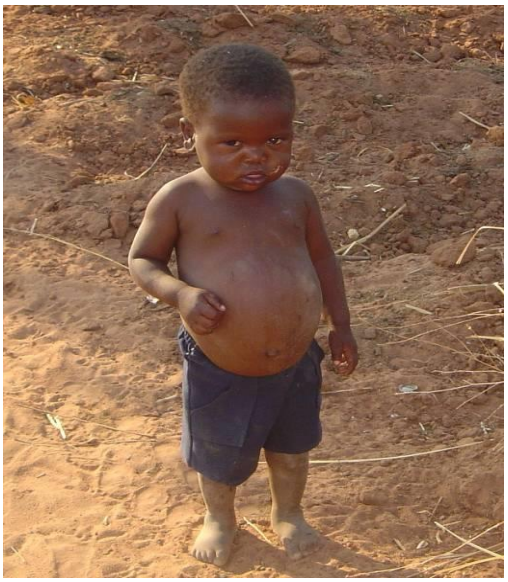
Integrated Management of Childhood Illness

Caring for Newborns and Children in the Community

Manual for the Health Surveillance Assistant

Revised version includes Community Management of Acute Malnutrition



Caring for the sick child in the community

Identify signs of illness, and decide to refer or treat the child

World Health Organization

unicef

Acknowledgements

The 2021 Edition of the Manual 'Caring for Newborns and Children in the Community' was adapted from the 2015 edition that included childhood TB, HIV and Child Protection. The original 2008 version was adapted from World Health Organisation (WHO) y the IMCI unit. The 2021 edition has been prepared specifically to integrate treatment protocols for Community Management of acute malnutrition (CMAM) within Integrated Community Case Management (iCCM).

The manual covers early identification and management of diarrhoea, pneumonia, malaria, malnutrition and eye infection.

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Contents

1. Introduction:

Situation analysis

The Ministry of Health (MoH) has been implementing a successful IMCI strategy since 1998 to deal with the high under-five morbidity and mortality. IMCI is a broad strategy with an overall objective of contributing to reducing childhood illnesses and deaths in developing countries (UNICEF and WHO, 2010). It encompasses a range of interventions through a holistic approach to prevent illness and reduce deaths from common childhood conditions as well as promoting child health and development at health facility, community and household levels (Ministry of Health, 2006a:3).

The Ministry also adopted the Community-based Management of Acute Malnutrition (CMAM) approach in 2006 to manage acute malnutrition in under- fifteen years children. CMAM is rooted in the public health principles of ensuring effective coverage and access to services. It is designed to achieve population-wide impact by focusing primarily on treating most acutely malnourished children as outpatients in their homes using existing community-based structures (Malawi. Community-based Management of Acute Malnutrition, 2016). Relatively few cases (about 10–20 percent) of children with severe acute malnutrition (SAM) develop medical complications and require treatment in 24-hour inpatient care facilities in the nutrition rehabilitation unit (NRU) (Collins and Sadler 2002).

Health Surveillance Assistants (HSAs) implementing iCCM assess children for acute malnutrition. However, children found with acute malnutrition are not treated but referred for treatment to the nearest health facility. One of the components of CMAM approach is community outreach which involves cases identification and treatment which could be offered at village clinic level. In view of this, the ministry, through I MCI and Nutrition units has decided integrate the treatment of acute malnutrition in the IMCI protocol. The integration of acute malnutrition treatment at village clinic level will reduce delays in management of acute malnutrition from health facility level.

The IMCI strategy has three main objectives. Firstly, it aims at improving health workers' skills through training of health workers in the integrated management of sick children. Secondly, it endeavours to improve the availability of essential medicines and referral mechanism, and thirdly, it aims at improving and promoting family and community childcare practices for child survival, growth and development. The three objectives constitute the components of the strategy. The three components were not implemented concurrently in that while component one started in 1998, the third component started in 2000. By 2006 when the IMCI policy was launched, the IMCI approach was scaled up to all districts. The 2003 Lancet child survival publication inspired the development of the ACSD policy and Strategic Plan (2008 to 2012) on focussing on the 15 high impact interventions.

Although the risk of death is high in the first month of life when 40% of deaths take place, the remaining 60% of deaths occur between 1-59 months (UN Report 2011). The major causes of under-five deaths in Malawi are malaria (17%), HIV/AIDS (14%), pneumonia (11%), and diarrhoea (11%) (Black et al, 2010).

According to the 2015 – 2016 DHS the prevalence of pneumonia in under-five children is 7%, of which 78% receive antibiotic treatment for pneumonia. The prevalence of diarrhoea is at 22% and stunting at 37%, malaria at 29%. Among children 6-59 months 64% receive vitamin a supplementation. The proportion of children sleeping under Long Lasting Insecticide Net (LLIN) is 38.4% and the proportion of children fully immunised is at 76%.. Early HIV testing for

infected infants is at 43% (HIV Unit 3rd quarter report 2014). *Stunting is at 37%, underweight is at 12%, wasted is at 3% and micronutrient deficiencies*

From 2008 IMCI has focussed on Community Case Management in which HSAs are trained and deployed in hard to reach areas where access to health services was restricted by distance (more than 5km) and other geographical features. The HSAs are entrusted to open village clinics where they manage uncomplicated cases of malaria, pneumonia, diarrhoea, uncomplicated severe acute malnutrition cases, newborn sepsis eye infection and refer the severe cases to the higher-level health facilities. To date CCM is implemented in all the 29 health districts with partners allocated to support specific districts.

Course objectives

This course on *Caring for Newborns and Children in the Community* helps you support families to provide good care for their children. It is part of the strategy called Integrated Management of Childhood Illness (IMCI).

In this manual you will learn to identify signs of illness in a sick child, age 2 months up to 5 years. Some children you will refer to the health facility for more care. For some children, you will help their families treat them at home. You will later learn more about how to treat a child with diarrhoea, fever, fast breathing, acute malnutrition at home.

This course also includes the actions that a HSA should take in high HIV or TB settings to identify sick children who have HIV, or risk of HIV or TB, in addition to the current illness, and see that they are taken to a health facility for assessment and any special care needed.

At the end of the training, you will be able to:

- Identify signs of common childhood illness and acute malnutrition.
- Assess whether the sick child has HIV, is at risk of HIV, or is exposed to TB in the household and acute malnutrition
- Decide whether to refer a child to a health facility, or to help the family treat the child at home.
- Assist the family with a child who is referred to a health facility.
- Help the family treat the child's illness and acute malnutrition at home.
- Counsel families to bring a child immediately, if the child becomes sicker, and to return for scheduled follow-up visits.
- Identify the child's progress and ensure good care at home; and, if the child does not improve, to refer the child to the health facility.
- Advise families on sleeping under a bed net and consumption of six food groups
- Use a Sick Child Recording Form to guide the tasks in caring for a sick child and to record decisions and actions.

With this training, you can be a more valuable member of your community.

Course methods and materials

In this course, you will read about, observe, and practise the case management tasks.

The course provides these materials:

- Manual for the Health Surveillance Assistant
- You are now reading the HSA Manual. It contains the content, discussions, and exercises for the course Caring for Children in the Community.
- Sick Child Recording Form
- The recording form also is a guide to identify signs of illness and refer or treat the child. On the form, you will record information on the child and the child's family. You will also record the child's signs of illness, treatments, and other actions.
- RDT and Rectal Artesunate administration guide
- Nutrition counselling cards
- RUTF , Treatment Guide

Other materials

- The facilitator will use photos, videotapes, and other materials to introduce and review the case management tasks.

You will have many chances to practise what you are learning: written exercises, games, and role plays in the classroom; and skill practice in the clinic and hospital.

Also, you will practise your new skills in the community. Towards the end of this training, the facilitator will discuss ways to supervise you as you continue to develop your skills in the community.

Caring for children in the community

Case Study 1

Two-year-old Linda has diarrhoea. She needs to go to the health facility. The health facility, however, is very far away. Mrs. Shaba, her mother, is afraid that Linda is not strong enough for the trip.

So Mrs. Shaba takes her daughter to see the Health Surveillance Assistant. The Health Surveillance Assistant asks questions. He looks at Linda from head to toe. Linda is weak. The Health Surveillance Assistant explains that Linda is losing a lot of fluid with the diarrhoea. She is in danger from dehydration. Linda needs medicine right away. The Health Surveillance Assistant praises Mrs. Shaba for seeking help for Linda.

The Health Surveillance Assistant shows Mrs. Shaba how to prepare Oral Rehydration Salts (ORS) solution and how to give it slowly with a spoon. Linda eagerly drinks the ORS solution and becomes more awake and alert. Mrs. Shaba continues to give Linda the ORS solution until Linda no longer seems thirsty and is not interested in drinking. The Health Surveillance Assistant then gives Mrs. Shaba more ORS packets for her to use at home. He explains when and how much ORS solution to give Linda.

Before Mrs. Shaba leave, the Health Surveillance Assistant dissolves a zinc tablet in water for Mrs. Shaba to give Linda by spoon. He gives Mrs. Shaba a packet of zinc tablets and asks her to give Linda one tablet each morning until all the tablets are gone. The zinc will help prevent Linda from having severe diarrhoea for the next few months.

The Health Surveillance Assistant also explains how to care for Linda at home. Mrs. Shaba should give breast milk more often, and continue to feed Linda while she is sick. If she becomes sicker or has blood in her stool, Mrs. Shaba should bring Linda back immediately.

Even if Linda improves, the Health Surveillance Assistant wants to see her again. Mrs. Shaba agrees to bring Linda back in 3 days for a follow up visit.

Mrs. Shaba is grateful. Linda has already begun treatment. If Linda gets better, they will not need to go to the health facility. And soon Linda will be smiling and playing again

Discussion: Care-seeking in the community

Your facilitator will lead a group discussion with these questions.

Common childhood illnesses. In your community, what are the most common illnesses children have?

Cause of deaths. Do you know any children under 5 years old who have died in your community?

If so, what did they die from?

Where families seek care. When children are sick in your community, where do their families seek help?

__ Neighbour or another family member
__ Traditional healer
__ Health Surveillance Assistant
__ Private doctor
__ Hospital
__ Health facility
__ Drug seller
__ Other? _____

Where do families usually first seek care for their sick children?

For what reason?

What determines whether families seek care for their sick children at the hospital?

Time to health facility. How long does it take to go from your community to the nearest health facility? And how—by transportation or by foot?

What Health Surveillance Assistants can do

Children can become sick many times in a year. Children often have cough, diarrhea, acute malnutrition fever.

Sometimes these illnesses become very severe, especially when children are weak from poor nutrition or have HIV. Children who have both HIV and poor nutrition are at much higher risk of dying.

The health facility (hospital or outpatient health facility) can provide life-saving care. However, some children, like Linda, have difficulty going to a health facility. Their families may not know they should seek care. The health facility may be far. Transportation and medicine may be expensive. The health facility staff may seem unfriendly. Unfortunately, there are many reasons that sick children die without going to a health facility.

Linda has a better chance to survive because one of her neighbours is a Health Surveillance Assistant. Trained Health Surveillance Assistants identify signs of illness and help families take care of their sick children at home.

HSAs can also identify sick children who are at risk of HIV or TB and refer them to a health facility for testing and special care if needed. Some children are too sick to be treated at home. Health Surveillance Assistants help families take their very sick children to a health facility.

Health Surveillance Assistants can identify and treat acute malnutrition and conduct follow ups to all malnourished children treated at the village clinic.

HSAs also promote good health. They advise families on how to care for their children at home. They help families prevent illness, give their children nutritious food, and take them for vaccinations. They support families as they teach their children the first steps to becoming happy and productive adults. Health Surveillance Assistants also organize their communities. They help their neighbours make a safer environment, and demand health and other services for children.

Take-home messages for this section:

- Children under 5 years of age die mainly from: pneumonia, diarrhoea, malaria, and acute malnutrition, HIV and AIDS-related diseases. All of these can easily be treated or prevented.
- There are many reasons that affect why and where families take their children for care.
- You will be able to treat many children in the community, and for those you cannot treat, you will refer them to the nearest health facility.

2. Welcoming the caregiver and child

At the end of this session, you will be able to:

- Greet and welcome a caregiver, and ask questions about her child
- Start to use the Sick Child Recording Form.

Who is the caregiver?

The caregiver is the most important person to the young child. The caregiver feeds and watches over the child, gives the child affection, communicates with the child, and responds to the child's needs. If the child is sick, the caregiver is usually the person who brings the child to you.

Who are caregivers in your community?

Often the caregiver is the child's mother. But the caregiver may be the father or another family member. In some communities, children have several caregivers. A grandmother, an aunt, an older sister, a worker at the community child care centre and a neighbour may share the tasks of caring for a child.

Important things are to encourage caregivers to bring all sick children to you without delay. If they have any questions or concerns about how to care for the child, welcome them. If the child cannot come to you, you may visit the child at home.

TIP: Greet caregivers in a friendly way whenever and wherever you see them.

Through good relationships with caregivers, you will be able to improve the lives of children in your community.

Ask about the child and caregiver

Greet the caregiver. Invite the caregiver to sit with the child in a comfortable place while you ask some questions. Sit close, talk softly, and look directly at the caregiver and child.

Communicate clearly and warmly.

Ask questions to gather information on the child and the caregiver. Listen carefully to the caregiver's answers. Record information about the child and the visit on a Sick Child Recording Form

[The facilitator will now give you a recording form.]

During the course, you will learn about the recording form, section by section. We will now start with the information on the top of the form.

- **Date:** the day, month, and year of the visit.
- **HSA:** the full name of the Health Surveillance Assistant seeing the child.
- **Child's name:** the first name and surname.
- **Other information on the child:**
- Write the **age** in years and/or months
    - Circle **boy** or **girl.**
    - **Caregiver's name, and relationship to child** Write the caregiver's name.
    - Circle the relationship of the caregiver to the child: **Mother, Father,** or **Other**. If other, describe the relationship (for example, grandmother, aunt, or neighbour).
    - **Address** or **Community:** to help locate where the child lives, in case the Health Surveillance Assistant needs to find the child.

TIP: Be ready with the following—

- Sick child recording form
- Pencil -
- Keep nearby— Medicine (ORS, zinc, antimalarial, and antibiotic)
- RUTF, albendazole, measles vaccine)
- Utensils to prepare and give ORS solution and other medicines

What do we know about Grace from the information on her recording form below?

Sick Child Recording Form

(for community -based treatment of child age 2 months up to 5 years)

Date: 16/5/2008 (Day/Month/Year) **HSA:** John Banda

Child's First **Name:** Grace Surname Wadza Age: 2 Years/ 2 Months Boy / (Girl)

Caregiver's name: Patricia Wadza **Relationship:** (Mother) / Father / Other: _____

Physical Address: behind Hilltop Mosque **Village / TA:** Ntonya / Malambe

Exercise: Use the recording form (1)

You will now practise completing the top of the recording form.

Child 1: Jenala Mariko

First, write today's date—the day, month, and year—in the space provided on the form below. You are the Health Surveillance Assistant. Write your full name.

Jenala Mariko is a 3 year old girl. Her mother Joyce Mariko brought her to your home. Her address is near Mataka C.C.A.P. church, village headman Mulamba, T.A.Chongoni. Complete the recording form below.

Sick Child Recording Form

(for community –based treatment of child age 2 months up to 5 years)

Date: _____/____/_____ (Day/Month/Year) HSA: _____

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____ **Village / TA:** _____

Child 2: Comfort Kazombo

Comfort Kazombo is a 4 month old boy. His father, Paul Kazombo, brought Comfort to see you. He usually takes care of the baby. The Kazombos live near you at Chitala Farm, VH Palasa, TA Nyanja. Complete the recording form below.

Sick Child Recording Form

(for community –based treatment of child age 2 months up to 5 years)

Date: _____/____/_____ (Day/Month/Year) **HSA**: _____

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____ **Village / TA:** _____

[Did you remember to add today's **date** and your **full name**?

Take-home messages for this section:

- The way you greet and talk with a caregiver is very important; she or he must be made to feel comfortable.
- Good relationships will help you to improve the lives of children in your community.

3. Identify problems

Next you will identify the child's health problems and signs of illness. Any problems you find will help to decide whether to:

- **Refer** the child to a health facility or
- **Treat** the child at home and **advise** the family on home care.

To identify the child's problems, first ASK the caregiver. Then LOOK at the child for signs of illness.

ASK: What are the child's problems?

Ask the caregiver, "**What are the child's problems?"** These are the reason the caregiver wants you to see the child.

The recording form lists common problems. A caregiver may report **cough, diarrhoea, diarrhoea with blood in stool, fever, convulsions, difficult drinking or feeding,** and **vomiting**, or other problems**.**

☐ Cough

If the child has cough, ask, *"For how long?"* Write how many days the child has had cough.

☐ Diarrhoea (3 or more loose stools in 24 hours)

If the child has diarrhoea, ask, *"For how long?"*

Use words the caregiver understands. For example, ask whether the child has had loose or watery stools. If yes, then ask how many times a day. It is diarrhoea when there are *3 or more loose or watery stools in a 24-hour day.* Frequent passing of normal, formed stools is not diarrhoea.

☐ Blood in stool

If the child has diarrhoea, ask, "Is there blood in the stool?" Check the caregiver understands of what blood in stool looks like.

☐ Fever (now or in the last 3 days)

Identify fever by the caregiver's report or by feeling the child. For the caregiver's report, ask, *"Does the child have fever now or did the child have fever anytime during the last 3 days?"* You ask about fever anytime during the last 3 days because fever may not be present all the time. If the caregiver does not know, feel the child's forehead. If the body feels hot, the child has a fever now.

If the child has fever, ask, *"When did it start?"* Record how many days since it started. The fever does not need to be present every day, all the time. Fever caused by malaria, for example, may not be present all the time, or the body may be hotter at some times than other times.

☐ Convulsions

During a convulsion, also called fits or spasms, the child's arms and legs stiffen. Sometimes the child stops breathing. The child may lose consciousness and for a short time cannot be

awakened. When you ask about convulsions, use local words the caregiver understands to mean a convulsion from this illness. Ask whether there was a convulsion in this episode of illness.

☐ Difficult drinking or feeding

Ask if the child is having any difficulty in drinking or feeding. If there is a problem, ask: *"Is the child not able to drink or feed anything at all?"* A child is not able to drink or feed if the child is too weak to suckle or swallow when offered a drink or breast milk.

TIP: If you are unsure whether the child can drink, ask the **caregiver** to offer a drink to the child.

For a child who is breastfed, see if the child can breastfeed or take breast milk from a cup.

☐ Vomiting

If the child is vomiting, ask: "Is the child vomiting everything?" A child who is not able to hold anything down at all has the sign "vomits everything". Ask the caregiver how often the child vomits. Is it every time the child swallows food or fluids, or only some times? A child who vomits several times but can hold down some fluids does not "vomit everything". The child who vomits everything will not be able to use the oral medicine you have in your medicine kit.

☐ Red eye

Ask the caregiver if the child has red eyes. Ask for how long the child has had the red eye. Record how many days it has been present.

A child who presents with red eyes may have redness of the eye, pus discharge and / or swollen sticky eyes. A child with red eye could have problems in seeing. You also need to ask for the duration the child has had difficulties in seeing. Prolonged red eyes with difficult seeing may lead to blindness.

☐ HIV

Ask if the child has HIV. If the mother says "Yes," the child has this sign. If the mother says "No," or "I don't know," go to the next question.

About HIV transmission

HIV is a virus infection. Transmission may occur:
Through unprotected sex with a person who has HIV
Through sharing of needles or blades (e.g. between intravenous drug users)
From a mother who has HIV to her baby:
during pregnancy
during labour and delivery
during breastfeeding

HIV <u>cannot</u> be transmitted by:
Touching or hugging a person who has HIV
Using the same eating utensils as a person who has HIV
Using the same toilet or chair as a person who has HIV
Mosquitoes

Preventing transmission of HIV

Using condoms will prevent transmission of HIV and other infections during sexual contact. Condoms must be used even while a woman is pregnant and while breastfeeding.

A pregnant woman who has HIV can prevent passing HIV to her baby by taking ARVs. ARVs are available at health facilities.

It is important that all adults have an HIV test to learn their HIV status, so that they can know how to best protect themselves and their partners.

If a person has HIV, daily ARVs can improve his or her own health and prevent transmission to others.

If a person does not have HIV, he or she should practice safe sex using condoms to prevent becoming infected with HIV.

In either case, the couple should share their HIV status with each other, and find out how to best care for their health and support each other

☐ At risk of HIV

To determine whether the child is at risk of HIV, **ask whether one or both parents have HIV**. This question aims to determine whether there is a risk that the child was infected with HIV during pregnancy or breastfeeding.

If a parent or caregiver chooses not to answer whether one or both parents have HIV, you may explain that the answer will remain confidential, or private, and will not be shared with anyone. Explain that you will use the information only to assess whether the child's illness could be related to having HIV. If the individual still chooses not to answer, consider the parents' HIV status unknown.

Also, ask if the child has been tested for HIV.

If one or both parents have HIV and the child has not been tested, there is a risk that the child may have HIV. Also, if the parents' HIV status is unknown (to them or to the HSA), the risk of HIV cannot be ruled out; therefore, there is a risk that the child may have HIV.

If both parents are known to NOT have HIV, or if the child was tested and found NOT to have HIV, the HSA can conclude that the child is not at risk of HIV.

☐ Lives in household with someone on TB treatment

Ask the caregiver if anyone living in the household with the child is on treatment for TB. If so, the child is exposed to TB.

TB is spread from person to person through the air. If a person has TB of the lung and they cough, sneeze or spit, the TB germs are propelled into the air. If a child inhales only a few of these TB germs, they will be infected with TB.

Infants and children who live in the household with someone who has TB can become ill with TB, even if they are vaccinated. Children who have HIV or malnutrition are most at risk of falling ill or dying from TB.

☐ Is the child at risk of malnutrition

To determine whether the child is at risk of malnutrition, **ask** if the child gets frequently sick. If the child is less than 2 years, ask whether the child is still breast feeding. If the child is less than 2 years, ask about types of complementary foods and source of water.

☐ Any other problem

There is a small space on the back of the recording form, item 5, to write any other problem to refer because you cannot treat it. For example, a child may have a problem in breastfeeding, a skin or ear infection, or a burn or other injury.

On the other hand, some other problems you may be able to treat. For example, you may have learned how to advise caregivers on how to feed their children. If the caregiver might have a question about feeding the child, you would be able to help overcome a feeding problem. The child may not need to be referred.

Record the child's problems

As the caregiver lists the problems, listen carefully and record them on the Sick Child Recording Form. The caregiver may mention more than one problem. For example, the child may have cough, signs of acute malnutrition and fever.

If the caregiver reports any of the listed problems, tick [✓] the small empty box next to the problem

Some items ask you to add brief answers. For example, write how many days the child has been sick.

Ask about *all* the problems on the list, even if the caregiver does not mention them. Perhaps the caregiver is only worried about one problem. If you ask, however, the caregiver may tell you about other problems. Record (tick or write) any problems you find.

If the caregiver says the child does NOT have a problem, circle the solid box next to the listed problem.

Now, look at the sample form for Grace Wadza on the next page. The Health Surveillance Assistant asked the caregiver, "What are the child's problems?"

What problems did the mother report?

What problems did the mother say Grace does not have?

Sick Child Recording Form

(for community –based treatment of child age 2 months up to 5 years)

Date: *16/5/2008* (Day/Month/Year) **HSA:** *John Banda*

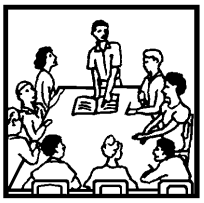
Child's First **Name:** *Grace* Surname *Wadza* Age: *2* Years/ *2* Months **Boy** / **Girl**

Caregiver's name: *Patricia Wadza* **Relationship:** Mother / Father / Other:_____

Physical Address: *Hilltop Road, Kasasa Hills* **Village / TA:** *Ntonya / Malambe*

1. Identify problems

ASK and LOOK	
ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present ➔ Tick ☑ **NO** sign ➔ Circle ■	
☑	■ Cough? If yes, for how long? *2* days
☐	■ Diarrhoea (loose stools)? IF YES, for how long? _____days. If Yes Blood in stool? ☐ ■
☑	■ Fever (reported or now)? If yes, started *4* days ago.
☐	■ Convulsions?
☑	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☑ ■
☑	■ Vomiting? If yes, vomits everything? ☑ ■
☐	■ Red eyes? If yes, for how long _____days. ☐ ■ Difficulty in seeing? If Yes for how long __days
☐	■ Has HIV?
☑	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV? Or ☑ Parents' current HIV status is unknown?
☐	■ Lives in household with someone on TB treatment?
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group ☐ Less than 6 months and stopped breast feeding
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.



Exercise: Use the recording form to identify problems (2)

Complete the recording form below for Joana. Indicate whether you had any difficulties.

Child: Joana Valani

Joana Valani is 3 and a half years old. She lives with her aunt Maria Lomos. They are your neighbours in Kalulu village T/A Nkhope near Amagwa CBCC.

Joana has been coughing. You ask her aunt, “For how long?” She says, “For 5 days.” Joana now seems to be breathing with greater difficulty than usual.

Miss Lomos says that Joana does not have any other problems. However, when you ask about diarrhoea, you learn that Joana has had diarrhoea for 3 days. You also ask about blood in stool, fever, convulsions, difficult drinking or feeding, vomiting, and any other problem. To each, Miss Lomos says, “No.” Joana does not have any of these problems.

When you ask whether Joana or her parents have HIV, she says “No, I don’t think so.” She also does not know if Joana has ever tested for HIV. Miss Lomos says that no one living in her home is on TB treatment.

Sick Child Recording Form

(for community –based treatment of child age 2 months up to 5 years)

Date: _/_/_ __ (Day/Month/Year) **HSA:** _

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____**Village / TA:** _____

1. Identify problems

ASK and LOOK	
ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present ➔Tick ☑ **NO** sign ➔ Circle ■	
☐	■ Cough? If yes, for how long? _____ days
☐	■ Diarrhoea (loose stools)?
☐	IF YES, for how long? _____days. If yes Blood in stool? ☐ ■
☐	■ Fever (reported or now)? If yes, started _____days ago.
☐	■ Convulsions?
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐ ■
☐	■ Vomiting? If yes, vomits everything? ☐ ■
☐	■ Red eyes? If yes, for how long _____days. ☐ ■Difficulty in seeing? If Yes for how long __days
☐	■ Has HIV?
☐	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV? Or ☐ Parents' current HIV status is unknown?
☐	■ Lives in household with someone on TB treatment?
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group ☐ Less than 6 months and stopped breast feeding
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.

Role Play Demonstration and Practice: Ask the caregiver

Part 1. Role-play demonstration

Tayeni Hanjahanja has brought her 12-week-old boy, Tatha to see the Health Surveillance Assistant at her home today.

A Health Surveillance Assistant greets Mrs. Hanjahanja at the door, and asks her to come in. You will observe the interview, and complete the recording form. Start by filling in the date, your initials, the child's name and age, and the caregiver's name

After the role-play, be prepared to discuss what you have seen.

1. How did the Health Surveillance Assistant greet Mrs. Hanjahanja?
2. How welcome did Mrs. Hanjahanja feel in the home? How do you know?
3. What information from the visit did you record? How complete was the information?

Sick Child Recording Form

(For community –based treatment of child age 2 months up to 5 years)

Date: _/_/_ _ (Day/Month/Year) **HSA:** _

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____**Village / TA:** _____

1. Identify problems

	ASK and LOOK
	ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present ➔Tick ☑ **NO** sign ➔ Circle ■
☐	■ Cough? If yes, for how long? _____ days
☐	■ Diarrhoea (loose stools)?
☐	IF YES, for how long? _____days. If yes Blood in stool? ☐ ■
☐	■ Fever (reported or now)? If yes, started _____days ago.
☐	■ Convulsions?
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐ ■
☐	■ Vomiting? If yes, vomits everything? ☐ ■
☐	■ Red eyes? If yes, for how long _____days. ☐ ■Difficulty in seeing? If Yes for how long __days
☐	■ Has HIV?
☐	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV? Or ☐ Parents' current HIV status is unknown?
☐	■ Lives in household with someone on TB treatment?
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group ☐ Less than 6 months and stopped breast feeding
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.

Part 2. Role play practice

Your facilitator will form groups of three persons each. In your group, decide who will be a **caregiver** with a child, the **Health Surveillance Assistant**, and an **observer.**

- A **caregiver** (mother or father) takes a sick child to the Health Surveillance Assistant. When asked, the caregiver provides information on the child and family. (There is no script.)
- The **Health Surveillance Assistant** greets the caregiver and asks questions to gather information. The Health Surveillance Assistant completes the recording form below.
- The **observer** observes the interview. The observer also completes the recording form below. Be prepared to discuss:
  1. How well does the Health Surveillance Assistant greet the caregiver?
  2. How welcome does the caregiver feel in the home? How do you know?
  3. What information from the visit did you record? How complete was the information?

Sick Child Recording Form

(for community –based treatment of child age 2 months up to 5 years)

Date: _/_/__ (Day/Month/Year) **HSA:** _

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____**Village / TA:** _____

1. Identify problems

	ASK and LOOK
	ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present ➔Tick ☑ **NO** sign ➔ Circle ■
☐	■ Cough? If yes, for how long? _____ days
☐	■ Diarrhoea (loose stools)?
☐	IF YES, for how long? _____days. If yes Blood in stool? ☐ ■
☐	■ Fever (reported or now)? If yes, started _____days ago.
☐	■ Convulsions?
☐	■ Difficulty drinking or feeding?
☐	■IF YES, not able to drink or feed anything?
☐	■ Vomiting?
☐	■If yes, vomits everything?
☐	■ Red eyes? If yes, for how long _____days.
☐	■Difficulty in seeing? If Yes for how long __days
☐	■ Has HIV?
☐	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV? Or ☐ **Parents' current HIV status is unknown?**
☐	■ Lives in household with someone on TB treatment?
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group ☐ Less than 6 months and stopped breast feeding
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.

After the first role play, **change roles.** Each person will play the caregiver, Health Surveillance Assistant, and observer at least once. Use the recording form below. Be prepared to discuss the role play practice when you are finished.

Sick Child Recording Form

(For community –based treatment of child age 2 months up to 5 years)

Date: _/_/_ _ (Day/Month/Year) **HSA:** _

Child's First **Name:** _____Surname _____ Age: __Years/__Months **Boy / Girl**

Caregiver's name: _____**Relationship:** Mother / Father / Other:_____

Physical Address: _____**Village / TA:** _____

Identify problems

	ASK and LOOK
	ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present ➔Tick ☑ **NO** sign ➔ Circle ■
	■ Cough? If yes, for how long? _____ days
	■ Diarrhoea (loose stools)? IF YES, for how long? _____days. If yes Blood in stool? ☐ ■
	■ Fever (reported or now)? If yes, started _____days ago.
	■ Convulsions?
	■ Difficulty drinking or feeding? ■IF YES, not able to drink or feed anything?
	■ Vomiting? ■If yes, vomits everything?
	■ Red eyes? If yes, for how long _____days. ■Difficulty in seeing? If Yes for how long __days
	■ Has HIV?
	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV? Or ☐ **Parents' current HIV status is unknown?**
	■ Lives in household with someone on TB treatment?
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group ☐ Less than 6 months and stopped breast feeding
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.

LOOK for signs of illness

Health Surveillance Assistants ask questions to identify the child's problems. They also look for signs of illness and check for malnutrition in the child.

Signs of illness are introduced here: **chest in drawing, fast breathing, very sleepy or unconscious, palmar pallor, Red or yellow on MUAC tape, swelling of both feet.**

These signs require skill and practice to learn to identify them and use them to determine what the child needs. You will practise looking for these signs in exercises, on videotapes, and with children in the health facility.

Chest in drawing

Children often have cough and colds. A child may have a cough because moisture drips from the nose down the back of the throat. The child with only a cough or cold is not seriously ill.

Sometimes a child with cough, however, is very sick. The child might have pneumonia. Pneumonia is an infection of the lungs.

Pneumonia can be severe. You identify SEVERE PNEUMONIA by looking for ***chest in drawing.***

When pneumonia is severe, the lungs become very stiff. Breathing with very stiff lungs causes chest in drawing. The chest works hard to pull in the air, and breathing can be difficult. Children with severe pneumonia must be referred to a health facility.

Look for chest in drawing in all sick children. Pay special attention to children with cough or cold, or children who are having any difficult breathing.

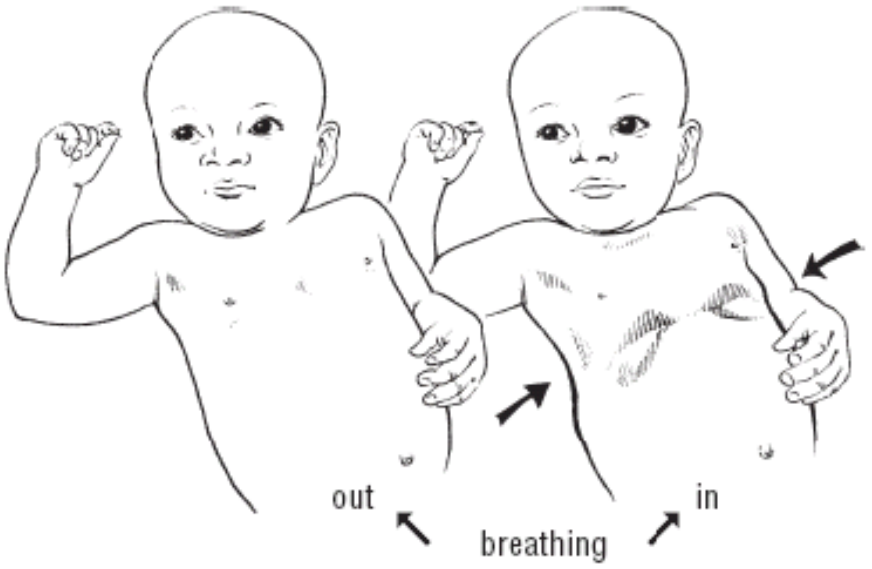
To look for chest in drawing, the child must be calm. The child should not be breastfeeding. If the child is asleep, try not to waken the child.

Ask the caregiver to raise the child's clothing above the chest. Look at the lower chest wall (lower ribs).

Look for chest in drawing when the child breathes IN. Normally when a child breathes IN, the chest and abdomen move out together.

In a child with chest in drawing, however, the chest below the ribs pulls in instead of moving out; the air does not come in and the chest is not filling with air.

In the picture below, the child on the right has chest in drawing. See the lines on the chest as the child on the right breathes in. The chest below the ribs pulls in instead of moving out. The child has chest in drawing if the lower chest wall goes **IN** when the child breathes **IN**.



Chest in drawing is not visible when the child breathes OUT. In the picture, the child on the left is breathing out—pushing the air out.

For chest in drawing to be present, it must be clearly visible and present at every breathing in.

If you see chest in drawing only when the child is crying or feeding, the child does not have chest in drawing. If you are unsure whether the child has chest in drawing, look again. If other Health Surveillance Assistants are available, ask what they see.

Discussion: Chest in drawing

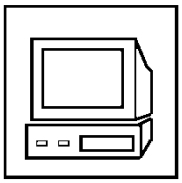
The facilitator will show photos of children with chest in drawing.

After you discuss chest in drawing in the photos, review the questions below with the facilitator.

1. Will you be able to look for chest in drawing in a child when:
    a. __The child's chest is covered?
    b. __The child is upset and crying?
    c. __The child is breastfeeding or suckling?
    d. __The child's body is bent?

2. The child must be calm for you to look for chest in drawing. Which of these would be appropriate to calm a crying child? Discuss these methods with the facilitator.

    a. Ask the caregiver to breastfeed the child, and look at the child's chest while the caregiver breastfeeds.
    b. Take the child from the caregiver and gently rock him in your lap.
    c. Ask the caregiver to breastfeed until the child is calm. Then, look for chest in drawing while the child rests.
    d. Continue looking for other signs of illness. Look for chest in drawing later, when the child is calm.



Video exercise: Identify chest in drawing

For each of the children shown in the video, answer the question: ***Does the child have chest in drawing?*** Circle Yes or No.

Does the child have chest in drawing?		
Mary	**Yes**	**No**
Jenna	**Yes**	**No**
Ho	**Yes**	**No**
Amma	**Yes**	**No**
Lo	**Yes**	**No**

You may ask to see any of these children again.

For additional practice, your facilitator will show you more children on the video. For each child, decide if the child has chest in drawing. Circle Yes or No.

Does the child have chest in drawing?		
Child 1	**Yes**	**No**
Child 2	**Yes**	**No**
Child 3	**Yes**	**No**
Child 4	**Yes**	**No**
Child 5	**Yes**	**No**
Child 6	**Yes**	**No**
Child 7	**Yes**	**No**

Look for signs of illness (continued)

☐ Fast breathing

Another sign of pneumonia is fast breathing. To look for fast breathing, count the child's breaths for one full minute. Count the breaths of all children with cough.

Tell the caregiver you are going to count her child's breathing. Ask her to keep her child calm. If the child is sleeping, do not wake the child.

The child must be quiet and calm when you count breaths. If the child is frightened, crying, angry, or moving around, you will not be able to do an accurate count.

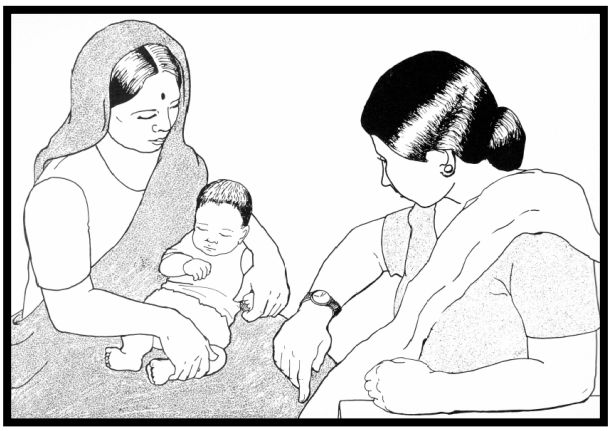
Choose a place on the child's chest or stomach where you can easily see the body move as the child breathes in. To count the breaths in one minute:

1. Use a watch with a second hand (or a digital watch, or a timer). Put the watch in a place where you can see the watch and the child's breathing.
2. Look for breathing movement anywhere on the child's chest or stomach.

TIP: Looking at the watch and the child's breathing at the same time can be difficult.

Ask someone, if available, to help time the count. Ask them to say "Start" at the beginning and "Stop" at the end of 60 seconds.

3. Start counting the child's breaths when the child is calm. Start when the second hand on the watch reaches an easy point to remember, such as at the number 12 or 6 on the watch face. (On a digital watch, start when the second numbers are :00.)When the time reaches exactly 60 seconds, stop counting.
4. Repeat the count if you have difficulty. If the child moves or starts to cry, wait until the child is calm. Then start again.
5. After you count the breaths, record the number of breaths per minute in the space provided on the recording form. Decide if the child has fast breathing.



Fast breathing depends on the child's age:

- In a child age 2 months up to 12 months, fast breathing is 50 breaths or more per minute.
- In a child age 12 months up to 5 years, fast breathing is 40 breaths or more per minute.

A child with cough and fast breathing has PNEUMONIA.

Photo WHO SEARO

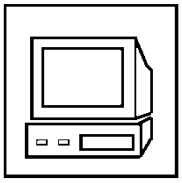
[If 60 second timers are available, your facilitator will now show you how to use them. See the Health Surveillance Assistant using a timer in the picture.]

Exercise: Identify fast breathing

For each of the children below, decide if the child has fast breathing. Circle Yes or No.

Refer to the Sick Child Recording Form for the breathing rates per minute of children with fast breathing, depending on age.

	Does the child have fast breathing?	
Carlos Age 2 years, has a breathing rate of 45 breaths per minute	**Yes**	**No**
Ahmed Age 4½ years, has a breathing rate of 38 breaths per minute	**Yes**	**No**
Artimis Age 2 months, has a breathing rate of 55 breaths per minute	**Yes**	**No**
Jan Age 3 months, has a breathing rate of 47 breaths per minute	**Yes**	**No**
James Age 3 years, has a breathing rate of 35 breaths per minute	**Yes**	**No**
Nindi Age 4 months, has a breathing rate of 45 breaths per minutes	**Yes**	**No**
Joseph Age 10 weeks, has a breathing rate of 57 breaths per minute	**Yes**	**No**
Anita Age 4 years, has a breathing rate of 36 breaths per minute	**Yes**	**No**
Becky Age 36 months, has a breathing rate of 47 breaths per minute	**Yes**	**No**
Will Age 8 months, has a breathing rate of 45 breaths per minute	**Yes**	**No**
Maggie Age 3 months, has a breathing rate of 52 breaths per minute	**Yes**	**No**



Video exercise: Count the child's breaths

You will practise counting breaths and looking for fast breathing on children in the videotape.

For each of the children shown:

1. Record the child's age below.
2. Count the child's breaths per minute. Write the breaths per minute in the box.
3. Then, decide if the child has fast breathing. Circle Yes or No.

	Age?	**Breaths per minute?**	**Does the child have fast breathing?**	
Mano			**Yes**	**No**
Wumbi			**Yes**	**No**

If there is time, the facilitator will ask you to practise counting the breaths of more children on the videotape. Complete the information below on each child.

	Age?	**Breaths per minute?**	**Does the child have fast breathing?**	
Child 1			**Yes**	**No**
Child 2			**Yes**	**No**
Child 3			**Yes**	**No**
Child 4			**Yes**	**No**

TIPS on looking for chest indrawing and counting the child's breaths:

Do not upset the child. The child must be calm to look for chest indrawing and count the child's breaths.

Look for signs of illness in the order they are listed on the recording form. The tasks start with those that require a calm child. Look for chest indrawing and count breaths before the tasks which require waking or touching the child.

If the child becomes upset, wait until the caregiver calms the child.

Ask the caregiver to slowly roll up the child's shirt. A rolled shirt will stay in place better. Tugging and pulling the shirt upsets the child.

If the child's body is bent at the waist, it is difficult to see the chest move. If you cannot see the chest, ask the caregiver to slowly, gently lay the child on her lap.

Stand or sit where you can see the chest movement. There needs to be enough light. The angle of light needs to show the indentation on the chest wall that occurs when there is chest indrawing.

A contrast in colour or light between the child's chest and the background makes it easier to see the chest expand when you count the child's breaths.

Look for signs of illness (continued)

☐ Very sleepy or unconscious

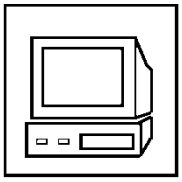
While looking for signs of illness, look at the child's general condition. Look to see if the child is very sleepy or unconscious.

If the child has been sleeping and you have not seen the child awake, ask the caregiver if the child seems very sleepy. Gently try to wake the child by moving the child's arms or legs. If the child is difficult to wake, see if the child responds when the caregiver claps.

A very sleepy child is not alert when the child should be. The child is drowsy and does not seem to notice what is around him or her.

An unconscious child cannot awaken. The child does not respond when touched or spoken to. An unusually sleepy or unconscious child will not be fussy or crying.

In contrast, an alert child pays attention to things and people around him or her. Even though the child is tired, the child awakens.



Video exercise: Identify an unusually sleepy or unconscious child and other signs of severe illness

Your facilitator will now show a video of signs of severe illness: not able to drink or feed anything, vomiting everything, convulsions, and unusually sleepy or unconscious.

You might not see these signs very often. However, when you do see these signs, it is important to recognize them. These children are very sick.

The video will then show an exercise with four children. For each child, answer the question: ***Is the child unusually sleepy or unconscious?*** Circle Yes or No.

Is the child unusually sleepy or unconscious?		
Child 1	**Yes**	**No**
Child 2	**Yes**	**No**
Child 3	**Yes**	**No**
Child 4	**Yes**	**No**

How are the children who are *very* sleepy or unconscious different from those who are just sleepy?

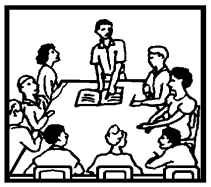
LOOK for signs of anaemia

☐ Palmar pallor

A child with palmar pallor has anaemia. Anaemia is a reduction of red blood cells. A child can develop anaemia as a result of:

- Malaria which can destroy the red blood cells. Children can develop anaemia if they have repeated episodes of malaria or if the malaria was inadequately treated.
- Parasites such as hook worm that can cause blood loss from the gut and lead to anaemia.

All sick children should be checked for signs of anaemia. Check anaemia by comparing the caregivers palm and the child's palm. If the child's palm looks white than the palm of the caregiver, the child has palmar pallor and should be considered as having anaemia. If the palm of the child looks red, the child does not have palmer pallor and anaemia.



Your facilitator will show you some photos with examples of palmar pallor.

Look at the photos in the photo booklet 40 - 46 and decide whether the child has palmar pallor. Tick Yes or No in the boxes below:

Does the child have palmar pallor?		
Child 40	**Yes**	**No**
Child 41	**Yes**	**No**
Child 42	**Yes**	**No**
Child 43	**Yes**	**No**

Does the child have palmar pallor?		
Child 44	**Yes**	**No**
Child 45	**Yes**	**No**
Child 46	**Yes**	**No**

LOOK for signs of severe acute malnutrition

Mrs. Diaz brought her son Julio to see you because she is worried that Julio is sick. Julio is also malnourished. However, Mrs. Diaz seems unconcerned. Many children in the community are small like Julio.

However, you are concerned. Children have acute malnutrition because they have a poor diet or because they are often sick.

Acute malnourished children do not grow well. Their bodies do not have enough energy and nutrients (vitamins and minerals) to meet their needs for growing, being active, learning, and staying healthy. By helping children receive better nutrition, you can help children develop stronger bodies and minds.

Acute malnourished children often become sick. Illness is a special challenge for a body that is weak from poor nutrition. Some children with poor nutrition may also have HIV. In this case, they are given extra attention because they susceptible to acute malnutrition.

Acute malnourished children are more likely to die from other common illnesses than well-nourished children are. Over half the children who die from common childhood illness—diarrhoea, pneumonia, malaria, and measles—are poorly nourished. Children with both poor nutrition and HIV are at much higher risk of dying. If you identify children with acute malnutrition, you can help them get proper care. This may include HIV testing. If the child has HIV, the health facility will start the child on antiretroviral treatment (ARVs), which will keep the child healthy. You might be able to prevent these children from dying.

Your facilitator will demonstrate two ways to look for SEVERE ACUTE MALNUTRITION:

Use a MUAC (Mid-Upper Arm Circumference) tape. A small arm circumference (red on the MUAC tape) identifies severe acute malnutrition in children with severe wasting (very thin), a condition called **marasmus.**

Look for oedema. This identifies severe acute malnutrition in children with the condition called **kwashiorkor**.

Oedema is graded into three categories

- Mild (+) affects feet
- Moderate (++) affects feet and legs or arms
- Severe (+++) affects the whole body
- Red on MUAC plus oedama is refered to marasmic-kwashiorkor

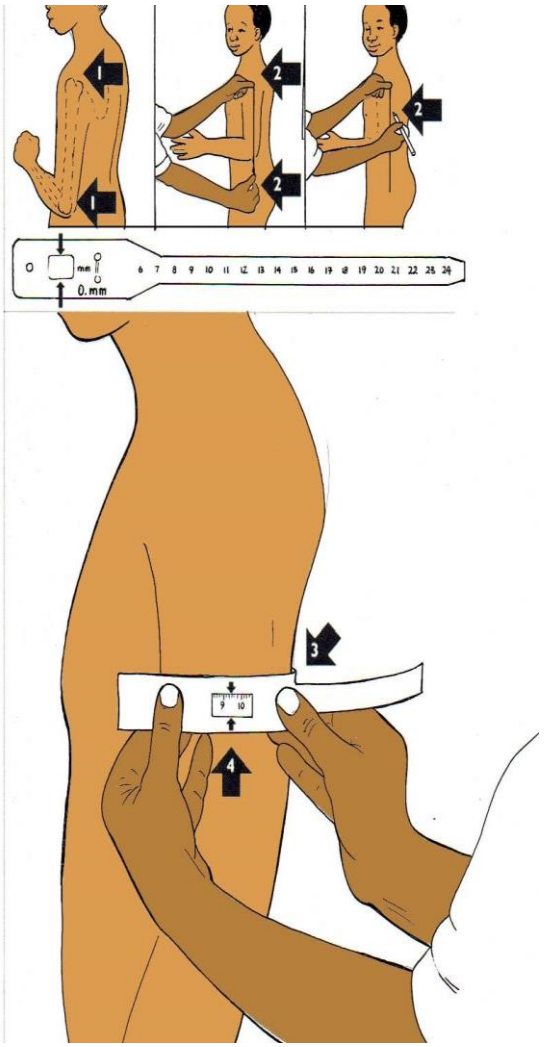
Although these children have severe acute malnutrition, their bodies are also swollen, round and plump, not thin.

Look for wasting

MUAC <11.5 cm **(**red on MUAC) is severe wasting, MUAC of 11.5 - <12.5 cm (yellow on MUAC) is moderate wasting, MUAC 12.5 cm or more (green on MUAC) is normal.

How to use a MUAC tape

MUAC is a very useful body measurement used for children. MUAC correlates well with muscle mass and, hence, with body nutritional reserves. Moreover, evidence supports the fact that MUAC correlates better with risk of death than WFH does.

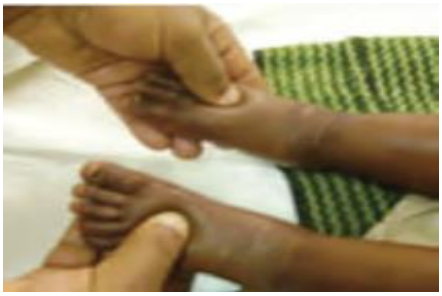


It is essential to use the age cut-off of 6 months for MUAC and not to use the height of the child as proxy for age[1].

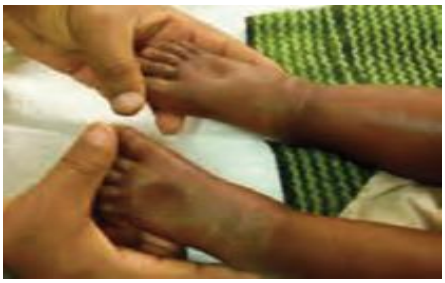
How to measure MUAC:

1. MUAC is always taken on the left arm. Have the child bend his/her left arm at a 90° angle. Measure the length of the child‘s upper arm, between the bone at the top of the shoulder and the tip of the elbow. [1]
2. Find the midpoint of the upper arm and mark it with a pen. It is recommended to use a string instead of the MUAC tape to find the midpoint. [2]
3. The child‘s arm should then be relaxed, falling alongside his/her body. Wrap the MUAC tape around the child‘s arm at the marked point, such that the entire tape is in contact with the child‘s skin. It should be neither too tight nor too loose. [3]
4. Insert the end of the tape through the narrow opening on the right. The measurement is read from the window where the arrows point inward. For a numbered tape, MUAC can be recorded with a precision of 1 mm. For three-colour tapes (red, yellow, green), read the colour that shows through the window at the point the two arrows indicate. [4]

Assessment of oedema

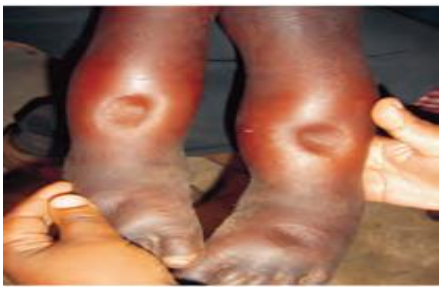


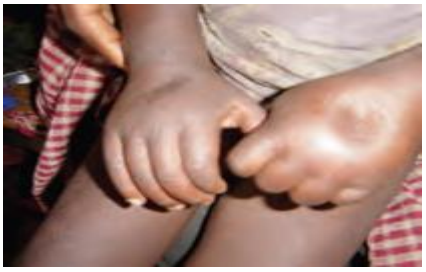
In order to determine the presence of oedema, you should apply normal thumb pressure on both feet for three seconds (count the numbers 1001, 1002, 1003 in order to estimate three seconds without using a watch)



Look and feel for a pit in each foot. Oedema in the feet only is classified as mild (+1) oedema.

If there is no oedema in the feet, STOP. Nutritional oedema always spreads from the feet upwards.





If oedema is present in the feet look for oedema in the lower legs. Use the same technique as for the feet checking both sides. Bilateral pitting oedema in the feet AND the lower legs and hands is classified as moderate (+2) oedema.

If moderate oedema is diagnosed, check for oedema around the eyes (periorbital oedema). Do not press on the eyes to look for pitting. If there is oedema around the eyes this is classified as severe (+3) oedema. Children with +3 oedema are at high risk of mortality and are always treated in NRU

Discussion: Severe Acute Malnutrition

Your facilitator will show photos of malnourished children and will demonstrate two ways to identify children with SEVERE acute malnutrition.

After the discussion, read below and on the following pages to review how to identify severe malnutrition.

Look for signs of severe malnutrition (continued)

The two signs of severe malnutrition are: Red on MUAC tape, and swelling on both feet.

- **Red on MUAC tape**

The circumference of the arm is the distance around the arm. Measure the arm circumference of all children aged 6 months up to 5 years with a MUAC tape. A RED reading on the MUAC tape indicates severe malnutrition.

Yellow colour on MUAC tape means that the child is moderately acute malnourished

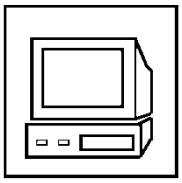
A MUAC tape is easy to use to identify a child with a very small mid-upper arm circumference. Review the instructions in the box on the next page.

Exercise: Use the MUAC tape

Use the MUAC tape on ten sample cardboard rolls that represent the arms of ten children. The arm of each is represented by a cardboard roll.

For each child, is the child severely malnourished (very thin or wasted)? Circle Yes or No.

Is the child severely or moderately malnourished? Tick the right answer		
	SAM	**MAM**
Child 1. Anna		
Child 2. Dan		
Child 3. Njeri		
Child 4. Sue		
Child 5. Timve		
Child 6. Tsala		
Child 7. Gwenembe		
Child 8.Sekani		
Child 9. Kelvin		
Child 10. Ida		



Video Demonstration: Look for severe acute malnutrition

A short videotape will summarize how to look for severe acute malnutrition using the MUAC tape and checking for swelling of both feet (oedema).

Take-home messages for this section:

- The recording form is like a checklist. It helps you remember everything you need to ask the caregiver.
- It is also a record of what you learned from the caregiver. With this information, you will be able to plan the treatment for the child.
- You learn some information by asking questions (about cough, diarrhoea, fever, convulsions, difficult drinking or feeding, vomiting, HIV, exposure to HIV, TB in the household, and any other problems).
- You learn other information by examining the child (for chest in drawing, fast breathing, unusually sleepy or unconscious, colour of the MUAC strap, and swelling of both feet).

Decide: Refer or treat the child

The problems identified will help you decide whether to **refer** the child to the health facility or **treat** the child at home.

Some problems are **Danger Signs.** A danger sign indicates that the child is too ill for you and the family to treat in the community. You do not have the medicines this child needs. To help this child survive, you must URGENTLY refer the child to the health facility.

You may see another problem you cannot treat. You may not be able to identify the cause of the problem, or you may not have the correct medicine to treat it. Although the problem is not a danger sign, you will refer the child to the health facility. There a trained health worker can better assess and treat the child.

Families can treat some sick children at home with your help. If you have the appropriate medicine, they can care for children with diarrhoea, fever, and cough with fast breathing.

In this section, you will learn to:

- Identify danger signs.
- Identify signs of illness(that are not danger signs) and acute malnutrition
- Decide if the child must be referred to the health facility or whether

Any DANGER SIGN: Refer the child

On the recording form, the middle column—**Any DANGER SIGN?**—lists the danger signs. *[Find the column that lists the danger signs.]*

Any one of these signs is a reason to refer the child URGENTLY to the health facility. Using the information you have about the child, tick [✓] the danger sign or signs you find, if any.

The first nine danger signs are found by asking the caregiver about the child's problems.

☐ Cough for 14 days or more

A child who has had cough for 14 days or more has a danger sign. The child may have tuberculosis (TB), asthma, whooping cough, or another problem. The child needs more assessment and treatment at the health facility. **Refer a child with cough for 14 days or more.**

☐ Diarrhoea for 14 days or more

Diarrhoea often stops on its own in 3 or 4 days. Diarrhoea for 14 days or more, however, is a danger sign. It may be a sign of a severe disease. The diarrhoea will contribute to malnutrition. Diarrhoea also can cause dehydration, when the body loses more fluids than

are being replaced. If not treated, dehydration results in death. **Refer a child with diarrhoea for 14 days or more.**

☐ Blood in stool

Diarrhoea with blood in the stool, with or without mucus, is *dysentery.* If there is blood in the stool, the child needs medicine that you do not have in the medicine kit. **Refer a child with blood in the stool.**

☐ Fever for last 7 days or more

Most fevers go away within a few days. Fever that has lasted for 7 days or more can mean that the child has a severe disease. The fever does not have to occur every day, all the time. **Refer a child who has had fever for the last 7 days or more**.

☐ Convulsions

A convulsion during the child's current illness is a danger sign. A serious infection or a high fever may be the cause of the convulsion. The health facility can provide the appropriate medicine and identify the cause. **Refer a child with convulsions.**

☐ Not able to drink or eat anything

One of the first indications that a child is very sick is that the child cannot drink or swallow. Dehydration is a risk. Also, if the child is not able to drink or eat anything, then the child will not be able to swallow the oral medicine you have in your medicine kit. **Refer a child who is not able to drink or eat anything.**

☐ Vomits everything

When the child vomits everything, the child cannot hold down any food or drink at all. The child will not be able to replace the fluids lost during vomiting and is in danger from dehydration. A child who vomits everything also cannot take the oral medicine you have in your medicine kit. **Refer a child who vomits everything.**

☐ Red eye for 4 days or more

A child who presents with red eye is commonly due to acute conjunctivitis. Acute conjunctivitis presents with discomfort in the eye, swollen eye lids, pus discharge and the redness in the white part of the eye. Refer a child with red eye if child has had 4 days or more of treatment for it. Also refer Visual problem or history of trauma and any other child with red eye but without signs of conjunctivitis.

☐ Has HIV and any other illness

A child who has HIV is more likely to get diarrhoea, pneumonia, TB and to become malnourished. When this child becomes sick, he or she is at risk of developing severe illness and needs special care for the illness. **Refer a child who has HIV and any other illness.**

These danger signs are identified based on the caregiver's answers to your questions. You identify other danger signs by looking at the child. The list of danger signs will continue after an exercise.

☐ Oedema +++

A child with oedema +++ is at higher risk of dying than other malnourished children. Therefore, they require special care to reverse their condition. **Refer a child who has oedema +++**

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☐ **Bilateral oedema + / ++ with any of the following medical complications**

- Any other danger signs PLUS
- no appetite for RUTF
- Diarrhoea of any duration
- Fever of any duration
- Fast breathing
- Red Eye of any duration
- Peeling of the skin

Refer all children with oedema + or ++ having any medical complication, no appetite or any danger sign

☐ **Red on MUAC tape (<11.5cm) with medical complication or no appetite**

Red on the MUAC tape indicates the child has severe acute malnutrition (SAM)

1. Check for medical complications:
   - Diarrhoea of any duration
   - Fever of any duration
   - Fast breathing
   - Red Eye of any duration
   - Peeling of the skin

2. Do an appetite test if there are no medical complications

Refer all children with red on MUAC tape (<11.5cm) with medical complication or no appetite

☐ Marasmic-kwashiokor

All children with MUAC < 11.5 cm (6–59 months) and Bilateral Oedema + OR ++ should be REFERED.

NOTE:

How to conduct an appetite test

Conduct appetite test for SAM children to be treated at community level

Offer the RUTF sachet to the caregiver

Advise the caregiver to wash hands, clean the sachet and then feed the child whilst alone

If the child eats one third or more of the sachet, there is appetite but if the child eats less than one third of the sachet, there is no appetite, then refer to NRU.

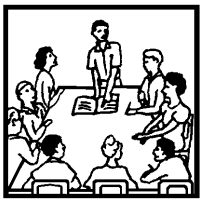
☐ **Special baby**

A special baby is an infant aged 0–6 Months with Severe Acute Malnutrition (oedema or visible severe wasting), OR an infant order than 6 months but weighing less than 3 kg.

Cases of special babies

- Breastfed infants 0–6 months with prospect to breastfeed
- Non-breastfed infants 0–6 months without the prospect of breastfeeding

The HSA should refer all special babies with acute malnutrition to the facility.



Exercise: Decide to refer (1)

The children below have cough, diarrhoea, fever, and other problems reported by the caregiver. Assume the child has no other relevant condition for deciding whether to refer the child. **Which children have a danger sign?** Circle Yes or No. To guide your decision, refer to the recording form.

Which children must be referred to the health facility? Tick [✓] if the child should be referred

[The facilitator may ask you to do this exercise as a group discussion.]

Does the child have a danger sign? (Circle Yes or No.)			**Refer child?** Tick [✓]
Sam – cough for 2 weeks	**Yes**	**No**	
Murat – cough for 2 months	**Yes**	**No**	
Beauty – diarrhoea with blood in stool	**Yes**	**No**	
Marco – diarrhoea for 10 days	**Yes**	**No**	
Amina – fever for 3 days	**Yes**	**No**	
Nilgun – low fever for 8 days,	**Yes**	**No**	
Ida – diarrhoea for 2 weeks	**Yes**	**No**	
Carmen – cough for 1 month	**Yes**	**No**	
Tika – convulsion yesterday	**Yes**	**No**	
Nonu – very hot body since last night	**Yes**	**No**	
Maria – vomiting food but drinking water	**Yes**	**No**	
Thomas – not eating or drinking anything because of mouth sores	**Yes**	**No**	

Any DANGER SIGN: Refer the child (continued)

Cough for 14 days or more, diarrhoea for 14 days or more, blood in stool, fever for the last 7 days or more, convulsions, not able to drink or eat anything, and vomits everything—all are danger signs, based on the caregiver's report.

There are six more danger signs. You may find these danger signs when you LOOK at the child:

☐ Chest in drawing

Chest in drawing is a sign of severe pneumonia. This child will need oxygen and appropriate medicine for severe pneumonia. **Refer a child with chest in drawing.**

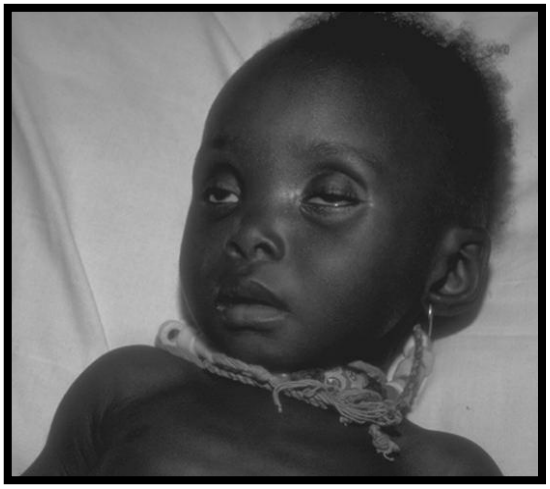


Photo WHO CAH

Refer a very sleepy or unconscious child urgently to the nearest health facility.

☐ Very sleepy or unconscious

A child who is unusually sleepy is not alert and falls back to sleep after stirring. An unconscious child cannot awaken. There could be many reasons. The child is very sick and needs to go to the health facility urgently to determine the cause and receive appropriate treatment. **Refer a child who is very sleepy or unconscious.**

☐ Anaemia

Anaemia presents with pallor. Pallor is unusual paleness of the skin. It is therefore a sign of anaemia.

Not eating foods rich in iron can lead to iron deficiency and anaemia.

Anaemia is a reduction of red cells or a reduced amount of haemoglobin in each red cell.

A child can develop anaemia as a result of:

- Malaria which can destroy red cells rapidly. Children can develop anaemia if they have repeated episodes of malaria or if the malaria was inadequately treated. The anaemia may develop very suddenly due to massive destruction of red blood cells.

- Infections

- Parasites such as hook worms or whip worms. They can cause blood loss from the gut and lead to anaemia.

To see if the child has palmar pallor, look at the skin of the child's palm. Hold the child's palm open by grasping it gently from the side. Do not stretch the fingers backwards. This may cause pallor by blocking the blood supply.

Compare the colour of the child's palm with mother's palm and with the palms of other children. If the skin of the child's palm is pale, the child has palmar pallor. All children with palmar pallor should be given pre-referral treatment and be referred urgently to health facility

☐ Yellow on MUAC tape

Yellow on the MUAC tape indicates the child is at risk for malnutrition. **Refer a child who has a yellow reading on the MUAC tape**

☐ Red on MUAC tape

Red on the MUAC tape indicates the child is at risk of severe acute malnutrition. **Treat a child who has a red reading on MUAC tape without complications.**

☐ Oedema of both feet

Swelling of both feet indicates severe acute malnutrition due to the lack of specific nutrients in the child's diet. Treat a child who has oedema of the feet but without complications**.**

Exercise: Decide to refer (2)

The children below have cough, diarrhoea, fever, acute or other problems reported by the caregiver and found by you. Assume the child has no other relevant condition for deciding whether to refer the child. **Does the child have a danger sign?** Circle Yes or No. **Should you urgently refer the child to the health facility?** Tick [✓] if the child should be referred. To guide your decision, use the recording form. *[The facilitator may ask you to put the example on a chart for the group discussion.]*

Does the child have a danger sign? (Circle Yes or No.)			**Refer child?** Tick [✓]
1. Child age 11 months has had cough during three days; he is not interested in eating but will breastfeed	**Yes**	**No**	
2. Child age 4 months is breathing 48 breaths per minute	**Yes**	**No**	
3. Child age 2 years vomits all liquid and food her mother gives her	**Yes**	**No**	
4. Child age 3 months frequently holds his breath while exercising his arms and legs	**Yes**	**No**	
5. Child age 12 months is too weak to drink or eat anything	**Yes**	**No**	
6. Child age 3 years with cough cannot swallow	**Yes**	**No**	
7. Child age 10 months vomits ground food but continues to breastfeed for short periods of time	**Yes**	**No**	
8. Arms and legs of child, age 4 months, stiffen and shudder for 2 or 3 minutes at a time	**Yes**	**No**	
9. Child age 4 years has oedema of both feet	**Yes**	**No**	
10. Child age 6 months has chest in drawing	**Yes**	**No**	
11. Child age 2 years has a YELLOW reading on the MUAC tape	**Yes**	**No**	
12. Child age 10 months has had diarrhoea with 4 loose stools since yesterday morning	**Yes**	**No**	
13. Child age 8 months has a RED reading on the MUAC tape	**Yes**	**No**	
14. Child age 36 months has had a very hot body since last night.	**Yes**	**No**	
15. Child age 4 years has had loose and smelly stools with white mucus for three days	**Yes**	**No**	
16. Child age 4 months has chest in drawing while breastfeeding	**Yes**	**No**	
17. Child age 4 and a half years has been coughing for 2 months	**Yes**	**No**	
18. Child age 2 years has diarrhoea with blood in her stools	**Yes**	**No**	
19. Child age 2 years has had diarrhoea for one week with no blood in her stools	**Yes**	**No**	
20. Child age 15 months has had a low fever (not very hot) for 2 weeks	**Yes**	**No**	
21. Child has had fever and vomiting (not everything) for 3 days and has HIV	**Yes**	**No**	
22. Child 8 months old with fever since 2 days ago and palmer pallor	**Yes**	**No**	

Exercise: Decide to refer (3)

The children below have acute malnutrition, cough, diarrhoea, fever, or other problems reported by the caregiver and found by you. Assume the child has no other relevant condition for deciding whether to refer the child. **Does the child have a danger sign?** Circle Yes or No. **Should you urgently refer the child to the health facility?** Tick [✓] if the child should be referred. To guide your decision, use the recording form. *[The facilitator may ask you to put the example on a chart for the group discussion.]*

Does the child have a danger sign? (Circle Yes or No.)			**Refer child?** Tick [✓]
23. Child 12 months with oedema + or ++ with cough more than 14 days	**Yes**	**No**	
24. Child 7 months with oedema + or ++ or Red on MUAC	**Yes**	**No**	
25. Child 20 months red on MUAC with + or ++ oedema	**Yes**	**No**	
26. Child 13 months yellow on MUAC with diarrhoea less than 14 days	**Yes**	**No**	
27. Child 21 months red on MUAC with diarrhoea	**Yes**	**No**	
28. Child 2 months with visible wasting or oedema	**Yes**	**No**	
29. Child 8 months weight 2.8 kilograms	**Yes**	**No**	
30. Child 10 months red on MUAC with diarrhoea more than 14 days	**Yes**	**No**	

SICK but NO DANGER SIGN: Treat the child

Look at the far right column on the recording form—**SICK but NO Danger Sign?** The column lists signs of illness that can be treated at home if the child has no danger sign. You will tick [✓] the signs of illness that are listed in this column, if the child has any.

For these problems, you treat the child with medicine, advise the family on home care for the sick child, and follow up until the child is well. If the child does not improve with home care, then refer the child to a health facility for assessment and treatment.

The list includes four signs of illness that require attention and can be treated at home:

☐ Diarrhoea (less than 14 days AND no blood in stool)

Diarrhoea for less than 14 days, with no danger sign, needs treatment. You will be able to give the child Oral Rehydration Salts (ORS) solution and zinc. Zinc helps to reduce the severity of diarrhoea and can even prevent diarrhoea in future months.

☐ Fever for less than 7 days

Various studies have shown that not all fevers are due to malaria. Giving antimalarial to children with fever without testing for malaria results in wastage of costly medicines and risk of drug resistance Therefore, the new policy in Malawi is to test all fever cases for malaria. If the test result is positive for malaria, you will treat the child with an antimalarial. If the test is negative, the child should return for a follow-up visit in 3 days or sooner if the child becomes sicker. During the follow-up visit, look for signs of illness again. Refer the child if the child is not improving.

☐ Red eye

Often a red eye in a child is a sign of local infection of the eye (conjunctivitis). A child with red eye may have difficulties in seeing. If left untreated, a red eye may become blind. Red eyes for less than 4 days have to be treated at home. The treatment policy is to apply an antibiotic eye ointment on the inner lower lids of both eyes.

☐ Fast breathing

Cough with fast breathing is a sign of pneumonia. If there is no chest in drawing or any other danger sign, you can treat the child at home with an oral antibiotic (Amoxicillin).

In addition, a cough for less than 14 days may be a simple cough or cold, if the child does not have a danger sign AND does not have fast breathing. A cough can be uncomfortable and can irritate the throat. A sore throat may prevent the child from drinking and eating well.

For a child who is not exclusively breastfed, sipping a safe, soothing remedy—like honey in warm (not hot) water—can help relieve a cough and soothe the throat. There is no need for other medicine. Tell the caregiver that cough medicines may contain harmful ingredients, and they are expensive.

There will be more information later on how to treat children with diarrhoea, malaria, or cough with fast breathing. You will also need to follow up these children. You will make sure that, if they become sicker, they go to a health facility for appropriate treatment without delay.

☐ At risk of HIV because

- One or both parents have HIV and child has not tested for HIV
- Parents' current HIV status is unknown

A sick child who is at risk of HIV needs to be tested for HIV. Advise the caregiver to take the child to the health facility soon for HIV testing. If the child is found to have HIV, the child can start taking ARVs and other medications to help the child stay healthy and grow. The child who has HIV will also receive special care for the current illness.

If the child does not have HIV, the health worker will know that the child can receive standard care for the illness.

If the parents' HIV status is unknown, advise the mother and father to test for HIV also.

☐ Living in household with someone on TB treatment

A child who lives in the same household with someone who is on TB treatment is exposed to TB. Advice the caregiver to take the child to the health facility soon to be screened for TB.

If the child has TB, the child will start TB treatment. If the child does not have TB, the child will be given TB preventive medicine disease.

There will be more information later on how to treat children with diarrhoea, malaria, or cough with fast breathing. You will also need to follow up these children. You will make sure that, if they become sicker, they go to a health facility for appropriate treatment without delay.

☐ Severe acute malnutrition

Often, children with uncomplicated severe malnutrition (SAM) have an appetite and no medical complications. If left untreated they may easily progress into complicated SAM hence increasing the risk of death. Therefore, they need to be treated at village clinic as their condition may not need inpatient management. These children are treated with RUTF.

☐ Moderate acute malnutrition

Children with moderate acute malnutrition who have good appetite and no medical complications should be referred to prevent progression to severe acute malnutrition.

Moderate acute malnutrition and HIV Positive

Children with MAM and HIV positive should also be referred to health facility HIV and MAM treatment

Demonstration and practice: Use the recording form to decide to refer or treat

The recording form guides you to make correct decisions. It helps you identify danger signs. It helps you decide whether to refer the child or treat the child at home.

Part 1. Demonstration

On the next page is the recording form for Grace Wadza. Your facilitator will use the recording form to guide you through the following steps.

1. What signs of illness did the Health Surveillance Assistant find? (See the ticked boxes in the first column, on the left.)

2. Identify danger signs or other signs of illness.

   For each sign found, the Health Surveillance Assistant ticked [✓] the appropriate box. She indicated ***Any DANGER SIGN?*** (in Column 2) or ***SICK but NO Danger Sign?*** (in Column 3, on the right).

   For example, Grace is not able to eat or drink anything. To decide whether to refer or treat Grace, which box, in which column, did the Health Surveillance Assistant tick?

3. What would you decide to do—refer Grace to the health facility or treat Grace at home and advise her mother on home care? For what reason?

Tick the decision box at the bottom of the recording form to indicate your decision to **refer to health facility** or **treat at home and advise caregiver.**

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 14/7/2008 (Day / Month / Year) **HSA:** John Banda

Child's First Name: Grace **Surname** Wadza Age: _2_Years/_2_Months Boy / (Girl)

Caregiver's name: Patricia Wadza **Relationship:** (Mother) / Father / Other: _____

Physical Address: Behind Hilltop Mosque **Village / TA:** Ntonya / Malemba

1. Identify problems

Ask and Look		Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... YES, sign present ➔Tick ☐ NO sign ➔ Circle ■			
☑	■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☐	■ Diarrhoea (loose stools)? IF YES, for how long? _____days. If Yes Blood in stool? ☐ ■	☐ Diarrhoea for 14 days or more ☐ Blood in stool	☐ Diarrhoea (less than 14 days AND no blood in stool)
☑ ✓	■ Fever (reported or now)? If yes, started 4 days ago.	☐ Fever for last 7 days	☑ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☑	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☑■	☑ Not able to drink or feed anything	
☑	■ Vomiting? If yes, vomits everything? ☑ ■	☑ Vomits everything	
☐	■ Red eyes? If yes, for how long _____days. ■ Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Visual problem	☐ Red eye less than 4 days
☐	■ Has HIV?	☐ Has HIV and any other illness	
☐	■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☐ Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ Parents' current HIV status unknown.
☐	■ **Lives in household with someone on TB treatment?**		☐**Lives with someone on TB Treatment**
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
☐	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☐	**IF COUGH, count breaths in 1 minute:** 36 breaths per minute ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour:** green **MUAC** _ 15 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

☐ If ANY Danger, Sign refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

The Health Surveillance Assistant found the signs for each of the children below. Identify which are **DANGER SIGNS** and which are other signs that the child is **SICK but NO Danger Sign**. Tick [✓] the appropriate box to indicate your decision.

Then, decide to **refer or treat the child at home**. Tick [✓] the appropriate decision box to indicate your decision.

Child 1: Sue Chimunthu

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 14/7/2008 (Day / Month / Year) **HSA:** Lameck Chirwa

Child's First Name: Sue **Surname** Chimuntha Age: 1 Year 2 Months **Boy** / **Girl**

Caregiver's name: Lin Chawinga **Relationship:** Mother / Father / Other: _____

Physical Address: Fodya School **Village / TA:** Sibweni / Khobwe

1. Identify problems

Ask and Look	Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... **YES**, sign present ➔ Tick ☐ **NO** sign ➔ Circle ■		
☐ ■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☑ ■ Diarrhoea (loose stools)? IF YES, for how long? 2 days. If Yes Blood in stool? ☐ ■	☐ Diarrhoea for 14 days or more ☐ Blood in stool	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐ ■ Fever (reported or now)? If yes, started __ days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐ ■ Convulsions?	☐ Convulsions	
☐ ■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐■	☐ Not able to drink or feed anything	
☑ ■ Vomiting? If yes, vomits everything? ☐ ■	☐Vomits everything	
☐ ■ Red eyes? If yes, for how long __3___days. ■ Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Visual problem	☐ Red eye less than 4 days
☐ ■ Has HIV?	☐ Has HIV and any other illness	
☐ ■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☐ Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ Parents' current HIV status unknown.
☐ ■ **Lives in household with someone on TB treatment?**		☐**Lives with someone on TB Treatment**
☐ ■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐ ■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:		
■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
IF COUGH, count breaths in 1 minute: 36 breaths per minute ☐ ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐ ■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☑ ■ Palmar pallor	☐ Palmar pallor	
☐ **For child 6 mo. up to 5 years, MUAC colour: Yellow MUAC** _ 11.8 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2. Decide: Refer or treat child

(tick decision)

Go to Page 2

☐ If ANY Danger, Sign refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

Child 2: Comfort Kazombo

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 16/7/2008 (Day / Month / Year) **HSA:** Lameck Chirwa

Child's First Name: Comfort **Surname** Kazombo Age: 0 Years/ 4 Months Boy / Girl

Caregiver's name: Paulos Kazombo **Relationship:** Mother / Father / Other: _____

Physical Address: Near Kapeni Mosque **Village / TA:** Palasa / Nyanja

a. Identify problems

Ask and Look		Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... **YES**, sign present ➔ Tick ☐ **NO** sign ➔ Circle ■			
☑	■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☐	■ Diarrhoea (loose stools)?	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	IF YES, for how long? _____days. If yes Blood in stool? ☐ ■	☐ Blood in stool	
☑	■ Fever (reported or now)? If yes, started 3 days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐Vomits everything	
☑	■ Red eyes? If yes, for how long ___2__days.	☐ Red eye for 4 days or more	☐ Red eye less than 4 days
	■ Difficulty in seeing? If Yes for how long __days	☐ Visual problem	
☑	■ Has HIV?	☐ Has HIV and any other illness	
☑	■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☑ Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ Parents' current HIV status unknown.
☐	■ **Lives in household with someone on TB treatment?**		☐**Lives with someone on TB Treatment**
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
☐	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☑	**IF COUGH, count breaths in 1 minute:** 63 breaths per minute ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Yellow** **MUAC** _ 12 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2. Decide: Refer or treat child

(tick decision) **Go to Page 2** ⇨

☐ If ANY Danger, Sign refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

Child 3: Karen Shabani

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 14/7/2008 (Day / Month / Year) **HSA:** Lameck Chirwa

Child's First Name: Karen **Surname** Shabani Age: 0 Years/ 3 Months **Boy / (Girl)**

Caregiver's name: Monika Shabani Relationship: Mother / Father / Other: (Aunt)

Physical Address: Tikambe Estate **Village/ TA:** Chamba / Zobwe

- **Identify problems**

Ask and Look		Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... **YES**, sign present ➔ Tick ☐ **NO** sign ➔ Circle ■			
☑	■ Cough? If yes, for how long? 3 days	☐ Cough for 14 days or more	
☐	■ Diarrhoea (loose stools)?	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	IF YES, for how long? _____days. If yes Blood in stool? ☐ ■	☐ Blood in stool	
☐	■ Fever (reported or now)? If yes, started 4 days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☑	■ Difficulty drinking or feeding? Sore throat IF YES, not able to drink or feed anything? ☐ ■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐Vomits everything	
☐	■ Red eyes? If yes, for how long _____days.	☐ Red eye for 4 days or more	☐ Red eye less than 4 days
☐	■ Difficulty in seeing? If Yes for how long __days	☐ Visual problem	
☐	■ Has HIV?	☐ Has HIV and any other illness	
☐	■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☐Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ **Parents' current HIV status unknown.**
☐	■ **Lives in household with someone on TB treatment?**		☐**Lives with someone on TB Treatment**
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
☐	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
	IF COUGH, count breaths in 1 minute: 47 breaths per minute ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Yellow MUAC** _ 12.4 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

Decide: Refer or treat child
(tick decision)

☐ If ANY Danger, refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

Looking ahead

You have learned to ASK and LOOK to identify signs of illness. Then, using the signs, you decided whether to refer a child or treat the child at home. Page 1 of the Sick Child Recording Form guides you in identifying signs of illness and deciding whether to refer the child or treat the child at home.

Next you will learn how to treat a child at home. You will start by learning some good communication skills. If you refer a child to the health facility, you can also help to prepare the child and the child's family for referral. Page 2 of the recording form helps you decide what to do to assist referral or treat the child at home. Page 2 also lists the schedule of vaccines the child needs to prevent many common childhood illnesses

Take-home messages for this section:

- There are **sixteen danger signs** for which a child must be referred to a health facility: cough for 14 days or more, diarrhoea for 14 days or more, diarrhoea with blood in the stool, fever for 7 days or more, convulsions, not able to drink or feed anything, vomits everything, has HIV and any other illness, red eye for 4 days or more, visual problem, chest in drawing, very sleepy or unconscious, Palmer pallor, shows red or yellow on the MUAC tape, or has oedema
- A child who has convulsions, fever for 7 days or more, is unable to drink or feed anything, who vomits everything or is unusually sleepy or unconscious is in danger of dying quickly and must be referred immediately.
- Other signs of illness (diarrhoea less than 14 days, fever less than 7 days and cough with fast breathing, can be treated in the community, by you and the caregiver.
- A child who is at risk of HIV or exposed to TB in the household should be referred to a health facility for HIV testing or TB screening. Advise the caregiver to take the child to the health facility soon.

Treat or refer children in the community

Introduction

Introduction

A Health Surveillance Assistant who has been well trained in community case management and provided with medicine for common childhood illness can bring treatment to many children. Children receive life-saving treatment with less delay, when medicine is available in the community.

You have learnt to identify signs of illness and decide whether to refer the child to a health facility or treat the child at home. This manual builds on these skills and provides more time to practice them. You will also learn how to give children life-saving medicine—Oral Rehydration Salts (ORS) solution ready to use therapeutic food, zinc supplement, albendazole, antimalarial, an antibiotic eye ointment and an oral antibiotic.

Course objectives

By the end of this section, you will be able to do the following **tasks:**

- To teach caregivers on how to give ORS solution and zinc for diarrhoea, an antimalarial medicine for fever, RUTF for acute malnutrition an eye ointment for red eye (conjunctivitis) and an oral antibiotic for fast breathing.
- To give pre-referral treatment children who are referred to a health facility
- To assist the families of children who are referred to health facility in taking care of their families
- To counsel families to bring their children immediately if they become sicker, and to return for scheduled follow-up visits.
- To identify the vaccines the child has received, and to help the family complete the child's remaining vaccines.
- To assess children on a follow up visit if improving, help the caregiver to continue appropriate treatment at home, and if child is not improving, refer to the health facility.
- To use a Sick Child Recording Form to guide the tasks in caring for a sick child and to record your decisions and actions.

With this additional training, you will be able to help many more children who have common illnesses including acute malnutrition.

Case Study 1

One-year-old Natasha has had fever and was coughing for three days. She is weak. She needs to go to the health facility. The health facility, however, is very far away.

So Mrs Phiri first takes her daughter to see the Health Surveillance Assistant. The Health Surveillance Assistant has medicine for children. He asks questions. He examines Natasha carefully. He decides that Natasha does not have any danger signs.

Malaria is very common in the area, and Natasha has fever. The Health Surveillance Assistant does a rapid diagnostic test (RDT) for malaria. The RDT result is positive, so Natasha needs an antimalarial.

The Health Surveillance Assistant also counts Natasha's breaths. He finds that Natasha has fast breathing and needs an oral antibiotic right away.

The Health Surveillance Assistant washes his hands, and shows Mrs. Phiri how to prepare the antimalarial medicine and the oral antibiotic by mixing each with water. Mrs. Phiri then gives Natasha the first dose of each medicine slowly with a spoon.

The Health Surveillance Assistant gives Mrs. Phiri medicine to give Natasha at home. He explains how much, at what time, and how many days to give the antibiotic and antimalarial to Natasha.

The Health Surveillance Assistant also explains how to care for Natasha at home. Mrs. Phiri should give breast milk more often, and continue to feed Natasha while she is sick. If Natasha becomes sicker, Mrs. Phiri should bring her back right away.

At home Mrs. Phiri has a bed net, treated with insecticide. The Health Surveillance Assistant asks Mrs. Phiri to describe how she uses the bed net. He explains that it is very important for Natasha and the other young children to sleep under the bed net, to prevent malaria.

Before Natasha leaves, the Health Surveillance Assistant checks her vaccination record. Natasha has had all his vaccines.

Mrs. Phiri agrees to bring Natasha back in 3 days for a follow-up visit. Even if Natasha improves, the Health Surveillance Assistant explains that he wants to see Natasha again.

Mrs. Phiri is grateful. Natasha has already begun treatment. If Natasha gets better, they will not need to go the long distance to the health facility.

A Health Surveillance Assistant who has medicine for common childhood illnesses and is trained to use it correctly can bring treatment to many children.

You have learned to identify signs of illness and to use the signs to decide whether to refer the child to a health facility or treat the child at home.

You will learn how to use good communication skills. Then you will learn to give children life-saving medicine—Oral Rehydration Salts (ORS) solution, zinc, an antimalarial, antibiotic eye ointment and an oral antibiotic (Amoxicillin).

If NO danger sign: Treat the child at home

You will see many sick children who do not have danger signs or any other problem needing referral. Children with diarrhoea, malaria, and fast breathing may be treated at home. **This treatment is essential.** Without treatment, they may become sicker and die.

You will be able to:

- Decide on treatment based on child's signs of illness.
- Decide when a child should come back for a follow up visit.
- Use the Sick Child Recording Form as a resource for determining the correct treatment and home care.

This box below summarizes the home treatments for diarrhoea, fever, and fast breathing:

☐ If **diarrhoea for less than 14 days**	☐ **Give ORS.** ☐ **Give zinc supplement.**
☐ If **fever** for less than 7 days (in malaria area)	**Do a rapid diagnostic test (RDT):** __POSITIVE __NEGATIVE **If RDT is positive, give oral antimalarial LA**
☐ If cough (for less than 14days) with **fast breathing**	☐ **Give oral antibiotic (Amoxicillin).**
☐**SAM**	☐**RUTF** ☐**DO RDT** ☐**Amoxicilline from first day** ☐**Albendazole on second visit after 1 week**
☐**MAM**	☐ **Refer** ☐**DO RDT** ☐**Amoxicillin from first day** ☐**Albendazole on second visit after 1 week**
☐**MAM PLUS HIV POSITIVE**	☐ **Refer** ☐**DO RDT** ☐**Amoxicillin from first day** ☐**Albendazole on second visit after 1 week**

For diarrhoea less than 14 days, give the child Oral Rehydration Salts (ORS) solution and a zinc supplement. For fever (less than 7 days, first do a rapid diagnostic test for malaria. (You will learn how to do the test later). If the test is negative, tick [✓] that the result was

negative. If the test is positive, tick [✓] that the result was positive, and give the child the oral antimalarial LA (Artemether-Lumefantrine). For cough (for less than 14 days) with fast breathing, give the child oral Amoxicillin. If MAM or MAM with HIV refer. If SAM give RUTF and amoxicillin.

It is common for a child to have two or all three of these signs. The child needs treatment for each. If a child has diarrhoea and malaria, for example, give the child: ORS, zinc supplement, and an oral antimalarial for treatment at home. More details on these medicines and how to give them will be discussed later.

In addition, advise caregivers on home care. The following box, copied from the recording form, summarizes the basic home care.

☐ For **ALL children treated at home, advise on home care**	☐ **Advise caregiver to give more fluids and continue feeding.** ☐ **Advise on when to return. Go to nearest health facility immediately** or if not possible return **if child** ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool ☐ **Follow up child in 3 days.** ☐**For SAM follow up after 1week**

The following box from the recording form states the advice to give the caregiver when a child is at risk of HIV or is living in a household with someone on TB treatment. In these situations, you will provide treatment at home for the child's diarrhoea, malaria, and fast breathing and also advise the caregiver to take the child to the health facility soon

☐ If at **risk of HIV**	☐ **Advise caregiver to take the child for HIV test soon and, if parents' HIV status is unknown, advise mother and father to test for HIV also.**
☐ If living in household with **someone on TB treatment**	☐ **Advise caregiver to take the child soon for TB screening and TB preventive medicine.**

 If at risk of HIV, advise the caregiver to take the child to the health facility to test for HIV soon. A child who is at risk of HIV should test for HIV soon. If the child has HIV, it is important to start the child on lifelong ARV treatment as soon as possible. Knowing the child's HIV status will also help the health worker decide how to treat the child's current illness. It is important that all adults have an HIV test to learn their HIV status, so that they can know how to best protect themselves and their partners.

 If a person has HIV, daily ARVs can improve his or her own health and prevent transmission to others. A pregnant woman who has HIV can prevent passing HIV to her baby by taking ARVs.

 If a person does not have HIV, he or she should practice safer sex using condoms to prevent becoming infected with HIV. Condoms must be used even while a woman is pregnant and while breastfeeding.

 In either case, the couple should share their HIV status with each other, and find out how to best care for their health and support each other.

 If living in a household with someone on TB treatment, advise the caregiver to take the child to the health facility soon for TB screening.

Children who live in a household with someone on TB treatment are exposed to TB. The caregiver should take the child to the health facility to be screened for TB. If the child is found to have TB, the health worker will start treating the child for TB right away. If the child does not have TB, the health worker will start the child preventive therapy (IPT) to prevent development of the disease.

Demonstration and Practice: Decide on treatment for the child

Part 1. Demonstration

Your facilitator will show you examples of the medicine you can give a child: ORS, zinc supplement, an oral antimalarial LA (Artemether-Lumefantrine), oral antibiotic (Amoxicillin) RUTF and albendazole

Part 2. Practice

For each child below, tick [✓] all the treatments to give at home. No child has a danger sign. Each child has ONLY the signs mentioned in the box. All children will be treated at home. No child will be referred.

To decide, refer to the yellow box for **TREAT at home and ADVISE on home care** on page 2 of the Sick Child Recording Form. Discuss your decisions with the group.

After you decide the treatment, the facilitator will give you medicine to select for the child's treatment. For a child with fever, the facilitator (and the worksheet below) will tell you whether the RDT was positive or negative for malaria.

1. Child age 3 years has cough and fever for 5 days. mRDT is positive	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
2. Child age 6 months has fever for 2 days and is breathing 55 breaths per minute. His mother has HIV. The child has not been tested for HIV. mRDT is positive	☐ Give ORS ☐ ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

3. Child age 11 months has diarrhoea for 2 days yellow reading on MUAC tape he is not interested in eating but will breastfeed	☐ Give ORS ☐ ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
4. Child age 2 years has a fever for 1 day and a GREEN reading on the MUAC tape. MRDT is positive	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

5. Child age 1 year has had fever, diarrhoea, and vomiting (not everything) for 3 days. MRDT is positive	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
6. Child age 10 months has cough for 4 days. He vomits ground food but continues to breastfeed for short periods of time. His HIV status and the HIV status of his parents are unknown.	☐ Give ORS ☐ ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

7. Child age 4 years has diarrhoea for 3 days and is weak. His father is on TB treatment.	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
8. Child age 6 months has fever and cough for 2 days. MRDT is positive	☐ Give ORS ☐ ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

9. Child age 11 months has red reading on MUAC but no danger signs	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
10. Child age 4 months has Oedema +or ++or +++ or visible wasting	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

11. Child age 24 months has Oedema +++	☐ Give ORS ☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days
12. Child age 37 months has Oedema +or ++ and Red on MUAC	☐ Give ORS ☐ Advise to give 10% sugar water or breast milk if still breast feeding ☐ Give zinc supplement ☐ Do a rapid diagnostic test (RDT) for malaria: __POSITIVE ___NEGATIVE ☐ If RDT is positive, give oral antimalarial LA ☐ Give oral antibiotic ☐ Give RUTF (indicate how much) ☐ Give Vitamin A on admission if the child has not received in the las 6 months or has signs of measles of vitamin A deficiency ☐ Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also. ☐ Advise caregiver to take the child soon for TB screening and TB preventive medicine ☐ Refer the child to a health facility ☐ Advise caregiver to give more fluids and continue feeding ☐ Advise on when to return ☐ Advise caregiver on sleeping under a bed net (LLIN) ☐ Follow up child in 3 days

Take-home messages for this section:

Each illness has its own treatment:

- ORS and zinc for diarrhoea for less than 14 days
- Amoxicillin for fast breathing (pneumonia)
- Antimalarial LA for fever for less than 7 days and confirmed malaria
- RUTF for malnutrition
- Eye ointment for red eye of less than 4 days

If a child is at risk of HIV, the caregiver should be advised to take the child for HIV testing soon. If the parents' HIV status is unknown, advise the mother and father to test for HIV also.

If a child lives in a household where someone is on treatment for TB, advise the caregiver to take the child for TB screening and TB preventive medicine.

Caregivers of all sick children should be advised on home care.

Give oral medicine and advise the caregiver

Sick children need treatment quickly. Begin treatment before the child leaves, if the child can drink.

Help the caregiver give the first dose in front of you. This way you can be sure that the treatment starts as soon as possible, and that the caregiver knows how to give it correctly. Then ask the caregiver to give the child the rest of the medicine at home.

The child you refer to a health facility should also receive the first dose, if the child can drink. It takes time to go to the health facility. The child may have to wait to receive treatment there. In the meantime, the first dose of the medicine starts to work.

This section presents:

- The treatment for diarrhoea (ORS solution and a zinc supplement)
- The treatment for malaria (an antimalarial) plus advice on using a bed net.
- The treatment for fast breathing (Amoxicillin).
- The treatment for acute malnutrition (RUTF and RUSF).
- The treatment for red eye (an antibiotic eye ointment)
- Home care for all sick children not referred to the health facility. The treatment for fever plus advice on using an LLIN.

You will be able to:

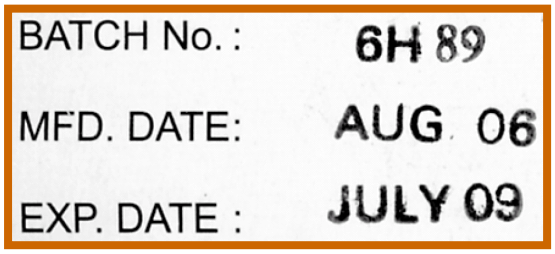
- Select the dose of the antimalarial LA, the antibiotic Amoxyicillin, and/or zinc to give a child, based on the child's age, including the amount, how many times a day, and for how many days.
- Demonstrate with ORS, zinc, antimalarial LA and antibiotic Amoxyicillin, how to give the child one dose, and help the mother to do this.
- Select proper treatment for malnutrition, RUTF and supplementary feeds according to classification.
- Follow correct procedures to do the Rapid Diagnostic Test (RDT).
- Read and interpret the results of the RDT.
- Identify, by the expiration date, the medicines and RDT kits that have expired.
- Advise caregivers of all sick children on home care: more fluids, continued feeding, when to return, and use of bednet.
- Identify and record the vaccines a child has had.
- Identify where the caregiver should take a child for the next vaccination (e.g. health facility, village health day, mobile clinic).

Check the expiration date

Old medicine loses its ability to cure illness, and may be harmful. Check the expiration date (also called "expiry date") on all medicines before you use them. Today's date should not be later than the expiration date.

For example, if it is now May 2010 and the expiration date is December 2009, the medicine has expired. Do not use expired medicines. They may no longer be effective, and may be harmful. If medicines expire, replace them during the next visit to the dispensary of the health facility.

The manufacturer put this stamp on the box of an antibiotic. In addition to the manufacturer's batch number, there are two dates: the medicine's manufacturing date (MFD date) and the expiration date (EXP. Date).



What is the expiration date?

What is today's date?

Has this medicine expired?

If this antibiotic was in your medicine kit, what would you do with it? Return it or use it?

Also check the expiration date on the rapid diagnostic test packet (RDT). Do not use an expired test. It may give false results.

Exercise:
Check the expiration date of medicine

The facilitator will show you sample packages of medicine and rapid diagnostic tests (RDT) for malaria. Find the expiration date on the samples. Decide whether the items have expired or are still useable.

Medicine or RDT kit	Expiration date	Expired? Circle Yes or No		Return? Tick [✓]	Use? Tick [✓]
		Yes	**No**		
		Yes	**No**		
		Yes	**No**		
		Yes	**No**		
		Yes	**No**		
		Yes	**No**		

☐ *If diarrhoea*

Diarrhoea is the passage of unusually loose or watery stools, at least 3 times within 24 hours. Mothers and other caregivers usually know when their children have diarrhoea.

Diarrhoea may lead to dehydration (the loss of water from the body), which causes many children to die. Frequent bouts of diarrhoea also contribute to malnutrition.

If the child has diarrhoea for less than 14 days, with no blood in stool and no other danger sign, the family can treat the child at home. A child with diarrhoea receives ORS solution and a zinc supplement.

Below is the box on treating diarrhoea, from page 2 of the recording form. The box is there to remind you about what medicine to give and how to give it.

☐ If **diarrhoea** (less than 14 days AND no blood in stool)	☐ **Give ORS.** Help caregiver to give child ORS solution in front of you until child is no longer thirsty. ☐ **Give caregiver 2 ORS packets to take home.** Advise to give as much as the child wants, but at least 1/2 cup ORS solution after each loose stool. ☐ **Give zinc supplement.** Give 1 dose daily for 10 days: ☐ Age 2 months up to 6 months—1/2 tablet (total 5 tabs) ☐ Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.

☐ Give ORS

A child with diarrhoea can quickly become dehydrated and may die. Giving water, breast milk, and other fluids to children with diarrhoea helps to prevent dehydration.

However, children who are already dehydrated—or are in danger of becoming dehydrated—need a mixture of Oral Rehydration Salts (ORS) and water. The ORS solution replaces the water and salts that the child loses in the diarrhoea. It prevents the child from getting sicker.

Use every opportunity to teach caregivers how to prepare ORS solution.

Ask the caregiver to wash her hands, then begin giving ORS in front of you, and give it until the child has no more thirst. The time the child is in front of you taking ORS helps you to see whether the child will improve. You also have a chance to see that the caregiver is giving the ORS solution correctly and continues to give it.

If the child does not improve, or develops a danger sign, urgently refer the child to the health facility.

If the child improves, give the caregiver 2 packets of ORS to take home. Advise the caregiver to give as much ORS solution as the child wants. But give ***at least 1/2 cup*** of a 250 ml cup (about 125 ml) after each loose stool.

ORS helps to replace the amount of fluids the child loses during diarrhoea. It also helps shorten the number of days the child is sick with diarrhoea.

(UNICEF distributes this packet of ORS to mix with 1 litre of water. A locally produced packet will look different and may require less than 1 litre of water. Check the packet for the correct amount of water to use.)

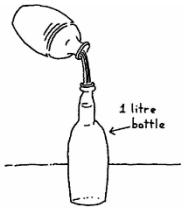
[If Health Surveillance Assistants are already preparing and giving ORS, the facilitator may go directly to the exercises. The exercises review how to prepare and give ORS solution. Participants will demonstrate their knowledge and skills in the review and role play exercises.]

Prepare ORS solution

1. Wash your hands with soap and water.

2. Pour the entire contents of a packet of ORS into a clean container (a mixing bowl or jar) for mixing the ORS. The container should be large enough to hold at least 1 litre.

3. Measure 1 litre of clean water (or correct amount for packet used). Use the cleanest drinking water available.



In your community, what are common containers caregivers use to measure 1 litre of water?

4. Pour the water into the container. Mix well until the salts completely dissolve.

Give ORS solution

1. Explain to the caregiver the importance of replacing fluids in a child with diarrhoea. Also, explain that the ORS solution tastes salty. Let the caregiver taste it. It might not taste good to the caregiver. But a child who is dehydrated drinks it eagerly.
2. Ask the caregiver to wash her hands and to start giving the child the ORS solution in front of you. Give frequent small sips from a cup or spoon. (Use a spoon to give ORS solution to a young child.)
3. If the child vomits, advise the caregiver to wait 10 minutes before giving more ORS solution. Then start giving the solution again, but more slowly. She should offer the child as much as the child will take, or at least ½ cup ORS solution after each loose stool.
4. Check the caregiver's understanding. For example:
   - Observe to see that she is giving small sips of the ORS solution. The child should not choke
   - Ask her: How often will you give the ORS solution at home? How much will you give?

5. The child should also drink the usual fluids that the child drinks, such as breast milk.

   If the child is not exclusively breastfed, the caregiver should offer the child clean water. Advise the caregiver not to give very sweet drinks and juices to the child with diarrhoea who is taking ORS.

   How do you know when the child can go home?

   A dehydrated child, who has enough strength to drink, drinks eagerly. If the child continues to want to drink the ORS solution, have the mother continue to give the ORS solution in front of you.

   If the child becomes more alert and begins to refuse to drink the ORS, it is likely that the child is not dehydrated. If you see that the child is no longer thirsty, then the child is ready to go home.

6. Put the extra ORS solution in a container and give it to the caregiver for the trip home (or to the health facility, if the child needs to be referred). Advise caregivers to bring a closed container for extra ORS solution when they come to see you next time.

7. Give the caregiver 2 extra packets of ORS to take home, in case she needs to prepare more.

   Encourage the caregiver to continue to give ORS solution as often as the child will take it. She should try to give at least ½ cup after each loose stool.

TIP: Be ready to give ORS solution to a child with diarrhoea. Keep with your medicine kit:

- A supply of ORS packets
- A 1 litre bottle or other measuring container
- A container and spoon for mixing the ORS solution
- A cup and small spoon for giving ORS
- A jar or bottle with a cover, to send ORS solution with the caregiver on the trip to health facility or home.

Store ORS solution

6. Keep ORS solution in a clean, covered container.

7. Ask the caregiver to make fresh ORS solution when needed. Do not keep the mixed ORS solution for more than 24 hours. It can lose its effectiveness.

Discussion: How to prepare and give ORS solution

Marianna is 2 years old. She has diarrhoea. Review what the Health Surveillance Assistant should do to treat Marianna's diarrhoea. **With the group, fill in the blank spaces below with the correct words, listed below:**

solution	no longer thirsty	one packet	litre	spoon
slowly	Dehydration	dissolve	spits up	loose stool
water	24 hours	Cup	one half	

The Health Surveillance Assistant will give Marianna ORS _____ for her diarrhoea. It will help prevent _____.

He empties _____ _____ of ORS into a bowl. He pours one _____ of drinking water into the bowl with the **ORS**. He stirs the ORS solution with a spoon until the salts _____.

He asks the mother to begin giving Marianna the ORS solution with a _____ or with a _____. He advises the mother to wait 10 minutes, if Marianna _____. Then she can start giving the ORS solution again, but more _____.

Marianna is no longer breastfeeding. Therefore, Marianna should also drink more _____, to increase the fluids she takes.

Marianna's mother should try to give her child _____ cup of ORS solution after each _____ _____, or as much as Marianna wants.
How does the Health Surveillance Assistant know that Marianna is ready to go home?
_____.

Her mother can keep unused ORS solution for _____ hours in a covered container.

What can the Health Surveillance Assistant do to check the mother's understanding of how to give Marianna ORS solution at home?
_____.

☐ Give zinc supplement

Zinc is an important part of the treatment of diarrhoea. Zinc helps to make the diarrhoea is less severe, and it shortens the number of days of diarrhoea. Zinc increases the child's appetite and makes the child stronger.

Zinc also helps prevent diarrhoea in the future. Giving zinc for the full 10 days can help prevent diarrhoea for up to the next three months.

For these reasons, we give zinc to children with diarrhoea. The diarrhoea treatment box on the recording form tells how much zinc to give (the dose). It also tells how many tablets (tabs) the child should take in 10 days. You will give the caregiver the total number of tablets for the 10 days, and help her give the first dose now.

Before you give a child a zinc supplement, **check the expiration date** on the package. Do not use a zinc supplement that has expired.

[Zinc supplements may come in a different size tablet, or may be in syrup form. If so, the national program will substitute the correct dose for the form of zinc available.]

☐ If **Diarrhoea** (less than 14 days AND no blood in stool)	☐ **Give ORS.** Help caregiver to give child ORS solution in front of you until child is no longer thirsty. ☐ **Give caregiver 2 ORS packets to take home.** Advise to give as much as the child wants, but at least 1/2 cup ORS solution after each loose stool. ☐ **Give zinc supplement.** Give 1 dose daily for 10 days: Age 2 months up to 6 months—1/2 tablet (total 5 tabs) Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.

Refer again to the diarrhoea box above (from your recording form). **How much zinc do you give a *child age 2 months up to 6 months?***

- Half (1/2) tablet of zinc
- One time daily
- For 10 days

Give the caregiver a supply of 5 tablets for a child age 2 months up to 6 months. Then, wash your hands and teach the caregiver how to cut the tablet and give the first dose — half a tablet to the child now.

How much zinc do you give a *child age 6 months up to 5 years?*

- One (1) whole tablet of zinc
- One time daily
- For 10 days.

Give the caregiver a supply of 10 tablets for the 10 days—the whole blister pack of 10 tablets. Ask the caregiver to give the first dose now.

For each child below, what dose of zinc supplement do you give?

Also, how many tablets totally would you give for the full 10-day treatment?

- *For a child age 2 months*
- *For a child age 3 months*
- *For a child age 6 months*

- *For a child age 3 years*
- *For a child age 5 months*
- *For a child age 4 years*
- *For a child age 4 months*

A 10-day treatment with zinc supplements helps to prevent diarrhoea for the next three months.

In some countries, zinc supplements come in a 10-tablet blister pack. One blister pack is enough for the full treatment of a child age 6 months up to 5 years.

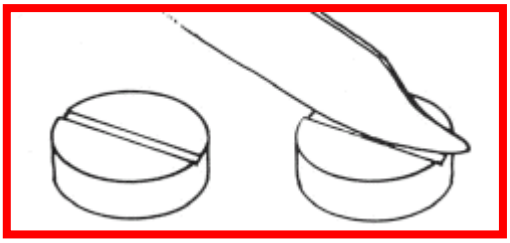
Cut the packet in half to give 5 tablets to the child age 2 months up to 6 months. (See the example.)

Help the caregiver give the first dose now

1. Wash your hands with soap and water. The caregiver should do the same.

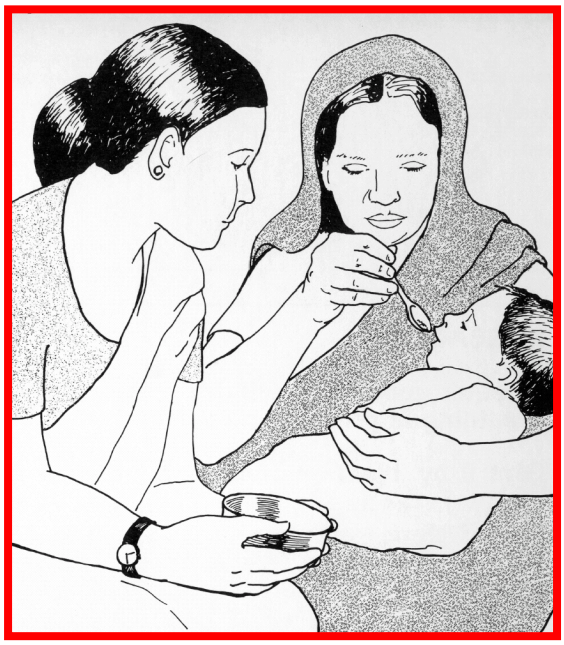
2. If the dose is for half of a tablet, help the caregiver cut it into two parts with a table knife.

3. Ask the caregiver to put the tablet or half tablet into a spoon with breast milk or water. The tablet will dissolve. The caregiver does not need to crush the tablet before giving it to the child.



4. Now, help the caregiver give her child the first dose of zinc. The child might spit out the zinc solution. If so, then use the spoon to gather the zinc solution and gently feed it to the child again. If this is not possible and the child has not swallowed the solution, give the child another dose.

5. Encourage the caregiver to ask questions. Praise the caregiver for being able to give the zinc to her child. Explain how the zinc will help her child. Ask good checking questions.



Give the caregiver enough zinc for 10 days. Explain how much zinc to give, once a day. Mark the dose on the packet of tablets.

Emphasize that it is important to give the zinc for the full ten days, even if the diarrhoea stops. Ten days of zinc will help her child have less diarrhoea in the months to come. The child will have a better appetite and will become stronger.

Then, advise the caregiver to keep all medicines out of reach of children. She should also store the medicines in a clean, dry place, free of mice and insects.

Finally, tick [✓] the treatment you gave in the diarrhoea box on the recording form (☐ Give ORS and ☐ Give zinc supplement, and the correct dose). The form is a record of the treatment, as well as a guide for making decisions.

Role play practice: Prepare and give ORS solution and zinc supplement

[This may be the first time that Health Surveillance Assistants will prepare an ORS solution or a zinc supplement. If so, the facilitator will demonstrate the unfamiliar tasks before this role play practice.]

Role play practice

Work with a partner who will be the caregiver. Make sure that the caregiver has a doll. If none is available, wrap a cloth to serve as a small child.

1. Follow the steps described in this manual to show the caregiver how to prepare the ORS solution.

   The caregiver should do *all* tasks. The Health Surveillance Assistant should coach so that the caregiver learns to prepare the ORS solution correctly. Guide the caregiver in measuring the water, emptying the entire packet, stirring the solution, and tasting it.

2. Help the caregiver give the ORS solution to her child.

3. Help the caregiver prepare and give the first dose of the zinc supplement to her child. Follow the steps in this manual.
4. Discuss any difficulties participants had in preparing and giving ORS solution and zinc supplement. Identify how to involve the caregiver in doing the tasks, and the best ways to check the caregiver's understanding.

Did you remember to wash your hands?

☐ *If fever*

Many children become sick with fever. You can identify fever by touch. Fever in a sick child, however, is not always present. Therefore, also ask the caregiver and accept the caregiver's report of fever now or in the last three days.

Often fever is a sign of malaria. Malaria is the most common cause of childhood deaths in some communities. Therefore, it is important to treat children who have malaria with an antimalarial.

The antimalarial medicine should not be given to a child who does not need it. Use a rapid diagnostic test (RDT) to determine whether a child with fever has malaria (for *falciparum* malaria). The test can be done in the community. The fever box (below) on the recording form reminds you to do the RDT before you treat the child for malaria.

☐ If **Fever** (less than 7 days)	☐ **Do a rapid diagnostic test (RDT):** __Positive __Negative ☐ **If RDT is positive, give oral antimalarial LA (Artemether-Lumefantrine)** **Give twice daily for 3 days:** ☐Age up to 5 months —not recommended ☐ Age 5 months up to 3 years—1 tablet (total 6 tabs) ☐ Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now. Advise to give 2nd dose after 8 hours, and to give dose twice daily for 2 more days.

Demonstration: Do a rapid diagnostic test for malaria

Your facilitator will demonstrate the steps to do a rapid diagnostic test (RDT) in a falciparum. As you follow the demonstration, read the summary of the steps in the section that follows. If you use a different RDT in your area, your facilitator will demonstrate using the locally available kit.

[Note: If there is a video available to demonstrate the use of the RDT you use locally, it may be used instead of this demonstration by your facilitator.]

☐ Do a rapid diagnostic test (RDT)[1]

Organize the supplies

First, collect the supplies for doing the RDT (see below). Organize a table area to keep all supplies ready for use.

For each child with fever, collect these supplies for the RDT:

1. NEW unopened **test packet**
2. NEW unopened **spirit (alcohol) swab**
3. NEW unopened **lancet**
4. New pair of **disposable gloves**
5. **Buffer**
6. **Timer** (up to at least 15 minutes)
7. **Sharps box**
8. **Non-sharps waste container (no photo)**

1. Test packet

2. Spirit (alcohol) swab

4. Disposable gloves

3. Lancet

5. Buffer

6. Timer

7. Sharps box

[1] The instructions with diagrams, here and in Annex A, are taken from *How to use a rapid diagnostic test (RDT): A guide for training at a village and clinic level* (2006). The Quality Assurance Project (QAP) and the World Health Organization (WHO). Bethesda, MD, and Geneva, Switzerland. The national malaria programme will substitute the instructions for the locally used test kit, if different.

Perform the test

1. **Check the expiry date of the packet.**

   The expiry date marked on the test package must be after today's date to be sure that the test materials will be effective.

2. **Put on the gloves. Use new gloves for each child.**

3. **Open the test packet and remove the test items: test, loop, and desiccant sachet.**

   The desiccant sachet is not needed for the test. It protects the test materials from humidity in the packet. Throw it away in a non-sharps waste container.

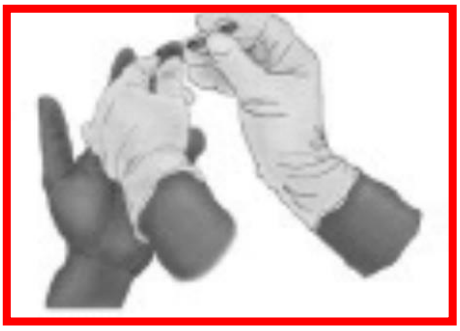
4. **Write the child's name on the test.**

5. **Open the spirit swab. Use the spirit swab to clean the child's fourth finger (ring finger) on the left hand** (or, if the child is left-handed, clean the fourth finger on the right hand).

   Then, allow the finger to dry in the air. Do not blow on it, or you will contaminate it again.

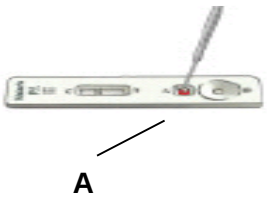
6. **Open the lancet. Prick the child's fourth finger—the one you cleaned—to get a drop of blood.** Prick towards the side of the ball of the finger, where it will be less painful than on the tip.

   Then, turn the child's arm so the palm is facing downward. Squeeze the pricked finger to form a drop of blood.



7. **Discard the lancet *immediately* in the sharps box.**

   Do not set the lancet down. There is an increased risk of poking yourself (with contamination by the blood) when you try to pick up the lancet later.



8. **Use the loop in the test kit to collect the drop of blood.**

9. **Use the loop to put the drop of blood into the square hole marked A. Discard the loop in the non-sharps box.**

10. **Put four drops of the buffer into the round hole marked B.**
    Record the time you added the buffer.

11. Wait 20 minutes after adding the buffer.

After 20 minutes, the red blood will drain from the square hole **A. Note**: The waiting time before reading the results may differ according to the type of RDT used in each country.

Exercise: Do an RDT

Your facilitator will divide the participants into groups of two or three participants to practice doing an RDT.

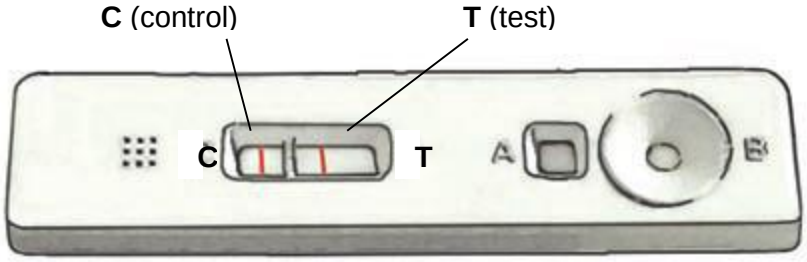
1. **Organize the supplies.** From the table display, take a set of supplies for performing the tests—one for each participant in your group. Lay them out in order of their use.
2. **Perform the test.** Do a rapid diagnostic test on each other. Use the job aid in Annex A to guide the test.

A facilitator will observe to ensure that the test is done correctly and the safety procedures are followed.

When you add the buffer, write the time on a piece of paper. Keep the test until later, when you will read the results.

Read the test results

12. Read and interpret the results in the C (control) and T (test) windows.



13. How to read and interpret the results:

Result	Decide	Comment
INVALID test: **No line in control window C.**	Repeat the test with a new unopened test kit	Control window C must *always* have a red line. If it does not, the test is damaged. The results are INVALID.
POSITIVE: **Red line in control window C AND** **Red line in test window T.** See the example in above test.	Child has **MALARIA**	The test is POSITIVE even if the red line in test window T is faint.
NEGATIVE: **Red line in control window C AND** **NO red line in test window T.**	Child has **NO MALARIA**	To confirm that the test is NEGATIVE, be sure to wait the full 20 minutes after adding the buffer.

14. Dispose off the gloves, spirit swab, desiccant sachet, and packaging in a non-sharps waste container. Wash your hands with soap and water.

Record the test results on the recording form. Tick [✓] the results of the test for malaria, __Positive or __Negative, in the fever box on the back of the recording form

Then dispose off the test in a non-sharps garbage container.

Each test can be used only once. For the safety of the child, start with a new unopened test packet, spirit (alcohol) swab, lancet, and disposable gloves. While doing the test and disposing of used items, prevent the possibility that one child's blood will be passed to yourself or to another child.

Exercise:
Read the RDT

Part 1. Read the result of the demonstration test

The results of the test done during the demonstration should now be ready. Your facilitator will ask you to read the results of the demonstration test. Remember to always check first whether the test is valid.

Tick [✓] the result here (do not share your answer with others):

Invalid__ Positive__ Negative__

The facilitator will then discuss the results. Be ready to explain your decision. What do the results mean?

Part 2. Read the result of the test you completed

If 15 minutes have passed since you added the buffer to the test you gave your partner, then read the results of the test: Tick [✓] the result here:

Invalid__ Positive__ Negative__

Discuss the results with the facilitator.

Part 3. More practice on reading test results

The facilitator will give you cards with sample test results on them. Write the test number for each below. Then read the results and record [✓] the results here:

Test number:____ Invalid__ Positive__ Negative__

Test number:____ Invalid__ Positive__ Negative__

Test number:____ Invalid__ Positive__ Negative__

Test number:____ Invalid__ Positive__ Negative__

Test number:____ Invalid__ Positive__ Negative__

When you have finished, the facilitator will discuss the test results with you.

RDT video exercises

Exercise: 1

You will watch the video and indicate using a Tick [✓] the result (do not share your answer with others): Invalid__ Positive__ Negative__.

For test number 1-5, you will be shown the correct answer after each test. For test number 6-10 you will be shown the correct answers at the end of the exercise.

Record [✓] the results here

Test number: 1	Invalid___	Positive___	Negative___
Test number: 2	Invalid___	Positive___	Negative___
Test number: 3	Invalid___	Positive___	Negative___
Test number: 4	Invalid___	Positive___	Negative___
Test number: 5	Invalid___	Positive___	Negative___

Record [✓] the results here

Test number: 6	Invalid___	Positive___	Negative___
Test number: 7	Invalid___	Positive___	Negative___
Test number: 8	Invalid___	Positive___	Negative___
Test number: 9	Invalid___	Positive___	Negative___
Test number: 10	Invalid___	Positive___	Negative___

Exercise: 2 (optional)

You will watch the video and indicate using a Tick [✓] the result (do not share your answer with others): Invalid__ Positive__ Negative__.
The correct answers will be shown at the end of the exercise.

Record [✓] the results here

Test number: 1	Invalid___	Positive___	Negative___
Test number: 2	Invalid___	Positive___	Negative___
Test number: 3	Invalid___	Positive___	Negative___
Test number: 4	Invalid___	Positive___	Negative___
Test number: 5	Invalid___	Positive___	Negative___
Test number: 6	Invalid___	Positive___	Negative___
Test number: 7	Invalid___	Positive___	Negative___
Test number: 8	Invalid___	Positive___	Negative___
Test number: 9	Invalid___	Positive___	Negative___
Test number: 10	Invalid___	Positive___	Negative___

Exercise: 3 (optional)

You will watch the video and indicate using a Tick [✓] the result (do not share your answer with others):

Invalid__ Positive__ Negative__.

The correct answers will be shown at the end of the exercise.

Record [✓] the results here			
Test number: 1	Invalid___	Positive___	Negative___
Test number: 2	Invalid___	Positive___	Negative___
Test number: 3	Invalid___	Positive___	Negative___
Test number: 4	Invalid___	Positive___	Negative___
Test number: 5	Invalid___	Positive___	Negative___
Test number: 6	Invalid___	Positive___	Negative___
Test number: 7	Invalid___	Positive___	Negative___
Test number: 8	Invalid___	Positive___	Negative___
Test number: 9	Invalid___	Positive___	Negative___
Test number: 10	Invalid___	Positive___	Negative___

☐ If RDT is positive, give oral antimalarial LA

If the rapid diagnostic test results are positive for malaria, your ability to start treatment quickly with an antimalarial medicine can save the child's life.

The malaria programme recommends the oral antimalarial LA. It combines medicines that together are currently effective against malaria in many communities.[1] Many countries provide pre-packaged AL for two age groups of children.

Before you give a child an antimalarial, **check the expiration date** on the package. Do not use an antimalarial that has expired.

Refer to the fever box below, which is also on the recording form.

☐ If **Fever** (less than 7 days) in a malaria area	☐ **Do a rapid diagnostic test (RDT):** __Positive __Negative ☐ **If RDT is positive, give oral antimalarial LA (Artemether-Lumefantrine)** **Give twice daily for 3 days:** ☐ Age up to 5 months – not recommended. ☐Age 5 months up to 3 years—1 tablet (total 6 tabs) ☐ Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now. Advise to give 2nd dose after 8 hours, and to give dose twice daily for 2 more days.

What is the dose for a child age 5 months up to 3 years?

- One (1) tablet of LA
- Twice daily
- For 3 days

[1] The effectiveness of an antimalarial in acting against malaria can be lost, sometimes quite quickly. The malaria programme responds with new guidelines when an antimalarial is no longer effective. Many malaria programs now distribute ACT (an Artemisinin-based Combination Therapy) for treating *falciparum* malaria. As this manual cannot present all formulations, the one discussed here is based on an antimalarial that combines Artemether (20 mg) and Lumefantrine (120 mg). Your malaria programme will adapt these guidelines to current policies and antimalarials available for use in community settings.

You will give a total of 6 tablets for the full 3-day treatment. Ask the caregiver to give the first dose immediately: 1 tablet..

What is the dose for a child age 3 years up to 5 years?

- Two (2) tablets of LA.
- Twice daily
- For 3 days

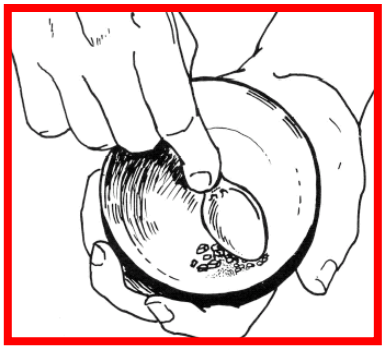
You will give a total of 12 tablets for the full 3-day treatment. Ask the caregiver to give the first dose immediately: 2 tablets, Advise her to give another 2 tablets after 8 hours. (It may be helpful to remember that the dose for a child this age is 2 times or double the dose for a child age 2 months up to 3 years.)

Then, ask the caregiver to give the remaining tablets, 2 in the morning and 2 at night, for 2 more days.

Help the caregiver give the first dose now

You will help the caregiver give the child the first dose right away in front of you. To make it easier for the child to take the tablet, help the caregiver prepare the first dose:

1. Wash your hands with soap and water.
2. Use a spoon to crush the tablet in a cup or small bowl.
3. Mix it with breast milk or with water. Or crush it with banana or another favourite food of the child.
4. Ask the caregiver to give the solution with the crushed tablet to the child with a spoon. Help her give the whole dose.



Then, remind the caregiver to give the child a second dose after 8 hours. The recommended time between tablets is to prevent giving the second dose too soon. This would make the dose too strong for the child. This recommendation also makes sure that the child does not wait until the next day to get the second dose. This would be too late.

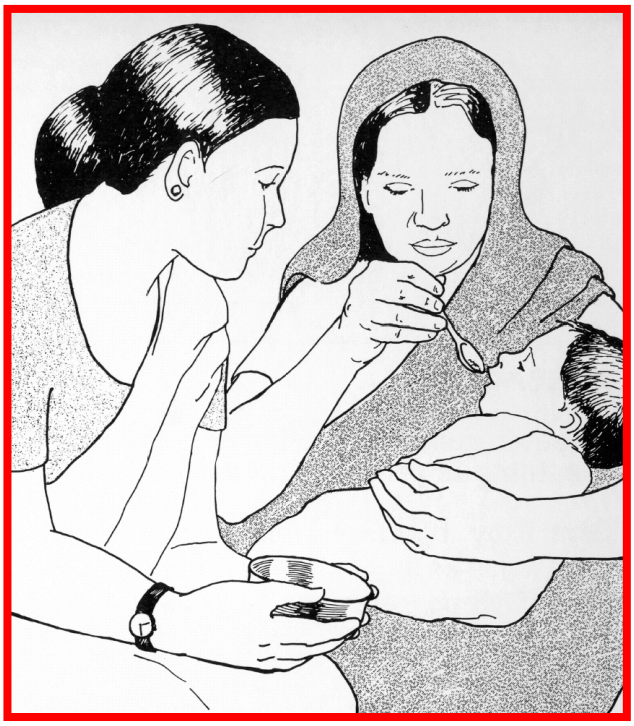
Advise the caregiver that on the next day (tomorrow), she must give one dose in the morning and one dose at night. Continue with this dose morning and night on the following day to finish all the pills. Emphasize that it is important to give the antimalarial for 3 days, even if the child feels better.

You do not have to memorize the doses. As with zinc and other treatments, refer to the box on the recording form. Tick [✓] the treatment and dose you give for malaria in the fever box.

Ask the caregiver for any questions or concerns she may have, and answer them. The caregiver should give the child the antimalarial the same way at home.

Before the caregiver leaves, ask the caregiver to repeat the instructions. Mark the dose on the packet to help the caregiver remember.

Help the caregiver give the first dose of a medicine. If the child spits up the medicine, help the caregiver use the spoon to gather up the medicine and try to give it again.



If the child spits up the entire dose, give the child another full dose. If the child is unable to take the medicine, refer the child to the health facility.

Many fevers are due to illnesses that go away within a few days. If the child has had fever for less than 7 days and the results of the RDT are negative, then ask to see the child in 3 days for a follow-up visit. Also advise the caregiver to bring the child back right away if the child becomes sicker.

If the child is not better when you see the child during the follow-up visit, refer the child to a health facility.

Give Paracetamol

A child with malaria should also be given paracetamol. Paracetamol lowers fever and reduces pain.

Paracetamol. Give 4 times a day for 3 days
Age 5 months up to 3 years - ¼ tablet (total 3 tabs)
Age 3 years up to 5 years – ½ tablet (total 6 tabs)

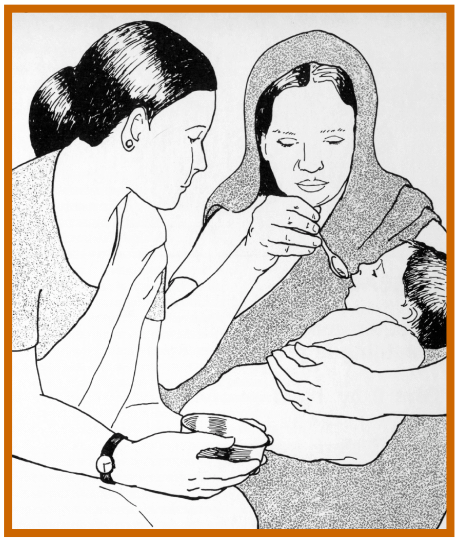
If a child has high fever, give one dose of paracetamol in clinic.

If the child has malaria, give the caregiver enough paracetamol for 3 days. Tell the caregiver to give one dose every 6 hours until fever or pain is gone.

You do not have to memorize the doses. As with zinc and other treatments, refer to the box on the Recording Form. Tick [✓] the treatment you give for fever in the fever box.

Ask the caregiver for any questions or concerns she may have, and answer them. The caregiver should give the child the antimalarial the same way at home.

Before the caregiver leaves, ask the caregiver to repeat the instructions. Mark the dose on the packet to help the caregiver remember.



Help the caregiver give the first dose of medicine. If the child spits up the medicine, help the caregiver use the spoon to gather up the medicine and try to give it again.

If the child spits up the entire dose, give the child another full dose. If the child is unable to take the medicine, refer the child to the health centre.

Exercise:
Decide on the dose of an antimalarial to give a child

Your facilitator will give you a card with the name and age of a child, from the list below. The child has fever (less than 7 days with no danger sign) and lives in a malaria area. The results of the RDT are **positive** for malaria, and the child will be treated at home. Complete the information for your child in the table below.

The facilitator will also give you blister packs of tablets of the antimalarial LA. Demonstrate the dosage using the tablets. Refer to the box on the treatment of fever on the recording form to guide your answers.

1. How many tablets should the child take in **a single dose? How many times a day? For how many days?**
2. Count out the tablets for the child's full treatment. (If the tablets are in a blister pack, do not remove them from the pack.) **How many tablets totally should the child take?**
3. Based on the time when the child received the first dose, **what time should the caregiver give the child the next dose?**

Raise your hand when you have finished. The facilitator will check your decisions, and then will give you a card for another child.

Child with fever and positive RDT result for malaria	Age	How many tablets are in a single dose?	How many times a day?	For how many days?	How many tablets totally?	First dose was given at:	What time to give next dose?
1. Carlos	2 years					8:00	
2. Ahmed	4 and a half years					14:00	
3. Jan	3 months					now	
4. Anita	8 months					10:00	
5. Nandi	6 months					15:00	
6. Becky	36 months					11:00	
7. Maggie	4 years					9:00	
8. William	3 and a half years					13:00	
9. Yussef	12 months					14:00	
10. Andrew	4 years					7:00	
11. Ellie	Almost 5 years					12:00	
12. Peter	5 months					16:00	

☐ Advise caregiver on use of a Long Lasting Insecticide Treated Nets (LLINs)

Children under 5 years (and pregnant women) are particularly at risk of malaria. They should sleep under an LLIN that has been treated with an insecticide to repel and kill mosquitoes.

The mosquitoes that carry the malaria parasite come out to bite at night. Without the protection of LLINs, children will get malaria repeatedly. They are at great risk of dying.

Further, malaria is a major cause of anaemia in young children. Anaemia makes a child very weak and tired. It limits the child's ability to learn.

Advise caregivers on using an LLIN for their young children. This advice is especially important for a caregiver of a child who receives an antimalarial.

If the family does not have an LLIN, provide information on where to get an LLIN. The Ministry distributes free LLINs

Types of insecticide-treated nets (ITNs).

- **The recommended net is now a long-lasting insecticidal net (LLIN).**

Discuss with the facilitator: **How do families get an LLIN in your community?** Some ways to get an LLIN might be:

- From the health facility—the **Ministry** may give an LLIN to all families with children under age 5 years or with a pregnant woman.
- From a local seller—a local store or market stand may sell LLIN at a reduced cost.

Unfortunately, many families who have an LLIN do not use it consistently and correctly. They do not

- ❖ Use the net every day and throughout the year
- ❖ Hang the net correctly over the sleeping area
- ❖ Replace a damaged or torn net.

Discuss: **Where do families learn how to use and maintain an LLIN** Refer families to the person in the community who is responsible for promoting the use of LLIN. You can also invite someone from the health facility to speak during the SADC malaria week about how to use an LLIN. How to maintain the effectiveness of an LLIN depends on the type of net. (see tip box).

☐ *If red eye*

Red eye may be a sign of local infection of the eye (conjunctivitis). A child with red eye may have difficulties in seeing. If untreated, red eye may lead to blindness – Give children with red eyes an antibiotic eye ointment.

☐ Give an antibiotic eye ointment

Check the expiry date on the eye ointment tube. Do not use it if the drug has expired.

Always wash hands before and after applying the ointment

Clean the child's eyes immediately before applying the tetracycline eye ointment.

Then apply tetracycline ointment in both eyes 3 times daily (in the morning, at mid-day and in the evening).

The dose is about the size of a grain of rice.

Squeeze the dose of tetracycline (or chloramphenicol) eye ointment onto both lower eyelids.

Treat for **three** days. Do not use other eye ointments or drops, or put anything else in the eye

Teach the caregiver to apply the antibiotic eye ointment.

Tell caregiver that treatment should be applied onto both eyes to prevent damage to the eyes.

Also tell the caregiver that the ointment will slightly sting the child's eye. Below is a box (from the recording form) showing treatment for red eye:

☐ **If red eye**	☐ **Apply antibiotic eye ointment.** Squeeze the size of a grain of rice on each of the inner lower eyelids, three times a day for 3 days

☐ *If fast breathing*

Cough with fast breathing is a sign of pneumonia. The child with cough and fast breathing must have an antibiotic or the child will die. With good care, families can treat a child with cough and fast breathing—with no chest in drawing or other danger sign—at home with an antibiotic (Amoxicillin).

☐ Give oral Amoxicillin

A child with cough and fast breathing needs an antibiotic. An antibiotic, such as Amoxicillin, is in your medicine kit. It may be in the form of a tablet. Or it may be a suspension in a bottle to mix with water to make a syrup.

Check the expiration date on the Amoxicillin package. Do not use Amoxicillin that has expired.

The instructions here are for Amoxicillin in the form of an adult 250 mg tablet. *NB: If you have a different antibiotic in your medicine kit, the national programme will adapt these instructions.*

☐ If **Fast Breathing**	☐ **Give oral antibiotic** (Amoxicillin—250 mg). Give twice daily for 5 days: ☐ Age 2 months up to 12 months—1 tablet (total 10tabs) ☐ Age 12 months up to 5 years—2 tablets (total 20 tabs) Help caregiver give first dose now.

Look in the box above (from the recording form). **What is the dose for a child age 2 months up to 12 months?**

- Open adult tablet of Amoxicillin
- Twice daily (morning and night)
- For 5 days

You will give the caregiver a supply of 10 tablets for the 5-day treatment for a child age 2 months up to 12 months.

What is the dose for a child age 12 months up to 5 years?

- Two adult tablets of Amoxicillin
- Twice daily (morning and night)
- For 5 days.

You will give the caregiver a supply of 20 tablets for the 5-day treatment for a child age 12 months up to 5 years.

Do not give medicine to a child who does not need it.

- Giving medicine to a child who does not need it will not help the child get well. An antibiotic, for example, does not cure a simple cough.
- Misused medicines can be harmful to the child.
- Misused medicines become ineffective. They lose their strength in fighting illness.
- Giving medicine to a child who does not need it is wasteful. It can mean that later the medicine is not there for that child or other children when they need it.

Ask the caregiver to give the first dose immediately. Help the caregiver crush the Amoxicillin tablet and add water or breast milk to it to make it easier for the child to take. Some countries use dispersible tablets that do not need to be crushed.

Then tell the caregiver to continue giving the dose morning and evening until the tablets are finished (for 5 days). Mark the dose on the package.

Ask the caregiver to repeat the instructions before leaving with the child. Ask good checking questions to make sure that the caregiver understands how much Amoxicillin to give, when, and for how long.

Emphasize that it is important to give the Amoxicillin for the full 5 days, even if the child feels better.

If the caregiver must give more than one medicine, review how to give each medicine to the child. Check the caregiver understands again.

Finally, advise the caregiver to keep all medicine out of reach of children. She should also store the medicine in a clean, dry place, free of mice and insects.

Exercise:
Decide on the dose of Amoxicillin to give a child

Your facilitator will give you a card with the name and age of a child, from the list below. The child has cough with fast breathing (with no danger sign) and will be treated at home. On the table below, write the dose of the antibiotic Amoxicillin to give the child. Complete the information for the child's treatment.

The facilitator will also give you Amoxicillin tablets. Demonstrate the dosage using the tablets. Refer to the box on the treatment of cough with fast breathing on the recording form to guide your answers.

1. How much should the child take in **a single dose? How many times a day? For how many days?**

2. Count out the tablets for the child's full treatment. (If the tablets are in a blister pack, do not remove them from the pack.) **How many tablets totally should the child take?**

   Raise your hand when you have finished. The facilitator will check your decisions, and then will give you a card for another child.

Child with fast breathing	Age	How many tablets are in a single dose?	How many times a day?	For how many days?	How many tablets totally?
1. Carlos	2 years				
2. Ahmed	4 and a half years				
3. Jan	3 months				
4. Anita	8 months				
5. Nandi	6 months				
6. Becky	36 months				
7. Maggie	4 years				
8. William	3 and a half years				
9. Yussef	12 months				
10. Andrew	4 years				
11. Ellie	Almost 5 years				
12. Peter	5 months				

☐ *If Acute Malnutrition*

ACUTE MALNUTRITION TREATMENT PROTOCOL WITHIN INTEGRATED COMMUNITY CASE MANAGEMENT

Admission criteria (Both SAM and MAM)	<12.5cm MUAC (YELLOW or RED) OR bipedal oedema (+/++) AND clinically uncomplicated (i.e., passes appetite test, no Integrated Community Case Management (iCCM) danger signs/no serious medical complications)
Treatment frequency	<11.5CM (RED): Weekly 11.5-<12.5cm (YELLOW): refer
Dosage	<11.5cm or oedema (+/++): • Two (92g sachet) RUTF/day (1000 kcal/day)
Transition from 2 RUTF to 1 RUTF (From RED to YELLOW)	Two consecutive weekly measurements at or above 11.5cm and no oedema
Cured	≥12.5cm for 2 consecutive measurements and no oedema, with 3-week minimum stay
Default	Absent for 2 consecutive visits
Non-recovered	Has not achieved discharge criteria within 16 weeks
Discharge procedures	Discharge ration of 7 RUTF sachets and nutrition counselling
Routine medical treatments (as per national protocol)	For all children with MUAC <11.5cm or bipedal oedema (+) on admission: • Amoxicillin: Give first dose at village clinic and then give remainder to caretaker with instructions to give twice daily for 7 days For all children with MUAC <11.5cm or bipedal oedema (+) on admission: • Malaria: according to national protocol • Refer for measles-rubella vaccine on 4th visit/4th week (children at least 9 months, unless already vaccinated) • Deworming: one dose (albendazole or mebendazole) on the second visit(second week) (children >1 year)
Referral procedures (as per national protocol)	Any child who develops medical complications and/ or Is not responding to treatment will be referred for a medical evaluation and/or to the Stabilization Center. Not responding to treatment will be defined in the following way: · MUAC still <11.5 cm for 5 consecutive weeks · Presence of oedema for 5 consecutive weeks · Worsening of oedema or MUAC in subsequent visits · Oedema still present (oedema still present either from ++ to + or remains + since enrolment) · Failure of appetite test

Feeding procedure

Explain the following to the caregiver about the feeding procedure:

- Ensure hand hygiene by washing hands with clean water and soap before feeding the child.
- She/he should feed the child small amounts of RUTF and the child should finish the allocated daily ration before being given any other food (with the exception of breast milk).
- She/he should encourage the child to eat as often as possible (every 3 hours during the day).
- If the child is breastfeeding, offer breast milk on demand and before feeding with RUTF.
- Give plenty of safe drinking water while feeding the child RUTF to keep the child hydrated.
- Do not to mix RUTF with liquids; this might foster bacterial growth.
- Do not mix RUTF with other food.

Ask the caregivers to return empty RUTF packets at each follow-up visit

- NB : RUTF is a medicine for the treatment of malnutrition , therefore should not be shared
- Caregiver for children on malnutrition treatment who are breastfeeding should breast-feed the child before offering RUTF.

Follow up

The HSA should review all malnourished children at the village clinic to check the children's health and the caregivers' compliance with treatment for SAM.

Actions on follow up

Continue treatment: Those who comply with treatment and responding well

Follow-Up Actions at the End of Every OTP Follow-Up Visit

The health care provider should indicate any necessary follow-up actions on the treatment chart, such as:

- Home visits for children requiring special attention
- Referral for further medical investigation

At each OTP follow-up visit, the caregiver should be informed of the child's progress, and individual and/or group counselling should be provided, including delivery of health and nutrition messages on hygiene, sanitation, breastfeeding, and appropriate complementary foods.

Home Visits for Children Who Require Special Attention

The HSA should assign care-group volunteer, or other community volunteer to each child admitted to the OTP. The HSA and volunteer should visit all patients at their homes between weekly OTP sessions to check the children's health and the caregivers' compliance with treatment for SAM.

The HSA should prioritise home visits for children who require special attention.

- Children who are not responding to treatment
- Caregivers who have refused referral
- Are absent or defaulting

Problems Related to Treatment Quality

- Inappropriate evaluation of the child's health condition or missed medical complication
- Inappropriate evaluation of the appetite test
- Non-adherence to the RUTF protocol
- Abrupt weaning from RUTF
- Non-adherence to the routine medication protocol
- Inadequate guidance provided for home care

Problems Related to the Home Environment

- Inappropriate frequency of visits to the village clinic and reception of RUTF
- Inadequate intake or sharing of RUTF and/or medicines

It is recommended that children who are referred to the health facility due to failure to respond to treatment be tested for other underlying chronic illnesses such as TB. If a child is referred for health facility due to deterioration in his/her condition, a referral form should be provided and information should be recorded in the child's health passport

If at risk of HIV

 Advise caregiver to take the child for HIV test soon, and, if parents' HIV status is not known, advise the mother and father to test for HIV also

The risk is that the child may have been infected with HIV by the mother during pregnancy or breastfeeding.

Infants and children who have HIV are more likely to get diarrhoea, pneumonia and to become malnourished. However, ARVs and other medications that can help these children are available at the health facility. For this reason, it is important that infants and children born to mothers who have HIV are tested for HIV, to know if they need ARVs.

Advise the caregiver to take the child for an HIV test soon. This is the only way to determine if the child's illness may be related to or complicated by HIV. If the parents' HIV status is unknown, advise the mother and father to test for HIV also. If one or both parents have HIV, they can benefit from ARVs and special care.

The Health Surveillance Assistant should share information on where and how to test for HIV

If living in household with someone on TB treatment

 Advise caregiver to take the child soon for TB screening and TB preventive medicine

Any infant or young child who lives in the household with a TB patient is exposed to TB. A young child who is exposed to TB is at risk of developing TB disease, even if the child has received BCG vaccine. Children with HIV or severe malnutrition are most at risk for falling ill or dying from TB.

Advise the caregiver to take the child to a health facility soon to be screened for TB.

If the child does not have TB, he should begin taking TB preventive medicine. This treatment can prevent the development of TB disease.

If the child has TB, he must begin TB treatment.

When any person in the household is diagnosed with TB, it is important that the person start TB treatment right away, take the TB medicines correctly, and complete the TB treatment. After 2 months of treatment, the TB is no longer contagious.

It is also important to ventilate the home well and protect young children from close contact (sharing air) with the TB patient.

☐ *For ALL children treated at home: Advise on home care*

Treatment with medicine is only one part of good care for the sick child. All sick children also need good home care to help them get well.

The box below (from the recording form) summarizes the advice on home care for a sick child.

☐ For **ALL children treated at home, advise on home care**	☐ **Advise the caregiver to give more fluids and continue feeding.** ☐ **Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool ☐ **Follow up child in 3 days.**

☐ Advise to give more fluids and continue feeding

During illness a child loses fluid. For children who are exclusively breastfeeding, advise the mother to breastfeed more frequently, and for longer at each feed. This should be enough fluid, even when the weather is hot and dry.

For children who are exclusively breastfeeding, advise the mother to breastfeed more frequently, and for longer at each feed. This should be enough fluid, even when the weather is hot and dry.

For children who are not exclusively breastfed, give clean water and more fluid foods. Soup and rice water will help to replace the lost fluid during illness. The child with diarrhoea should also take ORS solution.

A child often loses an appetite during illness and has less interest in food. The caregiver might think that she should stop offering food until the child feels better.

Instead, advise the caregiver of a sick child to continue feeding. If the child is breastfed, continue breastfeeding.

For the child who is taking foods, advise the caregiver to offer the child's favourite nutritious foods. Do not force the child to eat. But take more time and offer food more often. Expect that the appetite will improve as the child gets better.

Unfortunately, children who are frequently sick can become malnourished. Being malnourished makes the child more at risk of serious illness. Advise the caregiver to continue to offer more foods, more frequently after the child is well. This will help the child catch up after the illness.

A child with cough may also have a sore throat. A sore throat is uncomfortable and can prevent the child from drinking and feeding well.

If the child is *not* exclusively breastfed, advise the caregiver to soothe the throat with a safe remedy. For example, give the child warm—not hot—water with honey.

Tell the caregiver not to give cough medicine to a child. Cough medicines are expensive. And they often contain ingredients that are harmful for children. Warm water with honey will be comforting. It will be all that the child needs.

If the child is exclusively breastfed, advise the caregiver to continue offering the breast. Do not give any throat or cough remedy. A child, even with a sore throat, will usually take the breast when offered.

☐ Advise on when to return

Advise the caregiver to go to the nearest health facility if the child becomes sicker. This means that the medicine is not working or the child has another problem. If she cannot get to the health facility, she should return to see you.

Emphasize that it is urgent to seek care immediately if the child:

- Cannot drink or feed
- Becomes sicker
- Has blood in the stool

Usually a caregiver will know when a child is improving or becoming sicker. Ask the caregiver what she will look for. A child may become weaker and very sleepy. A child with

a cough may have difficulty in breathing. Make sure that the caregiver recognizes when the child is not getting better with home care.

If the caregiver sees signs that the child is getting sicker, she should take her child directly to the health facility. She should not delay. If this is not possible, she should return immediately to you, and you will assist the referral.

Check the vaccines the child received

Childhood vaccines

- BCG—tuberculosis vaccine
- OPV—oral polio vaccine
- Rota virus vaccine
- DPT- HepB + Hib (pentavalent)

DPT—combined diphtheria, pertussis (or whooping cough), and tetanus vaccine

- Hib—meningitis, pneumonia and other serious infections

Vaccines protect children from many illnesses. With vaccines, children no longer need to suffer and die from diphtheria, whooping cough, hepatitis, persistent diarrhoea, pneumonia, otitis media, meningitis or measles. A vaccine can protect against a life-long disability from polio. Vaccines can help prevent some forms of pneumonia and diarrhoea in children, including those exposed to HIV or living with HIV.

Health workers will tell the caregiver when to bring a child for the next vaccine. Your role with the caregiver is to ask about child vaccines and help make sure that the child receives each vaccine according to schedule.

Ask the caregiver to always bring the child's health card or other health record with her. Look at the child's record to see whether the vaccines are up to date. (If the caregiver forgets to bring the record, she may be able to tell you when and which vaccines the child has received.)

[The facilitator will show how the vaccines are recorded on the health card or other record.]

Note: Do not ask about the child's vaccines when you refer a child with a danger sign. Avoid any discussions that delay the child from going right away to the health facility.

With other children treated at home, however, do not miss the opportunity. Check whether the child's vaccines are up to date. Counsel the caregiver on when and where to take the child for the next vaccine.

Health cards list some vaccines by their initials. The recording form uses the same initials. (See the box.)

For example, OPV is the Oral Polio Vaccine. For the best protection against polio, one vaccine is not enough. The child must receive the vaccine four times. The polio vaccines are: OPV-0, OPV-1, OPV-2, and OPV-3. (The child receives OPV-4 only if the child did not receive the first vaccine at birth.)

4. CHECK VACCINES RECEIVED(Tick ☑ vaccines completed, circle (■) vaccines missed)

*Keep an interval of 4 weeks between DPT-HepB + Hib and OPV doses. Do not give OPV 0 if the child is 14 days old or more

Age	Vaccine	Advice to the Caregiver, if needed: WHEN is the next vaccine to be given WHERE?
Birth	□■BCG □■OPV-0	
6 weeks	□■DPT-Hib + HepB 1 □■OPV-1 □■ PCV □■Rotavirus	
10 weeks	□■ DPT-Hib + HepB 2 □■OPV-2 □■ PCV □■ Rotavirus	
14 weeks	□■ DPT -Hib + HepB 3 □■OPV-3 □■ PCV	
9 month	□■ Measles 1	
15 months	□■ Measles 2	

The box above, on the recording form, lists the vaccines according to the recommended schedule. It lists the vaccines given at birth, and at age 6 weeks, 10 weeks, 14 weeks, 9 months and 15 months.

For each vaccine:

1. ***How many times does the child receive the vaccine?***
2. ***What are the recommended ages to receive the vaccine?***

A child should receive the vaccines at the recommended age. If the child is too young, the child cannot fight the illness well. If the child is older, then the child is at greater risk of getting the illness without the vaccine.

The DPT- HepB+ Hib vaccines is given at the same time in the series with the oral polio vaccine (OPV) and PCV. The first time is when the child is age 6 weeks. Keep an interval of 4 weeks between the DPT-Hib + HepB vaccines and OPV. Rota virus vaccine is given twice at 6 weeks and 10 weeks.

The measles vaccine should not be given before the child is 9 months old. The child should receive all the vaccines, however, by no later than the child's first birthday.

The child should receive all the vaccines, however, by no later than the child's first birthday.

[The schedule may be different in your area. If so, the form will have your local schedule.]

Even if the child is sick and will be treated at home, give the needed vaccine at the first opportunity.

4. CHECK VACCINES RECEIVED

(Tick ☑ vaccines completed, circle ■ vaccines missed)

*Keep an interval of 4 weeks between DPT-HepB + Hib and OPV doses. Do not give OPV 0 if the child is 14 days old or more

Age	Vaccine	➔ Advise caregiver, if needed:
Birth	☑ BCG ☑ OPV-0	WHEN is the next vaccine to be given? *Tuesday*
6 weeks	☑ DPT-Hib + HepB 1 ☑ OPV-1 ☑ PCV1 ☑ Rotavirus 1	WHERE? *Magomero HC*
10 weeks	■ DPT-Hib + HepB 2 ■ OPV-2 ■ PCV 2 ■ Rotavirus 2	
14 weeks	■ DPT -Hib + HepB 3 ■ OPV-3 ■ PCV	
9 month 15 months	■ Measles 1 ■ Measles 2	

In the sample below, the Health Surveillance Assistant checked the vaccines given to Mary Kanthiti, a 12 week old child. A tick [✓] in the sample recording form below indicates a vaccine that Mary Kanthiti has received. A circle [O] indicates a missed vaccine—that is, a vaccine Mary Kanthiti should have received, based on her age and the schedule.

What vaccines did Mary Kanthiti receive?

Mary Kanthiti is 12 weeks old. Is she up to date on her vaccines? What vaccines did she miss?

Which vaccines should she receive next?

The Health Surveillance Assistant counselled Mrs. Kanthiti to be sure to take her daughter for her vaccination. When and where should they go, according to the note?

Which vaccines remain on the schedule to be completed later?

Reminder: A child may need to receive a set of vaccines to catch up on missed ones. If so, the child should wait 4 weeks before receiving the next, subsequent set of vaccines.

Ella is 2 and half years old and has not received any vaccines. What vaccines should Ella receive today or as soon as possible?

{She should receive BCG, OPV-1, DPT- HepB 1 + Hib , PCV 1, and measles vaccines. Four weeks later, what vaccines should Ella receive?]

Exercise: Advise on the next vaccines for the child

Check the vaccines given to the three children below. For each child:

1. What vaccines did the child receive?
2. Which vaccines, if any, did the child miss?
3. Which vaccines should the child receive next?
4. The child lives in your community. When and where would you advise the caregiver to take the child for the next vaccine? Write your advice in the space provided.

Discuss with your facilitator what to advise caregivers to do when their children are behind more than one set of scheduled vaccines.

Child 1. Sam Katola, age 6 months

4. CHECK VACCINES RECEIVED

(Tick ☐ vaccines completed, circle ■ vaccines missed)

*Keep an interval of 4 weeks between DPT-HepB + Hib and OPV doses. Do not give OPV 0 if the child is 14 days old or more

Age	Vaccine	➔ Advise caregiver, if needed:
Birth	☑ BCG ☑ OPV-0	WHEN is the next vaccine to be given? *Tuesday*
6 weeks	☑ DPT-Hib + HepB 1 ☑ OPV-1 ☑ PCV1 ☑ Rotavirus 1	WHERE? *Magomero HC*
10 weeks	☐ ■ DPT-Hib + HepB 2 ☐ ■ OPV-2 ☐ ■ PCV 2 ☐ ■ Rotavirus 2	
14 weeks	☐ ■ DPT -Hib + HepB 3 ☐ ■ OPV-3 ☐ ■ PCV	
9 month 15 months	☐ ■ Measles 1 ☐ ■ Measles 2	

Child 2. Wilson Manyozo, age 5 months

Wilson received only his BCG at birth. At age 6 weeks, 10 weeks, and 14 weeks, he received his DPT- HepB + Hib and his polio vaccine.

Complete the portion of the recording form below. Indicate the vaccines received, and the vaccines missed. Which vaccines should Wilson receive next?

In your community, when and where should his mother take him for his next vaccines?

Child 3. Joyce Tanyamula, age 12 weeks

Joyce was born in Malingunde Hospital. She received her BCG and OPV-0 vaccines at birth. She has not had any other vaccines since then.

Complete the record below. Identify the vaccines received, and the vaccines missed.

In your community, when and where should her father take her for her next vaccines?

Wilson Manyozo

4. CHECK VACCINES RECEIVED

(Tick ☐ vaccines completed, circle ■ vaccines missed)

*Keep an interval of 4 weeks between DPT-HepB + Hib and OPV doses. Do not give OPV 0 if the child is 14 days old or more

Age	**Vaccine**	**➔ Advise caregiver, if needed:**
Birth	□ ■BCG □ ■OPV-0	**WHEN is the next vaccine to be given?**
6 weeks	□ ■DPT-Hib + HepB 1 □ ■OPV-1 □ ■ PCV1 □ ■Rotavirus 1	
10 weeks	□ ■ DPT-Hib + HepB 2 □ ■OPV-2 □ ■ PCV 2 □ ■Rotavirus 2	
14 weeks	□ ■ DPT -Hib + HepB 3 □ ■OPV-3 □ ■ PCV	
9 month 15 months	□ ■ Measles 1 □ ■ Measles 2	**WHERE?**

Joyce Tanyamala

4. CHECK VACCINES RECEIVED

(Tick ☑ vaccines completed, circle ■ vaccines missed)

*Keep an interval of 4 weeks between DPT-HepB + Hib and OPV doses. Do not give OPV 0 if the child is 14 days old or more

Age	**Vaccine**	**➔ Advise caregiver, if needed:**
Birth	□ ■BCG □ ■OPV-0	**WHEN is the next vaccine to be given?**
6 weeks	□ ■DPT-Hib + HepB 1 □ ■OPV-1 □ ■ PCV □ ■Rotavirus	
10 weeks	□ ■ DPT-Hib + HepB 2 □ ■OPV-2 □ ■ PCV □ ■Rotavirus	
14 weeks	□ ■ DPT -Hib + HepB 3 □ ■OPV-3 □ ■ PCV	
9 month 15 months	□ ■ Measles 1 □ ■ Measles 2	**WHERE?**

Follow up the sick child treated at home

☐ Follow up child in 3 days

All sick children sent home for treatment or basic home care need your attention. This is especially important for children who receive an antimalarial for malaria or an antibiotic for fast breathing, as well as ORS and zinc for diarrhoea. The follow-up visit is a chance to check whether the child is receiving the medicine correctly and is improving.

Set an appointment for the follow-up visit

Even if the child improves, ask the caregiver to bring the child back to see you in 3 days for a follow-up visit. Help the caregiver agree on the visit. Record the day you expect the follow-up visit on the back of the recording form (item 6). If a time is set—for example, at 9:00 in the morning—also record the time.

If the caregiver says that the family cannot bring the child to see you, it is important to find a way to see the child. If the family cannot come, perhaps a neighbour might be willing to bring the child to see you. **If not, you must go to visit the child at home, especially if you have given the child an antimalarial or antibiotic.**

During the follow-up visit

During the follow-up visit, ask about and look for the child's problems. Look for danger signs, and any new problems to treat.

Then, make sure that the child is receiving correct treatment. Find out if the caregiver is continuing to give the medicine. Remind her that she must give the daily dose of zinc, or the antibiotic, until the tablets are gone, even if the child is better. Also she must give the missing doses of the antimalarial if the 6 recommended doses were not yet completed.

If you advised the caregiver to take the child to the health facility soon for HIV testing or TB screening, ask if she has taken the child yet. If not, encourage the caregiver again to take the child as soon as she can.If it is a new problem that you can treat, treat the child at home, and advise on good home care.

If you find that—in spite of treatment—the child has a danger sign, is getting sicker, or even is not getting better, refer the child urgently to the health facility. On the recording form, tick [✓] the appropriate note to indicate what you have found and your decision (item 7): **Child better, Child is not better,** or **Child has a danger sign**.

If the child is not better or now has a danger sign, write a referral note, and assist the referral to prevent delay.

If the child continues treatment at home, circle the next follow-up day. Ask the caregiver to bring the child back, for example, if you have found a new problem or you are concerned about whether the caregiver will finish the treatment with the oral medicine.

Remind the caregiver to bring the child back immediately if the child cannot drink or feed, becomes sicker, or has blood in the stool.

Record the treatments given and other actions

The recording form lists the treatments and home care advice for children treated at home. This list is a reminder of the important tasks to help the child get correct treatment at home. It also is a record. Tick [✓] the treatments given and other actions as you complete them.

> Note: During practice in the classroom, hospital, or outpatient health facility, you may not be able to give a recommended treatment to a sick child.
>
> If so, on the recording form ***tick [✓] all the treatments and other actions you would plan to give the child,*** if you saw the child in the community.

Exercise:
Decide on and record the treatment and advice for a child at home

Jenna Odala, age 6 months, has visited the Health Surveillance Assistant.

1. Use the information on the child's recording form on the next page to complete the rest of the form. Decide whether Jenna has fast breathing.

    a. Identify danger signs, if any, and other signs.
    b. Decide to refer or treat Jenna
    c. Decide on treatment
    d. Tick [□] the treatment you would give the child. Select the medicine to give, the dose, and how much to send home with the caregiver. Use your supply of medicine to demonstrate the treatment. Note: The result of the RDT was positive.
    e. Decide on the advice on home care to give the caregiver. Tick [✓] the advice.
    f. At birth, Jenna received her BCG and OPV vaccines. At six weeks, Jenna had her full series of vaccines, but since then she has not received any vaccines. Indicate on the form what vaccines Jenna received. In your community, when and where should she go to receive the vaccines?
    g. Indicate when the child should come back for a follow-up visit.
2. Do not complete item 7, the note on the follow-up visit that will happen later
3. Make sure that you have recorded all the decisions on the recording form.

Ask the facilitator to check the recording form and the medicine you have selected to give the child. If there is time, the facilitator will give you a second recording form to complete

Sick Child Recording Form (for community-based treatment of child age 2 months up to 5 years)

Date: 15/7/2008 (Day / Month / Year) **HSA:** Jane Manda

Child's First Name: Jenna **Surname** Odala **Age:** __Years/_6_Months **Boy** / **Girl**

Caregiver's name: Peter Odon **Relationship:** Mother / Father / Other: _____

Physical Address: Near Market Borehole **Village / TA:** Madala / Usipa

Identify problems

Ask and Look		Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... **YES,** sign present ➔ Tick ☑ **NO** sign ➔ Circle ■			
☐	■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☑	■ Diarrhoea (loose stools)?	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	IF YES, for how long? _____days. If Yes Blood in stool? ☐ ■	☐ Blood in stool	
☑	■ Fever (reported or now)? If yes, started 2 days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐ ■	☐ Not able to drink or feed anything	
☑	■ Vomiting? If yes, vomits everything? ☐ ■	☐Vomits everything	
☐	■ Red eyes? If yes, for how long _____days. ■ Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Visual problem	☐ Red eye less than 4 days
☐	■ Has HIV?	☐ Has HIV and any other illness	
☐	■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☐ Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ Parents' current HIV status unknown.
☑	■ **Lives in household with someone on TB treatment?**		☐**Lives with someone on TB Treatment**
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☐	**IF COUGH, count breaths in 1 minute:** 45 breaths per minute ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Red** **MUAC** _ 11 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2.Decide: Refer or treat child(tick decision)

☐ **If ANY Danger Sign, refer to health facility**

☐ **If NO Danger Sign, treat at home**

GO TO PAGE ⟶

Child's name: *Jenna Odala* **Age:** 6 Months

3. Refer or treat child (tick treatments given and other actions)

☐ **If ANY Danger Sign, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise careaiver**

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: ☐**Explain why child needs to go to health facility.** ☐**FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	☐**Begin giving ORS solution** immediately.
☐ If **Fever AND** ☐**Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	☐**Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years—- 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years—1 tablet ☐Age 3 years up to 5 years – 2 tablets
☐ If **Chest in drawing**, or ☐ **Fast breathing and danger sign**	☐**Give first dose of oral antibiotic** (Amoxicillin adult tablet—250grams) ☐Age 2 months up to 12 months— 1 ☐Age 12 months up to 5 years—2tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**
☐**For any sick child who can drink, advise to give fluids and continue feeding.** ☐**Advise to keep child warm, if child is NOT hot with fever.** ☐**Write a referral note.** ☐**Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.**	

If no danger sign, **TREAT at home and ADVISE on home care:**	
☐ If **Diarrhoea**	☐**Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. ☐**Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but at least ½ cup ORS solution after each loose stool. ☐**Give zinc supplement.** Give 1 dose daily for 10 days: ☐Age 2 months up to 6 months – ½ tablet (total 5 tabs) ☐Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever**	☐**Do rapid diagnostic test (RDT).** **_Positive_Negative** ☐If RDT is positive, give oral antimalarial LA Give twice daily for 3 days ☐Age up to 5 months —not recommended ☐Age 5 months up to 3 years—1 tablet (6 tablets) ☐Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now and 2nd dose after 8 hours. Then give dose twice daily for 2 more days. ☐**Give Paracetamol.** Give 4 times a day ☐ Age 5 months up to 3 years - ¼ tablet (total 3 tabs) ☐ Age 3 years up to 5 years – ½ tablet (total 6 tabs)
☐ If **Fast breathing**	☐**Give oral antibiotic** (Amoxicillin adult tablet—250g). Give twice daily for 5 days: ☐Age 2 months up to 12 months— 1 tablet (total10 tabs) ☐Age 12 months up to 5 years—2 tablets (total 20 tabs) Help caregiver give first dose now.
☐ **If red eye**	☐ **Apply antibiotic eye ointment.** Squeeze the size of a grain of rice on each of the inner lower eyelids, 3 times a day for 3 days.
☐ **If at risk of HIV**	☐ **Advise caregiver to take the child for HIV test soon and, if parents' HIV status is not known ,advise the mother and father to test for HIV also**
☐ **if living in household with someone on TB treatment**	☐ **Advise caregiver to take child soon for TB screening and TB preventive medicine**
☐ For **ALL children treated at home, advise on home care**	☐**Advise caregiver to give more fluids and continue feeding.** ☐**Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool ☐**Follow up child in 3 days** (schedule appointment in item 6 below).

4. CHECK VACCINES RECEIVED
(tick ☑ vaccines completed, circle ■ vaccines missed)
*Keep an interval of 4 weeks between DPT-Hib + HepB and OPV doses. Do not give OPV 0 if the child is 14 days old or more

5. If any Other problem or condition I cannot treat,refer child to health facility, write refrerral note.(If diarrhoea, give ORS.Do not give antibiotic or antimalarial.)
Describe problem:_____

Age	Vaccine		➔ **Advise caregiver, if needed:** **WHEN is the next vaccine to be given?** **WHERE?**
Birth	☐ ■ BCG ■	☐ OPV0	
6 weeks*	☐ ■ DPT—Hib + HepB 1 ☐ ■PCV1 ☐ ■Rota1	☐ ■ OPV-1	
10 weeks*	☐ ■ DPT—Hib + HepB 2 ☐ ■PCV2 ☐ ■Rota2	☐ ■ OPV-2	
14 weeks*	☐ ■ DPT—Hib + HepB 3 ☐ ■PCV3	☐ ■ OPV-3	
9 months 15Months	☐ ■ Measles 1 ☐ ■ Measles 2		

6.When to return for FOLLOW UP (circle): Monday Tuesday Wednesday Thursday Friday Weekend

7 **Note on follow up:** ☐Child better _ continue to treat at home. Day of next follow up_____
☐ Child is not better_ refer URGENTLY to health facility.
☐ Child has danger sign_ refer URGENTLY to health facility.

Sick Child Recording Form – PART B *page 2*

Child's name: __ *Joana* _____ Age: __ *Odala* _

(Treatment given and other actions)

☐ If ANY Danger, refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

If any danger sign, REFER URGENTLY to health facility:

ASSIST REFERRAL to health facility:

☐ Explain why child needs to go to health facility

☐ Advise to give 10% sugar water (Less than 6 months = 25 ml, 6 months or more = 50 ml)

☐ FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:

If	☐ **Give oral antibiotic** (Amoxicillin—250 mg single dose).
☐ Oedema +++ ☐ Red on MUAC with complication / danger sign ☐ Oedema + or ++ with danger sign / complication	☐ Age 2 months up to 12 months—1 tablet ☐ Age 12 months up to 5 years—2 tablets

If no danger sign,

TREAT at home and ADVISE on home care:

☐ If severe acute malnutrition (and eligible)

☐ Enroll

☐ Give RUTF

Food Item	Daily Quantity	For 7 Days	Ration to Give
☐ RUTF	2 sachets	14 sachets	14 sachets

☐ Give oral antibiotic (Amoxicillin—250 mg). Give twice daily for 7 days:

☐ Age 2 months up to 12 months—1 tablet (total 14 tabs)

☐ Age 12 months up to 5 years—2 tablets (total 28 tabs)

Help caregiver give first dose now.

☐ Do a rapid diagnostic test (RDT): {if not already done for fever in part A}

__Positive __Negative

☐ If RDT is positive, give oral antimalarial LA (Artemether-Lumefantrine) {if not already given for fever above}

Give twice daily for 3 days:

☐Age 5 months up to 3 years—1 tablet (total 6 tabs)

☐ Age 3 years up to 5 years—2 tablets (total 12 tabs)

Help caregiver give first dose now. Advise to give 2nd dose after 8 hours, and to give dose twice daily for 2 more days.

☐Advise caregiver to give more fluids and continue feeding.

☐Advise on when to return. Go to nearest health facility or, if not possible, return immediately if child

☐ Cannot drink or feed

☐ Becomes sicker

☐ Has blood in the stool

☐ **Follow up child in 3 days** (schedule appointment in item 6 below).

☐ **For SAM follow up in 7 days**

☐ **Encourage HIV test if not tested.**

Note on follow up: ☐ Child better—continue to treat at home. Day of next follow up: _____

Give Albendazole

☐ **Less than 2 years – 200 mg**

☐ **2 years or more – 400 mg single dose**

☐ Child is not better: — refer **URGENTLY** to health facility.

☐ Child has danger sign — refer **URGENTLY** to health facility.

Take-home messages for this section:

- In case of fever for less than 7 days, malaria should be confirmed using an RDT.
- Each medicine has its own dose. The dose depends on the child's age and size.
- All medicines have an expiration date, after which they may not be effective or could be harmful.
- The caregiver should give the first dose of treatment in your presence, and take home the correct amount of medicine to complete the child's treatment.
- Caregivers of children who are at risk of HIV should be advised to take the child for HIV testing soon.
- Advise the caregiver of a child from a household with someone on
- TB treatment to take the child soon for TB screening.
- RUTF are medicine for the treatment of acute malnutrition, therefore should not be shared
- Care giver for children on malnutrition treatment who are breastfeeding should breast feed the child before offering RUTF.

- Caregivers of all sick children should receive advice on home care and on when to return.
- All children should be vaccinated according to the national schedule.

If DANGER SIGN, refer urgently:
Begin treatment and assist referral

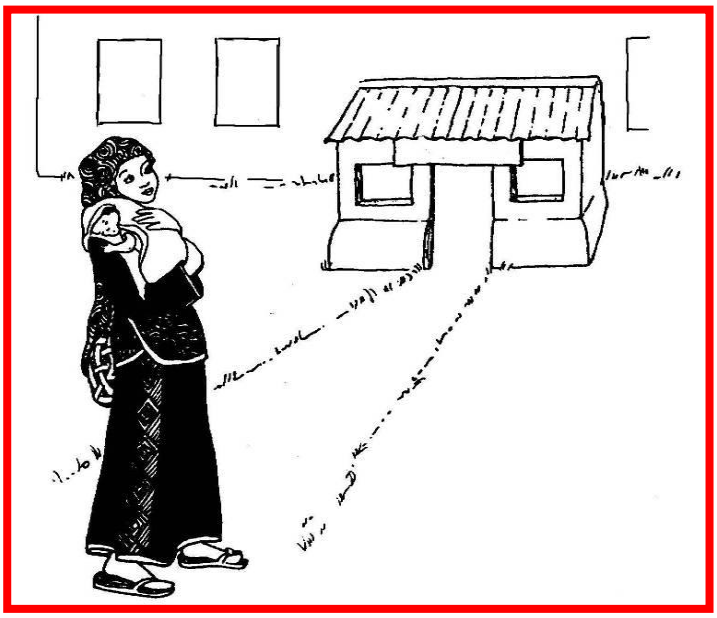
By the end of this section, you will be able to:

- Decide on pre-referral treatments for children who have a danger sign or other problem needing referral to a health facility.
- Use the Sick Child Recording Form to guide decisions on how to treat the child who will be referred.
- Assist referral and write a referral note.
- Follow-up the child at home.

Case study:

Joseph is very sick. He has had fever for 2 days and he has chest in drawing. He has a red reading on the MUAC tape. Joseph can still drink, but he is not interested in eating.

The Health Surveillance Assistant says that Joseph must go right away to the health facility. She explains that Joseph is very sick. He needs treatment that only the health facility can provide. Mrs. Kazombo agrees to take Joseph.



Before they leave, the Health Surveillance Assistant begins treatment. She helps Mrs. Kazombo give her son the first dose of Amoxicillin for the chest in drawing (severe pneumonia) and a dose of LA for fever. She explains that Joseph will receive additional treatment at the health facility.

She advises Mrs. Kazombo to continue giving breast milk and other fluids on the way. She advises Mrs Kazombo to give Joseph sugar water to prevent low blood sugar in the body. She wants her to lightly cover Joseph so he does not get too hot.

The Health Surveillance Assistant knows that she must do everything she can to assist the referral. Joseph must reach the health facility without delay.

The Health Surveillance Assistant writes a referral note to explain why she is sending Joseph to the health facility and what treatment Joseph has started.

She walks with Mrs. Kazombo and her son to the roadway in order to help them find a ride to the health facility.

As they leave, Mrs. Kazombo asks, “Will Joseph need to go to the hospital?” The Health Surveillance Assistant says she does not know. The nurse at the health facility will decide how to give Joseph the best care.

If Joseph must go to the hospital, the Health Surveillance Assistant says that she will find neighbours to help the family until she returns. Mrs. Kazombo should not worry about her family at home.

What did the Health Surveillance Assistant do to help Joseph get care at the health facility?

- ***What did the Health Surveillance Assistant do to encourage Mrs. Kazombo to agree to take Joseph to the health facility?***
- ***What treatment did Joseph begin?***
- ***What did the Health Surveillance Assistant do to help Joseph receive care as soon as possible after he arrives at the health facility?***

In some situations, it might be better for the child to go directly to the hospital. Discuss with the facilitator when, if ever, you might refer the child directly to the hospital.

Begin treatment

A very sick child needs to start treatment right away. You will be able to start *pre-referral treatment* before the child leaves for the health facility. You will begin treating a child with a danger sign and diarrhoea or fever or fast breathing. Also, you will begin treating a child with chest in drawing, one of the danger signs.

The pre-referral treatment is the same as **the first dose** of the medicine. The first dose of the medicine will start to help the child on the way to the health facility. ORS, an antimalarial, and an antibiotic are in your drug box to use as pre-referral treatments.

Do not waste time doing rapid diagnostic test for malaria; if the child with **fever has:**

•Convulsions, or is unusually sleepy or unconscious, or is vomiting everything or is not able to drink or feed anything and palmar pallor give rectal artesunate

Administration of Rectal Artesunate for treatment of severe malaria at community level

What is rectal Artesunate

Rectal Artesunate are antimalarial medicines prepared specifically for insertion into the rectum. They usually take a bullet-shaped form and they dissolve after insertion into the rectum. Rectal Artesunate medications are administered when a patient is vomiting everything, unable to swallow, convulsions, very sleepy or unconscious. Rectal Artesunate is therefore ideal at community level as it can be given to a sick child with danger signs (as pre-referral treatment) on the way to the health facility.

Precautions

Rectal medicines should not be taken orally. Only medications labelled as rectal preparations should be placed in the rectum. Rectal medication should not be given to children with rectal bleeding or with rectal prolapse i.e. where rectal tissue is protruding from the rectal opening/anus.

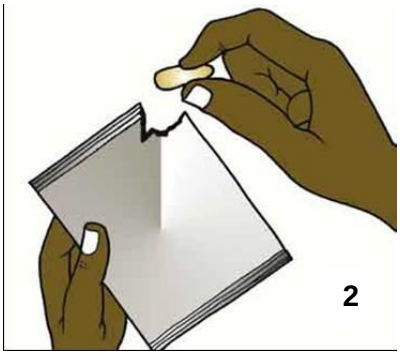
How to prepare Rectal Artesunate before administration

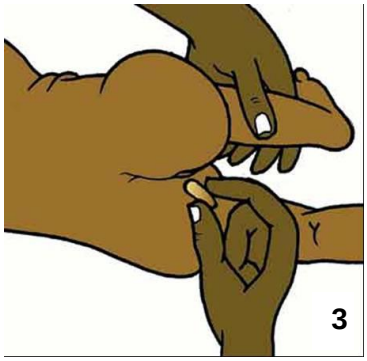
- Before administering rectal artesunate ensure the following are observed;
- Ensure patient privacy.
- Explain the procedure to the caregiver and ask her to support positioning the child.
- Ask the caregiver if she has any questions.
- Ask the caregiver to remove lower garments and underwear of the child.
- Position the patient on a mat on his or her left side, with the top knee bent and pulled slightly upward.
- If available, place a waterproof pad under the patient's hips to protect the beddings.
- Use a sheet (or Mothers wrapper) to cover all of the patients' body except the buttocks.

Procedures for administration of rectal artesunate

- Explain the procedure to the caregiver
- Caregiver should clean the anal area
- Wash your hands thoroughly with soap and water.
- Put on disposable gloves.
- If the suppository is soft, hold it under cool water for a few minutes to harden it before removing the wrapper
- Remove the suppository wrapper, if present
- Moisten the anal area with cotton swab soaked in clean cool water and cotton.
- Lie the child on his/her side with its lower leg straightened out and the upper leg bent forward toward his/her abdomen.
- Gently insert the suppository, pointed end first, with your finger until it passes the muscular sphincter of the rectum, about 1/2 to 1 inch in infants (If not inserted past this sphincter, the suppository may pop out.)
- Ask the caregiver or mother to hold buttocks of the child together for at least 30-60 seconds.
- The child should remain lying down for about 5 minutes to avoid having the suppository come out
- Discard used materials and wash your hands thoroughly with soap.

Pictures to demonstrate each step





For the rest of danger signs, give first dose of oral antimalarial LA and refer. Note that a **zinc supplement is not a pre-referral treatment**. You do not need to give it before referral.]

Refer to the box on the Recording Form to guide you in selecting and giving a pre-referral treatment. See the examples on the next page.

You will *not* take time to do a rapid diagnostic test for malaria; however you will give a pre-referral dose of an antimalarial if the child has fever:

- A rectal artesunate suppository if the child with fever has convulsions, or is unusually sleepy or unconscious, or is vomiting everything or is not able to drink or feed anything or palmar pallor.
- A first dose of the oral antimalarial LA if the child with fever has any other danger sign

The health worker at the health facility will determine whether the child has malaria. If the child has malaria, the health facility will be able to continue the most appropriate antimalarial treatment

The pre-referral treatment is the same as **the first dose** of the medicine. The first dose of the medicine will start to help the child on the way to the health facility. ORS, antimalarial LA, artesunate suppository and Amoxicillin are in your medicine kit to use as pre-referral treatments.

[Note that a zinc supplement is not a pre-referral treatment. You do not need to give it before referral.]

Note that a pre-referral treatment may not be for the reason the child is being referred.

For example, you are referring a child with cough for 14 days or more. Do you give a pre-referral treatment for the cough? No, there is no pre-referral treatment for just cough.

If the child has diarrhoea, however, you will start a pre-referral treatment. What pre-referral treatment do you give for diarrhoea? Note that you will give ORS to the child with diarrhoea, even though the child is being referred for another reason.

For all children referred due to severe acute malnutrition, or with medical complications should be given a single dose of oral antibiotic (Amoxicillin) as a prereferral treatment

Advise care givers to give sugar water to all referred malnourished children to avoid hypoglycaemia (low sugar level in the body). Sugar-water solution should contain approximately 10 percent sugar (10 g or one teaspoon of sugar dissolved in 100 ml) of water. If the child is breastfed, encourage the mother to breastfeed the child.

Remember: You cannot give oral medicine to a child who cannot drink.

If the child with fever is having convulsions, is unusually sleepy or unconscious, is vomiting everything, or in any other way unable to drink, do not give oral medicine. Give a rectal artesunate suppository and refer the child **urgently** to the health facility.

Discuss: Refer to the box on the recording form to guide you in selecting and giving a pre-referral treatment. Discuss the examples below.

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: ☐**Explain why child needs to go to health facility.** ☐**FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	☐**Begin giving ORS solution** immediately.
☐ If **Fever AND** ☐**Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	☐**Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years— - 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years— 1 tablet ☐Age 3 years up to 5 years - 2 tablets
☐ If **Chest in drawing,** or ☐ **Fast breathing, severe acute malnutrition and danger sign**	☐**Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years— 2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**
If ☐ Oedema +++ ☐ Red on MUAC with complication / danger sign ☐ Oedema + or ++ with danger sign / complication	☐ **Give oral antibiotic** (Amoxicillin—250 mg single dose). ☐ Age 2 months up to 12 months—1 tablet ☐ Age 12 months up to 5 years—2 tablets
☐**For any sick child who can drink, advise to give fluids and continue feeding.** ☐**Advise to keep child warm, if child is NOT hot with fever.** ☐**Advise the caregiver to give 10% sugar water to all SAM Children to drink on the way to the facility.** ☐**Write a referral note.** ☐**Write a referral note.** ☐**Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.**	

EXAMPLE 1. Amina is 6 months old with cough and chest in drawing for 3 days.

What is the reason to refer this child (the danger sign)?_____

On the form, tick [✓] all the signs requiring pre-referral treatment

Then, tick [✓] the pre-referral treatment you would give the child.

Tick [✓] the dose for the pre-referral treatment

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: ☐**Explain why child needs to go to health facility.** ☐**FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	☐**Begin giving ORS solution** immediately.
☐ If **Fever AND** ☐**Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	☐**Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years— - 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years— 1 tablet ☐Age 3 years up to 5 years - 2 tablets
☐ If **Chest in drawing,** or ☐ **Fast breathing, severe acute malnutrition and danger sign**	☐**Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years— 2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**
If ☐ Oedema +++ ☐ Red on MUAC with complication / danger sign ☐ Oedema + or ++ with danger sign / complication	☐ **Give oral antibiotic** (Amoxicillin—250 mg single dose). ☐ Age 2 months up to 12 months—1 tablet ☐ Age 12 months up to 5 years—2 tablets
☐**For any sick child who can drink, advise to give fluids and continue feeding.** ☐**Advise to keep child warm, if child is NOT hot with fever.** ☐**Advise the caregiver to give 10% sugar water to all SAM Children to drink on the way to the facility.** ☐**Write a referral note.** ☐**Write a referral note.** ☐**Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.**	

EXAMPLE 2. Ali is 4 years old. He has a red reading on the MUAC tape and has had diarrhoea for 6 days.

What is the reason to refer this child (the danger sign or other problem)?_____

On the form, tick [✓] all the signs requiring pre-referral treatment.

Then, tick [✓] the pre-referral treatment you would give the child.

Tick [✓] the dose for the pre-referral treatment.

Note that the pre-referral dose for ORS solution is: As much as the child will take. Then, help the caregiver start giving ORS right away. Continue to give ORS on the way to the health facility.

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: ☐**Explain why child needs to go to health facility.** ☐**FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	☐**Begin giving ORS solution** immediately.
☐ If **Fever AND** ☐**Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	☐**Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years— - 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years— 1 tablet ☐Age 3 years up to 5 years - 2 tablets
☐ If **Chest in drawing,** or ☐ **Fast breathing, severe acute malnutrition and danger sign**	☐**Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years— 2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**
If ☐ Oedema +++ ☐ Red on MUAC with complication / danger sign ☐ Oedema + or ++ with danger sign / complication	☐ **Give oral antibiotic** (Amoxicillin—250 mg single dose). ☐ Age 2 months up to 12 months—1 tablet ☐ Age 12 months up to 5 years—2 tablets
☐**For any sick child who can drink, advise to give fluids and continue feeding.** ☐**Advise to keep child warm, if child is NOT hot with fever.** ☐**Advise the caregiver to give 10% sugar water to all SAM Children to drink on the way to the facility.** ☐**Write a referral note.** ☐**Write a referral note.** ☐**Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.**	

EXAMPLE 3. Naome is 3 years old. She has fever for 2 days and is not able to drink.

What is the reason to refer this child (the danger sign or other problem)?_____

On the form, tick [✓] all the signs requiring pre-referral treatment.

Then, tick [✓] the pre-referral treatment you would give the child.

Tick [✓] the dose for the pre-referral treatment.

Discussion: Select a pre-referral treatment for a child

For each child listed below:

1. *Circle the sign or signs for which the child needs referral.*
2. *Decide which sign or signs need a pre-referral treatment.*
3. *Tick [✓] all the pre-referral treatments to give before the child leaves for the health facility.*
4. *Write the dose for each pre-referral treatment. Refer to the recording form to guide you.* Be prepared to discuss your decisions. *[The facilitator may give you a child's card for the group discussion.]*

Circle the **signs to refer the child**	Tick [✓] **pre-referral treatment**	Write the **dose** for each pre-referral treatment
Leslie (4 year old boy) – Cough for 14 days Fever	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Anita (2 year old girl) – Cough for 14 days, Diarrhoea for 3 days No blood in stool, at risk of HIV	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Sam (2 month old boy) – Diarrhoea for 3 weeks No blood in stool, Fever for last 3 days, red eye for 1 day	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of antibiotic eye ointment** ☐ **Give first dose of rectal artesunate**	

Kofi (3 year old boy) – Cough for 3 days, Chest in drawing, Very sleepy or unconscious	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Sara (3 year old girl) – Diarrhoea for 4 days Burns on both feet	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Thomas (3year old boy) – Diarrhoea for 8 days, cough for 14 days and Red on MUAC tape	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Maggie (5 month old girl) – Fever for last 7 days Diarrhoea less than 14 days and oedema +	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Nellie 7 months Diarrhoea for 2 days, palmar pallor with fever	☐ **Begin giving ORS solution** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Gambuleni 10 months has red on MUAC and Oedema + and has a positive MRDT	☐ **Begin giving ORS solution** ☐ **advise to give 10% sugar water** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	

Susan 4 months has diarrhoea, visible wasting and oedema +	☐ **Begin giving ORS solution** ☐ **Advise to give 10% sugar water** ☐ **Give first dose oral antimalarial LA** ☐ **Give first dose of oral antibiotic** ☐ **Give first dose of rectal artesunate**	
Makayiko 19 months has red on MUAC, diarrhoea and or cough more than 14 days	□ **Begin giving ORS solution** □ **Advise to give 10% sugar water** □ **Give first dose oral antimalarial LA** □ **Give first dose of oral antibiotic** □ **Give first dose of rectal artesunate**	

Assist referral

A pre-referral treatment for fever or fast breathing is only the first dose. This is not enough to treat the child. The child with a danger sign must go to the health facility.

The recording form guides you through a list of tasks to assist the child's urgent referral to the health facility. As you complete each task to assist referral, tick [✓] each task on the recording form.

☐ Explain why the child needs to go to the health facility

Once you have given the first dose, the caregiver may think that you have the medicine to save the child. You must be firm. Explain that this medicine alone is not enough. The child must go to the health facility for treatment.

Going right away to the health facility may not be possible in some conditions. Perhaps the child is too sick. Perhaps travel at night is dangerous. Perhaps the rains have closed or blocked the roads.

Discuss with your facilitator what you can do when referral is not possible. Remember that your medicine will not be enough for the child. You must try to get a child with a danger sign to a health facility as soon as possible.

☐ For any sick child who can drink, advise to give fluids and continue feeding

If the child can drink and feed, advise the caregiver to continue to offer fluids and food to the child on the way to the health facility.

If the child is still breastfeeding, advise the mother to continue breastfeeding. Offer the breast more frequently and for a longer time at each feed.

If the child is not breastfeeding, advise the caregiver to offer water to drink and some easy-to-eat food.

If the child has diarrhoea, help the caregiver start giving ORS solution right away. Sometimes the ORS solution can help the child stop vomiting. However if the child has SAM do not give ORS. Then the child can take other oral medicines.

☐ Advise to keep child warm, if child is NOT hot with fever

Some children have a hot body because of fever. The bodies of other sick children, however, may become too cold. How the caregiver covers the child's body will affect the body temperature. What to advise depends on whether the child has a fever and on the weather.

To keep the child warm, cover the child, including the child's head, hands, and feet with a blanket. Keep the child dry if it rains. If the weather is cold, advise the caregiver to put a cap on the child's head and hold the child close to her body.

If the child is hot with fever, covering the body too much will raise the body temperature. It may make the child sicker and increase the danger of convulsions.

A light cloth or blanket may be enough to cover the child with fever if the weather is warm. If the body becomes very hot, advise the caregiver to remove even the light blanket.

☐ Write a referral note

To prevent delay at the health facility, write a referral note to the nurse or other person who will first see the child. You may have a specific referral form to complete from your health facility.

A referral form or note should give:

1. The name and age of the child
2. A description of the child's problems
3. The reason for referral (list the danger signs or other reason you referred the child)
4. Treatment you have given
5. Your name
6. The date and time of referral

You also can make a simple referral note based on the Sick Child recording form. (An example of a referral note is in the next exercise.)

Tick [✓] each medicine and the dose you gave. It is very important for the health worker to know what medicine you have already given the child, and when. Send the referral note with the caregiver to the health facility.

☐ Arrange transportation, and help solve other difficulties in referral

Communities may have access to regular bus, mini-bus, or car transportation to the health facility.

If so, know the transportation available. Keep the schedule handy. You do not want to miss the bus or other transportation by a few minutes. You may need to rush or send someone to ask the driver to wait, if the child is very sick.

Some communities have no direct access to transportation. A Health Surveillance Assistant can help leaders understand the importance of organizing transportation to the health facility (and hospital). Or they can organize assistance to a road where there is regular bus service. A community leader may call on volunteers to assist families.

This service can be critical, especially for very sick children. Others also need this service, including women who have difficulty during pregnancy and delivery.

Keeping track of the numbers of children you have referred can help show the need. Use the recording forms or a logbook or register for this information.

Transportation is only one of the difficulties a family faces in taking a sick child to the health facility. In the earlier example, Mrs. Kazombo may have been concerned about how to reach her husband who was working in the field. She could not go without telling him. She also needed someone to care for the other children remaining at home, if Joseph needed to go to the hospital.

The Health Surveillance Assistant knew her community. She knew the family and neighbours of the sick child. Her knowledge helped Mrs. Kazombo solve the problems that prevented her from taking Joseph to the health facility.

Always ask the caregiver if there are any difficulties in taking the child to the health facility. Listen to her answers. Then, help her solve problems that might prevent her or delay her from taking the child for care.

If the caregiver does not want to take the child to the health facility, find out why. Calm the caregiver's fears. Help her solve any problems that might prevent the child from receiving care. Here are some examples.

The caregiver does not want to take the child to the health facility because:	**How to help and calm the caregiver's fears:**
The health facility is scary, and the people there will not be interested in helping my child.	Explain what will happen to her child at the health facility. Also, you will write a referral note to help get care for her child as quickly as possible.
I cannot leave home. I have other children to care for.	Ask questions about who is available to help the family, and locate someone who could help with the other children.
I don't have a way to get to the health facility.	Help to arrange transportation. In some communities, transportation may be difficult. Before an emergency, you may need to help community leaders identify ways to find transportation. For example, the community might buy a motor scooter, or arrange transportation with a produce truck on market days.
I know my child is very sick. The nurse at the health facility will send my child to the hospital to die.	Explain that the health facility and hospital have trained staff, supplies, and equipment to help the child.

Even if families decide to take their sick child to the health facility, they face many difficulties. The difficulties add delay. A study in rural Tanzania, for example, found that almost half of referrals took two or more days for the children to arrive at a health facility.[1] Delaying care—even only a few hours—for some sick children with danger signs can lead to death.

Discuss. What are the reasons that sick children in your community do not arrive at the health facility on time?

You and your community can help families solve some of the delays in taking children for care. When you assist the referral, families are more willing to take their children. Children can arrive at the health facility and receive care with less delay.

☐ Follow up the child on return at least once a week until child is well

The child will need care when he or she returns from the health facility. Ask the caregiver to bring the child to see you when they return. Ask her to bring any note from the health worker about continuing the child's treatment at home. If this is not possible, then try to check if the caregiver went to the health facility and how the child is doing.

During the follow-up visit, check for danger signs. If there are any danger signs, you will need to refer the child again to the health facility. The child is not improving as expected.

If there are no danger signs, help the caregiver continue appropriate home care. If the health worker at the health facility gave the child medicine to take at home, make sure that the caregiver understands how to give it correctly. Giving the medicine correctly means:

- The correct medicine
- The correct dose
- The correct time or times of the day
- For the correct number of days

Help the caregiver continue to follow the treatment that the health worker recommended to continue at home.

Remind the caregiver to offer more fluids and to continue feeding the child. Also, offer more food to the child as the child gets better. The extra food will help the child catch up on the growth the child lost during the illness.

If the child becomes sicker, or if the caregiver has any concerns, advise the caregiver to bring the child to you right away.

Follow up the child on return at least once a week until the child is well. If the child has an illness that is not curable, continue to support the family. Help the family give appropriate home care for the child.

If the mother is under treatment at the facility (being given RUSF), on return to the village clinic the HAS should assess or monitor nutrition status of the child on every visit (weekly).

Exercise: Complete a recording form and write a referral note

You are referring Joseph Banda to the health facility.

1. Complete Joseph's **recording form** on the next two pages. Based on the signs of illness found:
    a. Decide which signs are Danger Signs or other signs of illness. Tick [✓] any DANGER SIGN and other signs of illness.
    b. Decide: Refer, or treat Joseph at home
    c. Act as if you have seen Joseph. Tick [✓] treatments given and other actions.
    d. You will refer Joseph. Therefore, do not complete item 4 (vaccines), item 6 (follow up), or item 7 (note on follow up).

2. Then, use Joseph's recording form to complete a **referral note** for Joseph. Again, you are the referring HSA. Refer Joseph to the nearest health facility where you live. Put today's date and time, where you are asked for them.

If there is time, the facilitator will give you a sample recording form for another child. Complete the recording form and a referral note for the child.

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 17/7/2008 (Day / Month / Year) **HSA:** Obvious Tambo

Child's First Name: Joseph **Surname** Banda **Age:** __Years 4 Months (Boy) / **Girl**

Caregiver's name: Judith Banda **Relationship:** (Mother) / Father / Other: _____

Physical Address: 14 Orange Groove Road **Village /TA:** Kamalowa / Chitowamatambe

1. Identify problems

ASK and LOOK		Any DANGER SIGN to refer?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure: ..... YES, sign present ➔Tick ☐ NO sign ➔ Circle ■			
☐	■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☑	■ Diarrhoea (loose stools)? IF YES, for how long? _____days. *It yes* Blood in stool? ☐ ■	☐ Diarrhoea for 14 days or more ☐ Blood in stool	☐ Diarrhoea (less than 14 days AND no blood in stool)
☑	■ Fever (reported or now)? If yes, started 3 days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐ ■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐ Vomits everything	
☐	■ Red eyes? If yes, for how long 2 days.	☐ Red eye for 4 days or more	☐ Red eye (less than 4 days)
☐	■ Difficulty in seeing? If Yes for how long _____days	☐ Visual problem	
☐	■ Has HIV	☐ Has HIV and any other illness	
☐	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV or ☐Parents' current HIV status is unknown		☐One or both parents have HIV and child has not tested for HIV ☐Parents' current HIV status unknown
☐	■ Lives in a household with someone on TB treatment		☐ Lives with someone on TB treatment
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 **If any OTHER PROBLEMS, refer.**	☐ Other problem to refer:	
LOOK:			
☑	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☑	**IF COUGH, count breaths in 1 minute:** 68 breaths per minute (bpm) ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Green MUAC** _ 13 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2. Decide: Refer or treat child

(tick decision)

☐ If ANY Danger Sign, refer to health facility

☐ If NO Danger Sign, treat at home and advise caregiver

GO TO PAGE 2 ⟶

Child's name: _____ Age:_____

3. Refer or treat child (tick treatments given and other actions)

☐ If ANY Danger Sign, refer to health facility

☐ If NO Danger Sign, treat at home and

If any danger sign, **REFER URGENTLY to health facility:**

ASSIST REFERRAL to health facility:

☐Explain why child needs to go to health facility.

☐FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:

☐ If **Diarrhoea**	**☐Begin giving ORS solution** immediately.
☐ If **Fever AND** **☐Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	**☐Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years—- 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years—1 tablet ☐Age 3 years up to 5 years – 2 tablets
☐ If **Chest in drawing**, or ☐ **Fast breathing and danger sign**	**☐Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years—2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**

☐For any sick child who can drink, advise to give fluids and continue feeding.

☐Advise to keep child warm, if child is NOT hot with fever.

☐Write a referral note.

☐Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.

If no danger sign,

TREAT at home and ADVISE on home care:

☐ If **Diarrhoea**	**☐Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. **☐Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but at least ½ cup ORS solution after each loose stool. **☐Give zinc supplement.** Give 1 dose daily for 10 days: ☐Age 2 months up to 6 months – ½ tablet (total 5 tabs) ☐Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever**	**☐Do rapid diagnostic test (RDT).** **_Positive_Negative** ☐If RDT is positive, give oral antimalarial LA Give twice daily for 3 days ☐Age up to 5 months —not recommended ☐Age 5 months up to 3 years—1 tablet (6 tablets) ☐Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now and 2nd dose after 8 hours. Then give dose twice daily for 2 more days. **☐Give Paracetamol.** Give 4 times a day ☐ Age 5 months up to 3 years - ¼ tablet (total 3 tabs) ☐ Age 3 years up to 5 years – ½ tablet (total 6 tabs)
☐ If **Fast breathing**	**☐Give oral antibiotic** (Amoxicillin adult tablet—250g). Give twice daily for 5 days: ☐Age 2 months up to 12 months— 1 tablet (total 10 tabs) ☐Age 12 months up to 5 years—2 tablet (total 20 tabs) Help caregiver give first dose now.
☐ If red eye	**☐ Apply antibiotic eye ointment.** Squeeze the size of a grain of rice on each of the inner lower eyelids, 3 times a day for 3 days.
☐ If at risk of HIV	**☐ Advise caregiver to take the child for HIV test soon and, it parents' HIV status is not known, advise the mother and father to test for HIV also.**
☐If living in a household with someone on TB treatment	**☐ Advise caregiver to take child soon for TB screening and TB preventive medicine.**
☐ For **ALL children treated at home, advise on home care**	**☐Advise caregiver to give more fluids and continue feeding.** **☐Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool **☐Follow up child in 3 days** (schedule appointment in item 6 below).

4.Check Vaccines☑ (Tick vaccines completed ■Circle vaccines missed)

*Keep an interval of 4 weeks between DPT-Hib. + Hep B and OVP doses. Do not OVP 0 if the child is 14 days or more.

5.If any OTHER Problem or I can not treat,refer child to health facility,write referral note.(If diarrhoea ,give ORS .Do not give antibiotic or antimalarial)

6. When to return for FOLLOW UP (circle):
Monday Tuesday Wednesday Thursday Friday Weekend

Age	Vaccine		➔ **Advise caregiver, if needed:**
Birth	☑ ■ BCG	☑ ■ OPV-0	**WHEN is the next vaccine to be given?**
6 weeks*	☐ ■ DPT—Hib + HepB 1 ☐ ■PCV1 ☐ ■Rota1	☐ ■ OPV-1	
10 weeks*	☐ ■ DPT—Hib + HepB 2 ☐ ■PCV2 ☐ ■Rota2	☐ ■ OPV-2	**WHERE?**
14 weeks*	☐ ■ DPT—Hib + HepB 3 ☐ ■PCV3	☐ ■ OPV-3	
9 months 15months	☐ ■ Measles 1 ☐ ■ Measles 2		

7. Note on follow up: ☐ Child better—continue to treat at home. Day of next follow up:_____
☐ Child is not better __ refer **URGENTLY** to health facility.
☐ Child has danger sign ___refer **URGENTLY** to health facility

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 17/7/2008 (Day / Month / Year) **HSA:** Obvious Tambo

Child's First Name: Lucy **Surname** Phiri **Age:** __Years 8 Months **Boy** / (Girl)

Caregiver's name: Sophie Mkandawire **Relationship:** Mother / Father / (Other: Aunt)

Physical Address: Near Graveyard **Village /TA:** Kaphaizi / Mwase

1. Identify problems

ASK and LOOK		Any DANGER SIGN to refer?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure: …… **YES**, sign present ➔ Tick ☑ **NO** sign ➔ Circle ■			
☑	■ Cough? If yes, for how long? 2 days	☐ Cough for 14 days or more	
☐	■ Diarrhoea (loose stools)? IF YES, for how long? _____days. *It yes* Blood in stool? ☐ ■	☐ Diarrhoea for 14 days or more ☐ Blood in stool	☐ Diarrhoea (less than 14 days AND no blood in stool)
☑	■ Fever (reported or now)? If yes, started 3 days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐ ■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐ Vomits everything	
☐ ☐	■ Red eyes? If yes, for how long 2 days. ■ Difficulty in seeing? If Yes for how long _____days	☐ Red eye for 4 days or more ☐ Visual problem	☐ Red eye (less than 4 days)
☐	■ Has HIV	☐ Has HIV and any other illness	
☑	■ At risk of HIV because ☐ One or both parents have HIV and child has not tested for HIV or ☑ Parents' current HIV status is unknown		☐ One or both parents have HIV and child has not tested for HIV ☐ Parents' current HIV status unknown
☐	■ Lives in a household with someone on TB treatment		☐ Lives with someone on TB treatment
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types of food groups ☐ Less than 6 months and stopped breast feeding		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 **If any OTHER PROBLEMS, refer.**	☐ Other problem to refer:	
LOOK:			
☐	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☐	**IF COUGH, count breaths in 1 minute:** __breaths per minute (bpm) ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☑	■ Palmar pallor	☐ Palmar pallor	
☑	**For child 6 mo. up to 5 years, MUAC colour: Red MUAC** _ 11 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☑ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2. Decide: Refer or treat child
(tick decision)

☐ **If ANY Danger Sign, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

Child's name: __Lucy Phiri __ Age:_8 months__

3. Refer or treat child (tick treatments given and other actions)

☐ If ANY Danger Sign, refer to health facility

☐ If NO Danger Sign, treat at home and

If any danger sign, **REFER URGENTLY to health facility:**

ASSIST REFERRAL to health facility:

☐Explain why child needs to go to health facility.

☐FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:

☐ If **Diarrhoea**	**☐Begin giving ORS solution** immediately.
☐ If **Fever AND** **☐Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	**☐Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years— - 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years—1 tablet ☐Age 3 years up to 5 years – 2 tablets
☐ If **Chest in drawing**, or ☐ **Fast breathing and danger sign**	**☐Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years—2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**

☐For any sick child who can drink, advise to give fluids and continue feeding.

☐Advise to keep child warm, if child is NOT hot with fever.

☐Write a referral note.

☐Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.

If no danger sign,

TREAT at home and ADVISE on home care:

☐ If **Diarrhoea**	**☐Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. **☐Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but at least ½-cup ORS solution after each loose stool. **☐Give zinc supplement.** Give 1 dose daily for 10 days: ☐Age 2 months up to 6 months – ½ tablet (total 5 tabs) ☐Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever**	**☐Do rapid diagnostic test (RDT).** **_Positive _Negative** ☐If RDT is positive, give oral antimalarial LA Give twice daily for 3 days ☐Age up to 5 months —not recommended ☐Age 5 months up to 3 years—1 tablet (6 tablets) ☐Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now and 2nd dose after 8 hours. Then give dose twice daily for 2 more days. **☐Give Paracetamol.** Give 4 times a day ☐ Age 5 months up to 3 years - ¼ tablet (total 3 tabs) ☐ Age 3 years up to 5 years – ½ tablet (total 6 tabs)
☐ If **Fast breathing**	**☐Give oral antibiotic** (Amoxicillin adult tablet—250g). Give twice daily for 5 days: ☐Age 2 months up to 12 months— 1 tablet (total 10 tabs) ☐Age 12 months up to 5 years—2 tablet (total 20 tabs) Help caregiver give first dose now.
☐ If red eye	**☐ Apply antibiotic eye ointment.** Squeeze the size of a grain of rice on each of the inner lower eyelids, 3 times a day for 3 days.
☐ If at risk of HIV	**☐ Advise caregiver to take the child for HIV test soon and, it parents' HIV status is not known, Advise the mother and father to test for HIV also.**
☐If living in a household with someone on TB treatment	**☐ Advise caregiver to take child soon for TB screening and TB preventive medicine.**
☐ For **ALL children treated at home, advise on home care**	**☐Advise caregiver to give more fluids and continue feeding.** **☐Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool **☐Follow up child in 3 days** (schedule appointment in item 6 below).

4.Check Vaccines☑ (Tick vaccines completed ◉ circle vaccines missed)

*Keep an interval of 4 weeks between DPT-Hib.

+ Hep B and OVP doses. Do not OVP 0 if the child is 14 days or more.

Age	Vaccine		➔ **Advise caregiver, if needed:**
Birth	☑ ■ BCG	☑ ■ OPV-0	**WHEN is the next vaccine to be given?**
6 weeks*	☐ ■ DPT—Hib + HepB 1 ☐ ■PCV1 ☐ ■Rota1	☐ ■ OPV-1	
10 weeks*	☐ ■ DPT—Hib + HepB 2 ☐ ■PCV2 ☐ ■Rota2	☐ ■ OPV-2	**WHERE?**
14 weeks*	☐ ■ DPT—Hib + HepB 3 ☐ ■PCV3	☐ ■ OPV-3	
9 months 15months	☐ ■ Measles 1 ☐ ■ Measles 2		

5.If any OTHER Problem or I can not treat,refer child to health facility,write referral note.(If diarrhoea ,give ORS .Do not give antibiotic or antimalarial)

6. When to return for FOLLOW UP (circle): Monday Tuesday Wednesday Thursday Friday Weekend

7. Note on follow up: ☐ Child better—continue to treat at home. Day of next follow up: _____

☐ Child is not better __ refer **URGENTLY** to health facility.

☐ Child has danger sign ___refer **URGENTLY** to health facility

Child's name: __*Lucy Phiri* __ Age:_*8 months*__

(Treatment given and other actions)

☐ **If ANY Danger, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

If any danger sign, REFER URGENTLY to health facility:

ASSIST REFERRAL to health facility:

☐ **Explain why child needs to go to health facility**

☐ **Advise to give 10% sugar water (Less than 6 months = 25 ml, 6 months or more = 50 ml)**

☐ **FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**

If

☐ Oedema +++

☐ Red on MUAC with complication / danger sign

☐ Oedema + or ++ with danger sign / complication

☐ **Give oral antibiotic** (Amoxicillin—250 mg single dose).

☐ Age 2 months up to 12 months—1 tablet

☐ Age 12 months up to 5 years—2 tablets

If no danger sign,

TREAT at home and ADVISE on home care:

☐ **If severe acute malnutrition (and eligible)**

☐ Enroll

☐ Give RUTF

Food Item	Daily Quantity	For 7 Days	Ration to Give
☐ RUTF	2 sachets	14 sachets	14 sachets

☐ **Give oral antibiotic** (Amoxicillin—250 mg). Give twice daily for 7 days:

☐ Age 2 months up to 12 months—1 tablet (total 14 tabs)

☐ Age 12 months up to 5 years—2 tablets (total 28 tabs)

Help caregiver give first dose now.

☐ **Do a rapid diagnostic test (RDT): {if not already done for fever in part A}**

__Positive __Negative

☐ **If RDT is positive, give oral antimalarial LA (Artemether-Lumefantrine) {if not already given for fever above}**

Give twice daily for 3 days:

☐Age 5 months up to 3 years—1 tablet (total 6 tabs)

☐ Age 3 years up to 5 years—2 tablets (total 12 tabs)

Help caregiver give first dose now. Advise to give 2nd dose after 8 hours, and to give dose twice daily for 2 more days.

☐**Advise caregiver to give more fluids and continue feeding.**

☐**Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child

☐ Cannot drink or feed

☐ Becomes sicker

☐ Has blood in the stool

☐ **Follow up child in 3 days** (schedule appointment in item 6 below).

☐ **For SAM follow up in 7 days**

☐ **Encourage HIV test if not tested.**

Note on follow up: ☐ Child better—continue to treat at home. Day of next follow up: _____

Give Albendazole

☐ **Less than 2 years – 200 mg**

☐ **2 years or more – 400 mg single dose**

☐ Child is not better: — refer **URGENTLY** to health facility.

☐ Child has danger sign — refer **URGENTLY** to health facility.

Referral note from Health Surveillance Assistant: Sick Child

Child's First Name: _____ **Surname** _____ **Age:** __Years/__Months **Boy / Girl**
Caregiver's name: _____**Relationship:** Mother / Father / Other: _____

Physical Address: _____**Village / TA**_____

	The child has (tick ☐ sign, circle ■ no sign):	**Reason for referral:**	**Treatment given:**
☐	■ Cough? If yes, for how long? __ days	☐ Cough for 14 days or more	☐ Oral Rehydration Salts (ORS) solution for diarrhoea ☐ LA for fever ☐ Rectal Artesunate ☐ Antibiotic eye ointment ☐ Oral antibiotic Amoxicillin for chest in drawing or fast breathing or Severe Acute Malnutrition
☐	■ Diarrhoea (loose stools)? ____days.	☐ Diarrhoea for 14 days or more	
☐	■ If diarrhoea, blood in stool?	☐ Blood in stool	
☐	■ Fever (reported or now)? ____ days.	☐ Fever for last 7 days	
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? If yes, not able to drink or feed anything? ☐ ■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐ Vomits everything	
☐	■ Red eyes? If yes, for how long _____days. ■Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Visual problem	
☐	■Has HIV	☐ Has HIV and any other illness.	
☐	■ Chest in drawing?	☐ Chest In drawing	
☐	**IF COUGH, breaths in 1 minute:** _____bpm ■ Fast breathing: ☐ Age 2 months up to 12 months: 50 bpm or more ☐ Age 12 months up to 5 years: 40 bpm or more		
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Red** **MUAC** _ 11 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	

Any OTHER PROBLEM or reason referred:
_ TB screening _ Vaccines
_ HIV testing _ HIV care and treatment
_ Other: _____
Referred to (name of health facility): _____
Referred by (name of HSA):_____Date: _____ Time: _____

✂ ----------**Cut Here**----------

FEEDBACK FROM HEALTH FACILITY (Please give feedback)

Date : ……
Name of the Child :……..**Age**……
Child's identified problem(s) : ……
Treatments given and actions taken : ……
Advice given and to be followed : ……
Name of attending clinician : ……
Signature : ……
Name of Health Facility :……..

Take-home messages for this section:

- A very sick child needs to start treatment right away, thus in many cases you will give one dose before the child goes for referral.
- You cannot give oral medication to a child who cannot drink.
- You may need to help arrange transportation for referral, and to help solve other difficulties the caregiver may have.

Use good communication skills

You will practise good communication throughout this course.

You will be able to:

- Identify ways to communicate more effectively with caregivers.
- Phrase questions for checking the caregiver's understanding of treatment and other tasks she must carry out.

Where you sit and how you speak to the caregiver set the scene for good communication. Welcome the caregiver and child. Sit close, look at the caregiver, speak gently. Encourage the caregiver to talk and ask questions. The success of home treatment very much depends on how well you communicate with the child's caregiver.

The caregiver and others in the family need to know how to give the treatment at home. They need to understand the importance of treatment. They need to feel free to ask questions when they are unclear. You need to be able to check their understanding of what to do.

As a reminder, for good communication:

- **Ask** questions to find out what the caregiver is already doing for her child, and **listen** to what the caregiver says.
- **Praise** the caregiver for what she or he has done well.
- **Advise** the caregiver on how to treat the child at home.
- **Check** the caregiver's understanding.
- **Solve problems** that may prevent the caregiver from giving good treatment.

Here, we will focus on how to **advise the caregiver on how to treat the child,** and how to **check the caregiver's understanding.**

Advise the caregiver on how to treat the child at home

Some advice is simple. Other advice requires that you teach the caregiver how to do the task. For example, you have learned to teach a caregiver how to give an antibiotic (Amoxicillin). Teaching how to do a task requires several steps:

1. Give information.
2. Show an example.
3. Let the caregiver practise.

To give information, explain how to do the task. For example, explain how to divide a tablet, crush a tablet, mix it with water, and give it to the child.

To show an example, do the task so the caregiver can see. For example, cut a tablet in half.

To let the caregiver practise, ask the caregiver to do the task. For example, ask her to cut another tablet, and give the first dose to the child.

Letting the caregiver practise is the most important part of teaching a task. You will know what the caregiver understands and what is difficult. You can then help the caregiver do it better. The caregiver is more likely to remember something he or she has practised, than something just heard.

When the caregiver practises the task, the caregiver gains more confidence to do it at home.

When teaching the caregiver:

- Use words that the caregiver understands.
- Use objects that are familiar, such as common spoons, or common containers for measuring and mixing ORS solution.
- Give feedback. Praise what the caregiver does well. Make corrections, if necessary. Allow more practice, if needed.
- Encourage the caregiver to ask questions. Answer all questions simply and directly.

Check the caregiver's understanding

Giving even one treatment correctly is difficult. The caregiver who must give the child two or more treatments will have greater difficulty. The caregiver may have to remember the instructions for several treatments—ORS, zinc, an antimalarial, and an antibiotic (Amoxicillin).

After you teach the caregiver how to treat the child, be sure that the caregiver understands how to give the treatment correctly. Asking checking questions and asking the caregiver to show you are two ways to find out what the caregiver has learned.

State a checking question so that the caregiver answers more than "yes" or "no". An example of a yes/no question is, "Do you know how to give your child his antibiotic?"

Most people will probably answer "Yes" to this question, whether they do or do not know. They may be too embarrassed to say "no". Or they may think that they do know.

A question that the caregiver can answer with a "yes" or "no" is a poor checking question. The answer does not show you how much the caregiver knows.

It is better to ask a few good checking questions, such as:

"When will you give the medicine?"
" How much will you give?"
" For how many days will you give the medicine?"
" What mark on the packet would help you remember?"
" When should you bring your child back to see me?"

With the answer to a good checking question, you can tell whether the caregiver has understood. If the answer is not correct, clarify your instructions. Describing how to give the treatment and demonstrating with the first dose will also help the caregiver to remember.

Good checking questions require the caregiver to **describe how** to treat the child at home. They begin with questions, such as **what, how, when, how many,** and **how much.** You might also ask **why** to check the understanding of the importance of what the caregiver is doing. You can also ask for a demonstration: **show me.**

Good checking questions	**Poor checking questions**
How will you prepare the ORS solution?	Do you remember how to mix ORS?
How much ORS solution will you give after each loose stool?	Will you try to give your child 1/2 cup of ORS after each loose stool?
How many tablets will you give next time? **What** will help you remember how many tablets you will give?	Can you remember which tablet is which, and how much to give of each?
When should you stop giving the medicine to the child?	You know how long to give the medicine, right?
Let's give your child the first dose now. **Show me** how to give your child this antibiotic (Amoxicillin).	Do you think you can give the antibiotic at home?

Ask only one question at a time. After you ask a question, wait. Give the caregiver a chance to think and to answer. Do not answer the question for the caregiver.

Checking understanding requires patience. The caregiver may know the answer, but may be slow to speak. The caregiver may be surprised that you asked, and that you really want an answer. Wait for the answer. Do not quickly ask a different question.

If the caregiver answers incorrectly or does not remember, be careful not to make the caregiver feel uncomfortable. Give more information, another example or demonstration, or another chance to practise.

Exercise: Use good communication skills

In this exercise, you will review good communication skills.

Child 1. Sasha

The Health Surveillance Assistant must teach a mother to prepare ORS solution for her daughter Sasha who has diarrhoea. First the Health Surveillance Assistant explains how to mix the ORS, and then he shows Sasha's mother how to do it. He asks the mother, "Do you understand?" Sasha's mother answers, "Yes." The Health Surveillance Assistant gives her 2 ORS packets and says good-bye. He will see her in 3 days.

Discuss with the facilitator:

1. What information did the Health Surveillance Assistant give Sasha's mother about the task?
2. Did he show her an example? What else could he have done?
3. How did he check the mother's understanding?
4. How would you have checked the mother's understanding?

Child 2. Morris

The Health Surveillance Assistant gives Morris' mother some oral Amoxicillin to give her son at home. Before the Health Surveillance Assistant explains how to give them, he asks the mother if she knows how to give her child the medicine. The mother nods her head yes. So the Health Surveillance Assistant gives her the Amoxicillin, and Morris and his mother leave.

Discuss with the facilitator:

1. What information did the Health Surveillance Assistant give Morris's mother about the task?
2. Did he show her an example? What else could he have done?
3. How did he check the mother's understanding?
4. How would you have checked the mother's understanding?
5. If a mother tells you that she already knows how to give a treatment, what should you do?

Checking questions

The following are yes/no questions. Discuss how you could make them good checking questions, or how you could ask the caregiver to demonstrate.

This may be done in the form of a drill.

1. Do you remember how to give the antibiotic and the antimalarial?
2. Do you know how to get to the health facility?
3. Do you know how much water to mix with the ORS packet?
4. Do you have a 1 litre container at home?
5. Will you continue to give your child food and drink when you get home?
6. Did you understand when you should bring your child back?
7. Do you know how much ORS to give your child?
8. Will you keep the child warm?
9. Do you understand what you should do at home now?
10. You do know for how many days to give the medicine, don't you?

Take-home messages for this section:

- Good communication between you and the caregiver is essential.
- To help a caregiver understand treatment, you should give information, show an example, and let her practise.
- Use good checking questions to make sure the caregiver understands and feels capable of carrying out the treatment at home.

Role Play Practice: Give oral Amoxicillin to treat child at home

You will go into groups of three for the role play. In your groups, identify who will be the caregiver, the Health Surveillance Assistant, and an observer. Refer to the recording form on the next pages to guide your advice on correct treatment and home care for Katrina.

Katrina Yohane is 2 years old. She has had a cough for 3 days. The Health Surveillance Assistant has counted the child's breaths. The child has 45 breaths per minute, which is fast breathing. She is at risk of HIV because her parents' HIV status is unknown. She received all her vaccines except the 15 months measles vaccine.

In the role play, the **caregiver** should act like a real parent. Be interested in doing what is necessary to make sure that Katrina gets well. Listen carefully and ask questions. Only ask questions about what is not clear. (Do not add difficulties during this practice.)

The **Health Surveillance Assistant** will teach the caregiver how to treat Katrina for fast breathing at home.

1. Help the caregiver:
    a. Prepare the oral Amoxicillin to give Katrina, age 2 years.
    b. Give the first dose to Katrina.
2. Make sure that the caregiver can give the medicine correctly at home.
3. Give the caregiver enough medicine for the full treatment at home.
4. Advise the caregiver on HIV testing and basic home care for the sick child.
5. Set a day for a follow-up visit.

The **observer** will look for:

1. What did the Health Surveillance Assistant do that was helpful in teaching the caregiver how to treat the child at home?
2. What else could the Health Surveillance Assistant do to help?
3. Was the advice correct? If not, identify what was not correct.
4. How well did the caregiver understand what to do? How do you know?
5. What task, if any, might the caregiver not understand or remember?

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date: 17/7/2008 (Day / Month / Year) **HSA:** Dora Namoyo

Child's First Name: Keterina **Surname** Yohane **Age:** 2 Years Months **Boy** / (Girl)

Caregiver's name: Keyala Bamasi **Relationship:** Mother / (Father) / Other: _____

Physical Address: Near Mapazi Mosque **Village /TA:** Balakasi /Toleza

1. Identify problems

Ask and Look		Any DANGER SIGN?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure..... **YES,** sign present ➔ Tick ☑ **NO** sign ➔ Circle ■			
☐	■ Cough? If yes, for how long? 3 days	☐ Cough for 14 days or more	
☐	■ Diarrhoea (loose stools)?	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	If YES, for how long? _____days. If yes Blood in stool? ☐ ■	☐ Blood in stool	
☐	■ Fever (reported or now)? If yes, started ___ days ago.	☐ Fever for last 7 days	☐ Fever (less than 7 days)
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, not able to drink or feed anything? ☐■	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, vomits everything? ☐ ■	☐Vomits everything	
☐	■ Red eyes? If yes, for how long _____days. ■ Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Visual problem	☐ Red eye less than 4 days
☐	■ Has HIV?	☐ Has HIV and any other illness	
☑	■ **At risk of HIV because** ☐ **One or both parents have HIV and child has not tested for HIV? Or** ☑ Parents' current HIV status is unknown?		☐ **One or both parents have HIV and child has not tested for HIV** ☐ Parents' current HIV status unknown.
☐	■ At risk of acute malnutrition ☐ Frequently sick, Or ☐ Less than 4 types food group		☐ At risk of acute malnutrition
☐	■ Any other problem I cannot treat (E.g. problem in breast feeding, injury)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
	■ Chest in drawing? (FOR ALL CHILDREN)	☐ Chest in drawing	
☑	**IF COUGH, count breaths in 1 minute:** 45 breaths per minute ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
☐	**For child 6 mo. up to 5 years, MUAC colour: Green MUAC** _ 13 cm **For all children** ■ Oedema? If yes, ☐ Oedema + ☐ Oedema ++ ☐ Oedema +++	☐ Oedema +++ ☐ Red MUAC with complication ☐ Yellow on MUAC ☐ Oedema + or ++ with complications (age 6 mo. or more) ☐ Oedema + or ++ with or without complications (age 2 up to 6 mo.)	☐ Red on MUAC tape ☐ Oedema + ☐ Oedema ++

2. Decide: Refer or treat child

(Tick decision)

☐ **If ANY Danger Sign, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

GO TO PAGE 2

Child's name: _____ Age:_____

3. Refer or treat child (tick treatments given and other actions)

☐ If ANY Danger Sign, refer to health facility

☐ If NO Danger Sign, treat at home and

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: **☐Explain why child needs to go to health facility.** **☐FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	**☐Begin giving ORS solution** immediately.
☐ If **Fever AND** **☐Convulsions or** ☐Very sleepy or unconscious or ☐Not able to drink or feed anything ☐Vomits everything ☐Palmar pallor --- If Fever AND danger signs other than the 5 above	**☐Give Rectal Artesunate suppository (100mg)** ☐Age 2months up to 3 years—1 suppository ☐Age 3 yesr up to 5 years— - 2 suppositories --- ☐Give first dose of oral antimalarial LA ☐Age up to 5 months – not recommended ☐Age 5 months up to 3 years—1 tablet ☐Age 3 years up to 5 years – 2 tablets
☐ If **Chest in drawing**, or ☐ **Fast breathing and danger sign**	**☐Give first dose of oral antibiotic** (Amoxicillin adult tablet—250g) ☐Age 2 months up to 12 months— 1 tablet ☐Age 12 months up to 5 years—2 tablets
If red eye for 4 days or more	☐ **Apply antibiotic eye ointment**
☐For any sick child who can drink, advise to give fluids and continue feeding. **☐Advise to keep child warm, if child is NOT hot with fever.** **☐Write a referral note.** **☐Arrange transportation, and help solve other difficulties in referral. FOLLOW UP child on return at least once a week until child is well.**	

If no danger sign, **TREAT at home and ADVISE on home care:**	
☐ **If Diarrhoea**	**☐Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. **☐Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but at least ½ cup ORS solution after each loose stool. **☐Give zinc supplement.** Give 1 dose daily for 10 days: ☐Age 2 months up to 6 months – ½ tablet (total 5 tabs) ☐Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever**	**☐Do rapid diagnostic test (RDT).** **_Positive _Negative** ☐If RDT is positive, give oral antimalarial LA Give twice daily for 3 days ☐Age up to 5 months —not recommended ☐Age 5 months up to 3 years—1 tablet (6 tablets) ☐Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now and 2nd dose after 8 hours. Then give dose twice daily for 2 more days. **☐Give Paracetamol.** Give 4 times a day ☐ Age 5 months up to 3 years - ¼ tablet (total 3 tabs) ☐ Age 3 years up to 5 years – ½ tablet (total 6 tabs)
☐ If **Fast breathing**	**☐Give oral antibiotic** (Amoxicillin adult tablet—250g). Give twice daily for 5 days: ☐Age 2 months up to 12 months— 1 tablet (total 10 tabs) ☐Age 12 months up to 5 years—2 tablet (total 20 tabs) Help caregiver give first dose now.
☐ If red eye	**☐ Apply antibiotic eye ointment.** Squeeze the size of a grain of rice on each of the inner lower eyelids, 3 times a day for 3 days.
☐ If at risk of HIV	**☐ Advise caregiver to take the child for HIV test soon and, it parents' HIV status is not known, advise the mother and father to test for HIV also.**
☐If living in a household with someone on TB treatment	**☐ Advise caregiver to take child soon for TB screening and TB preventive medicine.**
☐ For **ALL children treated at home, advise on home care**	**☐Advise caregiver to give more fluids and continue feeding.** **☐Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool **☐Follow up child in 3 days** (schedule appointment in item 6 below).

4.Check Vaccines☑ (Tick vaccines completed ■ Circle vaccines missed)

*Keep an interval of 4 weeks between DPT-Hib. + Hep B and OVP doses. Do not OVP 0 if the child is 14 days or more.

5.If any OTHER Problem or I can not treat,refer child to health facility,write referral note.(If diarrhoea ,give ORS .Do not give antibiotic or antimalarial)

6. When to return for FOLLOW UP (circle):
Monday Tuesday Wednesday Thursday Friday Weekend

Age	Vaccine	
Birth	☐ ■ BCG	☐ ■ OPV-0
6 weeks*	☑ ■ DPT—Hib + HepB 1 ☐ ■PCV1 ☐ ■Rota1	☐ ■ OPV-1
10 weeks*	☑ ■ DPT—Hib + HepB 2 ☑ ■PCV2 ☑ ■Rota2	☑ ■ OPV-2
14 weeks*	☑ ■ DPT—Hib + HepB 3 ☑ ■PCV3	☑ ■ OPV-3
9 months 15months	☐ ■ Measles 1 ☐ ■ Measles 2	

➔ Advise caregiver, if needed:
WHEN is the next vaccine to be given?

WHERE?

7. Note on follow up: ☐ Child better—continue to treat at home. Day of next follow up:_____
☐ Child is not better __ refer **URGENTLY** to health facility.
☐ Child has danger sign ___refer **URGENTLY** to health facility

Practise your skills in the community

You have had many opportunities to practise what you are learning in this course. Now you will have another chance to practise your new skills in the community under supervision. You will not forget what you have learned if you begin to practise right away. Each task will become easier to do with practice.

The facilitator will discuss ways to provide supervision in the community. Possible ways are:

- The facilitator visits families together with you.
- The facilitator assigns you to a health worker or supervisor. The health worker will be your mentor in the community. A mentor helps you until you get more experience.
- Course participants meet regularly to practise together and discuss their experiences in the community.
- You continue to practise with a health worker in a health facility.

The record keeping system and the method of supplying you with medicine will be different in different places. Together the facilitator and supervisor will make arrangements for regularly refilling your medicine kit.

Before you leave, the facilitator also will give you the following items to use when you see sick children:

- Recording forms and referral notes
- ORS packets
- Zinc tablets
- Rapid Diagnostic Tests for malaria
- Antimalarial LA tablets
- Antibiotic Amoxicillin
- An extra MUAC tape
- Artesunate suppositories
- RUTF
- RUSF
- Albendazole
- Vitamin A
- Iron and Folic Acid
- In addition, keep the following items with you:
- Utensils to prepare and give ORS solution
- A table knife to cut a tablet, and a spoon and small cup to prepare the medicine to give the child
- Pencils

When you visit families or they bring their children to see you, complete a recording form for every sick child. Bring the completed recording forms to the next meeting with the facilitator or supervisor. You will discuss the children, their signs, and the actions you have taken. You can discuss any problems you found and how to solve them.

GUIDELINES FOR THE MANAGEMNENT OF COMMUNITY DRUGS

1.0 INTRODUCTION

1.1 PURPOSE OF THE COMMUNITY DRUGS GUIDELINES

The government of Malawi is making efforts to increase accessibility to health care at community level. Drugs for common childhood illnesses such as diarrhoea, pneumonia and malaria will be made available at community level. The guidelines are developed to provide direction in the management of community IMCI drugs at all levels and addresses the following important issues:

- Proper selection, estimation of quantities and procurement of drugs
- Proper ordering of drugs at community level
- Distribution, storage and dispensing of drugs
- Proper treatment given to patients
- Rational of drugs
- Referral of patients

1.2 USERS OF THE GUIDE

This guide is developed for all stakeholders involved in health related community interventions i.e. donors, NGOs, and village health committees. This guide will be used by the Health Surveillance Assistants who are trained in Community case management and will be operating the village clinics.

1.3 METHODS OF GUIDELINES FORMULATION

The formulation of the community village clinic drug guidelines was undertaken by organising a national workshop attended by the MOH, UNICEF, NGOs, DHOs, Community leaders and HSAs. The workshop extensively utilized experiences and expertise of the participants.

1.4. SIGNIFICANCE OF THE COMMUNITY DRUG GUIDELINES

Malawi has a high infant mortality rate and morbidity rate. According to a baseline survey conducted in the Year 2004, 60% of children were dying in the home without seeking medical attention and 48% of respondents indicated that health facilities were far.

The guidelines will ensure the realization of the following outcomes:

- Assure communities of drug availability, which in turn will create trust, influence proper utilization and alleviate disease burden.
- Easy accessibility to treatment
- Monitoring utilization of drugs and supplies is made easier.

2.0 SPECIFIC GUIDELINES AND KEY ACTIONS

2.1 Selection of drugs

Selection of community IMCI drugs is based on:

- Some conditions as outlined in the Essential Health Package (EHP) and detailed under relevant section in this guide.
- Dosage regimen i.e. ease of drug administration e.g. LA
- Storage i.e. drugs that do not require special conditions to be stored.

2.2 Estimation of required quantities

Required drug quantities shall be based on consumption and morbidity data once the HMIS and LMIS are in place and functioning.

The HSA. shall record Stock Balance (Stock on Hand), Losses and Expired quantities, and Quantity used on the Form 1A . The HSA. and one committee member shall sign at the space provided. Then the form shall be sent to the Pharmacy Technician / Pharmacy Assistant / SHSA either directly or through the Health Centre basing on the bureaucracies existing. The Pharmacy Technician shall collate the information provided in the LMIS reporting forms and calculates the quantity required for each facility using a formula that ensures that quantity requested are enough to last three months.

2.3 Source of community medicines and medical supplies

The community medicines will come from the Regional Medical Stores to services Delivery Point. These medicines and medical supplies will be delivered at the nearest Health centre of the village clinic.

2.3.1. Management of donated medicines and Medical supplies

All donated medicines will pass through Pharmacy and Medicines Regulatory Authority (CMS) for quality assurance**.**

- Relevant programs will determine allocation of these medicines
- Distribution of these medicines will be according to the channels stipulated by government
- All medicines and medical supplies from WELWISHERS should pass through the District Health Office

2.4 Quality assurance

Quality of medicines will be maintained at different levels of the system as follows:

- **Central Medical Stores** will test the medicines for potency and quality.
- **DHO** will play the important role of supervision, inventory management, monitoring and evaluating e.g. drug storage and checking expiry dates.
- **Health Centres** will ensure proper storage, resupplying and maintenance of tally sheets and drug registers

- **Communities** will ensure :

a) Proper storage and hygienic handling of medicines the HSA who is the

dispenser will ensure proper storage and hygienic handling of medicines. The HSA will also provide advice on proper storage and administration of oral medicines. The medicines will be stored in drug boxes at community level.

b) When expanding the programme the DHMTs will provide the drug boxes from their regular budget.

c) Return of expired medicines
The HSA shall report to the Health Centre about the expired medicines. The Health Centre shall in turn report to the DHO who would follow the required procedures for disposal of medicines. The Expired Community Medicines shall be replaced in the next consignment.

d) Proper transportation of medicines. The HSA with one community drug committee member will transport the medicines from the nearest health facilities with available means of transport e.g. bicycle. Use of tally sheets and patients registers

2.5 Ordering of medicines and medical supplies at community level

The dispenser who is the Health Surveillance Assistant will order the medicines from the nearest health facility after the Drug management subcommittee (DMSC) has signed the **Form 1A .**

2.6 Distribution of medicines and medical supplies

The health surveillance assistant with a representative from the CDC will collect medicines and medical supplies from the health facility.

Distribution of Community medicines and medical supplies will be based on the current Direct Delivery system from RMS to health facilities. Determination of what to distribute to communities will be done by the District Pharmacy Technician using the reported data as it is the case with all other medicines and medical supplies. The distribution and delivery to health facilities are done monthly while the requested quantities are calculated using a formula that ensures three months' supply.

Quantities for all the community Drug Kits shall be clearly spelt out in the Delivery Notes to various Health Centres and District Pharmacies.

Where government does not have its own health facility, a Cham Unit if present in the area will serve as a collection point for community medicines and medical supplies.

2.7 Types of medicines and medical supplies to be managed at community level

Health Surveillance Assistants at community level will manage the following drugs:

- LA
- Amoxicillin
- Paracetamol
- ORS
- Zinc

- Antibiotic Eye Ointment
- Rectal Artesunate
- RUTF
- RUSF
- Albendazole
- Vitamin A
- Iron and Folic Acid

2.8 Storage and security of medicines at community level

STORAGE

- The community Medicines and medical supplies shall be under the custody of the HSA.
- Patient registers and drug tally cards (showing the amount of medicines received, dispensed and the balance) will be maintained by the HSA's. The DHOs will provide these tally cards
- Storage place should be convenient to the dispenser
- Use lockable waterproof boxes and haversacks: **a 2-key lock system** is advocated for.
- Keep RUTF and RUSF in a separate wooden box with 2 –key lock system
- Store the medicines in a cool dry place.

SECURITY:

The following security measures should be observed at all times:

- Secure house with lockable door
- Lockable box with a double locking system – the Dispenser (herein referred to as HSA) will keep a set of keys for one padlock whilst the other one will be kept by a member of community drug committee (CDC). It is extremely recommended that a set of the keys be kept by a mature and elderly Committee member. The member should not allow any of his/her family to surrender the keys to anyone.
- **Haversack** will be used to carry medicines for dispensing
- Drug theft will be dealt with following normal legal Procedures

2.9 Age of patient to be managed at community level

- Only under five patients will be managed at community level by HSAs

2.10 Cost to the patient

- Community medicines will be dispensed to the under – fives free of charge in line with EHP and PRSP.

3.0 Conditions to be managed at Community level

The following conditions will be managed at community level:

- Pneumonia
- Malaria
- Diarrhoea
- Eye infection

- Uncomplicated Severe Acute malnutrition

3.1 Dispensing and administration of medicines

- Only oral medicines are to be used
- All first doses will be administered under observation (DOTS)
- All drug packets/envelopes should have the following information:
  (a) Name of drug
  (b) Dosage and frequency of administration
  (c) Expiry date
  (d) Name of patient
  (e)

All severe cases should be referred to a health facility by the HSA

3.2 Personnel to manage community medicines

- Only HSA's who have undergone the formal 10 week induction training will be eligible to keep the community drug kit at community level
- The HSA. shall also be responsible for administering of medicines to sick children
- A Member of the Drug Monitoring sub Committee (DMSC) shall be responsible for keeping a set of keys for the Drug box. No other member, including the HSA shall have the mandate of opening the drug box alone.

3.3 Hygiene to be ensured

- Medicines are to come in the usual containers from Central Medical Stores
- Small empty plastic packs shall be made available for HSAs for packing medicines and labelling instructions
- HSAs to give proper instructions on ORS preparation at home (No ORT Corner).
- HSAs to be supported with safe water and sanitary facilities (VIPs and hand washing facilities) at the dispensing points.
- HSAs should also be supported with supplies like cups, spoons, pails, soap, towels, basins, MUAC tapes, height and water purifiers etc.

3.4 Monitoring and Evaluation

- District IMCI team (IMCI coordinator, Malaria coordinator, Pharmacy, HMIS and Nutritionist) will oversee the activities i.e. to ensure that guidelines are being followed.
- HSAs should submit monthly reports containing a summary of drug consumption, cases seen by age groups using a monitoring tool, to Malaria and IMCI Coordinators, Nutritionist and the Pharmacy Technician
- The focal person will conduct monthly supervisory visits
- An evaluation will be conducted after 6 months of implementation using data from available surveys.

3.5 Referral procedures

- Give initial treatment according to diagnosis and refer
- Write a referral slip to include the following information:
  (a) Name and age of patient
  (b) Date and time of referral
  (c) Reason for referral (symptoms and signs leading to severe classification)

(d) Treatment given, dose, time and route
(e) Name of dispenser and the name of the referring village

- Organise local transport (e.g. bicycle ambulance, oxcart etc,send for an ambulance)

Refer all children with danger signs!!

GUIDELINES FOR USE mRDT AND RECTAL ARTESUNATE AT COMMUNITY LEVEL

Learning Objectives

By the end of this session, the participants should be able to:

- Perform malaria RDT procedure correctly
- Practice blood-safety procedures
- Interpret RDT results correctly

Procedure for performing an RDT

I. Read product instructions carefully.

II. Prepare the materials needed.

- RDT (new unopened test device, alcohol swab, buffer)
- New, unopened lancet
- Cotton, alcohol (if swab not supplied with the RDT)
- Disposable gloves
- Timer or watch
- Box / container for used lancets / sharps and other infectious waste
- Pencil or marker for labeling the RDT
- Record book and pen for results

III. Preparations before doing the malaria test

- Take time to explain briefly to the patient what you are going to do.
- Check expiry date of the RDT(color of desiccant)
- DO NOT use expired or damaged RDT or if there is a sign of exposure to humidity!

IV. Steps for performing a malaria rapid diagnostic tests

- Wear disposable gloves.
- Open the RDT packet and take out cassette or device
- Label RDT with patient's name or ID before doing the test
- Clean the patient's finger with an alcohol swab (or cotton and alcohol) and let it dry before doing a finger prick.
- Discard used lancet immediately in the sharps box / container. DO NOT set down lancet before discarding it.
- Touch the surface of the blood with the collecting tube / device to get 5μL of blood (or any prescribed volume by manufacturer).
- DO NOT collect too much blood as this may affect the test result.
- Slowly deliver the blood from the collecting tube / device on to the sample well.
- Discard the used blood collecting tube / device immediately in the sharps box / container.
- Invert the buffer bottle vertically and slowly dispense the required number of drops into the buffer well.
- After doing the test, discard used gloves, swab / cotton, desiccant in a non-sharp waste container
- Note: If RDT was stored in the refrigerator, allow test to reach room temperature before opening and using it.

5. Waiting Time

- Wait for 20 minutes before reading the results.
- DO NOT read test before the prescribed time as this may give FALSE results.

6. **Reading the test results**

- **Negative result**
  - ✓ Only one line in the control window "C" AND no line in the test window.
- **Positive results**
  - ✓ Line in the control window "C" AND one or two line(s) in the test window.
  - ✓ Test is positive even if the line in the test window is faint.
- **Invalid results**
  - ✓ No line in the control window OR no lines at all.

7. Interpretation of results

Antigen may be detected even when the infecting parasites have died after treatment or due to persistence of gametocyte forms of the parasites which do not cause illness. Presence of other factors in the blood may occasionally produce false-positive result.

There may be few parasites to register a positive result. The RDT may have been damaged by heat, moisture and freezing that can reduce its sensitivity. Malaria may be due to another parasite species for which the RDT is not designed to.

Positive results

Line in the control window "C" AND one or two line(s) in the test window.
Test is positive even if the line in the test window is faint.

Negative results

Line in the control window "C" AND no line(s) in the test window

Invalid results

No line in the control window OR no lines at all.

8. Points to remember

- Record results in the register.
- Discard used RDTs in the non-sharp waste container.
- Malaria RDT is a common test with common expected limitations …
- Antigen may be detected even when the infecting parasites have died after treatment or due to persistence of gametocyte forms of the parasites which do not cause illness.
- Presence of other factors in the blood may occasionally produce false-positive result.
- There may be few parasites to register a positive result.
- The RDT may have been damaged by heat, moisture and freezing that can reduce its sensitivity.
- Malaria may be due to another parasite species for which the RDT is not designed to detect.

9. Blood safety practices

- Never re-use lancets or needles.
- Discard used lancets, blood collecting tubes / devices and other infectious wastes in specially labelled puncture-free containers with covers.
- Disinfectant or antibacterial liquid should always be available. Always wash hands with soap and clean water after handling infectious materials.
- If hand has a cut or open wound, cover it with a bandage or adhesive tape before doing the test.
- If accidentally punctured or injured by a used lancet –
  - ✓ Wash the affected part thoroughly with water and disinfectant.
  - ✓ Immediately report incident to the designated infection control officer or supervisor.

10. Points to remember when using a RDT

- Read the product instruction carefully before performing the RDT. Keep a copy of the product insert handy.
- Follow manufacturer / product instructions strictly.
- Do not use expired RDTs.
- Do not use the RDT if the pouch / packet is punctured or damaged or if desiccant has changed colour.
- Do not mix up components of various products / lots.
- Open the RDT pouch just before using it. Avoid prolonged exposure to humidity during RDT preparation
- Store RDTs in shady, cool storage locations.
- If stored in refrigerator, let RDT reach room / ambient temperature before opening and using it.
- Read and interpret test results after or within the time specified by the manufacturer.
- Do not re-use RDTs.
- Always observe blood safety practices.

11. Storing, Transporting and Handling Malaria RDTs

a. Storage

- Ideally at 25 degrees C or below. For most RDTs the storing temperature varies between +2 and +30 degrees C
- Alternative: Simple storage and transport measure combined with good planning and practice of "good storage guidelines" can help maintain the quality of RDT.
- Clean, dry and disinfect storeroom regularly. Take precautions to prevent harmful insects and rodents from entering the storage area
- Store health commodities in a dry, well lit, well-ventilated storeroom—out of direct sunlight.
- Protect storeroom from water penetration
- Limit storage area access to authorized personnel. Lock up controlled substances.
- Keep fire safety equipment available, accessible, and functional. Train employees

b. Dispatching

- Always think First Expiry First Out(FEFO)
- Minimum 6 months shelf life for tests sent to HC
- Always notify the facility receiving the RDTs before sending, ensure that someone is available to receive
- Avoid sending RDTs to facilities on closure days (Friday, weekend, holyday…)
- Do not issue damaged or expired RDT

c. Transporting

- Avoid exposure to high temperature by:
    - Minimizing extended delays en route
    - Indicate on the carton that RDT are temperature sensitive
    - Load vehicle in the shade and park always out of sun
    - Protect from theft, loss, damage during transport
- If by foot, bicycle, or motorbike:
    - Leave early in the morning or evening
    - Always keep the box out of direct sunlight

BIOMEDICAL WASTE MANAGEMENT AT COMMUNITY LEVEL

Standard Operating Procedures for handling waste management at the village Clinic.

What are biomedical wastes?

These are solid or liquid wastes generated from medical activities suspected to contain infectious materials or which because of their physical or biological nature may be harmful to humans, animals, plants or the environment. These products may pose or present a threat of infection to humans, animals, crops, or natural ecosystem.

Solid or liquid waste which may present a threat of infection to humans include discarded sharps (medical items intended to cut or puncture skin, e.g. needles, lancets, scalpel blades), Blood, blood products (e.g. serum, plasma) and others.

Most of biomedical wastes are believed to be infectious by nature.

What are Infectious wastes?

These are wastes that contain microorganisms in sufficient quantity which could result in the multiplication and growth of those microorganisms in a host.

Handling of Biomedical wastes that will be used at community level in relation to use of malaria rapid diagnostic tests

- Wear appropriate personal protective equipment -PPE (gloves, disposable apron) when handling waste
- Always assume all Bio Medical Wastes are infectious

Sharps

- Only sharps and used test kits should go into sharps containers.
- Reusable Plastic Sharps container should be **located where the sharps are used**:
- Sharps containers should be replaced when necessary
- Empty sharps container before its ¾ full.
- Discard the lancet directly into a **puncture resistant container**
- The sharps container should only be opened when disposing off the sharps
- Dispose the sharps into a pit latrine
- After emptying the sharps container disinfect the container with 0.5% chlorine
- Keep the sharps container out of reach of children

Soft Items

- Used soft waste materials such as gloves, soaked cotton wool, swabs, aprons, tests pouch should be disposed in a bin with bin liner
- Burn soft items on daily basis in a rubbish pit.

Administration of Rectal Artesunate for treatment of severe malaria at community level

What is rectal Artesunate

Rectal Artesunate are antimalarial mediciness prepared specifically for insertion into the rectum. They usually take a bullet-shaped form and they dissolve after insertion into the rectum. Rectal Artesunate medications are administered when a patient is vomiting everything, unable to swallow, or unconscious. Rectal Artesunate is therefore ideal at community level as they can be given to a sick child with danger signs (as pre-referral treatment) on the way to the health facility.

Precautions

Rectal medicines should not be taken orally. Only medications labeled as rectal preparations should be placed in the rectum. Rectal medication should not be given to children with rectal bleeding or with rectal prolapsed i.e. where rectal tissue is protruding from the rectal opening/anus.

How to prepare Rectal Artesunate

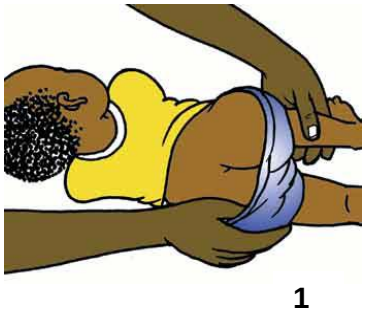
Before administering rectal artesunate ensure the following are observed;

- Ensure patient privacy.
- Explain the procedure to the guardian and ask her to support positioning the child.
- Ask the guardian if she has any questions.
- Ask the guarding to remove lower garments and underwear of the child.
- Position the patient on a couch on his or her left side, with the top knee bent and pulled slightly upward.
- If available, place a waterproof pad under the patient's hips to protect the beddings.
- Use a sheet (or Mothers wrapper) to cover all of the patients' body except the buttocks.

Procedures for administration of rectal artesunate

- Explain the procedure to the caregiver
- Caregiver should clean the anal area
- Wash your hands thoroughly with soap and water.
- Put on disposable gloves.
- If the suppository is soft, hold it under cool water for a few minutes to harden it before removing the wrapper
- Remove the suppository wrapper, if present
- Moist the anal and area with cotton swab soaked in clean cool water and cotton.
- Lie the child on his /her your side with its lower leg straightened out and the upper leg bent forward toward his / her abdomen.
- Gently insert the suppository, pointed end first, with your finger until it passes the muscular sphincter of the rectum, about 1/2 to 1 inch in infants (If not inserted past this sphincter, the suppository may pop out.)
- Ask the caregiver or mother to hold buttocks of the child together for at least 30-60 seconds.
- The child should remain lying down for about 5 minutes to avoid having the suppository come out
- Discard used materials and wash your hands thoroughly with soap.

Pictures to demonstrate each step



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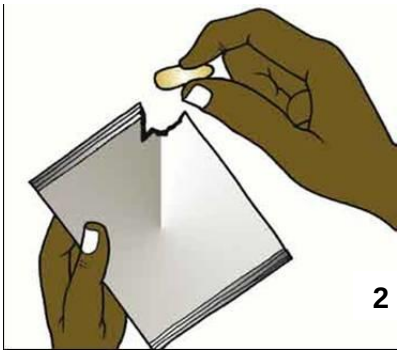

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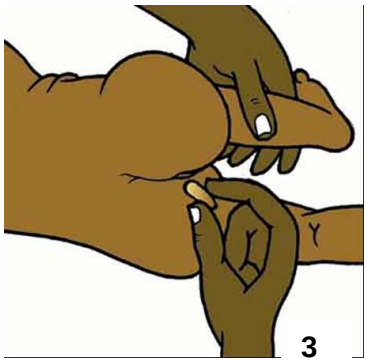

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List of CCM commodities

Type	Item	#	Comment
Medicines	Amoxicillin tablets	1000	
	LA 1X6 tablets	180	
	LA 2X6 tablets	360	
	ORS sachets	100	
	Zinc tablets	500	= 50 blister packets
	Paracetamol tablets	1000	
	Eye ointment tubes	50	
	Rectal artesunate	1	10 suppositories
Supplies	Drug box	1	
	Timer	1	
	Monthly Reports	2	
	Village Clinic Register	1	
	Sick Child Recording Form	1	Color, laminated
	Referral Slips	10	
	MUAC tape	1	
	Plastic pail	1	
	Basin	1	
	Cup	2	
	Spoon	2	
	mRDTs	2 boxes	50
	Gloves	1 box	
	Plastic Sharp container	1	
	Cotton	1 roll	Small
	Bin liners	30	
	Bin	1	
	Soap	1	
	Pail for hand washing	1	
	Macintosh	1	Half metre
	Disinfectant		For any spirages
	Aprons	20	
	Icepack	1	

How To Do the Rapid Test for Malaria

Collect:

a. **NEW unopened** test packet
b. **NEW unopened** spirit swab
c. **NEW unopened** lancet
d. **NEW** pair of disposable gloves
e. Buffer
f. Timer


Disposable gloves


Spirit swab


Lancet

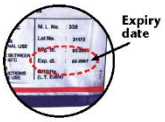

Timer


Buffer

Test packet

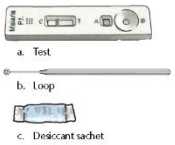
READ THESE INSTRUCTIONS CAREFULLY BEFORE YOU BEGIN.

1. Check the expiry date on the test packet.



2. Put on the gloves. Use new gloves for each patient

3. Open the packet and remove:



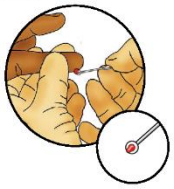
4. Write the patient's name on the test.

5. Open the alcohol swab. Grasp the 4th finger on the patient's left hand. Clean the finger with the spirit swab. Allow the finger to dry before pricking.

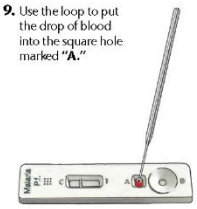
6. Open the lancet. Prick patient's finger to get a drop of blood.

7. Discard the lancet in the Sharps Box immediately after pricking finger. **Do not set the lancet down before discarding it.**

8. Use the loop to collect the drop of blood.



9. Use the loop to put the drop of blood into the square hole marked **"A."**



10. Discard the loop in the Sharps Box.

11. Put six (6) drops of buffer into the round hole marked **"B."**

12. Wait **15 minutes** after adding buffer.

13. Read test results.
(**NOTE: Do Not** read the test sooner than **15 minutes** after adding the buffer. You may get **FALSE** results.)

14. How to read the test results:

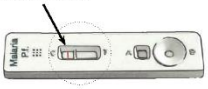
POSITIVE

One red line in window **"C" AND** one red line in window **"T"** means the patient **DOES** have *falciparum* malaria.

The test is **POSITIVE** even if the red line in window **"T"** is faint.

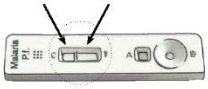
NEGATIVE

One red line in window **"C"** and **NO LINE** in window **"T"** means the patient **DOES NOT** have *falciparum* malaria.



INVALID RESULT

NO LINE in window **"C"** means the test is damaged.



A line in window **"T"** and **NO LINE** in window **"C"** also means the test is damaged. Results are **INVALID**.

If no line appears in window "C," repeat the test using a **NEW unopened** test packet and a **NEW unopened** lancet.

15. Dispose of the gloves, spirit swab, desiccant sachet and packaging in a non-sharps waste container.

16. Record the test results in your CHW register. Dispose of cassette in non-sharps waste container

NOTE: Each test can be used **ONLY ONE TIME.** Do not try to use the test more than once.

TDR
WORLD HEALTH ORGANIZATION
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QUALITY ASSURANCE PROJECT

Annex A. RDT Job Aid