**INTEGRATED MANAGEMENT OF CHILHOOD ILLNESSES (IMCI).**

**Introduction**

* More than 10 million children die each year in developing countries before they reach their fifth birthday. Seven in ten of these deaths are due to acute respiratory infections (mostly pneumonia), diarrhoea, measles, malaria, or malnutrition and often to a combination of these conditions.
* Most sick children present with signs and symptoms related to more than one. This overlap means that a single diagnosis may not be possible or appropriate, and that treatment may be complicated by the need to combine therapy for several conditions.
* Limited supplies and equipment, combined with an irregular flow of patients, leave health care providers at first-level facilities with few opportunities to practice complicated clinical procedures. Instead, they must often rely on history and signs and symptoms to determine a course of management that makes the best use of available resources.
* Providing quality care to sick children in these conditions is a serious challenge. In response to this challenge, WHO and UNICEF developed a strategy known as Integrated Management of Childhood Illness (IMCI).
* The objectives are to reduce deaths and the frequency and severity of illness and disability and to contribute to improved growth and development.
* The strategy includes three main components:
  + Improvements in the case-management skills of health staff through the provision of locally adapted guidelines on IMCI and through activities to promote their use
  + Improvements in the health system required for effective management of childhood illness
  + Improvements in family and community practices

The complete IMCI case management process involves the following elements:

* Assess a child by checking first for danger signs (or possible bacterial infection in a young infant), asking questions about common conditions, examining the child, and checking nutrition and immunization status. Assessment includes checking the child for other health problems.
* Classify a child’s illnesses using a colour-coded triage system. Because many children have more than one condition, each illness is classified according to whether it requires: urgent pre-referral treatment and referral (red), or specific medical treatment and advice (yellow), or simple advice on home management (green).
* After classifying all conditions, identify specific treatments for the child. If a child requires urgent referral, give essential treatment before the patient is transferred. If a child needs treatment at home, develop an integrated treatment plan for the child and give the first dose of drugs in the clinic. If a child should be immunized, give immunizations. Provide practical treatment instructions, including teaching the caretaker how to give oral drugs, how to feed and give fluids during illness, and how to treat local infections at home. Ask the caretaker to return for follow-up on a specific date, and teach her how to recognize signs that indicate the child should return immediately to the health facility.
* Assess feeding, including assessment of breastfeeding practices, and counsel to solve any feeding problems found. Then counsel the mother about her own health.
* When a child is brought back to the clinic as requested, give follow-up care and, if necessary, reassess the child for new problems.

**NOTE ;**

* The IMCI guidelines address most, but not all, of the major reasons a sick child is brought to a clinic.
* A child returning with chronic problems or less common illnesses may require special care which is not described in this handbook.
* The guidelines do not describe the management of trauma or other acute emergencies due to accidents or injuries.
* Although AIDS is not addressed specifically, the case management guidelines address the most common reasons children with HIV seek care: diarrhoea and respiratory infections. When a child, who is believed to have HIV, presents with any of these common illnesses, he or she can be treated the same as any child presenting with an illness.
* If a child’s illness does not respond to the standard treatments described in this handbook, or if a child becomes severely malnourished, or returns to the clinic repeatedly, the child is referred to a hospital for special care.
* Case management can only be effective to the extent that families bring their sick children to a trained health worker for care in a timely way. If a family waits to bring a child to a clinic until the child is extremely sick, or takes the child to an untrained provider, the child is more likely to die from the illness.
* Therefore, teaching families when to seek care for a sick child is an important part of the case management process.

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

1. Greet the mother appropriately and ask about the child
2. Look to see if the child’s weight and temperature have been recorded, if not, weigh the child and measure his or her temperature later when you assess and classify the child’s main symptoms.
3. Do not undress or disturb the child now.
4. Ask the mother what the child’s problems are important reasons for asking this question is to open good communication with the mother. Using good communication helps to reassure the mother that her child will receive good care. When you treat the child’s illness later in the visit, you will need to teach and advise the mother about caring for her sick child at home. So it is important to have good communication with the mother from the beginning of the visit. To use good communication skills: listen carefully to what the mother tells you. This will show her that you are taking her concerns seriously. use words the mother understands. If she does not understand the questions you ask her, she cannot give the information you need to assess and classify the child correctly. give the mother time to answer the questions. For example, she may need time to decide if the sign you asked about is present. Ask additional questions when the mother is not sure about her answer. When you ask about a main symptom or related sign, the mother may not be sure if it is present. Ask her additional questions to help her give clearer answers.
5. Determine if this is an initial or follow-up visit for this problem if this is the child’s first visit for this episode of an illness or problem, then this is an initial visit. If the child was seen a few days before for the same illness, this is a follow-up visit. A follow-up visit has a different purpose than an initial visit. During a follow-up visit, you find out if the treatment given during the initial visit has helped the child. If the child is not improving or is getting worse after a few days, refer the child to a hospital or change the child’s treatment. How you find out if this is an initial or follow-up visit depends on how the health facility registers patients and identifies the reason for their visit. Some clinics give mothers follow-up slips that tell them when to return. In other clinics a health worker writes a follow-up note on the multi-visit card or chart. Or, when the patient registers, clinic staff asks the mother questions to find out why she has come.
6. **Check for general danger signs**
   1. **Ask:** is the child able to drink or breastfeed?

A child has the sign “**not able to drink or breastfeed**” if the child is not able to suck or swallow when offered a drink or breastmilk. when you ask the mother if the child is able to drink, make sure that she understands the question. if she says that the child is not able to drink or breastfeed, ask her to describe what happens when she offers the child something to drink. for example, is the child able to take fluid into his mouth and swallow it? if you are not sure about the mother’s answer, ask her to offer the child a drink of clean water or breastmilk. look to see if the child is swallowing the water or breastmilk. a child who is breastfed may have difficulty sucking when his nose is blocked. if the child’s nose is blocked, clear it. if the child can breastfeed after the nose is cleared, the child does not have the danger sign, “not able to drink or breastfeed.”

* 1. **Ask**: does the child **vomit everything**? A child who is not able to hold anything down at all has the sign “vomits everything.” what goes down comes back up. a child who vomits everything will not be able to hold ask: look:
  2. **Ask**: has the child had **convulsions**? During a convulsion, the child’s arms and legs stiffen because the muscles are contracting. The child may lose consciousness or not be able to respond to spoken directions. Ask the mother if the child has had convulsions during this current illness. Use words the mother understands. For example, the mother may know convulsions as “fits” or “spasms.”
  3. **Look** to see if the child is **lethargic** or **unconscious**. A lethargic child is not awake and alert when she should be. The child is drowsy and does not show interest in what is happening around him. Often the lethargic child does not look at his mother or watch your face when you talk. The child may stare blankly and appear not to notice what is going on around him. An unconscious child cannot be wakened. He does not respond when he is touched, shaken or spoken to. Ask the mother if the child seems unusually sleepy or if she cannot wake the child. Look to see if the child wakens when the mother talks or shakes the child or when you clap your hands.

If the child has a general danger sign, complete the rest of the assessment immediately. This child has a severe problem. There must be no delay in his or her treatment.

**ASSESS AND CLASSIFY COUGH OR DIFFICULT BREATHING**

**Ask: does the child have cough or difficult breathing**?

Difficult breathing is any unusual pattern of breathing. Mothers describe this in different ways. They may say that their child’s breathing is “fast” or “noisy” or “inter- rupted.” If the mother answers NO, look to see if you think the child has cough or difficult breath- ing. If the child does not have cough or difficult breathing, ask about the next main symptom, diarrhoea. Do not assess the child further for signs related to cough or diffi- cult breathing. If the mother answers YES, ask the next question.

**ask: for how long**?

A child who has had cough or difficult breathing for more than 30 days has a chronic cough. This may be a sign of tuberculosis, asthma, whooping cough or another problem.

**Count the breaths in one minute**

You must count the breaths the child takes in one minute to decide if the child has fast breathing. The child must be quiet and calm when you look and listen to his breathing. If the child is frightened, crying or angry, you will not be able to obtain an accurate count of the child’s breaths. Tell the mother you are going to count her child’s breathing. Remind her to keep her child calm. If the child is sleeping, do not wake the child. To count the number of breaths in one minute, use a watch with a second hand or a digital watch. Look for breathing movement anywhere on the child’s chest or abdomen. Usually you can see breathing movements even on a child who is dressed. If you cannot see this movement easily, ask the mother to lift the child’s shirt. If the child starts to cry, ask the mother to calm the child before you start counting. If you are not sure about the number of breaths you counted (for example, if the child was actively moving and it was difficult to watch the chest, or if the child was upset or crying), repeat the count. The cut-off for fast breathing depends on the child’s age. Normal breathing rates are higher in children age 2 months up to 12 months than in children age 12 months up to 5 years. For this reason, the cut-off for identifying fast breathing is higher in children 2 months up to 12 months than in children age 12 months up to 5 years.

If the child is: The child has fast breathing if you count: 2 months up to 12 months: 50 breaths per minute or more 12 months up to 5 years: 40 breaths per minute or more. Note: The child who is exactly 12 months old has fast breathing if you count 40 breaths per minute or more.

Before you look for the next two signs—chest indrawing and stridor—watch the child to determine when the child is breathing IN and when the child is breathing OUT.

**Look for chest indrawing**.

If you did not lift the child’s shirt when you counted the child’s breaths, ask the mother to lift it now. Look for chest indrawing when the child breathes IN. Look at the lower chest wall (lower ribs). The child has chest indrawing if the lower chest wall goes IN when the child breathes IN. Chest indrawing occurs when the effort the child needs to breathe in is much greater than normal. In nor- mal breathing, the whole chest wall (upper and lower) and the abdomen move OUT when the child breathes IN. When chest indrawing is present, the lower chest wall goes IN when the child breathes IN. If you are not sure that chest indrawing is present, look again. If the child’s body is bent at the waist, it is hard to see the lower chest wall move. Ask the mother to change the child’s position so he is lying flat in her lap. If you still do not see the lower chest wall go IN when the child breathes IN, the child does not have chest indrawing. For chest indrawing to be present, it must be clearly visible and present all the time. If you only see chest indrawing when the child is crying or feeding, the child does not have chest indrawing. If only the soft tissue between the ribs goes in when the child breathes in (also called intercostal indrawing or intercostal retractions), the child does not have chest indrawing. In this assessment, chest indrawing is lower chest wall indrawing. This is the same as “subcostal indrawing” or “subcostal retractions.” It does not include “intercostal indrawing.”

**Look and listen for stridor**

Stridor is a harsh noise made when the child breathes IN. Stridor happens when there is a swelling of the larynx, trachea or epiglottis. These conditions are often called croup. This swelling interferes with air entering the lungs. It can be life-threatening when the swelling causes the child’s airway to be blocked. A child who has stridor when calm has a dangerous condition. To look and listen for stridor, look to see when the child breathes IN. Then listen for stridor. Put your ear near the child’s mouth because stridor can be difficult to hear. Sometimes you will hear a wet noise if the child’s nose is blocked. Clear the nose, and listen again. A child who is not very ill may have stridor only when he is crying or upset. Be sure to look and listen for stridor when the child is calm. You may hear a wheezing noise when the child breathes OUT. This is not stridor.

**CLASSIFY THE ILLNESS**

* Means to make a decision about the severity of the illness, for each of the child’s main symptoms, you will select a category, or “classification,” that corresponds to the severity of the disease.
* Classifications are not exact disease diagnoses. Instead, they are categories that are used to determine appropriate action or treatment.
* Each classification table on the ASSESS AND CLASSIFY chart lists clinical signs of illness and their classifications. The tables are divided into three columns titled signs, classify as, and treatment.
* Most classification tables also have three rows. If the chart is printed in colour, each row is colored pink, yellow or green. The colored rows signify the severity of the illness. To use a classification table, start at the top of the SIGNS column on the left side of the table. Read down the column and decide if the child has the sign or not. When you reach a sign that the child has, stop.
* The child will be classified in that row. In this way, you will always assign the child to the more serious classification**.** There are three possible classifications for a child with cough or difficult breathing: **SEVERE PNEUMONIA OR VERY SEVERE DISEASE, PNEUMONIA, and NO PNEUMONIA: COUGH OR COLD.** To classify cough or difficult breathing:
  + 1. Look at the signs in the pink (or top) row. Does the child have a general danger sign? Does the child have chest indrawing or stridor in a calm child? If the child has a general danger sign or any of the other signs listed in the pink row, select the severe classification, SEVERE PNEUMONIA OR VERY SEVERE DISEASE.
  + 2. If the child does not have the severe classification, look at the yellow (or second) row. Does the child have fast breathing? If the child has fast breathing, a sign in the yellow row, and the child does not have the severe classification, select the classification in the yellow row, PNEUMONIA.
  + 3. If the child does not have any of the signs in the pink or yellow row, look at the green (or bottom) row, and select the classification NO PNEUMONIA: COUGH OR COLD. The classifications for cough or difficult breathing can be described as follows:
* SEVERE PNEUMONIA OR VERY SEVERE DISEASE A child with cough or difficult breathing and with any of the following signs—any general danger sign, chest indrawing or stridor in a calm child—is classified as having SEVERE PNEUMONIA OR VERY SEVERE DISEASE. A child with chest indrawing usually has severe pneumonia. Or the child may have another serious acute lower respiratory infection such as bronchiolitis, pertussis, or a wheezing problem. Chest indrawing develops when the lungs become stiff. The effort the child needs to breathe in is much greater than normal. A child with chest indrawing has a higher risk of death from pneumonia than the child who has fast breathing and no chest indrawing. If the child is tired, and if the effort the child needs to expand the stiff lungs is too great, the child’s breathing slows down. Therefore, a child with chest indrawing may not have fast breathing. Chest indrawing may be the child’s only sign of severe pneumonia. A child classified as having SEVERE PNEUMONIA OR VERY SEVERE DISEASE is seriously ill. He or she needs urgent referral to a hospital for treatments such as oxy- gen, a bronchodilator, or injectable antibiotics. Before the child leaves, give the first dose of an appropriate antibiotic. The antibiotic helps prevent severe pneumonia from becoming worse. It also helps treat other serious bacterial infections such as sepsis or meningitis..
* PNEUMONIA A child with cough or difficult breathing who has fast breathing and no general danger signs, no chest indrawing and no stridor when calm is classified as having PNEUMONIA. A child with PNEUMONIA needs treatment with an appropriate antibiotic.
* NO PNEUMONIA: COUGH OR COLD A child with cough or difficult breathing who has no general danger signs, no chest indrawing, no stridor when calm and no fast breathing is classified as having NO PNEUMONIA: COUGH OR COLD. A child with NO PNEUMONIA: COUGH OR COLD does not need an antibiotic. The antibiotic will not relieve the child’s symptoms. It will not prevent the cold from developing into pneumonia. Instead, give the mother advice about good home care. A child with a cold normally improves in one to two weeks. However, a child who has a chronic cough (a cough lasting more than 30 days) may have tuberculosis, asthma, whooping cough or another problem. A child with a chronic cough needs to be referred to hospital for further assessment.

**ASSESS AND CLASSIFY DIARRHOEA**

what are the types of diarrhoea?

* Most diarrheas which cause dehydration are loose or watery. Cholera is one example of loose or watery diarrhoea. Only a small proportion of all loose or watery diarrhoeas are due to cholera.
* If an episode of diarrhoea lasts less than 14 days, it is acute diarrhoea. Acute watery diarrhoea causes dehydration and contributes to malnutrition. The death of a child with acute diarrhoea is usually due to dehydration.
* If the diarrhoea lasts 14 days or more, it is persistent diarrhoea. Up to 20% of episodes of diarrhoea become persistent. Persistent diarrhoea often causes nutritional problems that contribute to deaths in children who have diarrhoea. Diarrhoea with blood in the stool, with or without mucus, is called dysentery. The most common cause of dysentery is shigella bacteria. Amoebic dysentery is not common in young children. A child may have both watery diarrhoea and dysentery.

**Ask about diarrhoea in all children:**

* Ask: does the child have diarrhoea? Use words for diarrhoea the mother understands. if the mother answers no, ask about the next main symptom, fever. You do not need to assess the child further for signs related to diarrhoea. If the mother answers yes, or if the mother said earlier that diarrhoea was the reason for coming to the clinic, record her answer.
* Then assess the child for signs of dehydration, persistent diarrhoea and dysentery.
* Ask: for how long? Diarrhoea which lasts 14 days or more is persistent diarrhoea. give the mother time to answer the question. She may need time to recall the exact number of days.
* Ask: is there blood in the stool? Ask the mother if she has seen blood in the stools at any time during this episode of diarrhoea.
* Next, check for signs of dehydration. When a child becomes dehydrated, he is at first restless and irritable. If dehydration continues, the child becomes lethargic or unconscious. As the child’s body loses fluids, the eyes may look sunken. When pinched, the skin will go back slowly or very slowly.
* Look at the child’s general condition when you checked for general danger signs, you checked to see if the child was lethargic or unconscious. If the child is lethargic or unconscious, he has a general danger sign. Remember to use this general danger sign when you classify the child’s diarrhoea. A child has the sign restless and irritable if the child is restless and irritable all the time or every time he is touched or handled. if an infant or child is calm when breastfeeding but again restless and irritable when he stops breastfeeding, he has the sign “restless and irritable”. Many children are upset just because they are in the clinic. Usually these children can be consoled and calmed. They do not have the sign “restless and irritable”.
* Look for sunken eyes the eyes of a child who is dehydrated may look sunken. Decide if you think the eyes are sunken. Then ask the mother if she thinks her child’s eyes look unusual. Her opinion helps you confirm that the child’s eyes are sunken. Note: in a severely malnourished child who is visibly wasted (that is, who has marasmus), the eyes may always look sunken, even if the child is not dehydrated. Even though the sign sunken eyes are less reliable in a visibly wasted child, you should still use the sign to classify the child’s dehydration.
* Offer the child fluid ask the mother to offer the child some water in a cup or spoon. Watch the child drink. A child is not able to drink if he is not able to take fluid in his mouth and swallow it. For example, a child may not be able to drink because he is lethargic or unconscious. Or the child may not be able to suck or swallow. a child is drinking poorly if the child is weak and cannot drink without help. He may be able to swallow only if fluid is put in his mouth. A child has the sign drinking eagerly, thirsty if it is clear that the child wants to drink. Look to see if the child reaches out for the cup or spoon when you offer him water. When the water is taken away, see if the child is unhappy because he wants to drink more. If the child takes a drink only with encouragement and does not want to drink more, he does not have the sign “drinking eagerly, thirsty.”
* pinch the skin of the abdomen ask the mother to place the child on the examining table so that the child is flat on his back with his arms at his sides (not over his head) and his legs straight. Or, ask the mother to hold the child so he is lying flat in her lap. Locate the area on the child’s abdomen halfway between the umbilicus and the side of the abdomen. to do the skin pinch, use your thumb and first finger. Do not use your fingertips because this will cause pain. Place your hand so that when you pinch the skin, the fold of skin will be in a line up and down the child’s body and not across the child’s body. Firmly pick up all of the layers of skin and the tissue under them. Pinch the skin for one second and then release it. when you release the skin, look to see if the skin pinch goes back: very slowly (longer than 2 seconds) slowly (skin stays up even for a brief instant) immediately if the skin stays up for even a brief time after you release it, decide that the skin pinch goes back slowly. Note: in a child with marasmus (severe malnutrition), the skin may go back slowly even if the child is not dehydrated. In an overweight child, or a child with oedema, the skin may go back immediately even if the child is dehydrated. Even though skin pinch is less reliable in these children, still use it to classify the child’s dehydration.

**CLASSIFY DEHYDRATION**

There are three possible classifications for dehydration in a child with diarrhoea: SEVERE DEHYDRATION, SOME DEHYDRATION and NO DEHYDRATION

SEVERE DEHYDRATION If the child has two or more of the following signs lethargic or unconscious, not able to drink or drinking poorly, sunken eyes, skin pinch goes back very slowly classify as SEVERE DEHYDRATION. Any child with dehydration needs extra fluids. A child classified with SEVERE DEHYDRATION needs fluids quickly. Treat with IV (intravenous) fluids. The box “Plan C: Treat Severe Dehydration Quickly” on the TREAT chart describes how to give fluids to severely dehydrated children

SOME DEHYDRATION If the child does not have signs of SEVERE DEHYDRATION, look at the next row. Does the child have signs of SOME DEHYDRATION? If the child has two or more of the following signs—restless, irritable; drinks eagerly, thirsty; sunken eyes; skin pinch goes back slowly classify as SOME DEHYDRATION. If a child has one sign in the pink (top) row and one sign in the yellow (middle) row, classify the child in the yellow row (SOME DEHYDRATION). A child who has SOME DEHYDRATION needs fluid and foods. Treat the child with ORS solution. In addition to fluid, the child with SOME DEHYDRATION needs food. Breastfed children should continue breastfeeding. Other children should receive their usual milk or some nutritious food after 4 hours of treatment with ORS. The treatment is described in the box “Plan B: Treat Some Dehydration with ORS”.

NO DEHYDRATION A child who does not have two or more signs in the pink or yellow row is classified as having NO DEHYDRATION. This child needs extra fluid and foods to prevent dehydration. The three rules of home treatment are:

1) Give extra fluid

2) Continue feeding

3) Return immediately if the child develops danger signs.

**CLASSIFY PERSISTENT DIARRHOEA**

After you classify dehydration, classify the child for persistent diarrhoea if the child has had diarrhoea for 14 days or more. There are two possible classifications for persistent diarrhoea: SEVERE PERSISTENT DIARRHOEA and PERSISTENT DIARRHOEA.

SEVERE PERSISTENT DIARRHOEA If a child has had diarrhoea for 14 days or more and also has some or severe dehydration, classify the child’s illness as SEVERE PERSISTENT DIARRHOEA. Children who are classified with SEVERE PERSISTENT DIARRHOEA should be referred to hospital. These children need special attention to help prevent loss of fluid. They may need a change in diet. They may also need laboratory tests to identify the cause of the diar- rhoea. Treat the child’s dehydration before referral unless the child has another severe classifi- cation. Treating dehydration in children with another severe disease can be difficult. These children should be treated in a hospital

PERSISTENT DIARRHOEA A child who has had diarrhoea for 14 days or more and who has no signs of dehydration is classified as having PERSISTENT DIARRHOEA. Special feeding is the most impor- tant treatment for persistent diarrhoea. Feeding recommendations for persistent diar- rhoea are described in Chapter 29.

CLASSIFY DYSENTERY

There is only one classification for dysentery: DYSENTERY

DYSENTERY; Classify a child with diarrhoea and blood in the stool as having DYSENTERY. A child with dysentery should be treated for dehydration. You should also give an antibiotic recommended for Shigella in your area. You can assume that Shigella caused the dysentery because: Shigella causes about 60% of dysentery cases seen in clinics. Shigella causes nearly all cases of life-threatening dysentery. Finding the actual cause of the dysentery requires a stool culture for which it can take at least 2 days to obtain the laboratory results

**ASSESS AND CLASIFY FEVER**

* Fever is the main symptom of malaria. It can be present all the time or go away and return at regular intervals. Other signs of falciparum malaria are shivering, sweating and vomiting. A child with malaria may have chronic anaemia (with no fever) as the only sign of illness.
* Fever and a generalized rash are the main signs of measles. Measles is highly infectious. Maternal antibody protects young infants against measles for about 6 months. Then the protection gradually disappears. Most cases occur in children between 6 months and 2 years of age. Overcrowding and poor housing increase the risk of measles occurring early. Measles is caused by a virus. It infects the skin and the layer of cells that line the lung, gut, eye, mouth and throat.
* The measles virus damages the immune system for many weeks after the onset of measles. This leaves the child at risk for other infections.
* Complications of measles occur in about 30% of all cases. The most important are:
  + diarrhoea (including dysentery and persistent diarrhoea)
  + pneumonia stridor
  + mouth ulcers
  + ear infection
  + severe eye infection (which may lead to corneal ulceration and blindness).
  + Encephalitis (a brain infection) occurs in about one in one thousand cases. A child with encephalitis may have a general danger sign such as convulsions or lethargic or uncon- scious.
* Measles contributes to malnutrition because it causes diarrhoea, high fever and mouth ulcers. These problems interfere with feeding. Malnourished children are more likely to have severe complications due to measles. This is especially true for children who are deficient in vitamin A. One in ten severely malnourished children with measles may die. For this reason, it is very important to help the mother to continue to feed her child during measles.

Ask about (or measure) fever in ALL sick children.

* The child has a history of fever if the child has had any fever with this illness.
* Use words for “fever” that the mother understands.
* Make sure the mother understands what fever is. For example, ask the mother if the child’s body has felt hot.
* Feel the child’s stomach or axilla (underarm) and determine if the child feels hot.
* Look to see if the child’s temperature was measured today and recorded on the child’s chart. If the child has a temperature of 37.5C or above, the child has fever. If the child’s temperature has not been measured, and you have a thermometer, measure the child’s temperature.
* If the child has NO fever (by history, feel, or measured temperature of 37.5C or above), ask about the next main symptom, ear problem.
* Do not assess the child for signs related to fever. If the child HAS fever (by history, feel, or measured temperature of 37.5C or above), assess the child for additional signs related to fever. History of fever is enough to assess the child for fever.
* Assess the child’s fever even if the child does not have a temperature of 37.5C or above or does not feel hot now.

**Decide the malaria risk**

1. To classify and treat children with fever, you must know the malaria risk in your area. There is a high malaria risk in areas where more than 5% of the fever cases in children are due to malaria. There is a low malaria risk in areas where 5% or less of the fever cases in children is due to malaria.
2. There is no malaria risk in areas where no transmission of malaria occurs. Malaria risk can vary by season. If you do not have information telling you that the malaria risk is low in your area, always assume that children under 5 who have fever are at high risk for malaria.
3. If a child lives in a low or no malaria risk area, you may need to ask an additional question—Has the child travelled outside this area within the last 2 weeks? If yes, has the child been to a high or low malaria risk area? If the child has travelled to a high or low malaria risk area, you should assess the child as though he lived in the area to which he travelled.
4. Decide if the malaria risk is high, low or no. Circle the malaria risk on the recording form. You will use this information later when classifying the child’s fever.

**Ask: for how long? If more than 7 days, has fever been present every day?**

Ask the mother how long the child has had fever. If the fever has been present for more than 7 days, ask if the fever has been present every day. Most fevers due to viral illnesses go away within a few days. A fever which has been present every day for more than 7 days can mean that the child has a more severe disease such as typhoid fever.

**Ask: has the child had measles within the last 3 months?**

Measles damages the child’s immune system and leaves the child at risk for other infec- tions for many weeks. A child with fever and a history of measles within the last 3 months may have an infection, such as an eye infection, due to complications of measles. In areas with a high measles prevalence, mothers are often able to recognize the disease.

**Look or feel for stiff neck**

A child with fever and stiff neck may have meningitis. A child with meningitis needs urgent treatment with injectable antibiotics and referral to hospital. While you talk with the mother during the assessment, look to see if the child moves and bends his neck easily as he looks around. If the child is moving and bending his neck, he does not have a stiff neck. If you did not see any movement, or if you are not sure, draw the child’s attention to his umbilicus or toes. For example, you can shine a flashlight on his toes or umbilicus or tickle his toes to encourage the child to look down. Look to see if the child can bend his neck when he looks down at his umbilicus or toes. If you still have not seen the child bend his neck himself, ask the mother to help you lie the child on his back. Lean over the child, gently support his back and shoulders with one hand. With the other hand, hold his head. Then carefully bend the head forward toward his chest. If the neck bends easily, the child does not have stiff neck. If the neck feels stiff and there is resistance to bending, the child has a stiff neck. Often a child with a stiff neck will cry when you try to bend the neck.

**Look for runny nose**

A runny nose in a child with fever may mean that the child has a common cold. If the child has a runny nose, ask the mother if the child has had a runny nose only with this illness. If she is not sure, ask questions to find out if it is an acute or chronic runny nose. When malaria risk is low or no, a child with fever and a runny nose does not need an antimalarial. This child’s fever is probably due to a common cold.

**Look for signs suggesting measles**

* Assess a child with fever to see if there are signs suggesting measles.
* Look for a general- ized rash and for one of the following signs: cough, runny nose, or red eyes.
* Generalized rash in measles, a red rash begins behind the ears and on the neck. It spreads to the face. During the next day, the rash spreads to the rest of the body, arms and legs. After 4 to 5 days, the rash starts to fade and the skin may peel. Some children with severe infection may have more rash spread over more of the body. The rash becomes more discolored (dark brown or blackish), and there is more peeling of the skin. A measles rash does not have vesicles (blisters) or pustules. The rash does not itch.
* Do not confuse measles with other common childhood rashes such as chicken pox, scabies or heat rash. (The chicken pox rash is a generalized rash with vesicles.
* Scabies occurs on the hands, feet, ankles, elbows, buttocks and axilla. It also itches. Heat rash can be a generalized rash with small bumps and vesicles which itch. A child with heat rash is not sick.
* You can recognize measles more easily during times when other cases of measles are occurring in your community.
* To classify a child as having measles, the child with fever must have a generalized rash AND one of the following signs: cough, runny nose, or red eyes. The child has “red eyes” if there is redness in the white part of the eye. In a healthy eye, the white part of the eye is clearly white and not discoloured. IF THE CHILD HAS MEASLES NOW OR WITHIN THE LAST 3 MONTHS: Look to see if the child has mouth or eye complications. Other complications of measles such as stridor in a calm child, pneumonia, and diarrhoea are assessed earlier. Malnutrition and ear infection are assessed later.

**Look for mouth ulcers. Are they deep and extensive?**

Look inside the child’s mouth for mouth ulcers. Ulcers are painful open sores on the inside of the mouth and lips or the tongue. They may be red or have white coating on them. In severe cases, they are deep and extensive. When present, mouth ulcers make it difficult for the child with measles to drink or eat. Mouth ulcers are different than the small spots called Koplik spots. Koplik spots occur in the mouth inside the cheek during early stages of the measles infection. Koplik spots are small, irregular, bright red spots with a white spot in the center. They do not interfere with drinking or eating. They do not need treatment.

**Look for pus draining from the eye**

Pus draining from the eye is a sign of conjunctivitis. Conjunctivitis is an infection of the conjunctiva, the inside surface of the eyelid and the white part of the eye. If you do not see pus draining from the eye, look for pus on the conjunctiva or on the eyelids. Often the pus forms a crust when the child is sleeping and seals the eye shut. It can be gently opened with clean hands. Wash your hands after examining the eye of any child with pus draining from the eye.

**Look for clouding of the cornea**

The conjunctiva lines the eyelids and covers the white part of the eye. The iris is the coloured part of the eye. The normal cornea (the clear window of the eye) is bright and transparent. Through it, you can see the iris and the round pupil at its middle. A normal cornea is clear. You can see the colour of the iris clearly. The pupil is black.

When clouding of the cornea is present, there is a hazy area in the cornea. Look carefully at the cornea for clouding. The cornea may appear clouded or hazy, such as how a glass of water looks when you add a small amount of milk. The clouding may occur in one or both eyes. Corneal clouding is a dangerous condition. The corneal clouding may be due to vitamin A deficiency which has been made worse by measles. If the corneal clouding is not treated, the cornea can ulcerate and cause blindness. A child with clouding of the cornea needs urgent treatment with vitamin A. A child with corneal clouding may keep his eyes tightly shut when exposed to light. The light may cause irritation and pain to the child’s eyes. To check the child’s eye, wait for the child to open his eye. Or, gently pull down the lower eyelid to look for clouding. If there is clouding of the cornea, ask the mother how long the clouding has been present. If the mother is certain that clouding has been there for some time, ask if the clouding has already been assessed and treated at the hospital. If it has, you do not need to refer this child again for corneal clouding.

**How to classify fever**

1. If the child has fever and no signs of measles, classify the child for fever only.
2. If the child has signs of both fever and measles, classify the child for fever and for measles.

VERY SEVERE FEBRILE DISEASE

* If a child with fever has any general danger sign or a stiff neck, classify the child as having VERY SEVERE FEBRILE DISEASE.
* A child with fever and any general danger sign or stiff neck may have meningitis, severe malaria (including cerebral malaria) or sepsis. It is not possible to distinguish between these severe diseases without laboratory tests.
* A child classified as having VERY SEVERE FEBRILE DISEASE needs urgent treatment and referral. Before referring urgently, you will give several treatments for the possible severe diseases.

MALARIA

* If a general danger sign or stiff neck is not present, look at the yellow row. Because the child has a fever (by history, feels hot, or temperature 37.5C or above) in a high malaria risk area, classify the child as having MALARIA.
* When the risk of malaria is high, the chance is also high that the child’s fever is due to malaria. Most viral infections last less than a week.
* A fever that persists every day for more than 7 days may be a sign of typhoid fever or other severe disease. If the child’s fever has persisted every day for more than 7 days, refer the child for additional assessment.
* Treat a child classified as having MALARIA with an oral antimalarial. If the child also has cough and fast breathing, the child may have malaria or pneumonia, or both. It is not possible without laboratory tests to find out if the child has malaria or pneumonia. Cotrimoxazole is effective as both an antibiotic and an antimalarial.

**Low malaria risk**

There are three possible classifications for fever in an area with low malaria risk:

1. VERY SEVERE FEBRILE DISEASE
2. MALARIA
3. FEVER-MALARIA UNLIKELY In some low malaria risk areas, there may be families who have travelled to areas where the risk of malaria is high. If the mother or caretaker tells you that the child has travelled to an area where you know there is a high malaria risk, use the High Malaria Risk classification table. VERY SEVERE FEBRILE DISEASE If a child with fever has any general danger sign or a stiff neck, classify the child as having VERY SEVERE FEBRILE DISEASE

MALARIA

* When the risk of malaria is low, a child with fever and NO runny nose, NO measles and NO other cause of fever, is classified as having MALARIA.
* The chance that a child’s fever is due to malaria is low. The chance of malaria is even lower if the child has signs of another infection that can cause fever. For example, the child’s fever may be due to a common cold (suggested by the runny nose), measles, or another obvious cause such as cellulitis, an abscess or ear infection.
* However, when signs of another infection are not present, classify and treat the illness as MALARIA there are two possible classifications for fever in an area with no malaria risk: VERY SEVERE FEBRILE DISEASE, and FEVER—MALARIA UNLIKELY There may be families who have travelled to areas where there is low or high malaria risk. If the mother or caretaker tells you that the child has travelled to an area where you know the malaria risk is low or high, use the classification table for the area to which the child travelled.
* VERY SEVERE FEBRILE DISEASE If a child with fever has any general danger sign or a stiff neck, classify the child as having VERY SEVERE FEBRILE DISEASE
* FEVER—MALARIA UNLIKELY In areas with no malaria risk, if the child has not travelled to a low or high malaria risk area in the last 2 weeks, and if the child has no signs of VERY SEVERE FEBRILE DISEASE, look at the last row. Classify the child who has NO general danger signs and NO stiff neck as having FEVER—MALARIA UNLIKELY. Check for other possible causes of fever. If the child’s fever is high, give paracetamol. If the fever has been present every day for more than 7 days, refer for assessment.

**How to classify measles**

* A child who has the main symptom “fever” and measles now (or within the last 3 months) is classified both for fever and for measles.
* First you must classify the child’s fever.
* Next you classify measles. If the child has no signs suggesting measles, or has not had measles within the last three months, do not classify measles.
* Children with measles may have other serious complications of measles. These include stridor in a calm child, severe pneumonia, severe dehydration, or severe malnutrition.
* You assess and classify these signs in other parts of the assessment. Their treatments are appropriate for the child with measles. Some complications are due to bacterial infections. Others are due to the measles virus, which causes damage to the respiratory and intestinal tracts. Vitamin A deficiency contributes to some of the complications such as corneal ulcer. Any vitamin A deficiency is made worse by the measles infection.
* Measles complications can lead to severe disease and death. There are three possible classifications for measles: SEVERE COMPLICATED MEASLES, MEASLES WITH EYE OR MOUTH COMPLICATIONS and MEASLES
* SEVERE COMPLICATED MEASLES if the child has any general danger sign, clouding of cornea or deep or extensive mouth ulcers, classify the child as having SEVERE COMPLICATED MEASLES. This child needs urgent treatment and referral to hospital. If there is clouding of the cornea, or pus draining from the eye, apply tetracycline ointment. If it is not treated, corneal clouding can result in blindness. Ask the mother if the clouding has been present for some time. Find out if it was assessed and treated at the hospital. If it was, you do not need to refer the child again for this eye sign.
* MEASLES WITH EYE OR MOUTH COMPLICATIONS If the child has pus draining from the eye, or mouth ulcers which are not deep or extensive, classify the child as having MEASLES WITH EYE OR MOUTH COMPLICATIONS. A child with this classification does not need referral. Identifying and treating measles complications early in the infection can prevent many deaths.
* MEASLES A child with measles now or within the last 3 months and with none of the complications listed in the pink (top) or yellow (middle) rows is classified as having MEASLES.

**ASSESS AND CLASSIFY EAR PROBLEM**

A child with an ear problem may have an ear infection. When a child has an ear infection, pus collects behind the ear drum and causes pain and often fever. If the infection is not treated, the ear drum may burst. The pus discharges, and the child feels less pain. The fever and other symptoms may stop, but the child suffers from poor hearing because the ear drum has a hole in it. Usually the ear drum heals by itself. At other times the discharge continues, the ear drum does not heal and the child becomes deaf in that ear. Sometimes the infection can spread from the ear to the bone behind the ear (the mastoid) causing mastoiditis. Infection can also spread from the ear to the brain causing meningitis. These are severe diseases. They need urgent attention and referral. Ear infections rarely cause death. However, they cause many days of illness in children. Ear infections are the main cause of deafness in developing countries, and deafness causes learning problems in school

**How to assess a child with an ear problem**

Ask about ear problem in ALL sick children.

**Ask: does the child have an ear problem?**

If the mother answers NO, record her answer. Do not assess the child for ear problem. Go to the next box and check for malnutrition and anaemia. If the mother answers YES, ask the next question.

**Ask: does the child have ear pain?**

Ear pain can mean that the child has an ear infection. If the mother is not sure that the child has ear pain, ask if the child has been irritable and rubbing his ear.

**Ask: is there ear discharge? If yes, for how long?**

Ear discharge is also a sign of infection. When asking about ear discharge, use words the mother understands. If the child has had ear discharge, ask for how long. Give her time to answer the question. She may need to remember when the discharge started. You will classify and treat the ear problem depending on how long the ear discharge has been present. Ear discharge reported for 2 weeks or more (with pus seen draining from the ear) is treated as a chronic ear infection. Ear discharge reported for less than 2 weeks (with pus seen draining from the ear) is treated as an acute ear infection. You do not need more accurate information about how long the discharge has been present.

**Look for pus draining from the ear**

Pus draining from the ear is a sign of infection, even if the child no longer has any pain. Look inside the child’s ear to see if pus is draining from the ear.

**Feel for tender swelling behind the ear**

Feel behind both ears. Compare them and decide if there is tender swelling of the mas- toid bone. In infants, the swelling may be above the ear. Both tenderness and swelling must be present to classify mastoiditis, a deep infection in the mastoid bone. Do not confuse this swelling of the bone with swollen lymph nodes.

**How to classify ear problem**

There are four classifications for ear problem:

1. MASTOIDITIS
2. ACUTE EAR INFECTION
3. CHRONIC EAR INFECTION
4. NO EAR INFECTION

MASTOIDITIS

If a child has tender swelling behind the ear, classify the child as having MASTOIDITIS. Refer the child urgently to hospital. This child needs treatment with injectable antibiotics..

ACUTE EAR INFECTION

If you see pus draining from the ear and discharge is reported present for less than two weeks, or if there is ear pain, classify the child’s illness as ACUTE EAR INFECTION.

CHRONIC EAR INFECTION

If you see pus draining from the ear and discharge has been present for two weeks or more, classify the child’s illness as CHRONIC EAR INFECTION. Most bacteria that cause CHRONIC EAR INFECTION are different from those that cause acute ear infections. For this reason, oral antibiotics are not usually effective against chronic infections. Do not give repeated courses of antibiotics for a draining ear.

NO EAR INFECTION

If there is no ear pain and no pus is seen draining from the ear, the child’s illness is classified as NO EAR INFECTION. The child needs no additional treatment.

**ASSESS AND CLASIFY ANEMIA AND MALNUTRITION**

A mother may bring her child to clinic because the child has an acute illness. The child may not have specific complaints that point to malnutrition or anaemia. A sick child can be malnourished, but you or the child’s family may not notice the problem. A child with malnutrition has a higher risk of many types of disease and death. Even children with mild and moderate malnutrition have an increased risk of death. Identifying children with malnutrition and treating them can help prevent many severe diseases and death. Some malnutrition cases can be treated at home. Severe cases need referral to hospital for special feeding, blood transfusion, or specific treatment of a disease contributing to malnutrition (such as tuberculosis).

**Causes of malnutrition**

There are several causes of malnutrition. They may vary from country to country. One type of malnutrition is protein-energy malnutrition. Protein-energy malnutrition develops when the child is not getting enough energy or protein from his food to meet his nutritional needs. A child who has had frequent illnesses can also develop protein- energy malnutrition. The child’s appetite decreases, and the food that the child eats is not used efficiently. When the child has protein-energy malnutrition:

* The child may become severely wasted, a sign of marasmus.
* The child may develop oedema, a sign of kwashiorkor.
* The child may not grow well and become stunted (too short).

A child whose diet lacks recommended amounts of essential vitamins and minerals can develop malnutrition. The child may not be eating enough of the recommended amounts of specific vitamins (such as vitamin A) or minerals (such as iron). Not eating foods that contain vitamin A can result in vitamin A deficiency. A child with vitamin A deficiency is at risk of death from measles and diarrhoea. The child is also at risk of blindness. Not eating foods rich in iron can lead to iron deficiency and anaemia. Anaemia is a reduced number of red cells or a reduced amount of haemoglobin in each red cell. A child can also develop anaemia as a result of:

1. Infections
2. Parasites such as hookworm or whipworm that can cause blood loss from the gut and lead to anaemia.
3. Malaria, which can destroy red cells rapidly. Children can develop anaemia if they have repeated episodes of malaria or if malaria was inadequately treated. The anaemia may develop slowly. Often, anaemia in these children is due to both malnutrition and malaria.

**How to check a child for malnutrition and anemia**

Check ALL sick children for malnutrition and anaemia.

**Look for visible severe wasting**

A child with visible severe wasting has marasmus, a form of severe malnutrition. A child has this sign if he is very thin, has no fat, and looks like skin and bones. Some children are thin but do not have visible severe wasting. This assessment step helps you identify children with visible severe wasting who need urgent treatment and referral to a hospital. To look for visible severe wasting, remove the child’s clothes. Look for severe wasting of the muscles of the shoulders, arms, buttocks and legs. Look to see if the outline of the child’s ribs is easily seen. Look at the child’s hips. They may look small when you compare them with the chest and abdomen. Look at the child from the side to see if the fat of the buttocks is missing. When wasting is extreme, there are many folds of skins on the buttocks and thigh. It looks as if the child is wearing baggy pants. The face of a child with visible severe wasting may still look normal. The child’s abdomen may be large or distended.

**Look for palmar pallor**

Pallor is unusual paleness of the skin. It is a sign of anaemia. To see if the child has palmar pallor, look at the skin of the child’s palm. Hold the child’s palm open by grasping it gently from the side. Do not stretch the fingers backwards. This may cause pallor by blocking the blood supply.

Compare the colour of the child’s palm with your own palm and with the palms of other children. If the skin of the child’s palm is pale, the child has some palmar pallor. If the skin of the palm is very pale or so pale that it looks white, the child has severe palmar pallor.

**Look and feel for oedema of both feet**

A child with oedema of both feet may have kwashiorkor, another form of severe malnu- trition. Other common signs of kwashiorkor include thin, sparse and pale hair that easily falls out; dry, scaly skin especially on the arms and legs; and a puffy or “moon” face. Oedema is when an unusually large amount of fluid gathers in the child’s tissues. The tissues become filled with the fluid and look swollen or puffed up. Look and feel to determine if the child has oedema of both feet. Use your thumb to press gently for a few seconds on the top side of each foot. The child has oedema if a dent remains in the child’s foot when you lift your thumb.

**Determine weight for age**

Weight for age compares the child’s weight with the weight of other children who are the same age. You will identify children whose weight for age is below the bottom curve of a weight for age chart. These are children who are very low weight for age. Children on or above the bottom curve of the chart can still be malnourished. But children who are below the bottom curve are very low weight and need special attention to how they are fed. Look at the weight for age chart in the IMCI chart booklet. To determine weight for age:

1. Calculate the child’s age in months.

2. Weigh the child if he has not already been weighed today. Use a scale that you know gives accurate weights. The child should wear light clothing when he is weighed. Ask the mother to help remove any coat, sweater, or shoes.

3. Use the weight for age chart to determine weight for age. Look at the left-hand axis to locate the line that shows the child’s weight. Look at the bottom axis of the chart to locate the line that shows the child’s age in months. Find the point on the chart where the line for the child’s weight meets the line for the child’s age.

4. Decide if the point is above, on, or below the bottom curve. If the point is below the bottom curve, the child is very low weight for age. If the point is above or on the bottom curve, the child is not very low weight for age.

**How to classify nutritional status**

There are three classifications for a child’s nutritional status:

1. SEVERE MALNUTRITION OR SEVERE ANAEMIA,
2. ANAEMIA OR VERY LOW WEIGHT
3. NO ANAEMIA AND NOT VERY LOW WEIGHT.

You need to assess the feeding of children who:

* are classified as having ANAEMIA OR VERY LOW WEIGHT,
* are less than 2 years old.

SEVERE MALNUTRITION OR SEVERE ANAEMIA

If the child has visible severe wasting, severe palmar pallor or oedema of both feet, classify the child as having SEVERE MALNUTRITION OR SEVERE ANAEMIA.Children with oedema of both feet may have other diseases such as nephrotic syndrome. It is not necessary to distinguish these other conditions from kwashiorkor since they also require referral. Children classified as having SEVERE MALNUTRITION OR SEVERE ANAEMIA are at risk of death from pneumonia, diarrhoea, measles, and other severe diseases. These children need urgent referral to hospital where their treatment can be carefully monitored. They may need special feeding, antibiotics or blood transfusions. Before the child leaves for hospital, give the child a dose of vitamin A.

ANAEMIA OR VERY LOW WEIGHT

If the child is very low weight for age or has some palmar pallor, classify the child as having ANAEMIA OR VERY LOW WEIGHT. A child classified as having ANAEMIA OR VERY LOW WEIGHT has a higher risk of severe disease. When you record this classification, you can just write ANAEMIA if the child has only palmar pallor or VERY LOW WEIGHT if the child is only very low weight for age. Assess the child’s feeding and counsel the mother about feeding her child according to the instructions and recommendations. A child with some palmar pallor may have anaemia. Treat the child with iron. The anaemia may be due to malaria, Hookworm or Whipworm. When there is a high risk of malaria, give an antimalarial to a child with signs of anaemia. Hookworm and whip- worm infections contribute to anaemia because the loss of blood from the gut results in iron deficiency. Give the child mebendazole only if there is hookworm or whipworm in the area. Only give mebendazole if the child with anaemia is 2 years of age or older and has not had a dose of mebendazole in the last 6 months.

NO ANAEMIA AND NOT VERY LOW WEIGHT

If the child is not very low weight for age and there are no other signs of malnutrition, classify the child as having NO ANAEMIA AND NOT VERY LOW WEIGHT. Children less than 2 years of age have a higher risk of feeding problems and malnutrition than older children do. If the child is less than 2 years of age, assess the child’s feeding.

**ASSESS IMMUNIZATION STATUS**

**Check the immunization status of ALL sick children.**

**Use the recommended immunization schedule**

Use your country’s recommended immunization schedule when you check the child’s immunization status. Give the recommended vaccine only when the child is the appropriate age for each dose. If the child receives an immunization when he or she is too young, the child’s body will not be able to fight the disease very well. Also, if the child does not receive an immunization as soon as he is old enough, his risk of getting the disease increases. In exceptional situation where measles morbidity and mortality before nine months of age represent a significant problem (more than 15% of cases and deaths), an extra dose of measles vaccine is given at 6 months of age. This is in addition to the scheduled dose given as soon as possible after 9 months of age. This schedule is also recommended for groups at high risk of measles death, such as infants in refugee camps, infants admitted to hospitals, infants affected by disasters and during outbreaks.

For ALL sick children ask the mother about the child’s problem, check for general danger signs, ask about cough or difficult breathing, diarrhoea, fever, ear problem, and then check for malnutrition and anaemia and CHECK IMMUNIZATION STATUS.

**Then check the child’s immunization status**

Age vaccine immunization schedule: Birth BCG OPV-0 6 weeks DPT-1 OPV-1 10 weeks DPT-2 OPV-2 14 weeks DPT-3 OPV-3 9 months Measles

**Decide** if the child needs an immunization today, or if the mother should be told to come back with the child at a later date for an immunization. Note: Remember there are no contraindications to immunization of a sick child if the child is well enough to go home.

**Then CHECK for other problems**.

All children should receive all the recommended immunizations before their first birth- day. If the child does not come for an immunization at the recommended age, give the necessary immunizations any time after the child reaches that age. For each vaccine, give the remaining doses at least 4 weeks apart. You do not need to repeat the whole schedule.

**Observe contraindications to immunization**

In the past some health workers thought minor illness was a contraindication to immunization (a reason to not immunize the child). They sent sick children away and told the mothers to bring them back when the children were well. This is a bad practice because it delays immunization. The mother may have travelled a long distance to bring her sick child to the clinic and cannot easily bring the child back for immunization at another time. The child is left at risk of getting measles, polio, diphtheria, pertussis, tetanus or tuberculosis. It is very important to immunize sick and malnourished children against these diseases.

There are only three situations at present that are contraindications to immunization:

1. Do not give BCG to a child known to have AIDS.
2. Do not give DPT 2 or DPT 3 to a child who has had convulsions or shock within 3 days of the most recent dose.
3. Do not give DPT to a child with recurrent convulsions or another active neurological disease of the central nervous system.

In all other situations, here is a good rule to follow:

* There are no contraindications to immunization of a sick child if the child is well enough to go home.
* If a child is going to be referred, do not immunize the child before referral. The hospital staff at the referral site should make the decision about immunizing the child when the child is admitted. This will avoid delaying referral.
* Children with diarrhoea who are due for OPV should receive a dose of OPV (oral polio vaccine) during this visit. However, do not count the dose. The child should return when the next dose of OPV is due for an extra dose of OPV.
* Advise the mother to be sure that the other children in the family are immunized. Give the mother tetanus toxoid, if required.

**Decide if the child needs immunization.**

**Look at the child’s age on the clinical record** If you do not already know the child’s age, ask about the child’s age.

**Ask the mother if the child has an immunization card** If the mother answers YES, ask her if she brought the card to the clinic today. If she brought the card with her, ask to see the card:

* Compare the child’s immunization record with the recommended immunization sched- ule. Decide whether the child has had all the immunizations recommended for the child’s age.
* On the Recording Form, check all immunizations the child has already received. Write the date of the immunization the child received most recently. Circle any immuniza- tions the child needs today.
* If the child is not being referred, explain to the mother that the child needs to receive an immunization (or immunizations) today. If the mother says that she does NOT have an immunization card with her
* Ask the mother to tell you what immunizations the child has received.
* Use your judgement to decide if the mother has given a reliable report. If you have any doubt, immunize the child. Give the child OPV, DPT and measles vaccine according to the child’s age.
* Give an immunization card to the mother and ask her to please bring it with her each time she brings the child to the clinic. As you check the child’s immunization status, use the case recording form to check the immunizations already given and circle the immunizations needed today. If the child should return for an immunization, write the date that the child should return in the classification column

**ASSESS THE CHILD FOR OTHER PROBLEMS**

Assess any other problems that the child may have. Since the chart does not address all of the problems that a sick child may have, you will now assess other problems the mother told you about. For example, she may have said the child has a skin infection, itching or swollen neck glands. Or you may have observed another problem during the assessment. Identify and treat any other problems according to your training, experience and clinic policy. Refer the child for any other problem you cannot manage in clinic.