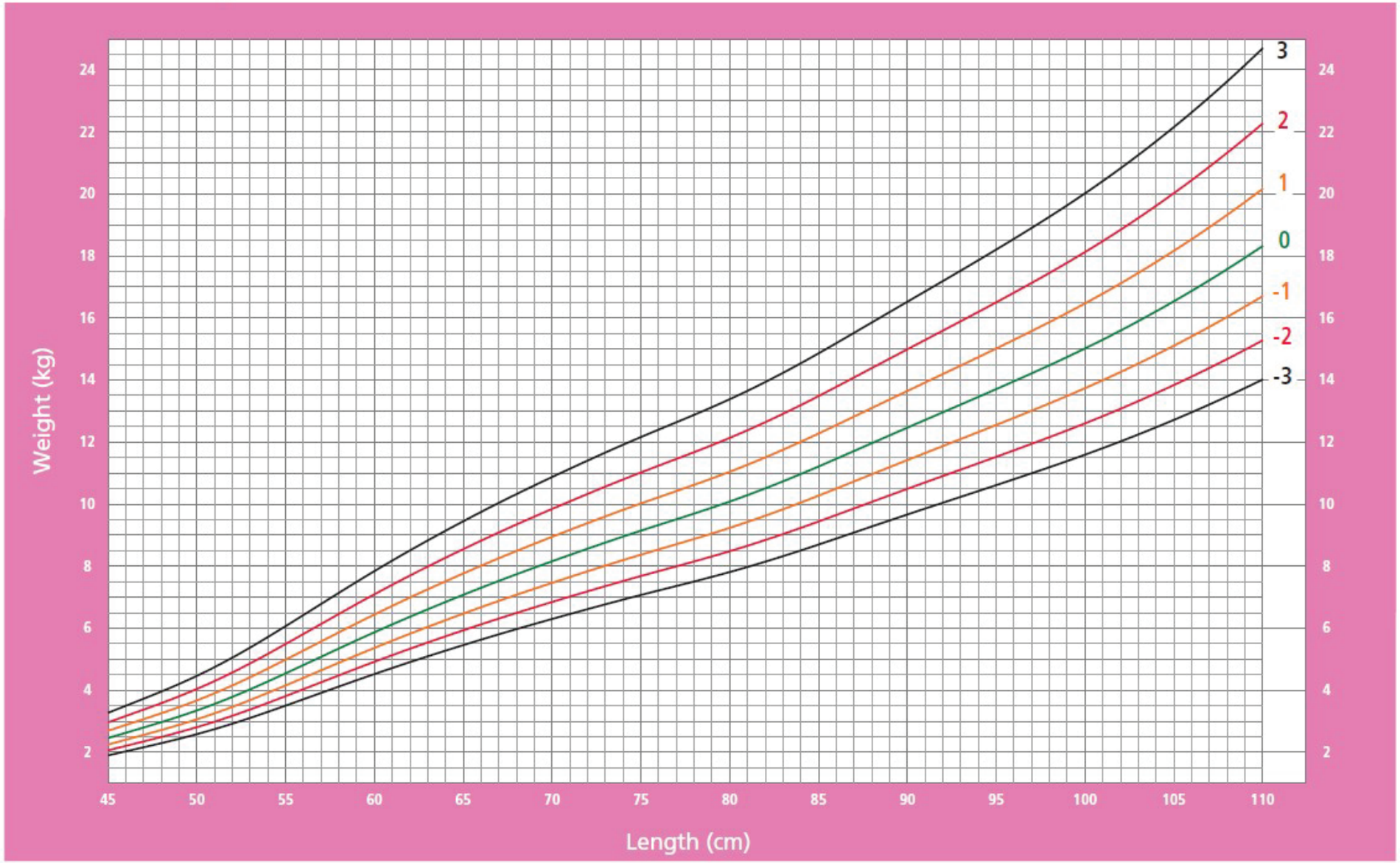


WHO Child Growth Standards

Weight-for-length GIRLS

Birth to 2 years (z-scores)

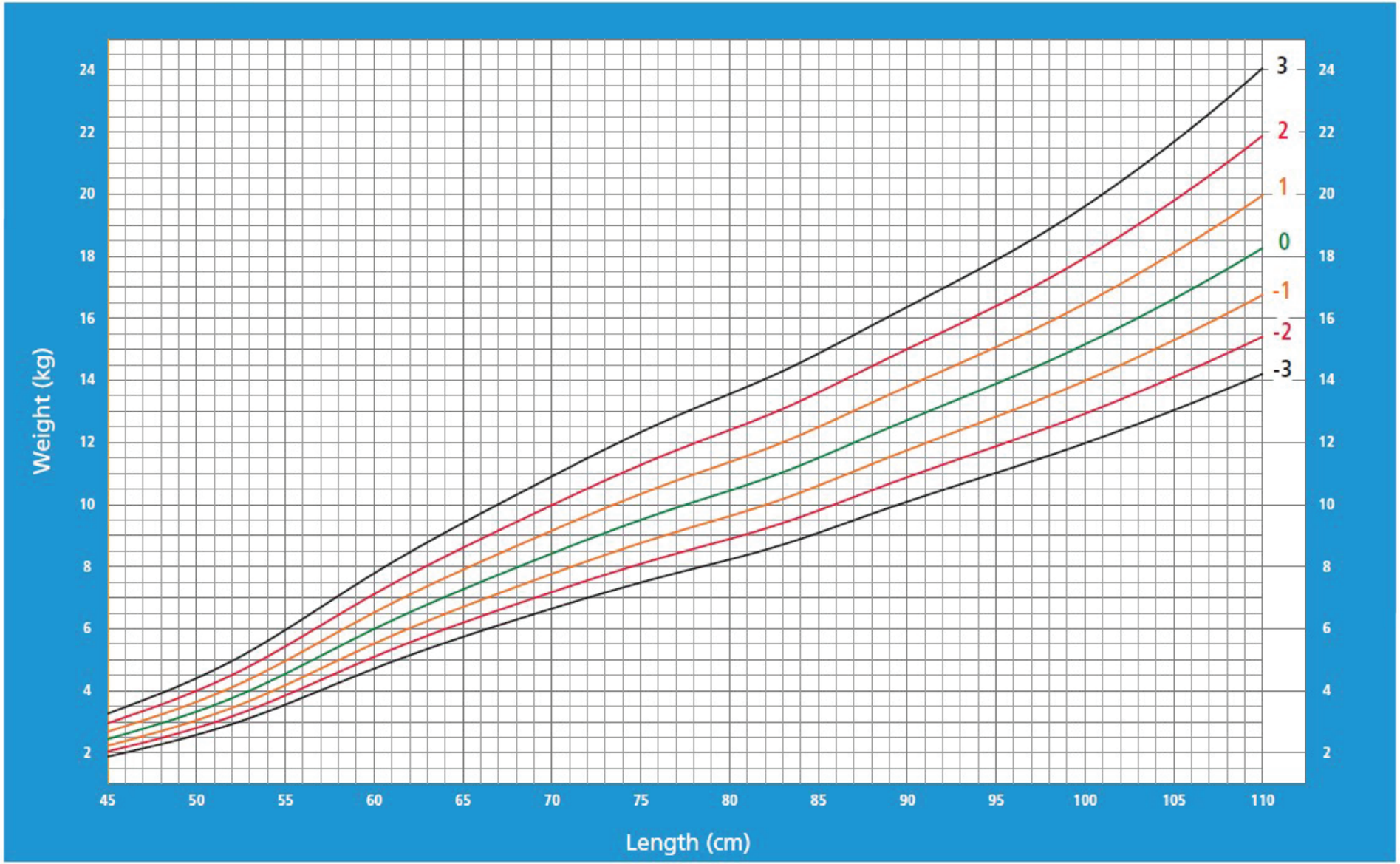
World Health Organization



Weight-for-length BOYS

Birth to 2 years (z-scores)

World Health Organization

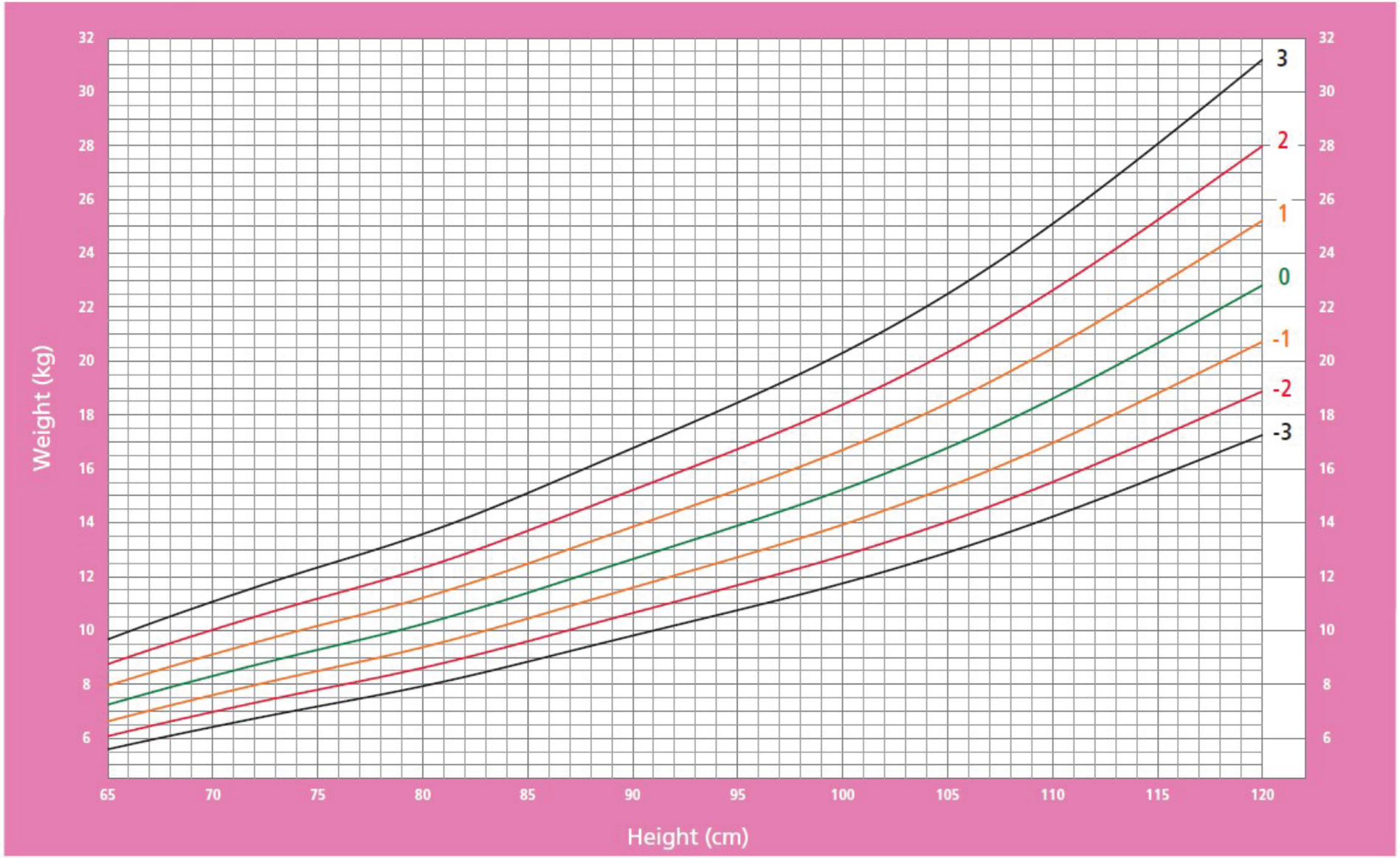


WHO Child Growth Standards

Weight-for-Height GIRLS

2 to 5 years (z-scores)

World Health Organization

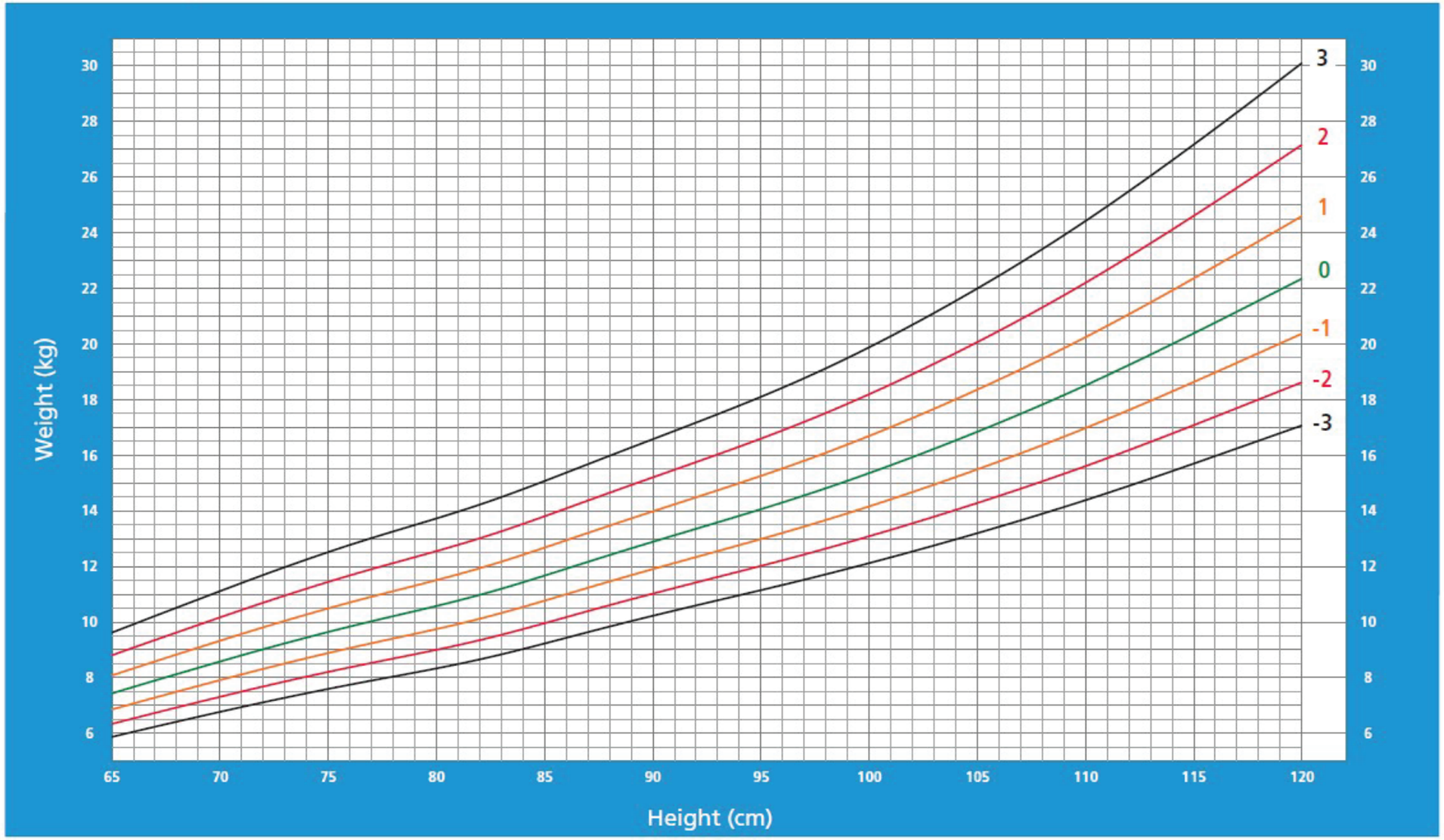


WHO Child Growth Standard

Weight-for-height BOYS

2 to 5 years (z-scores)

World Health Organization



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

IMCI Chart Booklet

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

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

- **SICK CHILD AGED 2 MONTHS TO 5 YEARS. This part contains all the necessary clinical algorithms, information and instructions on how to provide care to sick children aged 2 months to 5 years.**

and

- **SICK YOUNG INFANT AGED UP TO 2 MONTHS. This part includes case management clinical algorithms for the care of a young infant aged up to 2 months**

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

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