INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SICK CHILD
Age: 2 Months Up To 5 Years

ASSESS AND CLASSIFY THE SICK CHILD

TREAT THE CHILD

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

COUNSEL THE MOTHER

SICK YOUNG INFANT
Age: Birth Up To 2 Months

IMNCI PROCESS FOR THE SICK YOUNG INFANT

ASSESS, CLASSIFY AND TREAT THE YOUNG INFANT

TREAT THE YOUNG INFANT

COUNSEL THE MOTHER

GIVE FOLLOW-UP CARE

THE REPUBLIC OF UGANDA, 2017

WHO MOH UNICEF

Give Follow-Up Care continued

ANNEX

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

ASSESS AND CLASSIFY THE SICK CHILD

ASSESS

ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE

Determine if this is an initial or follow-up visit for this problem.

- If follow-up visit, use the follow-up instructions on TREAT THE CHILD chart.
- If initial visit, assess the child as follows:

CLASSIFY AS

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

IDENTIFY TREATMENT

CHECK FOR GENERAL DANGER SIGNS

ASK:

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

LOOK AND FEEL

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

URGENT attention

• Any general signs	**VERY SEVERE DISEASE**	• Give diazepam if convulsing now • Quickly complete the assessment • Give any pre-referral treatment immediately • Treat to prevent low blood sugar • Keep the child warm • **Refer URGENTLY**

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

THEN ASK ABOUT MAIN SYMPTOMS:

Does the child have cough or difficult breathing?

ASK:

- For how long?

LOOK, LISTEN, FEEL:

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

} Child must be calm

Classify COUGH or DIFFICULT BREATHING

If wheezing and either fast breathing or chest indrawing: Give a trial of rapid acting inhaled bronchodilator for up to three times 15–20 minutes apart. Count the breaths and look for chest indrawing again, and then classify.

If the child is:	**Fast breathing is:**
2 months up to 12 months	50 breaths per minute or more
12 months up to 5 years	40 breaths per minute or more

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

SIGN	CLASSIFY AS	IDENTIFY TREATMENT *(Urgent pre-referral treatments are in bold print)*
• Any general danger sign **OR** • Stridor in a calm child	**SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	• **Give first dose of an appropriate antibiotic** • **Refer URGENTLY to hospital**
- Chest indrawing **OR** - Fast breathing	**PNEUMONIA**	• Give oral Amoxicillin for 5 days • If wheezing (or wheezing has disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days • If recurrent wheeze, **refer for asthma assessment** • If chest indrawing in HIV exposed/infected child, give first dose of amoxicillin and **refer.** • Soothe the throat and relieve the cough with a safe remedy • If coughing for 14 days or more, check for TB (See page 9) • Advise mother when to return immediately (See page 30) • Follow-up in 3 days
• No sign of Pneumonia **OR** • Very severe disease	**COUGH OR COLD**	• If wheezing (or wheezing has disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days • If recurrent wheezing, **refer** for asthma assessment • If coughing for 14 days or more, check for TB (see page 9) • Advise mother when to return immediately • Follow-up in 5 days if not improving

DOES THE CHILD HAVE DIARRHOEA?

IF YES, ASK:

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

LOOK AND FEEL:

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

Classify Diarrhoea

for DEHYDRATION

and if diarrhoea for 14 days or more

and if blood in stool

* If referral is not possible, manage the child as described in Integrated Management of Childhood Illness, Treat the Child, Where Referral Is Not Possible.

If dysentry present with severe dehydration or some dehydration, treat with plan C and plan B respectively.

SIGN	CLASSIFY AS	IDENTIFY TREATMENT *(Urgent pre-referral treatments are in bold print)*
Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	• If child has no other severe classification: → Give fluid for severe dehydration (Plan C) OR ***If child also has another severe classification:*** → ***Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** *Advise the mother to continue breastfeeding* • If child is 2 years or older and there is cholera in your area, give antibiotic for cholera
Two of the following signs: • Restless, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly	**SOME DEHYDRATION**	• Give fluid, zinc supplements and food for some dehydration (Plan B) • If child also has a severe classification: → ***Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way*** *Advise the mother to continue breastfeeding* • Advise mother when to return immediately • Follow-up in 5 days if not improving.
Not enough signs to classify as some or severe dehydration	**NO DEHYDRATION**	• Give fluid, zinc supplements and food to treat diarrhoea at home (Plan A) • Advise mother when to return immediately • Follow-up in 5 days if not improving.
• Dehydration present	**SEVERE PERSISTENT DIARRHOEA**	• Treat dehydration before referral unless the child has another severe classification → ***Refer to hospital***
• No dehydration	**PERSISTENT DIARRHOEA**	• Check for HIV Infection • Advise the mother on feeding a child who has PERSISTENT DIARRHOEA • Give multivitamins and minerals including zinc for 10 days • Follow up in 5 days
• Blood in the stool	**DYSENTERY**	• Give ciprofloxacin for 3 days • Follow-up in 2 days

DOES THE CHILD HAVE FEVER?

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

IF YES:

Then ask:

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

Look and feel:

- Look or feel for stiff neck
- Look for runny nose
- Look for any bacterial cause of fever
- Look for any other cause of fever
- Generalized rash and one of these: cough, runny nose, or red eyes.

Do a malaria test for all children with fever:
If NO severe classification

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

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

Classify FEVER

Classify MEASLES

SIGN	CLASSIFY AS	IDENTIFY TREATMENT *(Urgent pre-referral treatments are in bold print)*
• Any general danger sign or • Stiff neck	**VERY SEVERE FEBRILE DISEASE**	• **Give 1st dose of rectal artesunate (10 mg/kg) or IM/IV artesunate (3 mg/kg if < 20 kg, 2.4 mg/kg if > 20 kg)** • **Give 1st dose of appropriate antibiotic** • **Treat child to prevent low blood sugar (breastfeed or give expressed breast milk or breastmilk substitute or sugar water by cup or NGT)** • **Give one dose of paracetamol 10 mg/kg for high fever (38.5°C)** • **Refer URGENTLY to hospital**
• Malaria test POSITIVE	**MALARIA**	• Give Artemether-Lumefantrine/Artemether-Amodiaquine • Advise mother when to return immediately • Follow-up in 3 days if fever persists • If fever is present every day for more than 7 days, **refer for further assessment**
• Malaria test Negative • Other causes of fever PRESENT	**FEVER NO MALARIA**	• Give one dose of paracetamol in the clinic for high fever (38.5 degree C or above) • Give appropriate antibiotic treatment for an identified bacterial cause of fever • Advise mother when to return immediately • Follow-up in 3 days if fever persists • If fever is present every day for more than 7 days, **refer for assessment** • Check for TB if fever is present for 14 days or more (see page 9)
• Any general danger sign or • Clouding of cornea or • Deep extensive mouth ulcers	**SEVERE COMPLICATED MEASLES*** **	• Give Vitamin A treatment • Give first dose of an appropriate antibiotic • If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment • **Refer URGENTLY to hospital**
• Pus draining from the eye or • Mouth ulcers	**MEASLES WITH EYE OR MOUTH COMPLICATIONS *** **	• Give Vitamin A treatment • If pus draining from the eye, treat eye infection with tetracycline eye ointment • If mouth ulcers, treat with gentian violet • Follow-up in 3 days.
• Measles now or within the last 3 months	**MEASLES**	• Give Vitamin A treatment

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

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

DOES THE CHILD HAVE 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

SIGN	CLASSIFY AS	IDENTIFY TREATMENT *(Urgent pre-referral treatments are in bold print)*
• Tender swelling behind the ear	**MASTOIDITIS**	• Give first dose of an appropriate antibiotic • Give first dose of paracetamol for pain • ***Refer URGENTLY to hospital***
• Pus is seen draining from the ear and discharge is reported for less than 14 days, OR • Ear pain	**ACUTE EAR INFECTION**	• Give Amoxicillin for 5 days • Give paracetamol for pain • Dry the ear by wicking • If ear discharge, check for HIV Infection • Follow-up in 5 days
• Pus is seen draining from the ear and discharge is reported for 14 days or more	**CHRONIC EAR INFECTION**	• Dry the ear by wicking • Treat with topical quinolone eardrops for 2 weeks • Check for HIV Infection (See page 8) and TB (see page 9) • Follow-up in 5 days
• No ear pain and No pus seen draining from the ear	**NO EAR INFECTION**	• No treatment

THEN CHECK FOR MALNUTRITION

Check for Malnutrition

CHECK FOR ACUTE MALNUTRITION

LOOK AND FEEL:

Look for signs of acute malnutrition

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

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

Check for any medical complication present:

- Any general danger signs
- Any severe classification
- Pneumonia with chest indrawing

If no medical complications present:

- Child is 6 months or older, offer RUTF*** to eat. Is the child:
  - Not able to finish RUTF portion?
  - Able to finish RUTF portion?
- Child is less than 6 months, assess breastfeeding:

  Does the child have a breastfeeding problem?

Classify NUTRITIONAL STATUS

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT *(Urgent pre-referral treatments are in bold print)*
• Oedema of both feet **OR** • WFH/L less than -3 zscores OR MUAC less than 115 mm AND any one of the following: • Medical complication present **OR** • Not able to finish RUTF **OR** • Breastfeeding problem	**COMPLICATED SEVERE ACUTE MALNUTRITION**	• Give first dose of an appropriate antibiotic • Keep the child warm • **Refer URGENTLY to hospital**
• WFH/L less than -3 zscores **OR** • MUAC less than 115 mm **AND** • Able to finish RUTF	**UNCOMPLICATED SEVERE ACUTE MALNUTRITION**	• Give oral antibiotics for 5 days • Give ready-to-use therapeutic food for a child aged 6 months or more • Counsel the mother on how to feed the child. • Check for TB (see page 9) • Advise mother when to return immediately • Follow up in 7 days
• WFH/L between -3 and -2 z-scores **OR** • MUAC 115 up to 125 mm	**MODERATE ACUTE MALNUTRITION**	• Assess the child's feeding and counsel the mother on the feeding recommendations • If feeding problem, follow up in 7 days • Check for TB (see page 9) • Advise mother when to return immediately (See page 16) • Follow-up in 30 days
• WFH/L - 2 z-scores or more **OR** • MUAC 125 mm or more	**NO ACUTE MALNUTRITION**	• Give mebendazole if child is 1 year or older and has not had a dose in the previous 6 months. • If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding according to the FOOD box on the COUNSEL THE MOTHER chart. • If feeding problem, follow-up in 7 days. • Advise mother when to return immediately. (See page 30)

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

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

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

CHECK FOR ANAEMIA

Look and Feel for palmar pallor

Is it:

- Severe palmar pallor?
- Some palmar pallor?

If palmar pallor present, assess for history and symptoms of Sickle Cell Disease(SCD);

Ask:

- Family history of SCD OR
- Death of sibling from anaemia
- Painful joints and bones
- History of previous blood transfusion more than once
- History of unexplained episodes of severe pain, such as pain in the abdomen, chest, bones or joints

Look and Feel for

- Swelling of hands & feet with persistent crying in infants due to pain
- Features suggestive of a stroke i.e. weakness of one side of the body
- Bossing skull

Classify ANAEMIA

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
• Severe palmar pallor	**SEVERE ANAEMIA**	• **Refer URGENTLY to hospital** • **If child has any history or symptoms suggestive of SCD recommend testing for SCD**
• Some pallor	**ANAEMIA**	• Give iron** • Give mebendazole if child is 1 year or older and has not had a dose in the previous 6 months • Advise mother when to return immediately • Follow-up in 14 days • If child has any history or symptoms suggestive of SCD recommend testing for HbS • **If child is already confirmed with SCD refer**
• No palmar pallor	**NO ANAEMIA**	• If child is less than 2 years old, assess the child's feeding and counsel the mother according to the feeding recommendations • If feeding problem, follow-up in 5 days

***If child has confirmed sickle disease and or severe acute malnutrition and is receiving RUTF, DO NOT give iron.*

THEN CHECK FOR HIV INFECTION

Use this chart if the child is NOT enrolled in HIV care. If already in HIV care, go to the next step and assess for TB.

ASK:

Has the mother or child had an HIV test?

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

IF YES:

- **Mother:**
  -- POSITIVE or NEGATIVE
- **Child:**
  -- DNA PCR test POSITIVE or NEGATIVE
  -- Rapid HIV test POSITIVE or NEGATIVE

IF MOTHER IS HIV POSITIVE AND CHILD'S STATUS IS NEGATIVE OR UNKNOWN, ASK:

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

IF NO: Mother & child HIV status unknown:-

- Then TEST mother
- If positive, then test the child

Classify ALL YOUNG INFANTS

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
• Positive DNA PCR test in child **OR** • Positive HIV rapid test in a child18 months or older	**CONFIRMED HIV INFECTION**	• Give cotrimoxazole prophylaxis* • Check for TB (see page 9) • Link child to Early Infant Diagnosis (EID) /ART Clinic for follow up care • Assess the child's feeding and provide appropriate counselling to the mother • Advise the mother on home care
• Mother HIV-positive AND negative DNA PCR test in a breastfeeding child or if only stopped less than 6 weeks ago **OR** • Mother HIV-positive, child not yet tested • Positive serological test in a infant less than 16 months	**HIV EXPOSED**	• Give cotrimoxazole prophylaxis • Check for TB (see page 9) • Link child to ART/Mother Baby care point to start or continue ARV prophylaxis • Do DNA PCR test to confirm HIV status** • Assess the child's feeding and provide appropriate counselling to the mother • Advise the mother on home care
• HIV test not done for mother or infant child less than 18 months old.	**HIV INFECTION STATUS UNKNOWN**	• Encourage mother to go for HIV counseling and testing in a health facility
• Negative HIV test in mother or child.	**HIV INFECTION UNLIKELY**	• Treat, counsel and follow-up existing infections

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

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

THEN CHECK FOR TB

ASSESS

ASK:-

For symptoms suggestive of TB

- Has the child been coughing for 14 days or more?
- Has the child had persistent fever for 14 days or more?
- Has the child had poor weight gain in the last one month?*

LOOK AND FEEL

Look or feel for physical signs of TB

- Swellings in the neck or armpit
- Swelling on the back
- Stiff neck
- Persistent wheeze not responding to brochodilaters

Classify TB Status

ASK: History of contact
Has the child had contact with a person with Pulmonary Tuberculosis or chronic cough?

Collect sample for GeneXpert or smear microscopy
If available, send the child for laboratory tests (GeneXpert or smear microscopy) and/ or Chest X-Ray.

** Poor weight gain (Weight loss, or very low weight (weight-for-age less than -3 z-score), or underweight (weight-for age less than -2 z-score), or confirmed weight loss (>5%) since the last visit, or growth curve flattening), yellow and red MUAC colour code.*

SIGNS	CLASSIFY	IDENTIFY TREATMENT
Two or more of the following in HIV Negative child AND one or more of the following in HIV Positive child: • At least two symptoms suggestive of TB • Positive history of contact with a TB case • Any physical signs suggestive of TB **OR** A positive GeneXpert or smear microscopy test	**TB**	• Start TB treatment • Treat, counsel, and follow up existing infections • Ask about the caregiver's health and treat as necessary • Link child to the nearest TB clinic • If GeneXpert or smear microscopy test is not available or negative, **refer for further assessment**
Positive history of contact with a TB case and NO other TB symptoms or signs listed above	**TB EXPOSURE**	• Start Isoniazid at 10mg/kg for 6 months • Treat, counsel, and follow up existing infections • Ask about the caregiver's health and treat as necessary • Conduct contact tracing
NO TB symptoms or signs	**NO TB**	• Treat, counsel, and follow up existing infections • Start Isoniazid in HIV positive child above 1 year at 10mg/kg for 6 months

* ***Refer*** *children with dangers signs as well as those where TB treatment is not available.*

THEN CHECK THE CHILD'S IMMUNIZATION AND VITAMIN A STATUS

Immunization Schedule:

- Follow National Guidelines:

AGE	VACCINE				
Birth	BCG*	OPV-O			
6 weeks	DPT+HepB+HIB	OPV-1		RTV1	PCV1
10 weeks	DPT+HepB+HIB	OPV-2		RTV2	PCV2
14 weeks	DPT+HepB+HIB	OPV-3	IPV	RTV3	PCV3
9 months	Measles				

*Children confirmed to be HIV positive should not be given BCG due to associated BCG disease among HIV infected children.

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

ROUTINE DEWORMING TREATMENT
Give every child mabendazole every six months from the age of 1 year. Record the dose on the child's chart.

Assess the child's growth and development milestones

- Plot the child's weight on his/her growth card (immunization or mother baby passport)
- Ask mother about what the child is now able to do in terms of physical movement, communication and interaction.
- See annex 1 for details of expected milestones for various age groups

Assess the Child for other problems including Congenital Malformations

- Ask mother for any other problem or identified external malformations
- Check child for any external malformations and abnormal signs
- **Refer infant to hospital,** if they have any external malformations

Assess the Mother's Health Needs

- Check if had full course of tetanus toxid, if not, give an appointment.
- Ask if pregnant , if so give antenatal appointment. If not, ask if interested to talk about family planning.
- Ask if RCT has been done and the results.
- If mother is an adolescent, link to appropriate clinic or service provider for support.

PRE-REFERRAL TREATMENT

If the child is classified as severe disease, give pre-referral treatment and refer urgently

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

Give diazepam to Stop Convulsions

- Position the child appropriately 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
- If convulsions have not stopped after 10 minutes, repeat diazepam dose

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

Give Artesunate Suppositories Or Intramuscular Artesunate Or Quinine For Severe Malaria

- **For children being referred with very severe febrile disease:**

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

For artesunate injection:

→ Give first dose of artesunate intramuscular injection
→ Repeat dose after 12 hrs and every 24 hours until the child can take orally
→ Give full dose of oral antimalarial as soon as the child is able to take orally.

For artesunate suppository:

→ Give first dose of suppository
→ Repeat the same dose after 12 hours, then every 24 hours until the child can take oral antimalarial. Give full dose of oral antimalarial as soon as the child is able to take orally

For quinine:

→ Give first dose of intramuscular quinine.
→ The child should remain lying down for one hour.
→ Repeat the quinine 8 hours later, and then every 8 hours until the child is able to take an oral antimalarial. Do not continue quinine injections for more than 1 week.

AGE or WEIGHT	RECTAL ARTESUNATE SUPPOSITORY		INTRAMUSCULAR ARTESUNATE	INTRAMUSCULAR QUININE	
	50 mg suppositories Dosage 10 mg/kg	200 mg suppositories Dosage 10 mg/kg	60 mg vial (20mg/ml) 2.4 mg/kg	150 mg/ml* (in 2 ml ampoules)	300 mg/ml* (in 2 ml ampoules)
2 months up to 4 months (4 - <6 kg)	1		1/2 ml	0.4 ml	0.2 ml
4 months up to 12 months (6 - <10 kg)	2	-	1 ml	0.6 ml	0.3 ml
12 months up to 2 years (10 - <12 kg)	2		1.5 ml	0.8 ml	0.4 ml
2 years up to 3 years (12 - <14 kg)	3	1	1.5 ml	1.0 ml	0.5 ml
3 years up to 5 years (14 - 19 kg)	3	1	2 ml	1.2 ml	0.6 ml

Give an Intramuscular Antibiotic

- Give to children being referred urgently
- Give Ampicillin (50 mg/kg) and Gentamicin (7.5mg/kg)

Ampicillin

→ Dilute 500mg vial with 2.1ml of sterile water (500mg/2.5ml)

Gentamicin

→ 7.5mg/kg/day once daily

→ 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	Ampicillin 500 mg vial	Gentamicin 2ml vial/40 mg/ml*
2 up to 4 months	4 – <6kg	1 ml	0.5 – 1.0 ml
4 up to 12 months	6 – <10kg	2 ml	1.1 – 1.8 ml
1 up to 3 years	10 – <15kg	3 ml	1.9 – 2.7 ml
3 up to 5 years	15 – 20kg	5 ml	2.8 – 3.5 ml

* Lower value for lower range of age/weight.

Treat the child to prevent low blood sugar

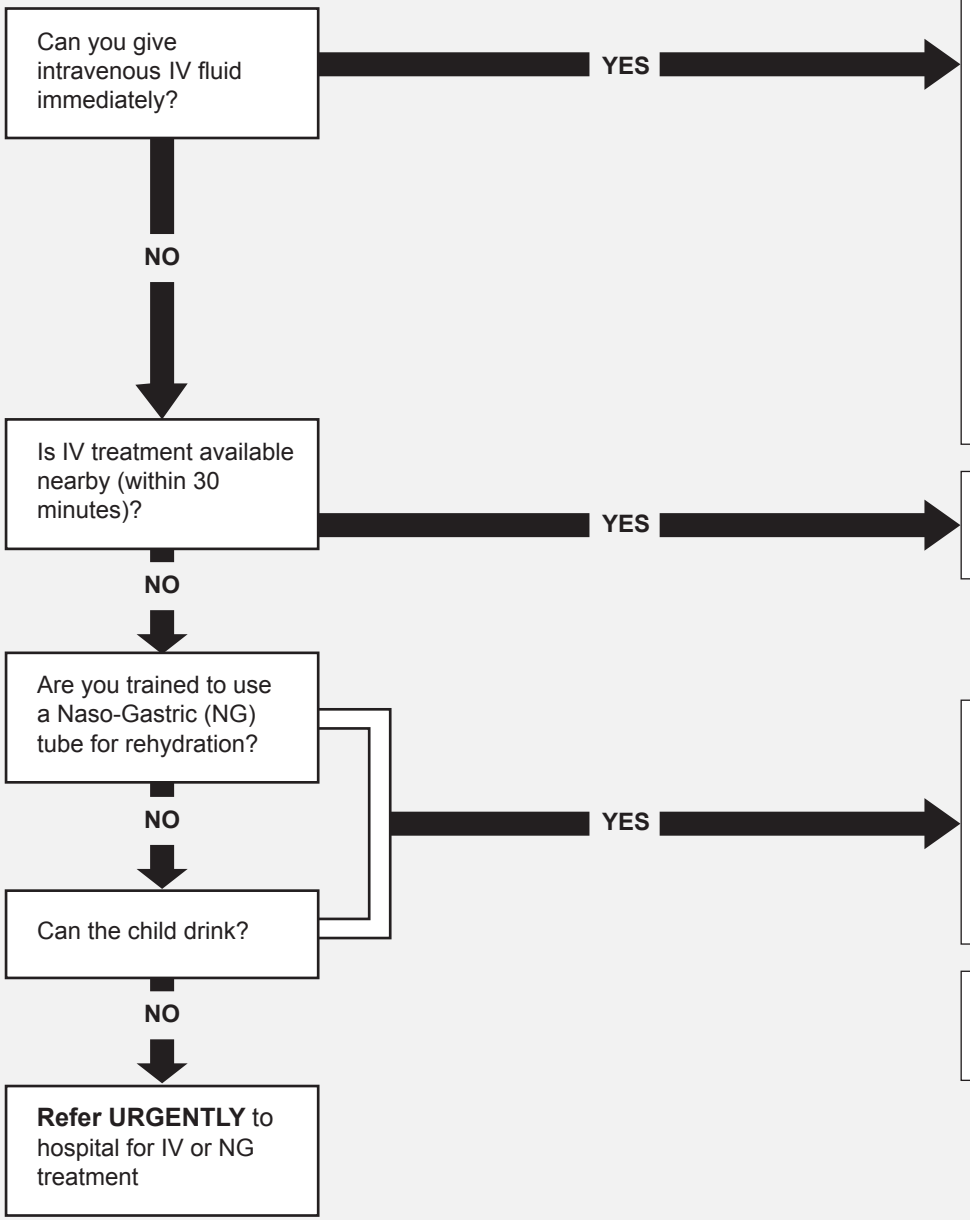
- If the child is able to breastfeed:
  Ask the mother to breastfeed the child
- If the child is not able to breastfeed,but is able to swallow:
  → Give expressed breast milk or breastmilk substitute
  → If neither of these is available,give sugar water
  → Give 30–50 ml of milk or sugar water before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

Refer Urgently

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

Plan C: Treat for Severe dehydration Quickly

Follow the arrows. If answer is “yes”, go across. If “no”, go down



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

AGE	First give 30ml/kg in	Then give 70ml/kg in
Infants (under 12 months)	1 hour	5 hours
Children (12 months up to 5 years)	30 minutes	2½ hours

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

- **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 nasogastic tube.

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

NOTE:

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

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

Teach the mother to give oral medicines at home

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

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

1. Give an appropriate oral antibiotic

► For pneumonia, acute ear infection:
First-line antibiotic: Oral Amoxicillin

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

► For prophylaxis, confirmed HIV or HIV exposed child:
ANTIBIOTIC FOR PROPHYLAXIS: Oral Cotrimoxazole

	CO-TRIMOXAZOLE Give once a day starting at 6 weeks of age to: ~~out~~ All infants HIV Exposed until HIV is definitively ruled → All infants and children with confirmed HIV infection.		
AGE	**5 ml syrup 40/200 mg**	**Single strength Dispersible tablet 20/ 100 mg**	**Single strength adult tablet 80/400 mg**
Less than 6 months	2.5 ml	1 tablet	-
6 months up to 5 years	5 ml	2 tablets	1/2 tablet

► For dysentery give ciprofloxacin 15mg/kg/day --- 2 times a day for 3 days:

	250 mg TABLET	**500 mg TABLET**
AGE or WEIGHT	DOSE/tabs	DOSE/ tabs
Less than 6 months	1/2 tablet	1/4 tablet
6 months up to 5 years	1 tablet	1/2 tablet

2. Give oral Antimalarial for Malaria

► If Artemether-Lumefantrine (AL)

- Give the first dose of Artemether-Lumefantrine (AL) in the clinic and observe for one hour
- If child vomits within an hour repeat the dose. Give the 2nd dose at home after 8 hours
- Then twice daily for further two days as shown below
- Artemether-Lumefantrine (AL) should be taken with food

		Coartem tablets (20mg artemether and 120mg lumefantrine)					
WEIGHT	**Age**	**0hr**	**8hr**	**24hr**	**36hr**	**48hr**	**60hr**
5–15 kg	4 months - <3 yrs	1	1	1	1	1	1
15–24 kg	4–8 years	2	2	2	2	2	2
25–34 kg	9–14 years	3	3	3	3	3	3
>34 kg	>14 years	4	4	4	4	4	4

► Artesunate Amodiaquine (AS + AQ)

If AL is not available:

- Give the first dose of Artemether- amodiaquine (AS+AQ) in the clinic and observe for one hour. If child vomits within an hour repeat the dose.
- Then daily for 2 days as per the table below using the fixed dose combination

		Dose in mg (No. of tablets)					
		Artesunate (50mg)			Amodiaquine (153 mg)		
WEIGHT	**Age**	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3
5–15 kg	4 months - <3 years	25 (½ tab)	25(½ tab)	25 (½ tab)	76 (½ tab)	76 (½ tab)	76 (½ tab)
15–24 kg	4–8 years	50 (1)	50 (1)	50 (1)	153 (1)	153 (1)	153 (1)
25–34 kg	9–14 years	100 (2)	100 (2)	100 (2)	306 (2)	306 (2)	306 (2)
>34 kg	>14 years	200 (4)	200 (4)	200 (4)	612 (4)	612 (4)	612 (4)

Note: *Do not use amodiaquine alone, use with artesunate tablets*

3. Give Paracetamol for High fever (> 38.50) or Ear pain

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

AGE OR WEIGHT	PARACETAMOL TABLET (500mg)
2 months up to 4 months (4 - <6kg)	1/4
4 months up to 12 months (6 - <10 kg)	1/2
12 months up to 5 years (10 - 19 kg)	1

4. Give extra fluid for diarrhoea and continue feeding

► Plan A: Treat for diarrhoea at Home

Counsel the mother on the 4 rules of Home Treatment:

1. Give Extra Fluid 2. Give Zinc Supplements (age 2 months up to 5 years)
3. Continue Feeding 4. When to return

1. Give extra fluid (as much as the child will take)

- **Tell the mother:**
  - → Breastfeed frequently and for longer at each feed
  - → If the child is exclusively breastfed, give ORS or clean water in addition to breastmilk
  - → If the child is not exclusively breastfed, give one or more of the following: Food-based fluids (such as soup, rice water, and yoghurt drinks), 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 ORS. Give the mother 2 packets of ORS to use at home.
- Show the mother how much fluid to give in addition to the usual fluid intake:
  - → Up to 2 years: 50–100 ml after each loose stool
  - → 2 years or more: 100–200 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

2. Give zinc (age 2 months up to 5 years)

- **Tell the mother how much zinc to give (20 mg tab):**
  - → 2 months up to 6 months —— 1/2 tablet daily for 10 days
  - → 6 months or more —— 1 tablet daily for 10 days
- **Show the mother how to give zinc supplements**
  - → ***Infants***—dissolve tablet in a small amount of expressed breastmilk, ORS or clean water in a cup
  - → ***Older children***—tablets can be chewed or dissolved in a small amount of clean water in a cup

3. Continue feeding (exclusive breastfeeding if age less than 6 months)

4. When to return: Tell mother to return if;
- Child has blood in stool
- and OR is drinking poorly

► Plan B: Treat for Some dehydration with ORS

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

- **Determine amount of ORS to give during first hours**

AGE*	Up to 6 months	6 months up to 12 months	12 months up to 2 yrs	2 years up to 5 years
WEIGHT	< 6 kg	6–< 10 kg	10–< 12 kg	12–<20kg
Amount of fluid (ml) over hours	200–450	450–800	800–960	960–1600

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

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

- **Show the mother how to give ORS solution:**
  - → Give frequent small sips from a cup
  - → If the child vomits, wait 10 minutes then continue - but more slowly
  - → Continue breastfeeding whenever the child wants
- **After 4 hours:**
  - → Reassess the child and classify the child for dehydration
  - → Select the appropriate plan to continue treatment
  - → Begin feeding the child in clinic
- **If the mother must leave before completing treatment:**
  - → Show her how to prepare ORS solution at home
  - → Show her how much ORS to give to finish 4-hour treatment at home
  - → Give her instructions how to prepare salt and sugar solution for use at home
  - → Explain the 4 Rules of Home Treatment:
    1. Give extra fluid
    2. Give zinc (age 2 months up to 5 years)
    3. Continue feeding (exclusive breastfeeding if age less than 6 months)
    4. When to return

5. Give Iron

▸ **Give one dose daily for 14 days**

AGE or WEIGHT	IRON/FOLATE TABLET Ferrous sulfate200 mg + 250 µg Folate (60 mg elemental\ iron)	IRON SYRUP Ferrous fumarate 100 mg per 5 ml (20 mg elemental iron per ml)	FOLIC ACID TABLET 5mg
2 months up to 4 months (4 – <6 kg)		1.0 ml (< 1/4 tsp)	1/2
4 months up to 12 months (6 – <10kg)		1.25 ml (1/4 tsp)	1
12 months up to 3 years (10 – <14 kg)	1/2 tablet	2.0 ml (<1/2 tsp)	1
3 years up to 5 years (14 – 19 kg)	1/2 tablet	2.5 ml (1/2 tsp)	1

6. Give salbutamol for wheezing

▸ **Dosaging for Salbutamol**

AGE OR WEIGHT	**Salbutamol** Three times daily for 5 days			
	2 mg tablet	4 mg tablet	Syrup	Inhaler (preferably use a spacer)
2 months up to 12 months (Less than 10 kg)	1/2	1/4	2.5ml	Give 2 doses (200 µg)
12 months up to 5 years (10 – 19 kg)	1	1/2	5.0ml	Give 2 doses (200 µg)

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

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:

For older children:

- Use a 500ml drink bottle or similar.
- Cut a hole using a sharp knife in the bottle base in the same shape as the Mouth piece of the inhaler.
- Flame the edge of the cut bottle with a candle or a lighter to soften it.

For a small baby:

- Use a 500ml drink bottle or similar.
- Cut a hole using a sharp knife in the bottle base in the same shape as the mouth piece of the inhaler.
- Cut the bottle between the upper quarter and the lower 3/4 and disregard the upper quarter of the bottle.
- Cut a small V in the border of the large open part of the bottle to fit to the child's nose and be used as a mask.
- Flame the edge of the cut bottle with a candle or a lighter to soften it.

Alternatively commercial spacers can be used if available.

To use an inhaler with a spacer:

- Remove the inhaler cap. Shake the inhaler well.
- Insert mouthpiece of the inhaler through the hole in the bottle or plastic cup.
- The child should put the opening of the bottle into his mouth and breathe in and out through the mouth.
- A carer then presses down the inhaler and sprays into the bottle while the child continues to breathe 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.

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

7. 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 gives the first treatment in the clinic (except for remedy for cough or sore throat)
- Tell her how often to do the treatment at home
- If needed for treatment at home, give mother a tube of tetracycline ointment or a small bottle of gentian violet or Nystatin
- Check the mother's understanding before she leaves the clinic

► Clear the ear by dry wicking and give eardrops*

- **Do the following 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
  - → Instil quinolone eardrops for two weeks

* Quinolone eardrops may contain ciprofloxacin, norfloxacin, or ofloxacin

► Soothe the throat, relieve the cough with a safe remedy

- **Safe remedies to recommend:**
  - → Breast milk for a breastfed infant
  - → Simple linctus
  - → Tea with lemon
- **Harmful remedies to discourage:**
  - → Ipecacuaanna
  - → Phenergan
  - → Codeine
  - → Piriton

► Treat eye infection with tetracycline eye ointment

- **Clean both eyes 4 times daily.**
  - → Wash hands.
  - → Use clean cloth and water to gently wipe away pus.
- **Then apply tetracycline eye ointment in both eyes 4 times daily.**
  - → Squirt a small amount of ointment on the inside of the lower lid.
  - → Wash hands again.
- **Treat until there is no pus discharge.**
- **Do not put anything else in the eye.**

► Treat mouth ulcers with gentian violet (GV)

- **Treat for mouth ulcers twice daily**
  - → Wash hands
  - → Wash the child's mouth with a clean soft cloth wrapped around the inger and wet with salt water
  - → Paint the mouth with 1/2 strength gentian violet (0.25% dilution)
  - → Wash hands again
  - → Continue using GV for 48 hours after the ulcers have been cured
  - → Give Paracetamol for pain relief

► Treat Oral Thrush with Nystatin

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

* Quinolone eardrops may contain ciprofloxacin, norfloxacin, or ofloxacin on clear the ear

Start Treatment for The Child with TB

All TB medicines should be taken under direct observation by a treatment supporter (Directly Observed Therapy – DOT). TB treatment is divided into 2 phases: an initial (intensive) phase for 2 months and a continuation phase for 4 or 10 months depending on the type of TB disease. TB treatment regimen is documented in a standard format, e.g. 2RHZE/4RH where:-

- Letters represent abbreviated anti-TB medicine names (R - Rifampicin; H – Isoniazid;
- Z – Pyrazinamide; E – Ethambutol)
- Numbers represent the duration in months / (forward slash sign) division between treatment phases

TB treatment regimen for a child who is diagnosed with TB

Types of disease	REGIMEN	
	Intensive phase	Continuation phase
All forms of TB (excluding TB meningitis and Bone TB)	2RHZE	4RH
TB meningitis Bone (Osteoarticular) TB	2RHZE	10RH

** Ethambutol is safe for use in children provided the dose is within the recommended range.*

** Streptomycin is no longer recommended for use in the treatment of susceptible TB.*

** Children with TB meningitis or airway obstruction due to TB adenopathy should be **referred to hospital.***

** Children diagnosed with drug resistant TB should be **referred** to the nearest MDR TB treatment site for further management.*

Dosage of anti-TB medicines by weight band

Weight bands	Number of tablets		
	Intensive Phase(2 months)		Continuation Phase (4 months)
	RHZ 75/50/150	E100	RH 75/50
4-7 kg	1	1	1
8-11 kg	2	2	2
12-15 kg	3	3	3
16-24 kg	4	4	4

** Continuation phase: 4 months for all forms of TB (excluding TB meningitis and Bone TB) and 10 months for TB meningitis and Bone TB.*

** If available, give pyridoxine at a dose of 12.5 mg/day for children < 5 years in addition to anti-TB medicines. However, absence of pyridoxine should not stop a health worker from initiating TB treatment.*

Start Isoniazid preventive therapy for the Child with TB Exposure and HIV positive child above 1 year with no TB

Isoniazid reduces the risk of TB development among children with a history of TB exposure as well as children living with HIV. Isoniazid is given at a dose of 10mg/kg/ day for 6 months

Dosage of Isoniazid by weight band

Tablet strength	Weight band				
	3–5.9 kg	6–9.9 kg	10–13.9 kg	14–19.9 kg	20–24.9 kg
Isoniazid 100 mg	½ Tablet	1 Tablet	1½ Tablets	2 Tablet	2½ Tablets

** If available, give pyridoxine at a dose of 12.5 mg/day for children < 5 years in addition to Isoniazid. However, absence of pyridoxine should not stop a health worker from initiating TB treatment.*

8. Give Vitamin A and mebendazole in clinic

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

▸ Give Vitamin A

Vitamin A Supplementation:

Give Vitamin A to all children to prevent severe illness:

- First dose in breastfed children to be given any time after 6 months of age
- Hereafter Vitamin A should be given every six months to ALL CHILDREN

Vitamin A Treatment:

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

Age	VITAMIN A DOSE
6 up to 12 months	100 000IU
One year and older	200 000IU

▸ Give Mebendazole

Give 500 mg mebendazole as a single dose in clinic if:

→ Hookworm/whipworm is a problem in your area

→ The child is 1 year of age or older, and

→ Has not had a dose in the previous 6 months

GIVE READY-TO-USE THERAPEUTIC FOOD

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

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

▸ Recommended Amounts of Ready-to-Use Therapeutic Food

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

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

Give follow-up care

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

1. Pneumonia

After 3 days:
→ Check the child for general danger signs.
→ Assess the child for cough or difficult breathing.
} See ASSESS & CLASSIFY chart

Ask:
→ Is the child breathing slower?
→ Is there less fever?
→ Is the child eating better?
Assess for HIV infection

Treatment:
→ If chest indrawing or a general danger sign, give a dose of second-line antibiotic or intramuscular chloramphenicol. Then **refer URGENTLY** to hospital.
→ If breathing rate, fever and eating are the same, change to the second-line antibiotic and advise the mother to return in 2 days or **refer.**(If this child had measles within the last 3 months or is known or suspected to have Symptomatic HIV Infection,**refer.**)
→ If breathing slower, less fever, or eating better, complete the 5 days of antibiotic.

2. Persistent Diarrhoea

After 5 days:
Ask:
→ Has the diarrhoea stopped?
→ How many loose stools is the child having per day?
Assess for HIV infection

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

3. Dysentery

After 2 days:
Assess the child for diarrhoea > See ASSESS & CLASSIFY chart

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

Treatment:
→ If the child is dehydrated, treat for dehydration.
→ If number of stools, blood in the stools, fever, abdominal pain, or eating is worse or the same:
- Change to second-line oral antibiotic recommended for shigella in your area. Give it for 5 days.
- Advise the mother to return in 2 days.
- If you do not have the second line antibiotic, **REFER TO HOSPITAL.**

Exceptions:
If the child is less than 12 months old or was dehydrated on the first visit, or if he had measles within the last 3 months, **REFER TO HOSPITAL.**
→ If fewer stools, less fever, less abdominal pain, and eating better, continue giving ciprofloxacin until finished.
Ensure that the mother understands the oral rehydration method fully and that she also understands the need for an extra meal each day for a week.
→ Care for the child who returns for follow-up using all the boxes that match the child's previous classification
→ If the child has any new problems, assess, classify and treat the new problem as on the ASSESS AND CLASSIFY chart

4. Malaria

If fever persists after 3 days, or returns within 7 days:

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

→ Assess for other causes of fever.

Treatment:

→ If the child has any general danger sign or stiff neck, treat as VERY SEVERE FEBRILE DISEASE.

→ If the child has any cause of fever other than malaria, provide treatment.

→ If malaria is the only apparent cause of fever:

- Treat with the second-line oral antimalarial (if no second-line antimalarial is available, refer to hospital.)
- Advise the mother to return again in 2 days if the fever persists.

→ If fever has been present for 7 days, **refer for assessment.**

5. Fever - No Malaria

If fever persists after 3 days:

→ Do a full reassessment of the child > See ASSESS & CLASSIFY chart. Assess for other causes of fever.

Treatment:

→ If the child has any general danger sign or stiff neck, treat as VERY SEVERE FEBRILE DISEASE.

→ If the child has any cause of fever other than malaria, provide treatment.

→ If malaria is the only apparent cause of fever:

- Treat with the first-line oral antimalarial.
- Advise the mother to return again in 2 days if the fever persists.

→ If fever has been present for 7 days, **refer for assessment.**

6. Measles with eye or mouth complications

After 3 days:

→ Look for red eyes and pus draining from the eyes.

→ Look at mouth ulcers.

→ Smell the mouth.

Treatment for Eye Infection:

→ If pus is draining from the eye, ask the mother to describe how she has treated the eye infection. If treatment has been correct, **refer to hospital**. If treatment has not been correct, teach mother correct treatment.

→ If the pus is gone but redness remains, continue the treatment.

→ If no pus or redness, stop the treatment.

Treatment for Mouth Ulcers:

→ If mouth ulcers are worse, or there is a very foul smell coming from the mouth, **refer to hospital.**

→ If mouth ulcers are the same or better, continue using half-strength gentian violet for a total of 5 days.

→ Care for the child who returns for follow-up using all the boxes that match the child's previous classification

→ If the child has any new problems, assess, classify and treat the new problem as on the ASSESS AND CLASSIFY chart

7. Ear infection

After 5 days:

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

→ Measure the child's temperature.

→ Check for HIV infection.

Treatment:

→ If there is tender swelling behind the ear or high fever (38.5°C or above), **refer URGENTLY to hospital.**

→ ***Acute ear infection:*** if ear pain or discharge persists, treat with 5 more days of the same antibiotic. Continue wicking to dry the ear. Follow-up in 5 days.

→ ***Chronic ear infection:*** Check that the mother is wicking the ear correctly. Encourage her to continue.

→ If no ear pain or discharge, praise the mother for her careful treatment. If she has not yet finished the 5 days of antibiotic, tell her to use all of it before stopping.

8. Feeding Problem

After 5 days:

→ Reassess feeding > See questions at the top of the COUNSEL chart.

→ Ask about any feeding problems found on the initial visit.

Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the child back again.

If the child is very low weight for age, ask the mother to return 30 days after the initial visit to measure the child's weight gain.

9. Anaemia

After 14 days:

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

10. Very low weight for age

After 3 days:

Weigh the child and determine if the child is still very low weight for age. Reassess feeding. See questions at the top of the COUNSEL chart.

Check for HIV infection.

Treatment:

- If the child is no longer very low weight for age, praise the mother and encourage her to continue.
- If the child is still very low weight for age, counsel the mother about any feeding problem found. Ask the mother to return again in one month. Continue to see the child monthly until the child is feeding well and gaining weight regularly or is no longer very low weight for age.

Exception:

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

11. Moderate Acute Malnutrition

After 30 days:

Assess the child using the same measurement (WFH/L or MUAC) used on the initial visit: If WFH/L, weigh the child, measure height or length and determine if WFH/L.

- If MUAC, measure using MUAC tape.
- Check the child for oedema of both feet.

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

Treatment:

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

Exception:

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

12. Uncomplicated Severe Acute Malnutrition

After 7 days or during regular follow up:

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

Assess child with the same measurements (WFH/L, MUAC) as on the initial visit. Check for oedema of both feet.

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

Treatment:

- If the child has **COMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or
- MUAC is less than 115 mm or oedema of both feet AND has developed a medical complication or oedema, or fails the appetite test), **refer URGENTLY to hospital.**
- If the child has **UNCOMPLICATED SEVERE ACUTE MALNUTRITION** (WFH/L less than -3 z-scores or MUAC is less than 115 mm or oedema of both feet but NO medical complication and passes appetite test), counsel the mother and encourage her to continue with appropriate RUTF feeding. Ask mother to return again in 7 days.
- If the child has **MODERATE ACUTE MALNUTRITION** (WFH/L between -3 and -2 z-scores or MUAC between 115 and 125 mm), advise the mother to continue RUTF. Counsel her to start other foods according to the age appropriate feeding recommendations (see COUNSEL THE MOTHER chart). Tell her to return again in 14 days. Continue to see the child every 14 days until the child's WFH/L is -2 z-scores or more, and/or MUAC is 125 mm or more.
- If the child has **NO ACUTE MALNUTRITION** (WFH/L is -2 z-scores or more, or MUAC is 125 mm or more), praise the mother, STOP RUTF and counsel her about the age appropriate feeding recommendations (see COUNSEL THE MOTHER chart).

COUNSEL THE MOTHER

ASSESS THE FEEDING OF SICK CHILD UNDER 2 YEARS

(or if child has MODERATE ACUTE MALNUTRITION, ANAEMIA, CONFIRMED HIV INFECTION, or is HIV EXPOSED)

Ask questions about the child's usual feeding and feeding during this illness. Note whether the mother is HIV infected, uninfected, or does not know her status. Compare the mother's answers to the Feeding Recommendations for the child's age

ASK — How are you feeding your child?

If the child is receiving any breastmilk, ASK:

→ How many times during the day?

→ Do you also breastfeed during the night?

If child 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 6 months)

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?

FEEDING RECOMMENDATIONS

► Feeding recommendation for all children during sickness and health, and including children on ARV or HIV exposed

Up to 6 Months of Age

- Breastfeed as often as the child wants, day and night at least 8 times in 24 hours
- Do not give other foods or fluids
- If a child between 4 and 6 months appears hungry after breast-feeding or is not gaining weight adequately, add complimentary foods (listed under 6 months up to 12 months)
- Give those foods 1 or 2 times per day after breastfeeding

6 Months up to 12 Months

- Breastfeed as often as the child wants
- Introduce child to some soft foods such as:
  - Thick porridge made out of either maize or cassava/millet/soya flour. Add sugar and oil mixed with wither milk or pounded ground nut.
  - Mixture of mashed foods made out of either matooke/potatoes/cassava/posho (maize/beans/pounded groundnuts. Add green vegetables
  - Start with 2-3 heaped tablespoons per feed and gradually increase to atleast one third of a nice plastic cup
- Feed child with soft foods three times a day if breastfeeding; and five times if child is not breastfeeding
- Give a snack like egg/banana/bread in between the feeds

12 Months up to 2 Years

- Breastfeed as often as the child wants and breastfed child atleast for 24 months
- In addition, give three to five feeds:
  - Mixtures of mashed foods made out of either matooke/potatoes/cassava/posho (maize/millet/rice. Mix with fish/beans/pounded groundnuts. Add green vegetables.
  - Thick porridge made out of either maize/cassava/millet/soya flour. Add sugar and oil mix with wither milk or pounded groundnuts
- Give a nutritious snack in between feeds
- If child is HIV exposed, mother should be encouraged to discontinue breastfeeding at 12 months

2 Years and Older

- Give family foods at least 3 meals each day. Also give a nutritious snack twice daily such as banana/eggs/bread.

► Feeding Recommendations for a child who has PERSISTENT DIARRHOEA

If still breastfeeding, give more frequent, longer breastfeeds, day and night. If taking other milk:

- Replace with increased breastfeeding OR
- Replace with fermented milk products, such as yoghurt OR
- Replace half the milk with nutrient-rich semisolid food

► Counsel the mother about feeding problems

- If the mother reports difficulty with breast- feeding, assess breast-feeding (see YOUNG INFANT chart).
  As needed, show the mother correct positioning and attachment for breast- feeding.

- **If the child is less than 6 months old and is taking other milk or foods*:**
  → Build mother's confidence that she can produce all the breast milk that the child needs.
  → Suggest giving more frequent, longer breastfeeds day or night, and gradually reducing other milk or foods.

- **If other milk needs to be continued, counsel the mother to:**
  → Breastfeed as much as possible, including at night.
  → Make sure that other milk is a locally appropriate breast milk substitute.
  → Make sure other milk is correctly and hygienically prepared and given in adequate amounts.
  → Finish prepared milk within an hour.

- **If the mother is using a bottle to feed the child:**
  → Recommend substituting a cup for bottle.
  → Show the mother how to feed the child with a cup.

- **If the child is not feeding well during illness, counsel the mother to:**
  → Breastfeed more frequently and for longer if possible.
  → Use soft, varied, appetizing, favourite foods to encourage the child to eat as much as possible, and offer frequent small feeds.
  → Clear a blocked nose if it interferes with feeding.
  → Expect that appetite will improve as child gets better.

- **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 snacks between meals.
  → Give high energy foods.
  → Check regularly.

- **If the child has sore mouth or ulcers:**
  → Give soft foods that will not burn the mouth, such as eggs, mashed potatoes, pumpkin or avocado.
  → Avoid spicy, salty or acid foods.
  → Chop foods finely.
  → Give cold drinks or ice, if available.

** if child is HIV exposed, counsel the mother about the importance of not mixing breast-feeding with replacement feeding.*

► Feeding advice for the mother of a child with confirmed HIV infection

- The child should be fed according to the feeding recommendations for his/her age.
- Mothers should be encouraged to breastfeed up to 12 months and discontinue thereafter
- Children with confirmed HIV infection often suffer from poor appetite and mouth sores, give appropriate advice.
- If the child is being fed with a bottle, encourage the mother to use a clean 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 mother about her own nutrition and the importance of a well balanced diet to keep herself healthy. Encourage mother to plant vegetables to feed her family

► "AFASS" criteria for stopping breastfeeding for HIV exposed

Acceptable:

Mother perceives no problem in replacement feeding.

Feasible:

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

Affordable:

Mother and family, with community can pay the cost of replacement feeding without harming the health and nutrition of the family.

Sustainable:

Availability of a continuous supply of all ingredients needed for safe replacement feeding for up to one year of age or longer.

Safe:

Replacement foods are correctly and hygienically prepared and stored.

▸ **Counsel the mother about early childhood development:** Responsive care giving and stimulating the child's brain

Newborn birth up to 1week

Your baby learns from birth.
Play: Provide ways for your baby to see ,hear, move arms and legs freely, Gently stroke and hold your baby.

Communicate: Look into baby's eyes and talk to your baby, when breast feeding. Even a new born baby sees your face and hears your voice.

1 week up to 6 months

Play: Provide ways for your child to see, hear, feel and move, show colorful things for your child.

Communicate: Smile and laugh with your child, get a conversation going by copying your child sounds and gestures.

6 months up to12 months

Play: Give your child clean safe household things to handle, bang and drop.

Communicate: Respond to your child's sounds and interests.

Tell your child the name of the things and people, sample toys

12 months up to 2 years

Play: Give your child things to stack up.

Communicate: Ask your child simple questions, respond to your child's attempt to talk. Show and talk about nature, picture and things

2 years and older

Play: Help your child count, name and compare things. Make simple colorful toys for your child.

Communicate: Encourage your child to talk and answer your child questions, teach your child stories, songs and games.

▸ Counsel the mother about her own health

- If the mother is sick, provide care for her, or **refer** her for help.
- If she has a breast problem (such as engorgement, sore nipples, breast infection), provide care for her or **refer** her for help.
- Advise her to eat well to keep up her own strength and health.
- Check the mother's immunization status and give her tetanus toxoid if needed.
- Make sure she has access to:
  - Family planning
  - Counselling on STD and HIV prevention.
- Encourage every mother to be sure to know her own HIV status and to seek HIV testing if she does not know her status or is concerned about the possibility of HIV in herself or her family.

▸ Fluids

Advise the Mother to Increase Fluid During Illness

For any sick child:

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

For child with diarrhoea:

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

WHEN TO RETURN

Advise the mother when to return to health worker

Follow-up visit

If the child has	**Return for first follow-up in**3
• Pneumonia • Dysentery 2 days • Malaria, if fever persists • Fever-malaria unlikely, if fever persists • Measles with eye or mouth complications	3 days
• Persistent diarrhoea • Acute ear infection • Chronic ear infection • Feeding problem • Cough or cold, if not improving	5 days
• Anaemia • Confirmed HIV infection • Suspected symptomatic HIV infection • HIV exposed/ possible HIV infection	14 days
• Very low weight for age	30 days

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

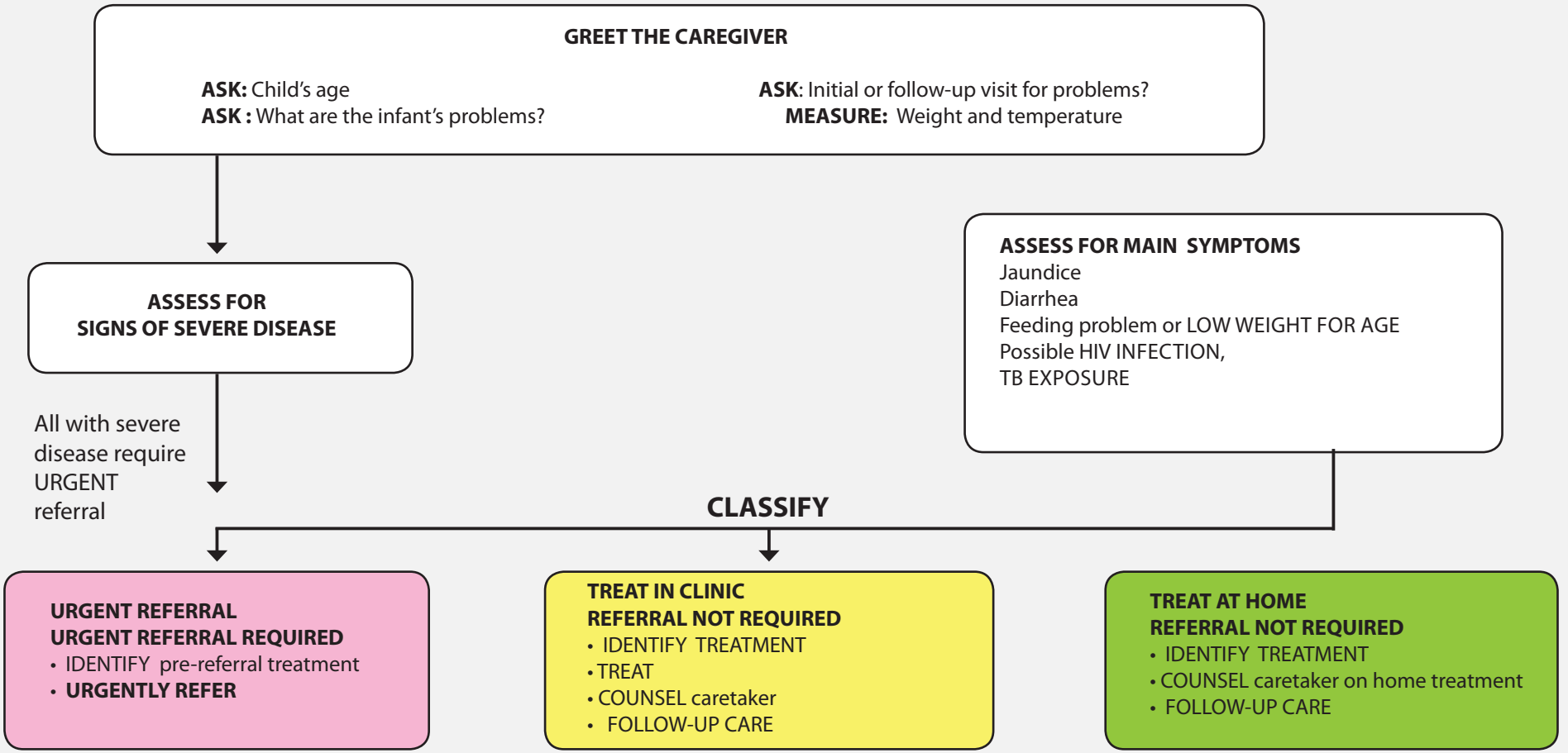
When to return immediately

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

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

SICK YOUNG INFANT AGE: BIRTH UP TO 2 MONTHS

IMNCI PROCESS FOR THE SICK YOUNG INFANT

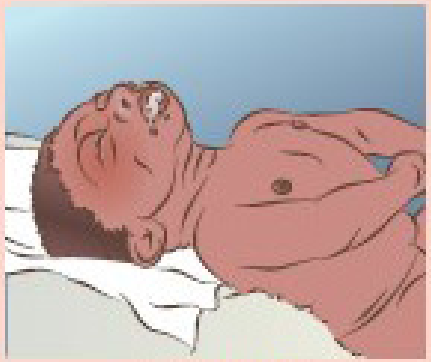


Within the first 90 minutes, periodically during the first day, and at any time if you suspect a problem

Assess for signs of severe disease

Not feeding

Severe chest indrawing or fast breathing



Convulsions

No movement

Temperature too low or high

To detect problems early and reduce the risk for death

ASSESS, CLASSIFY AND TREAT THE YOUNG INFANT

AGE: BIRTH UP TO 2 MONTHS

DO QUICK ASSESSMENT OF ALL YOUNG INFANTS BIRTH UP TO 2 MONTHS

ASK THE MOTHER WHAT THE YOUNG INFANT'S PROBLEMS ARE

- Determine if this is an initial or follow-up visit for this problem
- If initial visit, assess the child and classify as follows:

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

ASK:

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

LOOK AND FEEL:

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

} YOUNG INFANT MUST BE CALM

Classify ALL YOUNG INFANTS

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

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

* *These thresholds are based on axillary temperature.*

** *If referral is refused or not possible, see page 12.*

THEN CHECK FOR JAUNDICE

If jaundice present , ASK:

- When did the jaundice appear first?

LOOK AND FEEL

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

Classify ALL YOUNG INFANTS

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

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
- Any jaundice if age less than 24 hours or - Yellow palms and soles at any age	**SEVERE JAUNDICE**	• Treat to prevent low blood sugar • **Refer URGENTLY to hospital**
- Jaundice appearing after 24 hours of age and - Palms and soles not yellow	**JAUNDICE**	• Advise mother to give home care for the young infant • Advise mother to return immediately if palms and soles appear yellow • If young infant is older than 14 days, **refer to a hospital** for assessment • Follow up in 1 day
No Jaundice	**NO JAUNDICE**	Advise mother to give homecare for the young infant

THEN ASSESS FOR DIARRHOEA

ASK: Does the young infant have diarrhoea*?

IF YES, LOOK AND FEEL:

Look at the young infant's general condition:

- Infant's movements
  - Does the infant move on his/her own?
  - Does the infant not move even when stimulated but then stops?
  - Does the infant not move at all?
  - Is the infant restless and irritable?
- Look for sunken eyes.
- Pinch the skin of the abdomen. Does it go back:
  - Very slowly (longer than 2 seconds)?
  - or slowly?

Classify DIARRHOEA for DEHYDRATION

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
Two of the following signs: • Movement only when stimulated or no movement at all • Sunken eyes. • Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	Infant has no other severe classification: • Give fluid for severe dehydration (Plan C) • Start IV fluid immediately, or **Refer URGENTLY** for IV fluid. If that is not possible, start rehydration by NG tube **OR** • If infant also has another severe classification: • **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way** • Advise the mother to continue breastfeeding • Teach the mother how to keep the infant warm on the way to the hospital
Two of the following signs: • Restless, irritable. • Sunken eyes. • Skin pinch goes back slowly.	**SOME DEHYDRATION**	• Give fluid and breastmilk for some dehydration (Plan B) **If infant has any severe classification:** • **Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way** • Advise the mother to continue breastfeeding • Advise mother when to return immediately • Follow-up in 2 days if not improving
Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	• Give fluids to treat diarrhoea at home and continue breastfeeding (Plan A) • Advise mother when to return immediately • Follow-up in 2 days if not improving

**** What is diarrhoea in a young infant?***

A young infant has diarrhoea if the stools have changed from usual pattern and are many and watery (more water than faecal matter). The normally frequent or semi-solid stools of a breastfed baby are not diarrhoea.

THEN CHECK FOR HIV INFECTION

ASK:

- **Has the mother had an HIV test?**

If yes:

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

If yes:

- Virological test POSITIVE or NEGATIVE?
- Serological test POSITIVE or NEGATIVE?

If mother is HIV positive and there is NO positive virological test in infant,

ASK:

- Is the young infant breastfeeding now?
- Was the young infant breastfeeding at the time of test or before it?
- Are the mother and young infant on ePMTCT ARV prophylaxis?

IF NO test: Mother and young infant status unknown

- Perform HIV test for the mother. If positive, perform virological test for the young infant

Classify HIV INFECTION by test results

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
• Infant has positive virological test	**CONFIRMED HIV INFECTION**	• Give cotrimoxazole prophylaxis from age 6 weeks • Check for TB (see page 37) • Link infant to Early infant Diagnosis (EID)/Mother Baby Care point for follow up • Assess the infant's feeding and counsel as necessary • Advise the mother on home care
• Mother HIV positive AND negative virological test in young infant who is breastfeeding or stopped less than 6 weeks ago **OR** • Mother HIV positive, young infant not yet tested **OR** • Infant has positive serological test (HIV antibody test)	**HIV EXPOSED: POSSIBLE HIV INFECTION**	• Give cotrimoxazole prophylaxis from age 6 weeks • Start or continue ARV's for prophylaxis • Check for TB (see page 37) • Assess the infant's feeding and give appropriate feeding advice • Do virological test at age 6 weeks or repeat 6 weeks after the infant stops breastfeeding • Advise the mother on home care • Follow-up regularly
• HIV test not done for mother or infant	**HIV INFECTION STATUS UNKNOWN**	• Encourage HIV testing where it is available
• Negative HIV test for mother or infant	**HIV UNLIKELY**	• Treat, counsel and follow-up existing infections • Advise the mother about feeding and about her own health

THEN CHECK FOR TB

ASSESS

ASK:-

For symptoms suggestive of TB

- Has the young infant had contact with a person with Pulmonary Tuberculosis or chronic cough?
- Has the young infant had persistent fevers for 14 days or more?
- Does the young infant have pneumonia which is not responding to standard therapy?
- Has the young infant been coughing for 14 days or more?

LOOK AND FEEL

Look or feel for physical signs of TB

- Determine weight for age
  - Weight less than 1.5kg?
  - Weight for age less than -3 Z score?

Classify TB Status

SIGNS	CLASSIFY	IDENTIFY TREATMENT
Presence of ANY of the symptoms suggestive of TB OR weight less than 1.5kg or -3Z score with any symptom.	**PRESUMPTIVE TB**	• **Refer to hospital for further assessment and management** • Ask about the caregiver's health and treat as necessary
A sick young infant with no TB symptoms or signs	**NO PRESUMPTIVE TB**	• Treat, counsel, and follow up existing infections • Ask about the caregiver's health and treat as necessary

* ***Refer*** *young infants with dangers signs as well as those where TB treatment is not available.*

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

ASK:

- Is the infant breastfed? If yes, how many times in 24 hours?
- Does the infant usually receive any other foods or drinks?
  - If yes, how often?
  - If yes, what do you use to feed the infant?

LOOK AND FEEL:

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

ASSESS BREASTFEEDING:

- Has the infant breastfed in the previous hour?

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

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

- Is the infant well attached?
  not well attached good attachment

TO CHECK ATTACHMENT, LOOK FOR:
- More areola seen above infant's top lip than below bottom lip
- Mouth wide open
- Lower lip turned outwards
- Chin touching breast

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

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  not suckling effectively suckling effectively
- Clear a blocked nose if it interferes with breastfeeding.

Classify ALL FEEDING

SIGNS	CLASSIFY AS	IDENTIFY TREATMENT
• Weight < 1.5 kg, or • Weight < -3 Z score	**VERY LOW WEIGHT**	• **Treat to prevent low blood sugar.** • **Refer URGENTLY to hospital.** • Teach the mother to keep the young infant warm on the way to hospital
• Not well attached to breast or • Not suckling effectively, or • Less than 8 breastfeeds in 24 hours, or • Receives other foods or drinks, or • Low weight for age, or • Thrush (ulcers or white patches in mouth)	**FEEDING PROBLEM and/or LOW WEIGHT FOR AGE**	• If not well attached or not suckling effectively, teach correct positioning and attachment. - If not able to attach well immediately, teach the mother to express breastmilk and feed by a cup • If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Advise the mother to breastfeed as often and for as long as the infant wants, day and night. • If receiving other foods or drinks, counsel mother about breastfeeding more, reducing other foods or drinks, and using a cup. • If not breastfeeding at all: - **Refer for breastfeeding counselling and possible relactation.** - Advise about correctly preparing breastmilk substitutes and using a cup. • Check for TB (See card 37) • Advise the mother how to feed and keep the low weight infant warm at home • If thrush, teach the mother how to treat thrush at home. • Advise mother to give home care for the young infant. • Follow up FEEDING PROBLEM or thrush on day 3. • Follow up LOW WEIGHT FOR AGE on day 14.
• Not low weight for age and no other signs of inadequate feeding	**NO FEEDING PROBLEM**	• Advise mother to give home care for the young infant. • Praise the mother for feeding the infant well.

THEN CHECK THE YOUNG INFANT 'S IMMUNIZATION STATUS

	AGE	VACCINES*			
IMMUNIZATION SCHEDULE:	**Birth**	BCG**	Hep B0	OPV0	
	6 weeks	DPT+HIB-1+Hep B1	OPV-1	Rotavirus-1	Pneumococcal conjugate vaccine (PCV) 1
	10 weeks	DPT+HIB-2+Hep B2	OPV-2	Rotavirus-2	Pneumococcal conjugate vaccine (PCV) 2
		3rd dose at 14 weeks			

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

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

ASSESS YOUNG INFANT FOR OTHER PROBLEMS INCLUDING CONGENITAL MALFORMATIONS

- Ask mother for any other problem or identified external malformations
- Check child for any external malformations and abnormal signs
- **Refer infant to hospital** if they have any external malformations or problems that you cannot handle

ASSESS THE MOTHER'S HEALTH NEEDS

Ask and check for any postpartum complications such as bleeding and infections. Ask if mother has identified and has been counselled about family planning; if not link to FP clinic. If mother is an adolescent, link to appropriate clinic or service provider for support.

TREAT THE YOUNG INFANT

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

1. Give First Doses of Intramuscular Gentamicin and Intramuscular Ampicillin

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

Ampicillin: Give 50mg/kg IM

**** If refferal is not possible, continue treatment for seven days***

2. Prevent Low Blood Sugar

- ***If the young infant is able to breastfeed:***
  Ask the mother to breastfeed the young infant.
- ***If the young infant is not able to breastfeed but is able to swallow:***
  Give 20–50 ml (10 ml/kg) expressed breastmilk before departure. If not possible to give expressed breastmilk, give 20–50 ml (10 ml/kg) sugar water. ***(To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water.)***
- ***If the young infant is not able to swallow:***

  Give 20–50 ml (10 ml/kg) of expressed breastmilk or sugar water by nasogastric tube.

3. Keep the Young Infant Warm on the Way to the Hospital

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

4. Refer Urgently

- **Write a referral note for the mother to take to the hospital.**
- ***If the infant also has SOME DEHYDRATION OR SEVERE DEHYDRATION and is able to drink:***

  Give the mother some prepared ORS and ask her to give frequent sips of ORS on the way. Advise mother to continue breastfeeding.

PLAN C : TREAT SEVERE DEHYDRATION QUICKLY

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

Can you give intravenous IV fluid immediately?

YES →

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

AGE	First give 30 ml/kg in :	Then give 70 ml/kg in :
Infants (under 12 months)	1 hour	5 hours

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

NO ↓

Is IV treatment available nearby (within 30 minutes)?

YES →

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

NO ↓

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

NO ↓

Can the young infant drink?

YES →

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

NO ↓

Refer URGENTLY to hospital for IV or NG treatment.

NOTE:

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

6. How to Give Oral Medicines at Home

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

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

7. Give Oral Amoxicillin

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

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

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

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

PLAN A: TREAT DIARRHOEA AT HOME

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

1. **Give Extra Fluids**
2. **When to Return**

1. ***GIVE EXTRA FLUID*** **(as much as the young infant will take) TELL THE MOTHER:**

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

It is especially important to give ORS at home when:

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

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

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

Up to 2 years, 50 to 100 ml after each loose stool

Tell the mother to:

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

2. WHEN TO RETURN

PLAN B: TREAT SOME DEHYDRATION WITH ORS

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

WEIGHT	**< 6 kg**
AGE*	**Up to 4 months**
ORS	200 – 450 ml

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

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

SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.

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

AFTER 4 HOURS:

- Reassess the young infant and classify the infant for dehydration.
- Select the appropriate plan to continue treatment.
- **Continue breastfeeding the young infant in clinic**.

IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:

- Show her how to prepare ORS solution at home.
- Show her how much ORS to give to finish 4-hour treatment at home.
  Give her enough ORS packets to complete rehydration. Also give her 2 packets as recommended in **Plan A**.

Explain the Rules of Home Treatment for Young Infant:

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

Start Treatment for The Young Infant with TB

All TB medicines should be taken under direct observation by a treatment supporter (Directly Observed Therapy – DOT). TB treatment is divided into 2 phases: an initial (intensive) phase for 2 months and a continuation phase for 4 or 10 months depending on the type of TB disease. TB treatment regimen are documented in a standard format, e.g. 2RHZE/4RH where:-

- Letters represent abbreviated anti-TB medicine names (R - Rifampicin; H – Isoniazid;
- Z – Pyrazinamide; E – Ethambutol)
- Numbers represent the duration in months / (forward slash sign) division between treatment phases

TB treatment regimen for a young infant who is diagnosed with TB

Types of disease	REGIMEN	
	Intensive phase	Continuation phase
All forms of TB (excluding TB meningitis and Bone TB)	2RHZE	4RH
TB meningitis Bone (Osteoarticular) TB	2RHZE	10RH

** Ethambutol is safe for use in children provided the dose is within the recommended range.*

** Streptomycin is no longer recommended for use in children with TB.*

** Children with TB meningitis or airway obstruction due to TB adenopathy should be **referred to hospital.***

** Children diagnosed with drug resistant TB should be **referred** to the nearest MDR TB treatment site for further management.*

Dosage of anti-TB medicines by weight band

Weight bands	Number of tablets		
	Intensive Phase(2 months)		Continuation Phase (4 months)
	RHZ 75/50/150	E100	RH 75/50
4-7 kg	1	1	1
8-11 kg	2	2	2
12-15 kg	3	3	3
16-24 kg	4	4	4

** Continuation phase: 4 months for all forms of TB (excluding TB meningitis and Bone TB) and 10 months for TB meningitis and Bone TB.*

** Give pyridoxine at a dose of 12.5 mg/day for children < 5 years in addition to anti-TB medicines. However, absence of pyridoxine should not stop a health worker from initiating TB treatment.*

Start Young Infant With TB Exposure On Isoniazid Preventive Therapy

Isoniazid reduces the risk of TB development among young infants and children with a history of TB exposure as well as infants living with HIV. Isoniazid is given at a dose of 10mg/kg/ day for 6 months

Dosage of Isoniazid by weight band

Tablet strength	Weight band				
	3–5.9 kg	6–9.9 kg	10–13.9 kg	14–19.9 kg	20–24.9 kg
Isoniazid 100 mg	½ Tablet	1 Tablet	1½ Tablets	2 Tablet	2½ Tablets

** Give pyridoxine at a dose of 12.5 mg/day for children < 5 years in addition to Isoniazid. However, absence of pyridoxine should not stop a health worker from initiating TB treatment.*

How to Treat Local Infections at Home

- Explain how the treatment is given.

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

To Treat Skin Pustules or Umbilical Infection

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

- Wash hands
- Gently wash off pus and crusts with soap and water
- Dry the area
- Paint the skin or umbilicus/cord with full strength gentian violet (0.5%)
- Wash hands again

To Treat Thrush (ulcers or white patches in mouth)

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

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

COUNSEL THE MOTHER

1. Correct Positioning and Attachment for Breastfeeding

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

2. How to Express Breastmilk

Ask the mother to:

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

3. How to Feed by a Cup

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

4. How to Keep the Low Weight Infant Warm at Home

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

5. How to Give Home Care for the Young Infant

1. **EXCLUSIVELY BREASTFEED THE YOUNG INFANT (for breastfeeding mothers)**
   - Give only breastfeeds to the young infant.
   - Breastfeed frequently, as often and for as long as the infant wants, day or night, during sickness and health.
2. **MAKE SURE THAT THE YOUNG INFANT IS KEPT WARM AT ALL TIMES**
   - In cool weather cover the infant's head and feet and dress the infant with extra clothing.
3. **WHEN TO RETURN:**

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

WHEN TO RETURN IMMEDIATELY:

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

- Breastfeeding poorly
- Reduced activity
- Becomes sicker
- Develops a fever
- Feels unusually cold
- Develops fast breathing
- Develops difficult breathing
- Palms or soles appear yellow

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

1. Pneumonia or Severe Disease

Follow up on day 4 of treatment.

→ Reassess the young infant for POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE, PNEUMONIA AND LOCAL INFECTION as on page 2.

→ ***Refer young infant if:***

- **Infant becomes worse after treatment is started or**
- **Any new sign of VERY SEVERE DISEASE appears while on treatment**

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

→ Ask the mother to bring the young infant back in 4 more days.

→ Young infants with fast breathing alone should be checked as often as possible but it is mandatory to do so on day 4 of treatment.

2. Local Infection

On day 3 of treatment:

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

Treatment:

→ If umbilical ***pus or redness remains same or is worse***, **refer to hospital.** If ***pus and redness are improved***, tell the mother to continue giving the 5 days of antibiotic and continue treating the local infection at home.

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

3. Jaundice

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

→ If palms or soles are yellow, **refer to hospital.**

→ If palms or soles are not yellow, but jaundice **has not decreased**, advise the mother about home care and ask her to return for follow up again tomorrow.

→ If jaundice has **started decreasing**, reassure the mother and ask her to continue home care. Ask her to return for follow up at 3 weeks of age.

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

4. Diarrhoea

On day 3,

ASK: Has the diarrhoea stopped?

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

5. Feeding Problem

On day 3:

Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" above (page 6 or 7). Ask about any feeding problems found on the initial visit.

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the young infant back again.
- If the young infant is low weight for age, ask the mother to return 14 days after the initial visit to measure the young infant's weight gain.

Exception:

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

6. Low Weight For Age

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

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

Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" on page 6 or 7.

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

Exception:

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

7. Thrush

On day 3 of treatment:

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

Reassess feeding. Use "Then Check for Feeding Problem or Low Weight for Age" (page 6 or 7).

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

ANNEX

ANNEX1

Assess child development milestones

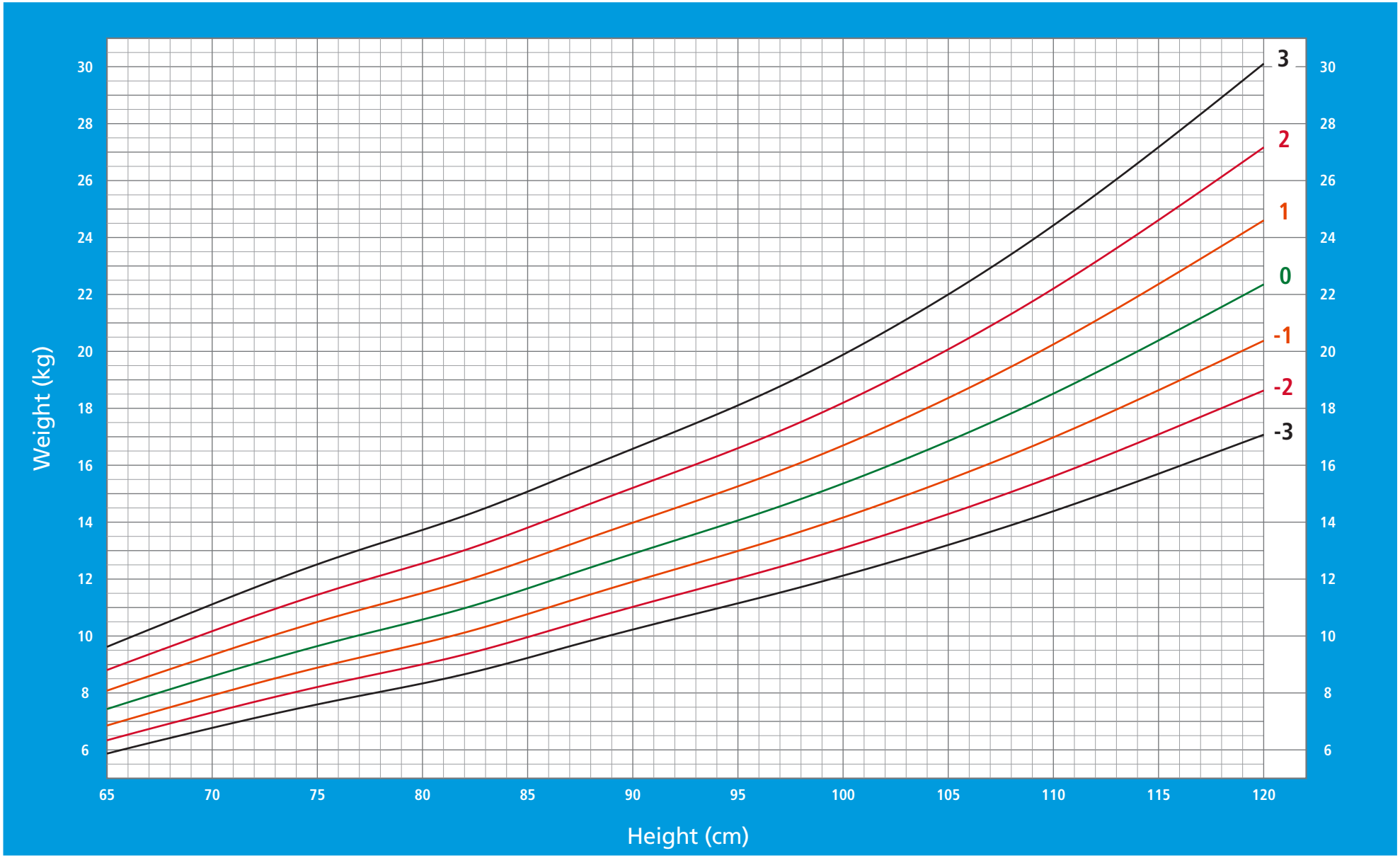
AGE	GROSS MOTOR	FINE MOTOR	SPEECH AND LANGUAGE	ADAPTIVE AND SOCIAL SKILLS
6 weeks	Prone-lifts-chin intermittently			
10 weeks	Prone- arms extended forward	Pulls at clothes	Coos	
14 weeks	Prone-raises head and chest, rolls rolls over front to back, no head lag	Reach and grasp, objects to mouth	Responds to voice	
6 months	Prone-weight on hands, tripod sit	Ulnar grasp	Begins to babble, responds to name	Stranger anxiety
9 months	Pulls to stand	Finger-thumb grasp	Mama, dada, imitates one word	Plays games, separation anxiety
12 months	Walks with support, "cruises"	Pincer grasp, throws	2 other words with meaning besides mama or dada	Plays peek-a-boo, drinks with cup
15 months	Walks without support	Draws a line	Jargon	Points to needs
18 months	Up steps with help	Piles up to three levels, scribbling	10 words, follows simple commands	Uses spoon, points to body parts
24 months	Up 2 feet per step, runs, kicks ball	Piles things up to six levels, undresses	2–3 word phrases, uses I, me, you, 25% intelligible	Parallel play, helps to undress

w

Weight-for-height BOYS

2 to 5 years (z-scores)

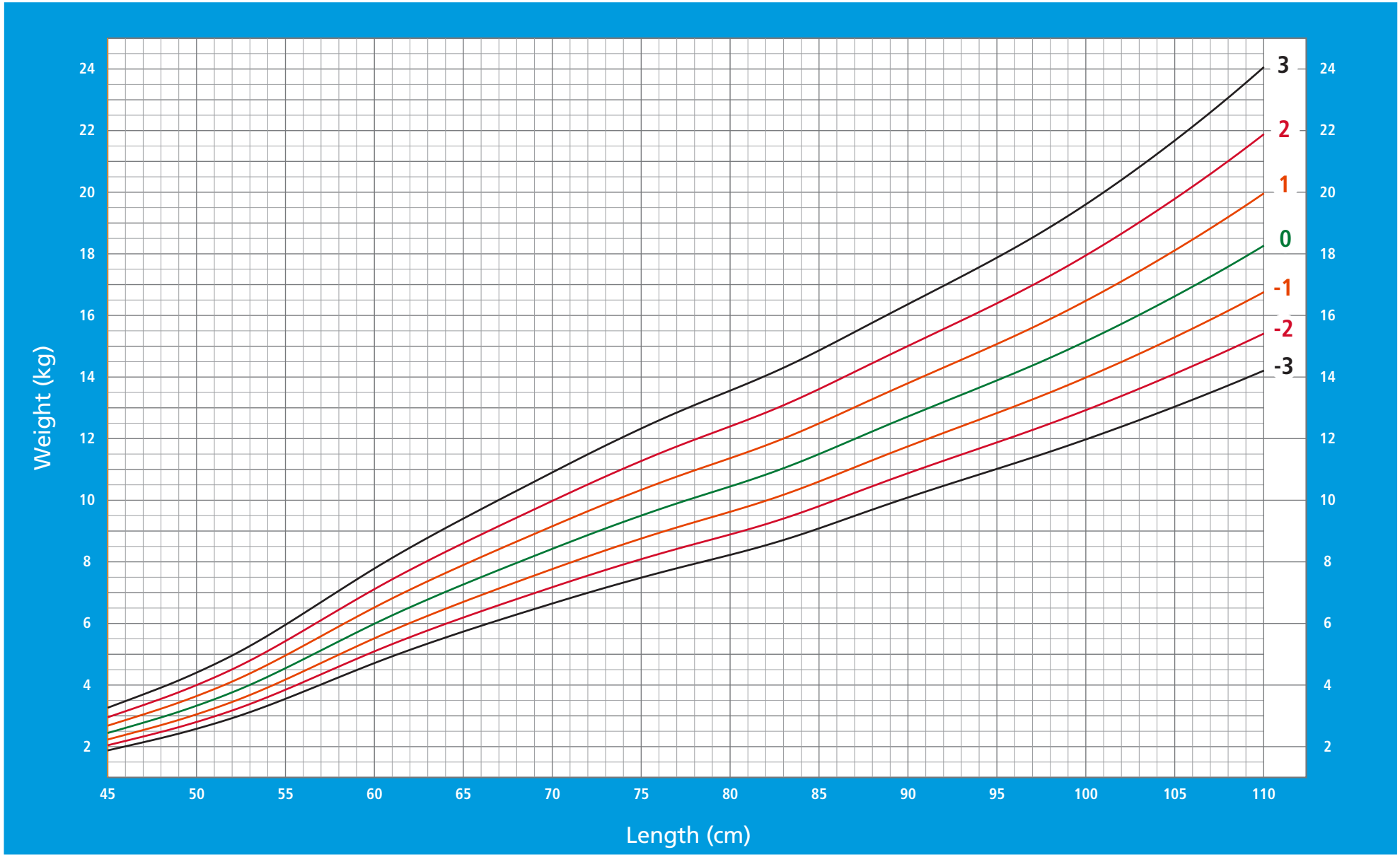
World Health Organization



Weight-for-length BOYS

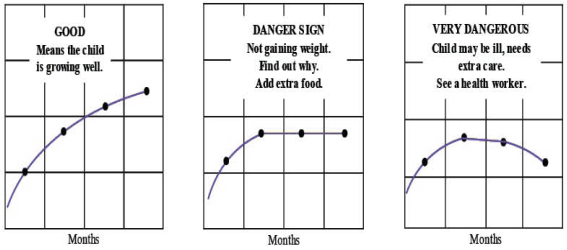
Birth to 2 years (z-scores)

World Health Organization

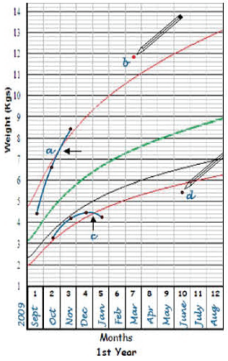


ANNEX4

Watch the line showing the child's growth:
The growth curve should continue to go up every time you have your child weighed.



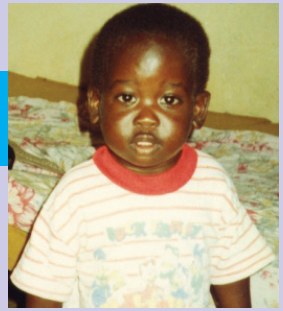
- A child is severely over-weight for his or her age when the growth line crosses the upper-most curve ("a") or the weight lies above the upper-most curve ("b")
- A child is severely under-weight when the growth curve crosses the lower-most curve ("c") or the weight lies below the lower-most curve ("d")



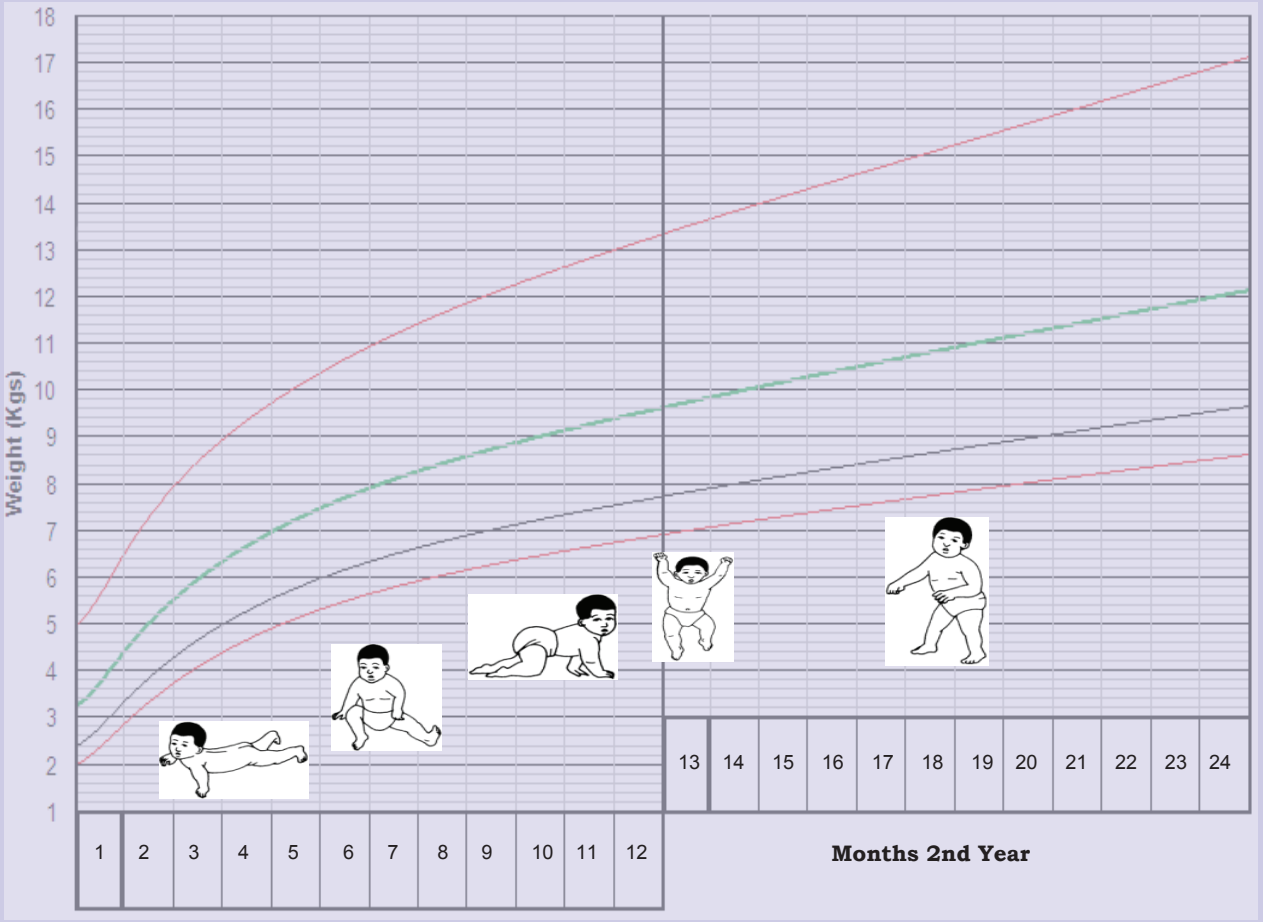
Spend time with your child. Playing with him or her; talking to him or her; and encouraging him or her to learn will help him or her to develop.

GROWTH CHART

Weight for age: BOY (Birth to 2 years)



IMPORTANT: Give your baby only breast milk for the first 16 months
Add foods and other liquids only at 6 months

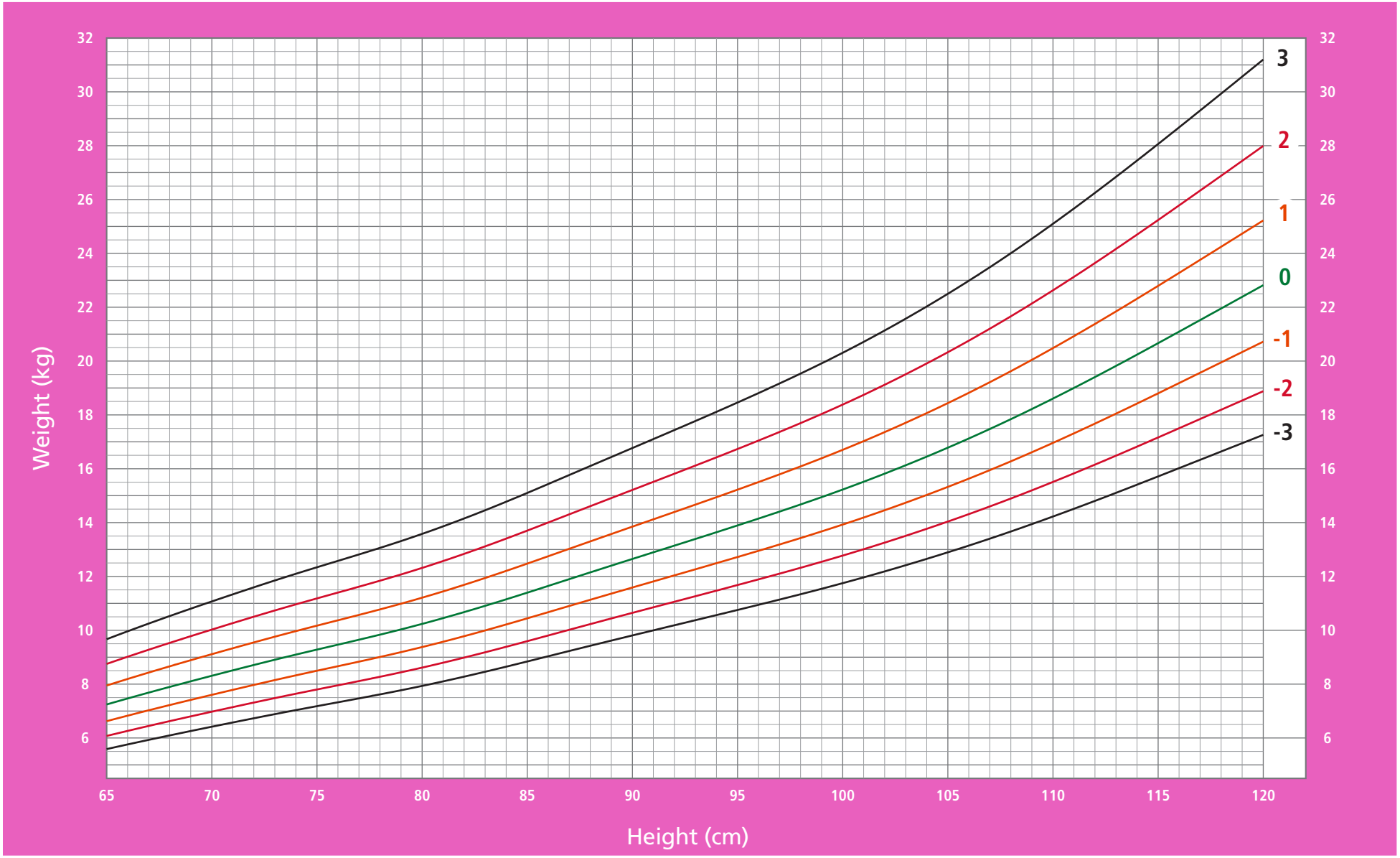


Weight the child during each visit, properly record on the card and interpret to the mother or caretaker

Weight-for-Height GIRLS

2 to 5 years (z-scores)

World Health Organization

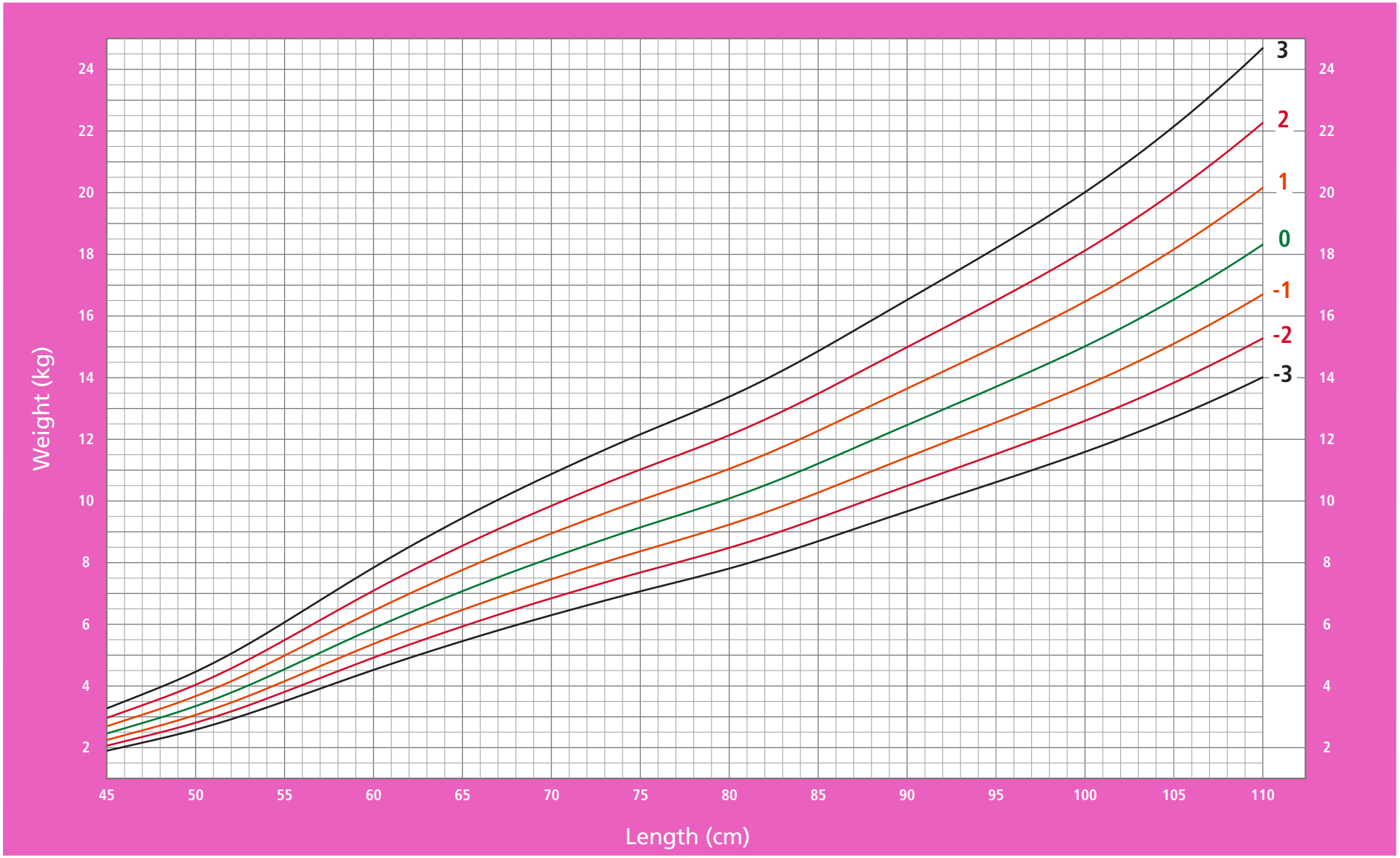


WHO Child Growth Standards

Weight-for-length GIRLS

Birth to 2 years (z-scores)

World Health Organization



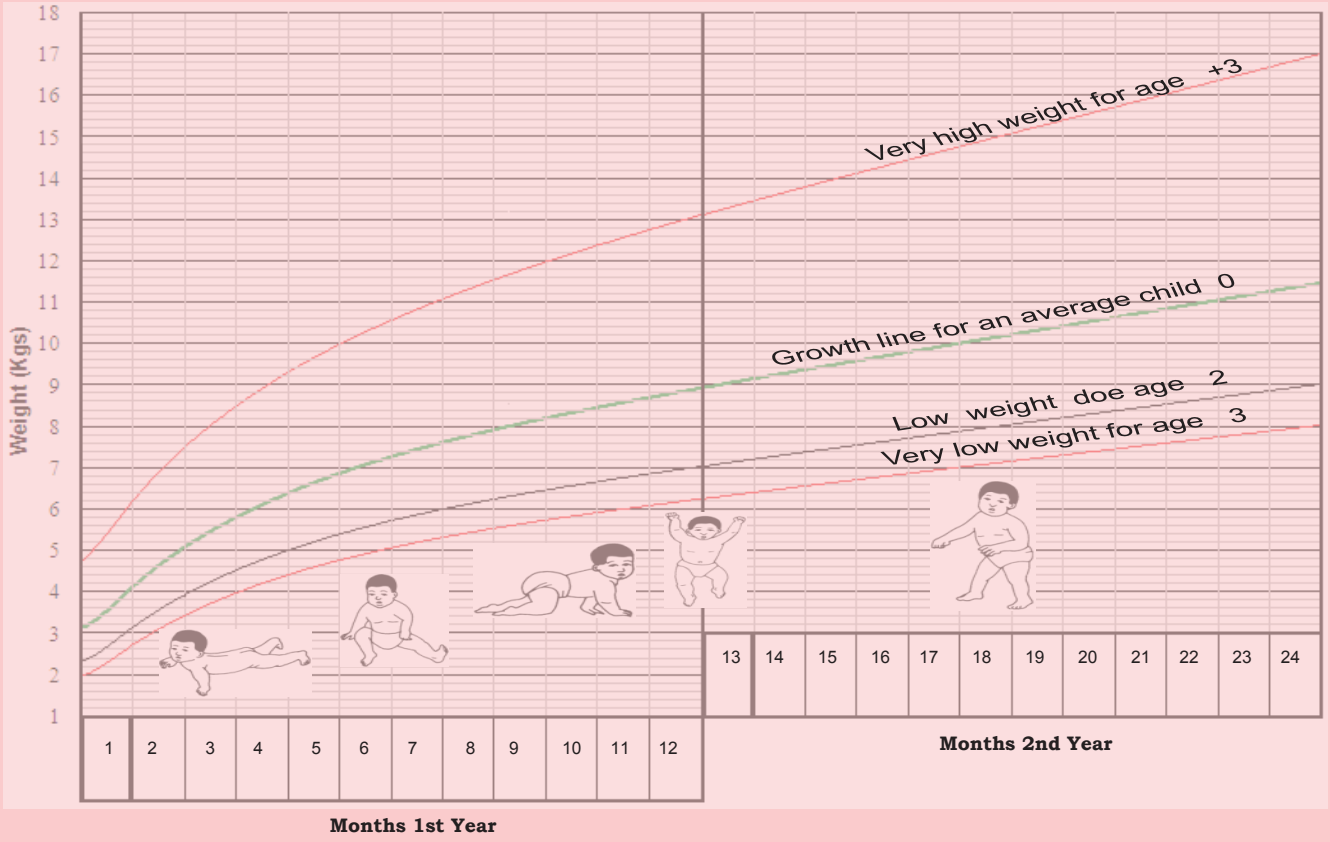
WHO Child Growth Standards

ANNEX7

GROWTH CHART

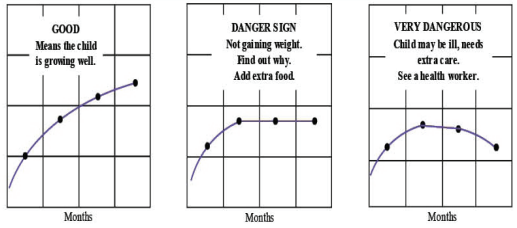
Weight for age: GIRL (Birth to 2 years)

IMPORTANT: Give your baby only breast milk for the first 16 months
Add foods and other liquids only at 6 months

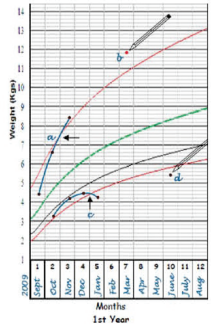


Weight the child during each visit, properly record on the card and interpret to the mother or caretaker

Watch the line showing the child's growth:
The growth curve should continue to go up every time you have your child weighed.



- A child is severely over-weight for his or her age when the growth line crosses the upper-most curve ("a") or the weight lies above the upper-most curve ("b")
- A child is severely under-weight when the growth curve crosses the lower-most curve ("c") or the weight lies below the lower-most curve ("d")



Spend time with your child. Playing with him or her; talking to him or her; and encouraging him or her to learn will help him or her to develop.

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