



INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS



World Health Organization
Division of Child Health
and Development (CHD)

UNICEF

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ASSESS AND CLASSIFY THE SICK CHILD

Assess, Classify and Identify Treatment

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Assess, Classify and Identify Treatment

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



DO RAPID APPRAISAL ON ALL WAITING CHILDREN

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 pages 17-20
- If initial visit assess the child as follows:

CHECK FOR GENERAL DANGER SIGNS

ASK: Is the child able to drink or breastfeed?
Does the child vomit everything?
Has the child had convulsions during this illness? (if convulsing now see p.13)

LOOK: Is the child
a) lethargic or
b) unconscious

A child with any general danger sign requires urgent attention: complete the assessment, start pre-referral treatment and refer urgently. Test for low blood sugar— then treat or prevent.

ASSESS

CLASSIFY

IDENTIFY TREATMENT

THEN ASK ABOUT MAIN SYMPTOMS:

Does the child have cough or difficult breathing?

IF YES, ASK:

LOOK, LISTEN,
FEEL:

- For how long?

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



CHILD
MUST
BE
CALM

Classify
COUGH or
DIFFICULT
BREATHING

AND IF WHEEZE, ASK:

- Has the child had a wheeze before this illness?
- Does the child have frequent cough at night?
- Has the child had a wheeze for more than a week?
- Is the child a known asthmatic?

And if
wheeze
classify:

RESPIRATORY RATE

If the child is:
2 months up to 12 months:
12 months up to 5 years

Fast breathing is:
50 or more breaths per minute
40 or more breaths per minute

- Any general danger sign
OR
- Chest indrawing
OR
- Stridor in calm child

SEVERE
PNEUMONIA
OR VERY
SEVERE DISEASE

- Give first dose of ampicillin OR ceftriaxone IM. (p.13)
- If child under 6months old: give 5 mls co-trimoxazole stat
- Give oxygen (p. 13)
- If stridor: give nebulised adrenaline (p.13)
- Test blood sugar. Then treat/prevent low blood sugar (p. 14)
- Keep child warm, and refer URGENTLY to hospital.

- Fast breathing.

PNEUMONIA

- Give amoxycillin for 5 days (p.9)
- Soothe the throat and relieve the cough (p.11)
- Consider symptomatic HIV (p.7)
- If coughing for more than 21 days refer for possible TB or asthma
- Advise mother when to return immediately (p.26)
- Follow-up in 2 days

- No signs of pneumonia
or very severe disease.

COUGH OR COLD

- Soothe the throat and relieve cough (p.11)
- If coughing for more than 21 days refer for possible TB or asthma
- Advise mother when to return immediately (p.26)
- Follow up in 5 days if not improving

Yes to any question

RECURRENT
WHEEZE

- Give salbutamol via spacer for 5 days (p. 9)
- Give oral prednisone for three days (p. 9).
- If there is any severe classification, give first dose of prednisone and salbutamol before referral
- Refer for non urgent assessment for possible asthma

All other children with wheeze

WHEEZE
(FIRST EPISODE)

- Give salbutamol via spacer for 5 days (p. 9)
- If any severe classification give salbutamol before referral
- Follow-up in 5 days if still wheezing
- Advise the mother to return if wheeze recurs

Does the child have diarrhoea?

IF YES, ASK:

- For how long?
- If diarrhoea for 14 days or more, has the child lost weight?
- Is there blood in the stool?
- What treatment is the mother giving?

LOOK OR 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:
 - slowly?
 - or very slowly? (more than 2 seconds)

Classify all children with diarrhoea for DEHYDRATION

Classify DIARRHOEA

And if diarrhoea 14 days or more classify:

And if blood in stool classify:

Two of the following signs: <ul style="list-style-type: none"> • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly. 	DIARRHOEA WITH SEVERE DEHYDRATION	➤ Start treatment for severe dehydration (Plan C p.16). ➤ REFER URGENTLY to hospital ➤ Give frequent sips of ORS on the way ➤ Advise the mother to continue breastfeeding ➤ Keep the child warm on the way to hospital
Two of the following signs: <ul style="list-style-type: none"> • Restless, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly. 	DIARRHOEA WITH SOME DEHYDRATION	➤ Give fluid and food to treat for some dehydration (Plan B p.15) ➤ Advise mother to continue breastfeeding ➤ Advise the mother when to return immediately (p.26) ➤ Follow-up in 2 days if not improving
• Not enough signs to classify as severe or some dehydration	NO VISIBLE DEHYDRATION	➤ Give fluid and food to treat for diarrhoea at home (Plan A p.15) ➤ Advise mother when to return immediately (p.26) ➤ Follow-up in 5 days if not improving
• Dehydration present OR • History of weight loss	SEVERE PERSISTENT DIARRHOEA	➤ Start treatment for dehydration (if present) ➤ Give Vitamin A unless a dose has been given in the last month (p.12) ➤ Consider symptomatic HIV (p.7) ➤ Give frequent sips of ORS on the way ➤ Refer to hospital
• No dehydration and • No history of weight loss	PERSISTENT DIARRHOEA	➤ Counsel the mother about feeding (p.25) ➤ Give vitamin A unless a dose has been given in the last month (p.12) ➤ Consider symptomatic HIV (p.7) ➤ Advise mother when to return immediately (p.26) ➤ Follow-up in 5 days
• Dehydration present OR • Child is below the age of 12 months	SEVERE DYSENTERY	➤ Start treatment for dehydration if present ➤ Refer URGENTLY to hospital ➤ Give frequent sips of ORS on the way
• Blood in the stool	DYSENTERY	➤ Treat for 5 days with nalidixic acid (p.9) ➤ Advise the mother when to return immediately (p.26) ➤ Follow-up in 2 days

Does the child have fever?

By history, or temperature 37.5° C or above

IF YES, ASK:

- For how long?
- If more than 7 days, has fever been present every day?

LOOK AND FEEL:

- For stiff neck and bulging fontanelle.
- Look for other causes of fever

THEN DECIDE THE CHILD'S MALARIA RISK:

Malaria Risk means: Lives in Malaria zone or visited a malaria zone in the previous month. If in doubt, **also** classify for malaria.

- Do a rapid malaria test if available

Classify all children with fever for **MENINGITIS**

Classify **FEVER**

And if malaria risk present classify:

<ul style="list-style-type: none"> • Any general danger sign OR • Stiff neck OR • Bulging fontanelle. 	SUSPECTED MENINGITIS	<ul style="list-style-type: none"> ➤ Give first dose of ampicillin IM or ceftriaxone IM (p.13) ➤ Test the blood sugar, then treat or prevent low blood sugar (Page 14) ➤ Give one dose of paracetamol for fever 38°C or above (p.10) ➤ Refer URGENTLY
<ul style="list-style-type: none"> • No general danger signs and • No stiff neck or bulging fontanelle 	FEVER - OTHER CAUSE	<ul style="list-style-type: none"> ➤ Treat cause of fever if found ➤ Give paracetamol in the clinic for high fever 38°C or above (p.10) ➤ If fever is present every day for more than 7 days refer for assessment ➤ Advise mother when to return immediately (p.26) ➤ Follow-up in 2 days if fever persists
<ul style="list-style-type: none"> • Any general danger sign OR • Stiff neck OR • Bulging fontanelle <p>(Malaria rapid test positive or negative or not done)</p>	SUSPECTED SEVERE MALARIA	<ul style="list-style-type: none"> ➤ If child aged over one year: Give first dose of co-artemether for severe malaria (p.10). Do not give co-artemether to babies less than 12 months old. ➤ Give treatment for SUSPECTED MENINGITIS as above ➤ Refer URGENTLY
<ul style="list-style-type: none"> • Rapid malaria test positive 	MALARIA	<ul style="list-style-type: none"> ➤ Refer URGENTLY for malaria treatment if aged less than 12 months ➤ If the child is over a year old give first dose co-artemether in the clinic and continue at home for 3 days (p.10) ➤ Give paracetamol in the clinic for high fever 38°C or above (p. 10) ➤ Notify confirmed malaria cases ➤ Advise mother when to return immediately (p.26) ➤ Follow-up in 2 days if fever persists ➤ Follow-up if fever recurs within 14 days
<ul style="list-style-type: none"> • Rapid malaria test not done. 	POSSIBLE MALARIA	<ul style="list-style-type: none"> ➤ Refer for malaria testing. Do not give co-artemether without a positive rapid malaria test ➤ Give paracetamol in the clinic for fever 38°C or above (p.10)
<ul style="list-style-type: none"> • Rapid malaria test negative. 	FEVER - OTHER CAUSE	<ul style="list-style-type: none"> ➤ Treat as for FEVER-OTHER CAUSE above.

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**

<ul style="list-style-type: none"> • Tender swelling behind the ear 	MASTOIDITIS	<ul style="list-style-type: none"> ➤ Give ampicillin IM OR ceftriaxone IM (p.13) ➤ Give first dose of paracetamol (p.10) ➤ Refer URGENTLY to hospital
<ul style="list-style-type: none"> • Pus seen draining from the ear and discharge is reported for less than 14 days, OR • Ear pain 	ACUTE EAR INFECTION	<ul style="list-style-type: none"> ➤ Give amoxycillin for 5 days (p.9) ➤ If ear discharge: <ul style="list-style-type: none"> - Teach mother to clean ear by dry wicking (p.11) - Consider symptomatic HIV (p.7) ➤ Give paracetamol for pain (p.10) ➤ Follow-up in 5 days if pain or discharge persists
<ul style="list-style-type: none"> • Pus is seen draining from the ear and discharge is reported for 14 days or more 	CHRONIC EAR INFECTION	<ul style="list-style-type: none"> ➤ Teach mother to clean ear by dry wicking (p.11) ➤ Consider symptomatic HIV (p.7) ➤ Tell the mother to come back if she suspects hearing loss ➤ Follow up in 14 days if discharge persists
<ul style="list-style-type: none"> • No ear pain AND no pus seen draining from the ear 	NO EAR INFECTION	<ul style="list-style-type: none"> ➤ No additional treatment

THEN CHECK FOR MALNUTRITION

<p>ASK:</p> <p>Has the child lost weight?</p> <p>LOOK and FEEL:</p> <p>GROWTH</p> <p>Plot the weight on the growth chart:</p> <ul style="list-style-type: none"> Is the child: <ul style="list-style-type: none"> Low weight (below 3rd centile) Very low weight (below 60% of expected weight) <p>Look at the shape of the weight curve:</p> <ul style="list-style-type: none"> Is the child: <ul style="list-style-type: none"> Gaining weight well? Gaining weight but curve is flattening? Losing weight ? Look for visible severe wasting Feel for oedema of both feet <p>ANAEMIA</p> <ul style="list-style-type: none"> Look for palmar pallor. Is it: <ul style="list-style-type: none"> Severe palmar pallor? Some palmar pallor? If any pallor check the haemoglobin (Hb) level 	<p>Classify all children for GROWTH</p>	<ul style="list-style-type: none"> Very low weight OR Visible severe wasting OR Oedema of both feet 	<p>SEVERE MALNUTRITION</p>	<ul style="list-style-type: none"> Give Vitamin A unless a dose has been given in past month (p.12) Test for low blood sugar, then treat or prevent (p.14) Refer URGENTLY to hospital Keep the child warm
	<p>A N D</p> <p>ANAEMIA</p>	<ul style="list-style-type: none"> Low weight OR Poor weight gain OR Mother reports weight loss OR 	<p>NOT GROWING WELL</p>	<ul style="list-style-type: none"> Assess feeding & counsel about feeding (p.21) Check for and treat thrush (p.11) Give mebendazole if the child is older than one year and has not had a dose in the past six months (p.12) Follow Vitamin A schedule (p.12) Consider symptomatic HIV infection (p.7) Advise mother when to return immediately (p. 26) If feeding problem follow up after 5 days If no feeding problem follow up after 14 days
		<ul style="list-style-type: none"> Not low weight AND Good weight gain 	<p>GROWING WELL</p>	<ul style="list-style-type: none"> If child is less than 2 years, assess and counsel on feeding (p.21) If feeding problem, check for thrush, and treat (p.11). Follow-up in five days Give mebendazole if the child is older than one year and has not had a dose in the past six months (p.12) Follow Vitamin A schedule (p.12)
		<ul style="list-style-type: none"> Severe palmar pallor OR Hb < 6g/dl 	<p>SEVERE ANAEMIA</p>	<ul style="list-style-type: none"> Refer URGENTLY to hospital Keep the child warm
	<p>And classify all children For ANAEMIA</p>	<ul style="list-style-type: none"> Some palmar pallor OR Hb <10g/dl 	<p>ANAEMIA</p>	<ul style="list-style-type: none"> Give iron (p.10) Do a feeding assessment and counsel about feeding Follow-up in 14 days
		<ul style="list-style-type: none"> No pallor OR Hb >10g/dl 	<p>NO ANAEMIA</p>	<ul style="list-style-type: none"> No additional treatment

IF THE CHILD-

- has a classification today of PNEUMONIA or PERSISTENT DIARRHOEA or NOT GROWING WELL
OR
- Has had an episode of persistent diarrhoea in the past three months
OR
- Has had a discharging ear at any time
OR
- If the mother is known to be HIV positive*

ASSESS FOR SYMPTOMATIC HIV INFECTION *:

<p>NOTE (as above): <u>Does the child have</u></p> <ul style="list-style-type: none"> • any PNEUMONIA now? • ear discharge now OR in the past? • low weight for age? • poor weight gain or weight loss? • Any episode of persistent diarrhoea in the past three months? 	<p>LOOK AND FEEL FOR:</p> <ul style="list-style-type: none"> • enlarged lymph glands in two or more of the following sites: neck, axilla or groin? • oral thrush? • parotid gland enlargement? 	<p>CLASSIFY by counting the number of positive findings</p>	<p>• three or more positive findings</p>	<p>SUSPECTED SYMPTOMATIC HIV</p> <ul style="list-style-type: none"> ➢ Discuss reasons for classification with mother and advise her to take the child for HIV testing ➢ Arrange pre-test counselling and HIV testing ➢ Assess feeding and counsel (p.21) ➢ Counsel mother about her own health ➢ Follow-up in 14 days as follows: <ul style="list-style-type: none"> - if mother agrees to have the child tested, discuss the result and arrange regular follow up if positive (p.20) - if mother refuses testing, review the child and for further discussion. Offer treatment to the child including regular follow-up and co-trimoxazole prophylaxis if HIV testing is refused (p.20).
		<p>• less than three positive findings</p>	<p>SYMPTOMATIC HIV UNLIKELY</p>	<ul style="list-style-type: none"> ➢ If the mother is known HIV positive: <ul style="list-style-type: none"> - give appropriate feeding advice (p. 23) - if the child is under one year start co-trimoxazole prophylaxis (p. 9) and test to determine whether the child is infected at age 12 months - if the child is over one year arrange testing to determine if the child is infected ➢ Counsel mother about her own health and about prevention of HIV infection ➢ If breastfeeding counsel about importance of safe sex during breastfeeding to prevent HIV transmission to the baby if the mother becomes infected while breastfeeding

***If the child has been classified as symptomatic HIV in the past and had a positive HIV test, do not assess again - give follow-up care for confirmed symptomatic HIV (p. 20)**

THEN CHECK THE CHILD'S IMMUNISATION STATUS

- Give all missed immunisations today. This includes sick children (unless being referred) and those without their cards
- If there is no RTHC give a new one today
- Advise the mother when to come for the next immunisation

	<u>AGE</u>	<u>VACCINE</u>		
IMMUNISATION SCHEDULE:	Birth	BCG	OPV-0	
	6 weeks	DPT+HIB-1	OPV-1	Hep B1
	10 weeks	DPT+HIB-2	OPV-2	Hep B2
	14 weeks	DPT+HIB-3	OPV-3	Hep B3
	9 months			Measles 1
	18 months	DPT-4	OPV-4	Measles 2
	5 years	DT	OPV-5	

} Check vitamin A and give dose if none given in past 6 months (p.12)

VITAMIN A PROPHYLAXIS

Give every child a dose of vitamin A every six months from the age of 6 months (p.12). Record the dose on the RTHC

ROUTINE WORM TREATMENT

Give every child mebendazole every 6 months from the age of one year. Record the dose on the RTHC.

ASSESS OTHER PROBLEMS:

Remember to ask if the child has any other problems like skin sores not covered in the IMCI assessment

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



TREAT THE CHILD

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



TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Follow the **general 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
- Advise the mother to store the drugs safely
- Explain that all the tablets or syrup must be used to finish the course of treatment, even if the child gets better
- Check the mother's understanding before she leaves the clinic

For HIV INFECTION give Co-trimoxazole to Prevent Infections

- SHOULD NOT BE GIVEN TO BABIES UNDER 6 WEEKS OF AGE
- For **babies of mothers who are HIV infected**, give co-trimoxazole once daily for five days a week from the age of 6 weeks. If the baby has no symptoms at 12 months arrange HIV testing to determine if child is infected
- For **children with symptomatic HIV infection** give once daily five days per week (can be given even if mother refuses HIV testing)

CO-TRIMOXAZOLE SYRUP (40/200mg/5ml) Once daily five days per week	
WEIGHT	DOSE
4-5 kg	2.5ml
>5– 10 kg	5ml
>10– 14 kg	5 ml
>14-20 kg	7.5ml

For WHEEZE give Salbutamol and Prednisone

SALBUTAMOL (Rapid acting bronchodilator)

Salbutamol metered dose inhaler (100ug/puff) 5 puffs with a spacer for 5 days

WEIGHT	PREDNISONE (5mg) Once daily for three days
4-6kg	2 tabs
>6-9kg	3 tabs
>9-12kg	4 tabs
>12-14kg	5 tabs
>14-17kg	6 tabs
>17-19kg	7 tabs
>19-20kg	8 tabs

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.

Spacers can be made in the following way:

- Use a 500ml cool drink bottle.
- Cut a hole in the end or the top of the bottle in the same shape as the mouthpiece of the inhaler. This can be done using a sharp knife
- 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:

- 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 total of five sprays
- For younger children place the cup over the child's mouth and use as a spacer in the same way

ENSURE THAT ALL CARERS OF CHILDREN USING INHALERS ARE ABLE TO USE AN INHALER AND SPACER EFFECTIVELY

For PNEUMONIA and ACUTE EAR INFECTION give Amoxycillin

AGE	WEIGHT	AMOXYCILLIN SYRUP (125 mg per 5 ml) Give three times daily for 5 days
2 to 12 months	4-5 kg	2,5 ml
	>5– 10 kg	5 ml
12 months to 5 years	>10– 14 kg	7.5 ml
	>14-20 kg	10 ml

For DYSENTERY give Nalidixic Acid

AGE or WEIGHT	NALIDIXIC ACID SUSPENSION (250 mg / 5 ml.) Give four times daily for 5 days
12-24 months (7- <15kg)	2.5 ml
2-5 years (15- <20kg)	5 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 Paracetamol for chronic pain relief (stage 1)**
- **Add regular Codeine for chronic severe pain (stage 2)**

- Safe doses of Paracetamol can be slightly higher for pain. Use the table and teach mother to measure the right dose.
- Give Paracetamol every 6 hours if pain (Stage 1) persists.

Stage 2 pain is chronic severe pain as might happen in illnesses such as AIDS.

- Start treating Stage 2 pain with regular (not prn) paracetamol.
- In older children, ½ Paracetamol tablet can replace 10 ml syrup
- If the pain is not controlled, **add** regular (not prn) codeine.
- Start Codeine on the lower dose, gradually increasing depending on the child's response, to the maximum dose.

WEIGHT	AGE (Only if you do not know the weight)	Pain Stage 1 Paracetamol 6 hrly	Pain Stage 2 Add Codeine Phosphate syrup 25 mg per 5 ml 6 hrly	
			Initial dose	Maximum
2 - <3 kg	Under 2 months	2 ml	0.2 ml	1.0 ml
3 - <5 kg	2 up to 6 months	2.5 ml	0.3 ml	2.0 ml
5 - <8 kg	6 up to 12 months	5 ml	0.5 ml	3 ml
8 - <12 kg	1 up to 3 years	7.5 ml	1.0 ml	5 ml
12 - <16 kg	3 up to 4 years	10 ml	1.5 ml	6 ml
16 - <20 kg	Over 4 years	12.5 ml	2 ml	8 ml

For ANAEMIA give Iron

- Check the strength and dose of the iron syrup/ tablet very carefully
- Give two doses daily for 2 months. Follow-up every 14 days for 2 months
- Give Iron syrup with food. Iron may make the stools black.
- Overdose with iron is dangerous, caution the mother to keep it out of reach of children.

AGE or WEIGHT	IRON SYRUP Ferrous gluconate Give twice daily
2 months upto 4 months (4 - <6 kg)	5 drops
4 months upto 24 months (6-<15kg)	10 drops
2—5 years (15 - 23 kg)	20 drops

For MALARIA Give Co-artemether

- **REFER ALL CHILDREN UNDER ONE YEAR URGENTLY TO HOSPITAL**
- Give the first dose of co-artemether in the clinic and observe for one hour. If child vomits within an hour repeat the dose
- Second dose should be taken at home 8 hours later
- Then twice daily for further two days
- Co-artemether should be taken with food

WEIGHT (age)	CO-ARTEMETHER DOSE	TOTAL NUMBER OF TABLETS
10 – 15kg (1-5 years)	1 tablet	6
Over 15kg	2 tablets	12

For High Fever or Ear Pain give Paracetamol

- Give single dose in the clinic for high fever
- For ear pain: give paracetamol every 6 hours until ear pain is gone.
- Tepid sponging can also bring down the temperature

PARACETAMOL		
AGE or WEIGHT	SYRUP (120 mg / 5 ml)	TABLET (500 mg)
2 months up to 3 years (4 - <14 kg)	5 ml	—
3 years up to 5 years (14 - <23 kg)	10 ml	1/2

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 remedy for cough or sore throat)
- Tell her how often to do the treatment at home.
- If needed for treatment at home, give mother a small bottle of gentian violet or nystatin
- Check the mother's understanding before she leaves the clinic

Clear the Ear by Dry Wicking

- 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
 - The ear should not be plugged between dry wickings

Treat for Mouth Ulcers with Gentian Violet

- Treat for mouth ulcers twice daily
 - Wash hands
 - Wet a clean soft cloth with salt water and use it to wash the child's mouth
 - Paint the mouth with 0,5 % gentian violet (GV)
 - Wash hands again
 - Continue using GV for 48 hours after the ulcers have been cured
 - Give paracetamol for pain relief (p.10)

Soothe the Throat, Relieve the Cough with a Safe Remedy

- Safe remedies to recommend:
 - Breastmilk for exclusively breastfed infant
 - Honey and lemon
- Harmful remedies to discourage:
 - Herbal smoke inhalation
 - Vicks® drops by mouth

Treat for Thrush with Nystatin or Gentian Violet

- Treat for thrush four times daily for 7 days
 - Wash hands
 - Wet a clean soft cloth with salt water and use it to wash the child's mouth
 - Instill nystatin 1ml four times a day or paint with GV as above for 7 days
 - Avoid feeding for 20 minutes after medication
 - If breastfed check mother's breasts for thrush. If present treat with nystatin or GV
 - Advise mother to wash breasts after feeds. If bottle fed advise change to cup and spoon
 - If severe, recurrent or pharyngeal thrush consider symptomatic HIV (p. 7)
 - Give paracetamol if needed for pain (p.10)

GIVE THESE PREVENTIVE TREATMENTS IN CLINIC

- Explain to the mother why the drug is given
- Determine the dose appropriate for the child's weight (or age)
- Measure the dose accurately

Give Vitamin A to all Children every 6 months

PREVENTION:

- Give Vitamin A to all children to **prevent** severe illness
 - First dose at 6 weeks in a child that is **not** being breastfed
 - First dose in breastfed children to be given any time after 6 months of age
 - Thereafter vitamin A should be given **every six months** to ALL CHILDREN

TREATMENT:

- Give an extra dose of Vitamin A (same dose) for **treatment** if the child has SEVERE MALNUTRITION or PERSISTENT DIARRHOEA. If the child has had a dose of vitamin A within the past month, DO NOT GIVE VITAMIN A.
- Check the strength of Vitamin A:
 - Vitamin A capsules come in 50 000IU, 100 000IU, and 200 000IU
 - If 100 000IU is required, and only the 200 000IU capsules are available, cut open the capsules using a sterile needle and given the child every second drop
- Always chart the dose of Vitamin A given on the RTHC.

Age	VITAMIN A DOSE
<6 months	50 000IU
6- <12 months	100 000IU
One year and older	200 000IU

Give Mebendazole or Albendazole to all Children Every 6 Months

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

**IMMUNISE EVERY SICK CHILD,
AS NEEDED**

Give treatments in clinic only
Treat the child

GIVE EMERGENCY TREATMENTS IN 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 Oxygen to a Child with Severe Pneumonia

- Oxygen should be given to all children with SEVERE PNEUMONIA OR VERY SEVERE DISEASE with or without a wheeze.
- Use nasal prongs or cannulae with flow rate of 2 L/min

Give Nebulised Adrenaline to a Child with Stridor

- Add 1ml of 1:1000 adrenaline (one vial) to 1ml of saline and give as a nebuliser
- Repeat every 20 minutes until the child is transferred

Give Diazepam to Stop a Convulsion

- 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 (p. 14)
- Give oxygen and REFER
- If convulsions have not stopped after 10 minutes repeat diazepam dose

WEIGHT	AGE	DOSE OF DIAZEPAM (10mg/2mls)
< 5kg	<6 months	0.5 mls
5- < 10kg	6- < 12 months	1.0 mls
10- < 15kg	1- < 3 years	1.5mls
15- 19 kg	4- < 5years	2.0 mls

Give An Intramuscular Antibiotic

- **GIVE TO CHILDREN BEING REFERRED URGENTLY**
- Give either Ceftriaxone OR Ampicillin, whichever is available in your clinic
- Wherever possible use the weight of the child to calculate the dose

CEFTRIAZONE

- Dose of ceftriaxone is 50mg per kilogram
- Dilute 250mg vial with 1ml of sterile water (250mg/ml)
- IF REFERRAL IS NOT POSSIBLE OR DELAYED, repeat the ceftriaxone injection every 24 hours
- **Where there is a strong suspicion of MENINGITIS the dose of ceftriaxone may be doubled**

AGE	WEIGHT	DOSE CEFTRAXONE / mg	DOSE CEFTRIAZONE / mls
2 – 4months	4 – <6kg	250mg	1.0
4 – 12months	6 – <10kg	500mg	2.0
1 – 3yrs	10 – <15kg	750mg	3.0
3-5years	15 – 19kg	1g	4.0 (give 2ml in each thigh)

AMPICILLIN

- Check strength of ampicillin. Usually 250mg vials but other strengths are available.
- Dilute 250mg vial with 1ml of sterile water (250mg/ml)
- 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**

AGE	WEIGHT	DOSE AMPICILLIN/mg	DOSE AMPICILLIN/ mls
2 – 4months	4 – <6kg	125mg	0.5ml
4 – 12months	6 – <10kg	250mg	1.0ml
1 – 3yrs	10 – <15kg	375mg	1.5ml
3-5years	15 – 19kg	500mg	2.0ml

GIVE THESE TREATMENTS IN CLINIC ONLY

- Explain to the mother why the treatment is being given

Prevent Low Blood Sugar (Hypoglycaemia) during Transfer to Hospital

- If the child is able to swallow:
 - If breastfed: ask the mother to breastfeed the child, or give expressed breastmilk
 - If not breastfed: give a breastmilk substitute or sugar water. Give 30-50 ml of milk or sugar water before departure
 - *To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water*
- If the child is not able to swallow:
 - Insert nasogastric tube and check the position of the tube
 - Give 50mls of milk or sugar water before transfer

Treat the child for Low Blood Sugar

LOW BLOOD SUGAR IS LESS THAN 3 mmol/l IN A CHILD OR LESS THAN 2.5 mmol/l IN A YOUNG INFANT

- Suspect low blood sugar in any infant or child that:
 - is convulsing or unconscious OR
 - has a temperature below 35,5°C, OR
 - is drowsy and sweating OR
 - is lethargic, floppy or jittery — particularly when less than 2 months old
 - Children with kwashiorkor are particularly likely to be hypoglycaemic
- Confirm low blood sugar using blood glucose testing strips
- Treat with:
 - 10% Glucose - Give 5ml 10% Glucose for every kilogram body weight - by nasogastric tube OR intravenous line
 - Keep the child warm
 - Refer urgently and continue feeds during transfer
 - To make 10% glucose if this is not available:
 - mix 4 mls of 50% glucose with 16 mls sterile water in a 20 ml syringe or
 - mix 2 mls of 50% glucose with 18 mls of 5% glucose in a 20 ml syringe

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

Plan A: Treat for Diarrhoea at Home

Counsel the mother on the 3 Rules of Home Treatment:

1. Give Extra Fluid, 2. Continue Feeding, 3. When to Return

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

➤ TELL THE MOTHER:

- Breastfeed frequently and for longer at each feed
- If the child is exclusively breastfed, give sugar-salt solution (SSS) in addition to breastmilk
- If the child is not receiving breastmilk or is not exclusively breastfed, give one or more of the following: food-based fluids such as soft porridge, amasi (maas), SSS or ORS.

It is especially important to give ORS at home when:

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

➤ TEACH THE MOTHER HOW TO MIX AND GIVE SSS or ORS:

To make SSS: 1 litre boiled (or clean) water +
8 teaspoons sugar +
half a teaspoon salt

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

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

Tell the mother to:

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

SSS is the solution to be used at home to prevent dehydration
ORS sachets mixed with clean water are used to correct dehydration.

2. **CONTINUE FEEDING**

3. **WHEN TO RETURN**

See **COUNSEL THE MOTHER** chart (p.21-27)

Plan B: Treat for Some Dehydration with ORS

Give in clinic recommended amount of ORS over 4-hour period

➤ DETERMINE AMOUNT OF ORS TO GIVE DURING FIRST 4 HOURS.

Give 20mls of ORS for each kg of body weight every hour

AGE*	Up to 4 months	4 months up to 12 months	12 months up to 2 years	2 years up to 5 years
WEIGHT	< 6 kg	6 - < 10 kg	10 - < 12 kg	12 - <20kg
Amount of fluid over 4 hours in mls	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 20 and give this amount of fluid every hour (20mls/kg). One teacup is approximately 200mls*

➤ SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.

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

➤ AFTER 4 HOURS:

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

➤ IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:

- Show her how to prepare ORS solution at home
- Show her how much ORS to give to finish 4-hour treatment at home
- Give her instructions how to prepare SSS for use at home
- Explain the 3 Rules of Home Treatment:

1. **GIVE EXTRA FLUID**

2. **CONTINUE FEEDING**

3. **WHEN TO RETURN**

See Plan A for recommended fluids
and See **COUNSEL THE MOTHER**
chart (p.21-27)

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

Plan C: Treat for Severe Dehydration Quickly

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

START HERE

Can you give intravenous (IV) fluid immediately?

YES →

- **Start IV fluid immediately.**
- If the child can drink, give ORS by mouth while the drip is set up.
- Give 20 ml/kg Ringer's Lactate Solution (or, if not available, normal saline) every hour

In the first half hour:	Plan for the next 5 hours:
Give 20 ml IV for each kilogram weight, before referral Repeat this amount if brachial pulse is weak or not detectable.	Give 20 ml IV for each kilogram weight, every hour while the child is in the clinic awaiting transfer. Monitor and record how much fluid the child receives

- **Arrange urgent referral to hospital for further management**
- **Reassess the child every 1-2 hours while awaiting transfer.** If hydration status is not improving, give the IV drip more rapidly.
- Also give ORS (about 5 ml/kg/hour) as soon as the child can drink: usually after 3-4 hours (infants) or 1-2 hours (children).
- Reassess an infant after 3 hours if he is still at the clinic. Classify dehydration. Then choose the appropriate plan (A, B, or C) to continue treatment.
- If you cannot refer observe for at least 6 hours after the child has been fully rehydrated

Is IV treatment available nearby (within 30 minutes)?

YES →

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

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

NO

YES →

Can the child drink?

NO

Refer URGENTLY to hospital for IV or NG treatment

- **Start rehydration by tube (or mouth) with ORS solution:** give 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- **Arrange urgent referral to hospital for further management**
- **Reassess the child every 1-2 hours while waiting transfer:**
 - If there is repeated vomiting or abdominal distension, give the fluid more slowly.
- After 6 hours reassess the child if he is still at the clinic. Classify dehydration. Then choose the appropriate plan (A, B, or C) to continue treatment.

NOTE:

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

GIVE FOLLOW-UP CARE

Care for the child who returns for follow-up using **ALL** the boxes that match 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 2 days: Check the child for general danger signs.

Assess the child for cough or difficult breathing.

} **SEE ASSESS & CLASSIFY**
(P. 2)

- Ask:**
- Is the child breathing slower?
 - Is there less fever?
 - Is the child eating better?

Treatment:

- If **chest indrawing or a general danger sign**, give first dose of ceftriaxone or ampicillin IML. Then **REFER URGENTLY** to hospital.
- If **breathing rate, fever and eating are the same, or worse** **REFER** (unless the child has not been taking the antibiotics correctly).
- If **breathing slower, less fever, or eating better**, complete the 5 days of antibiotic.

Remind the mother to give one extra meal daily for a week.

➤ WHEEZE (FIRST EPISODE)

After 2 or 5 days if still wheezing:

Check the mother is using the inhaler and spacer correctly
Assess and classify the child for cough or difficult breathing and treat according to classification. (see **ASSESS & CLASSIFY** p.2)

- Ask:**
- Has the child's breathing improved?

Treatment:

- If the child is still wheezing and the mother is using the inhaler correctly **REFER**.
- If the child is still wheezing, and the mother is not using the inhaler correctly— show her how to use it and let her practise until she feels confident. Review in another five days. If still wheezing after a further 5 days refer.
- If the wheezing has stopped advise the mother to keep the inhaler and spacer at home and use it if the wheezing recurs. She should bring the child back if the wheeze recurs.

➤ DIARRHOEA

After 2 days (diarrhoea with some dehydration) or 5 days (no visible dehydration), if diarrhoea persists:

Assess the child for general danger signs and diarrhoea.

} **SEE ASSESS & CLASSIFY**

- Ask:**
- Are there fewer stools?
 - Is the child eating better?

Treatment:

- If **child is dehydrated now, treat for dehydration and REFER**
- If diarrhoea same as before and classified as **NO VISIBLE DEHYDRATION** continue with plan A at home and review again in 5 days. If diarrhoea still continuing after a further 5 days, treat for persistent diarrhoea and **REFER**
- If diarrhoea improving continue with home treatment

➤ DYSENTERY:

After 2 days:

Assess the child for diarrhoea. > See **ASSESS & CLASSIFY** (p3)

- 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 for dehydration (p.15 & 16) and **REFER**
- If **number of stools, blood in the stools, fever, abdominal pain, or eating is worse or the same** **REFER**
- If **fewer stools, less fever, less abdominal pain, and eating better**, continue giving nalidixic acid until finished

Ensure that

- the mother understands the oral rehydration method fully
- the mother understands the need for an extra meal each day for a week

GIVE FOLLOW-UP CARE

- 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.

➤ PERSISTENT DIARRHOEA

After 5 days:

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

Treatment:

- If the diarrhoea has **not stopped** (child is still having 3 or more loose stools per day). Treat for dehydration if present. Then **REFER** to hospital.
- If the diarrhoea has **stopped** (child having less than 3 loose stools per day), counsel on feeding (p.21-24) and tell the mother to **give one extra meal every day for one week**

NOTE: Attention to the diet is an essential part of the management of the child with persistent diarrhoea.

➤ MALARIA

If fever persists after 2 days, or returns within 14 days:

Do a full reassessment of the child for fever. See **ASSESS & CLASSIFY** (p 4)

Treatment:

- If the child has **any general danger sign, bulging fontanelle or stiff neck**, treat as **SUSPECTED MENINGITIS** (p.4) and **REFER**.
- If **malaria rapid test was positive at initial visit** and fever persists or recurs **REFER** the child to hospital
- If the child has any **cause of fever other than malaria**, give treatment

Counsel: about prevention of malaria including the importance of insecticide-treated bed nets

➤ FEVER - OTHER CAUSE

If fever persists after 2 days:

Do a full reassessment of the child for fever. > See **ASSESS & CLASSIFY** (p. 4)
Assess for other causes of fever.

Treatment:

- If the child has **any general danger sign or stiff neck or bulging fontanelle**, treat as for **SUSPECTED MENINGITIS** (p. 4) and **REFER urgently**
- If the child has any **identified cause of fever** give treatment
- If **no cause of fever is found**, **REFER**
- If **fever has been present every day for 7 days**, **REFER**

➤ EAR INFECTION

After 5 days if pain or discharge persists:

Reassess for ear problem. > See **ASSESS & CLASSIFY chart**. (p. 5)
Check for fever

Treatment:

ACUTE EAR INFECTION:

- If there is **tender swelling behind the ear or high fever** (38°C or above), **refer UR-GENTLY** to hospital
- If **ear pain or discharge worse** than before **REFER**
- If **ear pain or discharge the same or better**, treat with 5 more days of amoxycillin. Continue dry wicking. Follow-up in 5 days– if still no improvement after a further 5 days refer.

CHRONIC EAR INFECTION:

- If there is **tender swelling behind the ear or high fever** (38°C or above), **refer UR-GENTLY** to hospital
- If **no improvement** or persistent pain or foul smelling discharge, **REFER**
- If **some improvement**, check that the mother is wicking the ear correctly. Continue dry wicking, and review in further 14 days. If still discharging in a further 14 days **REFER**
- If **no ear pain or discharge**, praise the mother. Ask about child's hearing. If hearing loss suspected, **REFER**.

GIVE FOLLOW-UP CARE

- 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 for the new problem as on the **ASSESS AND CLASSIFY** chart.

➤ FEEDING PROBLEM

After 5 days:

- Assess feeding (p.21) and counsel (p.21-24).
- Review the feeding problem identified at the last visit
- If you counsel her to make further changes to her child's feeding follow up again in another 5 days
- Check on available resources and ensure that advice is appropriate

- Review every 30 days until the child is gaining weight

➤ ANAEMIA

After 14 days:

- Check haemoglobin,

Treatment:

- If **haemoglobin lower than before**, **REFER**
- If the **haemoglobin has not improved** or the child has palmar pallor after one month, **REFER** for assessment
- If **haemoglobin is higher than before**, continue iron. Review in 14 days. Continue giving iron every day for 2 months

➤ NOT GROWING WELL

After 14 days:

- Weigh the child and determine if the child is still low weight for age.
- Determine weight gain
- Reassess feeding (p.21) and counsel (p.21-24)

Treatment:

- If the child **gaining weight well**, praise the mother. Review monthly for growth monitoring.
- If the child is still **low weight for age**, counsel the mother about feeding. Ask the mother to return in 14 days. Review monthly until the child is feeding well and gaining weight regularly or is no longer low weight for age.
- If the **child has not gained weight or has lost weight**, check for possible symptomatic HIV (p.7). Assess feeding and if there is a feeding problem counsel and review in further 14 days. If poor weight gain continues after another 14 days **REFER**
- **Exception:** If you do not think that feeding will improve, refer the child.

IF ANY MORE FOLLOW-UP VISITS ARE NEEDED, ADVISE THE MOTHER OF THE **NEXT FOLLOW-UP VISIT**
ADVISE THE MOTHER **WHEN TO RETURN IMMEDIATELY** (p.26)

GIVE FOLLOW-UP CARE FOR THE CHILD WITH SUSPECTED SYMPTOMATIC HIV OR KNOWN HIV

➤ FOLLOW-UP FOR SUSPECTED SYMPTOMATIC HIV (first return visit only)

If child has had an HIV test, check results

If testing not done:

- Advise the mother about benefits of HIV testing and refer for further counselling if necessary.
- Arrange HIV counselling and testing if mother agrees.
- Tell mother about available support structures and if acceptable, put her in contact with these people.
- If mother refuses testing provide ongoing care for the child according to routine monthly follow-up of all HIV infected children (this page). Discuss with the mother whether she wishes the child to have co-trimoxazole.

If HIV test positive:

- Ensure that the mother receives post-test counselling.
- Discuss with her any other worries or questions that she has.
- Tell her about organisations, support groups or focal people that could provide support.
- Treat according to routine monthly follow-up of all HIV infected children (this page)
- If child is below 12 months the test will need to be repeated after 12 months of age to confirm infection

IF HIV test negative

- Counsel mother on preventing HIV infection and about her own health
- If breastfeeding advise her about the importance of safe sex during breastfeeding

➤ FOLLOW-UP MONTHLY FOR SUSPECTED OR CONFIRMED HIV INFECTION

For all children confirmed HIV positive or where there is SUSPECTED SYMPTOMATIC HIV and the status is still unknown

- Start/continue co-trimoxazole prophylaxis (p.9)
- Assess and classify the child at each visit and treat according to classifications
- Assess feeding, and check weight and weight gain.
 - Encourage breastfeeding mothers to continue breastfeeding
 - Poor appetite and low weight are common in these children, advise on any new or continuing feeding problems (p.21-24)
 - Check for oral thrush and mouth sores and treat (p.11)
 - If any history of diarrhoea, check for nappy rash and treat
- Give Vitamin A according to schedule (p.12).
- Provide pain relief if the child is in any pain (p.10).
- Tell the mother about community support structures and if acceptable, put her in contact with them.
- Advise about home care
 - Advise mother to bring the child back if any new illness develops because it is important to treat infections
 - Advise the mother about the importance of hygiene in the home, in particular when preparing food for the child.
- Follow-up monthly
- Monitor the health of the mother.
 - Advise about safe sex and family planning
 - If the mother is pregnant refer her for counselling her about prevention of transmission of HIV and feeding choices for her new baby.

➤ PALLIATIVE CARE FOR SYMPTOMATIC HIV INFECTION

- This should help the family care for the child with as little suffering as possible. This starts at the time of diagnosis and continues throughout the illness
- Medical therapy may be discontinued because it is leading to unnecessary suffering and separation of the child from his family. THIS DECISION SHOULD BE MADE AT THE REFERRAL CENTRE AFTER THE CHILD HAS BEEN FULLY ASSESSED.
- After this decision has been made palliative care alone can be offered at primary care level. Until then palliative care should be offered together with routine medical treatment

Palliative care should be given as follows:

- If the child has pain provide adequate **pain relief**. A 3 stage process may be used (p.10):
 - Stage 1: paracetamol
 - Stage 2 (if pain is not well controlled): codeine phosphate
 - Stage 3 (if pain relief still not well controlled): morphine may be used as prescribed by the doctor.
- **Counsel** the mother so that:
 - the child remains nourished and well hydrated
 - the child remains clean, dry and comfortable
 - any skin lesions (abscesses or ulcers) are dressed and kept clean
- **Support** the mother and other family members:
 - Refer to community support structures (if acceptable)
 - Provide information and counselling to help the family with questions and fears they may have
 - The family/mother should make a decision about where it is best for the child to die
 - Counsel the mother about her own health



COUNSEL THE MOTHER



➤ **Assess the Feeding of Sick Children under 2 years (or if ANAEMIA or NOT GROWING WELL)**

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 on p 19

ASK — How are you feeding your child?

If the baby is receiving any breastmilk, ASK:

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

If baby is receiving replacement milk, ASK:

- What replacement milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How is the milk prepared?
- How is the milk being given? Cup or bottle?
- How are you cleaning the utensils?
- If still breastfeeding as well as giving replacement milk could the mother give extra breastmilk instead of replacement milk (especially if the baby is below 6months)

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 low weight for age, ASK:

- 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? If yes, how



COUNSEL THE MOTHER



FEEDING RECOMMENDATIONS IN SICKNESS AND IN HEALTH

NOTE: These feeding recommendations should be followed for infants of all mothers who **DO NOT KNOW** their HIV status

Up to 6 Months of Age

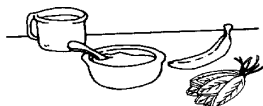


- Breastfeed as often as the child wants, day and night,
- Feed at least 8 times in 24 hours.
- Do not give other foods or fluids

6 Months up to 12 Months



- Continue to breastfeed as often as the child wants
- Give **3 servings** of nutritious complementary foods. **Always** mix margarine, fat, oil, peanut butter or ground nuts with porridge.
Also add:
 - chicken, egg, beans, fish or full cream milk, or
 - mashed fruit and vegetables, at least once each day.
- If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well.
- If baby gets no milk, give 6 complementary feeds per day

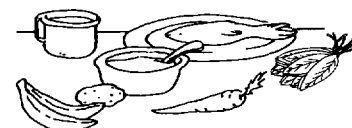


12 Months up to 2 Years



- Continue to breastfeed as often as the child wants. Breastmilk is still an important food at this age and helps prevent infections
- Give at least 5 adequate nutritious feeds. Increase the variety and quantity with family foods:
 - Mix margarine, fat, oil, peanut butter or ground nuts with porridge
 - Give egg, meat, fish or beans daily
 - Give fruit or vegetables twice every day
 - Give milk every day, especially if no longer breast feeding.

Feed actively with her own serving



2 Years and Older



- Give the child her own serving of family foods 3 times a day.
- In addition, give 2 nutritious snacks such as bread with peanut butter, full cream milk or fresh fruit between meals
- Continue active feeding



REMEMBER TO ENCOURAGE FEEDING DURING ILLNESS AND TO ADVISE TO GIVE AN EXTRA MEAL A DAY FOR ONE WEEK AFTER AN ILLNESS.

FEEDING RECOMMENDATIONS IF MOTHER IS HIV POSITIVE

Up to 6 Months of Age



Breastfeed exclusively as often as the child wants, day and night.

- Feed at least 8 times in 24 hours.
- Do not give other foods or fluids (Mixed feeding could lead to HIV transmission)
- Safe transition to replacement milk and complementary feeds at 4 to 6 months

OR (if feasible and safe)

Formula feed exclusively (no breast milk at all *).

- Give formula or modified cow's milk
- Other foods or fluids are not necessary
- Prepare correct strength and amount just before use (p.36).
- Use milk within an hour and discard any left (a fridge can store formula for 24 hours)
- Cup feeding is safer than bottle
- Clean the cup and utensils with soap
- If using a bottle, also boil 5 minutes or sterilise after each use
- Give formula 6 to 8 times a day (p.36)

*** Exception: only heat treated or boiled breast milk can still be given**

Safe transition from exclusive breastfeeding



Safe transition means rapidly changing from all breast milk, to none *.

Avoid mixing breast milk with other food or fluids (this increases risk of HIV transmission).

Suggest transition some time between 4 and 6 months, or earlier if mother can safely do so. Do not breast feed after 6 months.

Help mother prepare for transition:

- Mother should discuss weaning with her family if possible
- Express milk to practice cup feeding
- Find a regular supply of formula or other milk
- Learn how to safely prepare and store milk at home

Help mother make the transition:

- Teach mother to cup feed her baby (p.36)
- Start giving only formula or cows milk. Stop breastfeeding completely.
- Express and discard some breastmilk, to keep comfortable till lactation stops.
- Give complementary feeds from 6 months

*** Exception: only heat treated or boiled breast milk can still be given**

6 Months up to 12 Months



Do not breast feed after six months unless the child is already known to be infected.

Give 3 servings of nutritious complementary foods. Always mix margarine, fat, oil, peanut butter or ground nuts with porridge.

Also add:

- chicken, egg, beans, fish or full cream milk, or
- mashed fruit and vegetables, each day.

Give at least 3 cups (3 x 200 ml) of full cream milk (or infant formula) per day. Give milk with a cup, not a bottle.

If no milk available, give 6 complementary feeds per day



12 Months up to 2 Years

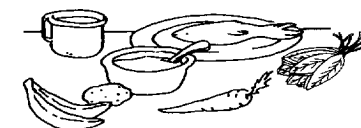


Give at least 5 adequate nutritious feeds.

Increase the variety and quantity with family foods:

- Mix margarine, fat, oil, peanut butter or ground nuts with porridge
- Give egg, meat, fish or beans daily
- Give fruit or vegetables twice every day
- Give milk every day

Feed actively with her own serving



➤ Counsel the Mother About Feeding Problems

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

If mother reports difficulty with breastfeeding, assess breast feeding. (See *YOUNG INFANT* chart p.30)

- Identify the reason for the mother's concern and manage any breast problem
- If needed, show correct positioning and attachment
- Build the mother's confidence. Advise her that frequent feeds improve lactation.

If the child is less than 6 months old and is taking other milk or foods:

- Build mother's confidence that she can produce all the breastmilk that the child needs. Water and other milk are not necessary
- If she has stopped breastfeeding, refer her to a breastfeeding counsellor to help with re-lactation
- Suggest giving more frequent, longer breastfeeds, day or night, and gradually reducing other milk or foods.

If other milk needs to be continued, counsel the mother to:

- Breastfeed as much as possible, including at night (unless mother is HIV +ve and has chosen exclusive formula feeding)
- Make sure the other milk is infant formula or breastmilk substitute.
- Prepare other milk correctly and hygienically, and give adequate amounts.
- Finish prepared milk within an hour.

If she has started complementary feeds

- Encourage her to give milk feeds first
- If the infant is 4 - 6 months, advise her to continue to give 1 - 2 nutritious complementary feeds per day.

If the mother is using a bottle to feed the child

- Recommend a cup instead of a bottle
- Show mother how to feed the child with a cup (p.36)

If the child is not being fed actively

- Sit with the child and encourage eating
- Give the child an adequate serving in a separate plate or bowl

If the child has a poor appetite, or is not feeding well during this illness

- Breastfeed more frequently and for longer if possible
- Use soft, varied, favourite foods to encourage the child to eat as much as possible.
- Give foods of a suitable consistency, not too thick or dry
- Offer small, frequent feeds. Try when the child is alert and happy, and give more food if he shows interest
- Clear a blocked nose if it interferes with feeding
- If the child has a sore mouth, suggest soft foods that don't burn the mouth e.g. eggs, mashed potatoes, pumpkin or avocado.
- Give physical help - a spoon the right size, food within reach, child sitting on caregiver's lap while eating
- Expect the appetite to improve as the child gets better

If there is no food available in the house

- Help mother to get a Child Support Grant for all her children under 7 years
- Put her in touch with a Social Worker and local organisations that may assist
- Give her vegetables from the clinic garden
- Supply milk and Super Porridge from the PEM scheme
- Give mother recipes for locally appropriate Super Porridge



Special Feeding Recommendations

➤ Feeding Advice for the Mother of a Child with SYMPTOMATIC HIV INFECTION

- The child with symptomatic HIV infection should be encouraged to breastfeed. There is no danger of infection through breastmilk when the child has symptoms
- The child should be fed according to the feeding recommendations for his age (p.22)
- These children often suffer from poor appetite and mouth sores, give appropriate advice (this page)
- If the child is being fed with a bottle encourage the mother to use a cup as this is more hygienic and will reduce episodes of diarrhoea
- Inform the mother about the importance of hygiene when preparing food because her child can easily get sick. She should wash her hands after going to the toilet and before preparing food. If the child is not gaining weight well, the child can be given an extra meal each day and the mother can encourage him to eat more by offering him snacks that he likes if these are available
- Advise her about her own nutrition and the importance of a well balanced diet to keep herself healthy. Encourage her to plant vegetables to feed her family.

➤ If the child has a poor appetite:

- Plan small frequent meals.
- Give milk rather than other fluids except where there is diarrhoea with some dehydration
- Give foods with a high energy content.
- Give snacks between meals.
- Check for oral thrush or mouth ulcers.
- Consider HIV if the appetite remains persistently poor.

➤ If the child has mouth sores:

- Recommend soft foods that don't burn the mouth e.g. eggs, mashed potatoes, pumpkin or avocado. Avoid spicy, salty and rough foods.
- Chop foods finely and give cold drinks or crushed ice, if available.

➤ Feeding Recommendations For PERSISTENT DIARRHOEA

- If still breastfeeding, give more frequent, longer breastfeeds, day and night.
- If taking other milk:
 - 1st choice: replace with increased breastfeeding OR
 - 2nd choice: replace with fermented milk products, such as amasi (maas) or yoghurt OR
 - 3rd choice: replace half the milk with nutrient-rich semisolid food (like mashed fruit or vegetables.)
- For other foods, follow feeding recommendations for the child's age
- Avoid very sweet foods or drink
- Give small, frequent meals at least 6 times a day

➤ Advise the Mother to Increase Fluid During Illness

FOR ANY SICK CHILD:

- If child 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. For example, give soft porridge, amasi, SSS or clean water.

FOR CHILD WITH DIARRHOEA:

- Giving extra fluid can be lifesaving. Give fluid according to Plan A or Plan B (p.15)

➤ Advise the Mother When to Return to Health Worker

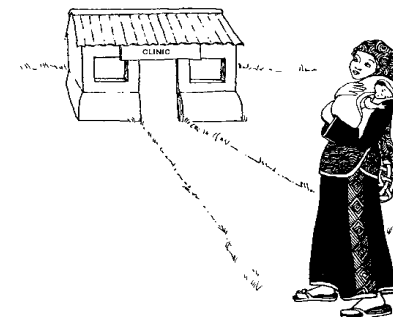
FOLLOW-UP VISIT

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, FEVER- OTHER CAUSE, if fever persists	2 days
PERSISTENT DIARRHOEA CHRONIC EAR INFECTION FEEDING PROBLEM WHEEZE (FIRST EPISODE), if still wheezing ANY OTHER ILLNESS, if not improving	5 days
ANAEMIA	14 days
NOT GROWING WELL - but no feeding problem	14 days
SUSPECTED SYMPTOMATIC HIV SYMPTOMATIC HIV (confirmed)	14 days monthly

NEXT WELL-CHILD VISIT

Advise mother when to return for next immunisation according to immunisation schedule. Encourage monthly visits for growth monitoring



WHEN TO RETURN IMMEDIATELY

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

Any sick child	<ul style="list-style-type: none"> • Becomes sicker • Not able to drink or breastfeed • Vomiting everything • Develops a fever
If child has COUGH OR COLD, return if:	<ul style="list-style-type: none"> • Fast breathing • Difficult breathing • Wheezing
If child has Diarrhoea, return if:	<ul style="list-style-type: none"> • Blood in stool

➤ **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 (p.35).
- Advise her to eat well to keep up her own strength and health.
- Check the mother's immunisation status and give her tetanus toxoid if needed.
- Make sure she has access to:
 - Family planning
 - Counselling on STD and AIDS prevention
- Encourage mother to speak about social problems
- If the mother is HIV positive give her advice about her own health and consider starting her on co-trimoxazole

**REMEMBER THAT THE HEALTH OF A CHILD DEPENDS ON THE HEALTH OF THE MOTHER.
ALWAYS THINK OF THE MOTHERS HEALTH WHEN YOU ARE CARING FOR A SICK CHILD**



ASSESS, CLASSIFY AND TREAT THE SICK YOUNG INFANT AGE 1 WEEK UP TO 2 MONTHS



DO A RAPID APPRAISAL OF ALL WAITING CHILDREN

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 on page 38
 - if initial visit, assess the young infant as follows:

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

CHECK FOR POSSIBLE BACTERIAL INFECTION		SIGNS	CLASSIFY AS	TREATMENT
ASK: <ul style="list-style-type: none"> • Has the infant had convulsions? • Has the infant had any attacks where he stops breathing, becomes stiff and blue (apnoea)? • Is the infant taking feeds well? • Has the mother ever had an HIV test? What was the result? 	LOOK, LISTEN, FEEL: <ul style="list-style-type: none"> • Is the infant convulsing now? • Count the breaths in one minute. Repeat the count if elevated. • Look for severe chest indrawing. • Look for nasal flaring. • Listen for grunting. • Look and feel for full or bulging fontanelle. • Look at the umbilicus. Is it red or draining pus? Does the redness extend to the skin? • Measure temperature (or feel for fever or low body temperature). • Look for skin pustules. Are there many or severe pustules? • Look for pus draining from the eye or ear. • Look at the young infant's general condition. Is the young infant lethargic or unconscious? • Look at the young infant's movements. Are they less than normal? • Look for jaundice: ask if it is getting worse. 	Classify ALL YOUNG INFANTS	POSSIBLE SERIOUS BACTERIAL INFECTION	<ul style="list-style-type: none"> ➤ Give rectal diazepam if convulsing at present (p.13) ➤ Give oxygen (p.13) ➤ Give first dose of im ceftriaxone (p.33) ➤ Test for low blood sugar, and treat or prevent (p.14) ➤ Refer URGENTLY to hospital ➤ Advise mother to continue breastfeeding and keep the infant warm on the way to the hospital
			LOCAL BACTERIAL INFECTION	<ul style="list-style-type: none"> ➤ Give erythromycin for 7 days (p.33) ➤ Teach the mother to treat local infections at home (p.34) ➤ Advise mother to give home care for the young infant ➤ If pus draining from the eye give single dose im ceftriaxone (p. 33) ➤ Follow-up in 2 days ➤ If mother HIV positive give appropriate feeding advice and start the baby on co-trimoxazole from the age of 6 weeks (p. 9)
			NO BACTERIAL INFECTION	<ul style="list-style-type: none"> ➤ Check mothers health ➤ Counsel about general hygiene and care ➤ If mother is HIV positive give appropriate feeding advice and start the baby on co-trimoxazole from the age of 6 weeks (p.9)

Does the young infant have diarrhoea?

IF YES, ASK:

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

LOOK AND FEEL:

- Look at the young infant's general condition. Is the infant:
 - Lethargic or unconscious?
 - Restless and irritable?
- Look for sunken eyes.
- Pinch the skin of the abdomen. Does it go back:
 - Very slowly (longer than 2 seconds)?
 - or Slowly?

Classify DIARRHOEA

for DEHYDRATION

Two of the following signs:

- Lethargic or unconscious
- Sunken eyes
- Skin pinch goes back very slowly.

DIARRHOEA WITH SEVERE DEHYDRATION

- Refer **URGENTLY** to hospital with intravenous infusion (see plan C p.16).
- Give the first dose of ceftriaxone IMI (p.33)
- Give frequent sips of ORS on the way, if possible. Breastfeeding can continue
- Keep the child warm.

Two of the following signs:

- Restless, irritable
- Sunken eyes
- Skin pinch goes back slowly.

DIARRHOEA WITH SOME DEHYDRATION

- Give fluid for some dehydration (Plan B p.15)
- Advise the mother to continue breastfeeding
- Follow up in 2 days

- Not enough signs to classify as some or severe dehydration.

NO VISIBLE DEHYDRATION

- Give fluids to treat for diarrhoea at home (Plan A p.15)
- Follow up in 2 days.
- If exclusively breastfed do not give other fluids except SSS

and if diarrhoea 14 days or more

- Diarrhoea lasting 14 days or more.

SEVERE PERSISTENT DIARRHOEA

- **REFER** and treat for dehydration if present.
- Keep the baby warm on the way to hospital.

and if blood in stool

- Blood in the stool.

POSSIBLE SERIOUS ABDOMINAL PROBLEM

- Refer **URGENTLY** to hospital
- Keep warm on the way to hospital

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT IN BREASTFED BABIES*:

ASK:

- How are you feeding the baby?
- How is feeding going?
- How many times do you breastfeed in 24 hours?
- What foods and fluids in addition to breastmilk are you giving to baby?
 - if yes how often?
 - how is it given?

LOOK, LISTEN,FEEL:

- Plot the weight on the RTHC to determine the weight for age.
- Look for white patches in the mouth (thrush)

Classify FEEDING

IF AN INFANT:

**Has any difficulty feeding, OR
Is breastfeeding less than 8 times in 24 hours, OR
Is taking any other foods or drinks, OR
Is low weight for age, AND
Has no indications to refer urgently to hospital,**

THEN ASSESS A BREASTFEED

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

CHECK FOR ATTACHMENT, LOOK FOR:

- Chin touching breast
- Mouth wide open
- Lower lip turned outward
- More areola visible above than below the mouth

(All these signs should be present if the attachment is good.)

Is the infant able to attach?

no attachment at all not well attached good attachment

Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?

Clear a blocked nose with saline drops if it interferes with breastfeeding.

<ul style="list-style-type: none"> • Not able to feed or • No attachment at all or • Not suckling at all. 	NOT ABLE TO FEED	<ul style="list-style-type: none"> ➤ Give first dose of ceftriaxone IMI (p.33) ➤ Check blood sugar then treat or prevent low blood sugar. (p. 14) ➤ Advise the mother how to keep the young infant warm on the way to the hospital. ➤ Refer URGENTLY to hospital.
<ul style="list-style-type: none"> • Not well attached to breast or • Not suckling effectively or • Mother experiencing problems feeding or • Less than 8 breastfeeds in 24 hours or • Receives other foods or drinks or • Low weight for age or • Weight gain is unsatisfactory or • Thrush (ulcers or white patches in mouth) 	FEEDING PROBLEM OR NOT GROWING WELL	<ul style="list-style-type: none"> ➤ Advise the mother to breastfeed as often and for as long as the infant wants, day and night. <ul style="list-style-type: none"> - If not well attached or not suckling effectively, teach correct positioning and attachment. - If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. - If mother has a breastfeeding problem see advice for common breastfeeding problems (p.35) ➤ If receiving other foods or drinks, counsel mother about breastfeeding more, reducing other foods or drinks, and using a cup. ➤ If thrush, teach the mother to treat for thrush at home. (p. 34) ➤ Advise mother to give home care for the young infant. (p.37) ➤ Follow-up any feeding problem or thrush in 2 days. ➤ Follow-up low weight for age in 7 days.
<ul style="list-style-type: none"> • Not low weight for age and no other signs of inadequate feeding. 	NO FEEDING PROBLEM	<ul style="list-style-type: none"> ➤ Advise mother to give home care for the young infant. (p. 37) ➤ Praise the mother for feeding the infant well.

*** Use this page to assess feeding if the infant is receiving any breastmilk**

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT IN BABIES RECEIVING NO BREASTMILK*:

ASK:

- How are you feeding the baby?
- How is feeding going?
- What made you decide not to breastfeed*?
- 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 baby
- What foods and fluids in addition to replacement milk is given?
- How is the milk being given? Cup or bottle
- How are you cleaning the utensils?

LOOK, LISTEN,FEEL:

- Plot the weight on the RTHC to determine the weight for age.
- Look for ulcers or white patches in the mouth (thrush).

Classify FEEDING

<ul style="list-style-type: none"> • Not able to feed or • Not sucking at all. 	NOT ABLE TO FEED -	<ul style="list-style-type: none"> ➢ Treat as possible severe bacterial infection (p.28) ➢ Give first dose of ceftriaxone IMI (p.33) ➢ Refer URGENTLY to hospital
<ul style="list-style-type: none"> • Milk incorrectly or unhygienically prepared or • Giving inappropriate replacement milk or other foods/fluids or • Giving insufficient replacement feeds or • Using a feeding bottle or • Thrush (ulcers or white patches in the mouth) or • Low weight for age or • Weight gain is unsatisfactory 	FEEDING PROBLEM OR NOT GROWING WELL	<ul style="list-style-type: none"> ➢ Counsel about feeding ➢ Explain guidelines for safe replacement feeding (p.36) ➢ Identify mothers and family's concerns about feeding. Suggest that mother gradually decreases the amount of food or fluids other than milk being given ➢ Advise the mother to use a cup rather than a bottle to feed the baby and show her how to do this (p.36) ➢ If thrush, teach the mother to treat for thrush at home (p.34) ➢ Follow-up any feeding problem in 2days ➢ Follow up in 7 days
<ul style="list-style-type: none"> • Not low weight for age and no other signs of inadequate feeding. 	NO FEEDING PROBLEM	<ul style="list-style-type: none"> ➢ Advise mother to continue feeding, and ensure good hygiene ➢ Praise the mother

***NOTE: A child may not be breastfed because the mother is HIV infected. If this is not the reason, consider restarting breastfeeding or referral to a breastfeeding counsellor if available**

THEN CHECK IF THE YOUNG INFANT HAS ANY SPECIAL RISK FACTORS

IF

- the infant was premature or low birth weight
- there was birth asphyxia
- the infant is not breastfed
- the mother is a young adolescent
- the mother is known to be HIV positive
- there is severe socioeconomic deprivation



This infant is at high risk and special care should be taken to ensure that there are no feeding problems and the child is gaining weight well.
Arrange appropriate regular follow-up with the mother
Refer to an appropriate support group if possible.

THEN CHECK THE YOUNG INFANT'S IMMUNISATION STATUS:

IMMUNISATION SCHEDULE:	AGE	VACCINE		VITAMIN A	
	Birth	BCG	OPV-0	200 000 IU to the mother at delivery	
	6 weeks	DPT+HIB-1	OPV-1	Hep B 1	50 000 IU for infants at 6 weeks if not breastfed
	10 weeks	DPT+HIB-2	OPV-2	Hep B 2	

- **Give all missed doses on this visit.**
- Include sick babies and those without a RTHC
- If the child has no RTHC, issue a new one to-day.
- Advise the caretaker when to return for the next dose.

ASSESS OTHER PROBLEMS

ASSESS THE MOTHER'S HEALTH NEEDS

eg. Nutritional status and anaemia, contraception etc. Check hygiene practises

TREAT THE YOUNG INFANT

➤ Treat LOCAL BACTERIAL INFECTION with Erythromycin syrup

ERYTHROMYCIN SYRUP	
➤ Give three times daily for seven days	
AGE or WEIGHT	Erythromycin Syrup 125 mg in 5 ml
Birth up to 1 month (< 3 kg)	1.25 ml
1 month up to 2 months (3-4kg)	2.5 ml

➤ Treat POSSIBLE SERIOUS BACTERIAL INFECTION with Intramuscular Ceftriaxone

- Give first dose of Ceftriaxone IMI before the infant is referred urgently. Give a single dose of ceftriaxone to an infant with pus draining from the eye
- The dose of Ceftriaxone is 50mg per kilogram
- Dilute 250mg vial with 1ml of sterile water

CEFTRIAXONE INJECTION	
WEIGHT	Ceftriaxone 250mg in 1ml
2 -3 kg	0.5 ml
>3 - 6 kg	1 ml

TREAT THE YOUNG INFANT

➤ To Treat for Diarrhoea, See TREAT THE CHILD, p.15-16

If there is DIARRHOEA WITH SEVERE DEHYDRATION or DIARRHOEA WITH SOME DEHYDRATION (p.15-16).

If there is "severe dehydration" commence intravenous rehydration, give the first dose of ceftriaxone IMI (p.33) and REFER urgently.

➤ Immunise Every Sick Young Infant, as Needed.

➤ 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.
- She should return to the clinic if the infection worsens.

➤ Treat for Eye Infection with Chloramphenicol Eye Ointment

- The mother should wash hands before and after treatment
- The eyes must be cleaned with a clean cloth then
- Chloramphenicol or tetracycline eye ointment is instilled inside the lower eyelid

} Four times per day

➤ To Treat for Skin Pustules or Umbilical Infection

The mother should do the treatment twice daily:

- Wash hands
- Gently wash off pus and crusts with soap and water
- Dry the area
- Paint with polyvidone iodine lotion or gentian violet
- Wash hands

➤ Treat for Thrush with Nystatin or Gentian Violet

The mother should:

- Wash hands
- Wash mouth with clean soft cloth wrapped around the finger and wet with salt water
- Give nystatin 1 ml 4 times a day or paint with diluted 0.5% gentian violet
- Wash hands
- Advise the mother on breast care
- Check bottle or other utensil in use for hygiene.

COUNSEL THE MOTHER

➤ Teach Correct Positioning and Attachment for Breastfeeding



- the mother must be seated comfortably
- Show the mother how to hold her infant
 - with the infant's head and body straight
 - facing her breast, with infant's nose opposite her nipple
 - with infant's body close to her body
 - supporting infant's whole body, 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.
- Most of the common breastfeeding problems expressed by mothers are related to poor positioning and attachment (see below)

COMMON BREAST FEEDING PROBLEMS:

"NOT ENOUGH MILK"

The commonest reason why mothers add other feeds early or stop breastfeeding. Usually the mother has enough milk but lacks confidence that it is enough.

Why does the mother think the baby is not getting enough milk? The baby may cry a lot, or want to feed often and for a long time, or her breasts do not feel very full. She may have tried giving a formula feed and noticed that the baby slept for longer afterwards.

Does she give the baby any other food or fluids? This will reduce breast milk production but if she breastfeeds more there will be more milk. Advise her to gradually stop giving other foods or fluids and increase the number of breastfeeds. She should breastfeed as often as the child wants, at least eight times in 24 hours both day and night.

Check position and attachment- if the baby is not well attached, he may not be getting enough milk and want to feed often and for a long time.

If the baby is growing well you can reassure the mother that she has enough milk and the baby is getting enough food.

SORE OR CRACKED NIPPLES

Sore nipples are caused by poor attachment during suckling and can lead to breastfeeding failure if it is so painful that the mother is reluctant to feed. The baby is not getting much milk and wants to feed more often. Breastfeeding should *not* be painful. A poorly attached infant is suckling on the sensitive nipple rather than taking the whole breast in the mouth. When you reposition the infant so that it is well attached there is immediate relief and the baby begins to suckle effectively.

If the poorly attached baby continues to suck, cracks may develop in the nipple. As you improve attachment, the pain is less and the mother may continue to breastfeed as the cracks heal. If the pain is too severe, express breastmilk until the nipple has healed and feed the baby from the other breast or with expressed milk in a cup. Putting a drop of hindmilk on the nipple after feeding will also help healing.

Soreness may also be caused by thrush infection, particularly if pain develops after a period of pain free feeding. Treat both the mother and baby with nystatin drops or cream.

THE BABY FEEDS OFTEN or CRIES A LOT

This may be because the infant is poorly attached and not suckling effectively so that he is quickly hungry again.

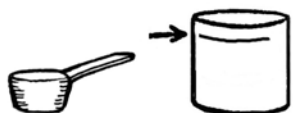
Assess breastfeeding, check the positioning and attachment and advise the mother

If the baby is feeding often or the mother thinks the child is more settled after a formula feed, this may be because the feeding pattern is different in a formula fed baby, not because the child is hungry. Breastfed infants may feed more often and also suckle for comfort.

Formula milk is more difficult for the baby to digest which makes the interval between feeds longer but this does not mean it is better for the baby.

COUNSEL THE MOTHER

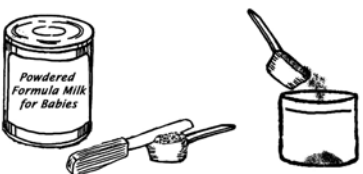
➤ Safe Preparation of Formula Milk



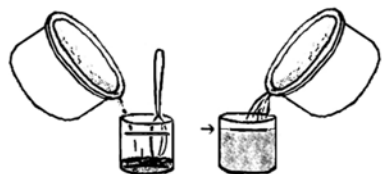
Always use a marked cup or glass and spoon to measure water and the scoop to measure the formula powder.



Wash your hands before preparing a feed



Bring the water to the boil and then let it cool. Keep it covered while it cools.



Measure the formula powder into a marked cup or glass. Make the scoops level. Put in one scoops for every 25 mls of water.

Add a small amount of the cooled boiled water and stir. Fill the cup or glass to the mark with the water. Stir well.

Feed the baby using a cup.

Wash the utensils.



➤ How to feed a baby with a cup

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

➤ Approximate amount of formula needed per day

Age in months	Weight in kilos	Approx. amount of formula in 24 hours	Previously boiled water per feed	Number of scoops per feed	Approx. number of feeds
Birth	3	400 ml	50	2	8 x 50 ml
2 weeks	3	400 ml	50	2	8 x 50 ml
6 weeks	4	600 ml	75	3	7 x 75 ml
10 weeks	5	750 ml	125	5	6 x 125 ml
14 weeks	6.5	900 ml	150	6	6 x 150 ml
4 months	7	1050 ml	175	7	6 x 175 ml
5 months	8	1000ml	200	8	5 x 200 ml

➤ Advise Mother to Give Home Care for the Young Infant

1. FLUIDS Breastfeed frequently, as often and for as long as the infant wants, day or night, during sickness and health.

2. WHEN TO RETURN Follow-up Visit

If the infant has:	Return for follow-up in:
<ul style="list-style-type: none">• LOCAL BACTERIAL INFECTION• ANY FEEDING PROBLEM• THRUSH	2 DAYS
<ul style="list-style-type: none">• LOW WEIGHT FOR AGE	7 DAYS

3. 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.

When to Return Immediately:

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

- Breastfeeding poorly or drinking poorly
- Becomes sicker
- Develops a fever
- Fast breathing
- Difficult breathing
- Blood in stool
- Vomits everything
- Irritable or lethargic
- Convulsions

GIVE FOLLOW-UP CARE FOR THE SICK YOUNG INFANT

If there is a new problem- assess, classify and treat the new problem as on the ASSESS AND CLASSIFY chart

➤ **LOCAL BACTERIAL INFECTION**

After 2 days:

Look at the umbilicus. Is it red or draining pus? Does redness extend to the skin?

Look at the skin pustules. Are there many or severe pustules?

Look at the pus draining from the eye. Has the eye improved? Is there less pus draining?

Treatment:

- If **condition remains the same or is worse**, refer to hospital.
- If **condition is improved**, tell the mother to continue giving the 5 days of antibiotic and continue treating for the local infection at home.

➤ **THRUSH**

After 2 days:

Look for white patches in the mouth (thrush).

Reassess feeding. ➤ See "Then Check for Feeding Problem or Low Weight" above (p. 30).

- If **thrush is worse** check that treatment is being given correctly, consider HIV (p.7)
- If the infant has **problems with attachment or suckling**, refer to hospital.
- If thrush is the same or better, and the baby is feeding well, continue with nystatin (or gentian violet) for a total of 5 days.

GIVE FOLLOW-UP CARE FOR THE SICK YOUNG INFANT

➤ FEEDING PROBLEM

After 2 days:

Reassess feeding p.30

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 after 5 days.
- If the young infant is low weight for age, ask the mother to return after a further 5 days after the initial visit to measure the young infant's weight gain. Continue follow-up until the infant is gaining weight well.
- if the young infant has **lost weight**, REFER the child.

Exception:

If you do not think that feeding will improve, refer the child.

➤ NOT GROWING WELL

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" above.

- 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 gaining weight**, praise the mother. Ask her to have her infant weighed again within 14 days or when she returns for immunisation., whichever is the earlier.
- If the infant is **still low weight for age and has not gained weight** REFER.

Exception:

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