

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

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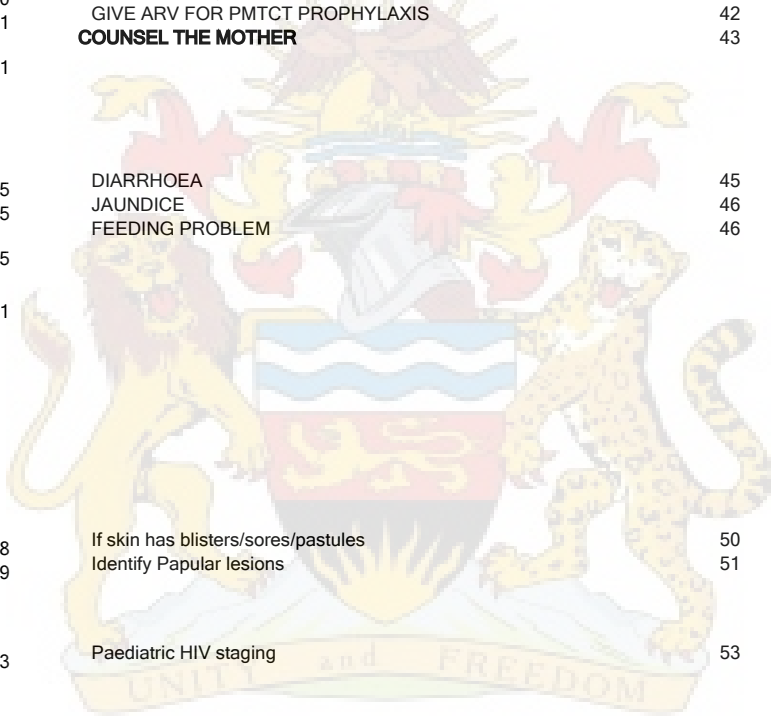
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SICK CHILD AGE 2 MONTHS UP TO 5 YEARS



ASSESS AND CLASSIFY THE SICK CHILD

ASSESS

CLASSIFY

IDENTIFY TREATMENT

ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE

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

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

CHECK FOR GENERAL DANGER SIGNS

Ask:

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

Look:

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

URGENT attention

- Any general danger sign

Pink:
VERY SEVERE DISEASE

- Give diazepam if convulsing now
- Quickly complete the assessment
- Give any pre-referral treatment immediately
- Treat to prevent low blood sugar
- Keep the child warm
- Refer **URGENTLY**.

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

THEN ASK ABOUT MAIN SYMPTOMS:

Does the child have cough or difficult breathing?

If yes, ask:

- For how long?

Look, listen, feel*:

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

CHILD
MUST BE
CALM

If wheezing with either fast breathing or chest indrawing:

Give a trial of rapid acting inhaled bronchodilator for up to three times 15-20 minutes apart. Count the breaths and look for chest indrawing again, and then classify.

If the child is:

2 months up to 12 months

12 Months up to 5 years

Fast breathing is:

50 breaths per minute or more

40 breaths per minute or more

Classify COUGH or DIFFICULT BREATHING

- Any general danger sign or
- Stridor in calm child.

Pink: SEVERE PNEUMONIA OR VERY SEVERE DISEASE

- Give first dose of an appropriate antibiotic
- Refer **URGENTLY** to hospital**

- Chest indrawing or
- Fast breathing.

Yellow: PNEUMONIA

- Give oral Amoxicillin for 5 days***
- If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****
- If chest indrawing in HIV exposed/infected child, give first dose of amoxicillin and refer.
- Soothe the throat and relieve the cough with a safe remedy
- If coughing for more than 14 days or recurrent wheeze, refer for possible TB or asthma assessment
- Advise mother when to return immediately
- Follow-up in 3 days

- No signs of pneumonia or very severe disease.

Green: COUGH OR COLD

- If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****
- Soothe the throat and relieve the cough with a safe remedy
- If coughing for more than 14 days or recurrent wheezing, refer for possible TB or asthma assessment
- Advise mother when to return immediately
- Follow-up in 5 days if not improving

*If pulse oximeter is available, determine oxygen saturation and refer if < 90%.

** If referral is not possible, manage the child as described in the pneumonia section of the national referral guidelines or as in WHO Pocket Book for hospital care for children.

***Oral Amoxicillin for 3 days could be used in patients with fast breathing but no chest indrawing in low HIV settings.

**** In settings where inhaled bronchodilator is not available, oral salbutamol may be tried but not recommended for treatment of severe acute wheeze.

Does the child have diarrhoea?

If yes, ask:

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

Look and feel:

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

Classify DIARRHOEA

for DEHYDRATION

Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly.	Pink: SEVERE DEHYDRATION	■ If child has no other severe classification: ◦ Give fluid for severe dehydration (Plan C) OR ■ If child also has another severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding ■ If child is 2 years or older and there is cholera in your area, give antibiotic for cholera
Two of the following signs: • Restless, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly.	Yellow: SOME DEHYDRATION	■ Give fluid, zinc supplements, and food for some dehydration (Plan B) ■ If child also has a severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding ■ Advise mother when to return immediately ■ Follow-up in 5 days if not improving
Not enough signs to classify as some or severe dehydration.	Green: NO DEHYDRATION	■ Give fluid, zinc supplements, and food to treat diarrhoea at home (Plan A) ■ Advise mother when to return immediately ■ Follow-up in 5 days if not improving

and if diarrhoea 14 days or more

• Dehydration present.	Pink: SEVERE PERSISTENT DIARRHOEA	■ Treat dehydration before referral unless the child has another severe classification ■ Refer to hospital
• No dehydration.	Yellow: PERSISTENT DIARRHOEA	■ Advise the mother on feeding a child who has PERSISTENT DIARRHOEA ■ Give multivitamins and minerals (including zinc) for 14 days ■ Follow-up in 5 days

and if blood in stool

• Blood in the stool.	Yellow: DYSENTERY	■ Give ciprofloxacin for 3 days ■ Follow-up in 3 days
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Does the child have fever?

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

If yes:

Decide Malaria Risk: high or low

Then ask:

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

Look and feel:

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

Do a malaria test***: If NO severe classification

- In all fever cases if High malaria risk.
- In Low malaria risk if no obvious cause of fever present.

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

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

Classify FEVER

High or Low Malaria Risk

No Malaria Risk and No Travel to Malaria Risk Area

If MEASLES now or within last 3 months, Classify

• Any general danger sign or • Stiff neck.	Pink: VERY SEVERE FEBRILE DISEASE	■ Give first dose of artesunate or quinine for severe malaria ■ Give first dose of an appropriate antibiotic ■ Treat the child to prevent low blood sugar ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Refer URGENTLY to hospital
• Malaria test POSITIVE.	Yellow: MALARIA	■ Give recommended first line oral antimalarial ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Give appropriate antibiotic treatment for an identified bacterial cause of fever ■ Advise mother when to return immediately ■ Follow-up in 3 days if fever persists ■ If fever is present every day for more than 7 days, refer for assessment
• Malaria test NEGATIVE • Other cause of fever PRESENT.	Green: FEVER: NO MALARIA	■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Give appropriate antibiotic treatment for an identified bacterial cause of fever ■ Advise mother when to return immediately ■ Follow-up in 3 days if fever persists ■ If fever is present every day for more than 7 days, refer for assessment
• Any general danger sign • Stiff neck.	Pink: VERY SEVERE FEBRILE DISEASE	■ Give first dose of an appropriate antibiotic. ■ Treat the child to prevent low blood sugar. ■ Give one dose of paracetamol in clinic for high fever (38.5°C or above). ■ Refer URGENTLY to hospital.
• No general danger signs • No stiff neck.	Green: FEVER	■ Give one dose of paracetamol in clinic for high fever (38.5°C or above) ■ Give appropriate antibiotic treatment for any identified bacterial cause of fever ■ Advise mother when to return immediately ■ Follow-up in 2 days if fever persists ■ If fever is present every day for more than 7 days, refer for assessment
• Any general danger sign or • Clouding of cornea or • Deep or extensive mouth ulcers.	Pink: SEVERE COMPLICATED MEASLES****	■ Give Vitamin A treatment ■ Give first dose of an appropriate antibiotic ■ If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment ■ Refer URGENTLY to hospital
• Pus draining from the eye or • Mouth ulcers.	Yellow: MEASLES WITH EYE OR MOUTH COMPLICATIONS****	■ Give Vitamin A treatment ■ If pus draining from the eye, treat eye infection with tetracycline eye ointment ■ If mouth ulcers, treat with gentian violet ■ Follow-up in 3 days
• Measles now or within the last 3 months.	Green: MEASLES	■ Give Vitamin A treatment

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

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

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

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

Does the child have an ear problem?

If yes, ask:

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

Look and feel:

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

Classify EAR PROBLEM

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

THEN CHECK FOR ACUTE MALNUTRITION

CHECK FOR ACUTE MALNUTRITION

LOOK AND FEEL:

Look for signs of acute malnutrition

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

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

- Check for any medical complication present:
 - Any general danger signs
 - Any severe classification
 - Pneumonia with chest indrawing
- If no medical complications present:
 - Child is 6 months or older, offer RUTF*** to eat. Is the child:
 - Not able to finish RUTF portion?
 - Able to finish RUTF portion?
 - Child is less than 6 months, assess breastfeeding:
 - Does the child have a breastfeeding problem?

Classify
NUTRITIONAL
STATUS

• Oedema of both feet - OR • WFH/L less than -3 z-scores OR MUAC less than 115 mm AND any one of the following: ◦ Medical complication present or ◦ Not able to finish RUTF or ◦ Breastfeeding problem.	Pink: COMPLICATED SEVERE ACUTE MALNUTRITION	■ Give first dose appropriate antibiotic ■ Treat the child to prevent low blood sugar ■ Keep the child warm ■ Refer URGENTLY to hospital
• WFH/L less than -3 z-scores - OR • MUAC less than 115 mm - AND • Able to finish RUTF.	Yellow: UNCOMPLICATED SEVERE ACUTE MALNUTRITION	■ Give oral antibiotics for 5 days ■ Give ready-to-use therapeutic food for a child aged 6 months or more ■ Counsel the mother on how to feed the child. ■ Assess for possible TB infection ■ Advise mother when to return immediately ■ Follow up in 7 days
• WFH/L between -3 and -2 z-scores - OR • MUAC 115 up to 125 mm.	Yellow: MODERATE ACUTE MALNUTRITION	■ Assess the child's feeding and counsel the mother on the feeding recommendations ■ If feeding problem, follow up in 7 days ■ Assess for possible TB infection. ■ Advise mother when to return immediately ■ Follow-up in 30 days
• WFH/L - 2 z-scores or more - OR • MUAC 125 mm or more.	Green: NO ACUTE MALNUTRITION	■ If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding according to the feeding recommendations ■ If feeding problem, follow-up in 7 days

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

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

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

THEN CHECK FOR ANAEMIA

Check for anaemia

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

**Classify
ANAEMIA** **Classification
arrow**

• Severe palmar pallor	<i>Pink:</i> SEVERE ANAEMIA	■ Refer URGENTLY to hospital
• Some pallor	<i>Yellow:</i> ANAEMIA	■ Give iron** ■ Give mebendazole if child is 1 year or older and has not had a dose in the previous 6 months ■ Advise mother when to return immediately ■ Follow-up in 14 days
• No palmar pallor	<i>Green:</i> NO ANAEMIA	■ • If child is less than 2 years old, assess the child's feeding and counsel the mother according to the feeding recommendations ◦ If feeding problem, follow-up in 5 days

*Assess for sickle cell anaemia if common in your area.

**If child has severe acute malnutrition and is receiving RUTF, DO NOT give iron because there is already adequate amount of iron in RUTF.

THEN CHECK FOR HIV INFECTION

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

ASK

Has the mother or child had an HIV test?

IF YES:

Decide HIV status:

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

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

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

IF NO, THEN TEST:

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

**Classify
HIV
status**

- Positive DNA-PCR test age at 6 weeks to 12 months of age OR - Positive HIV rapid test in a child 12 months or older	Yellow: HIV INFECTED	- Refer to ART clinic for initiation of treatment and follow up - Perform confirmatory test according to age - Manage child's presenting illness - Ensure mother is tested and started on ART if positive - Give Cotrimoxazole prophylaxis* - Assess the child's feeding and provide appropriate counselling to the mother - Advise the mother on home care - Assess for TB and start INH preventive therapy - Treat opportunistic infections (pneumonia) with dispersible Amoxicillin for 5 days
Positive HIV rapid test in a child less than 12 months with Presumed Severe HIV Disease (PSHD)		
- Mother HIV-positive AND negative DNA-PCR test in a breastfeeding child or only stopped less than 6 weeks ago OR - Mother HIV-positive, child not yet tested OR - Positive HIV rapid test in a child less than 12 months old without signs of PSHD	Yellow: HIV EXPOSED	- Refer to HIV Care Clinic (HCC) for management and follow up - Treat counsel and follow up existing illness - Give cotrimoxazole prophylaxis - Assess for TB and start INH preventive therapy if no active TB - Do DNA-PCR** as soon as possible to confirm HIV status in a child less than 24 months of age. - Ensure mother is started on ART - Assess the child's feeding and provide appropriate counselling to the mother - Advise the mother on home care
HIV test not done for mother or infant	Green: HIV infection status unknown	Encourage HIV testing where it is available
Negative HIV test in mother or child	Green: HIV INFECTION UNLIKELY	Treat, counsel and follow-up existing infections

* Give cotrimoxazole prophylaxis to all HIV infected and HIV-exposed children from 6 weeks until confirmed negative after cessation of breastfeeding.

** If DNA-PCR test is negative, repeat test 6 weeks after the breastfeeding has stopped; if HIV rapid test is positive, do a DNA-PCR test as soon as possible.

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

IMMUNIZATION SCHEDULE:	Follow national guidelines					
	AGE	VACCINE				
	Birth	BCG*	OPV-0			VITAMIN A SUPPLEMENTATION Give every child a dose of Vitamin A every six months from the age of 6 months. Record the dose on the child's chart.
	6 weeks	DPT-Hep B- HIB-1	OPV-1	Rotavirus -1	PCV - 1	
	10 weeks	DPT-Hep B- HIB-2	OPV-2	Rotavirus - 2	PCV - 2	
	14 weeks	DPT-Hep B- HIB-3	OPV-3 and IPV		PCV - 3	ROUTINE WORM TREATMENT Give every child mebendazole every 6 months from the age of one year. Record the dose on the child's card.
	9 months	Measles - Rubella 1				
	15 months	Measles - Rubella 2				

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

ASSESS OTHER PROBLEMS:

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

HIV TESTING AND INTERPRETING RESULTS

HIV testing is **RECOMMENDED** for:

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

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

For HIV exposed children 12 months or older, a positive HIV antibody test result means the child is infected.

For HIV exposed children less than 12 months of age:

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

Interpreting the HIV Antibody Test Results in a Child less than 12 months of Age		
Breastfeeding status	POSITIVE (+) test	NEGATIVE (-) test
NOT BREASTFEEDING, and has not in last 6 weeks	HIV EXPOSED and/or HIV infected - Manage as if they could be infected. Repeat test at 12 months.	HIV negative Child is not HIV infected
BREASTFEEDING	HIV EXPOSED and/or HIV infected - Manage as if they could be infected. Repeat test at 12 months or once breastfeeding has been discontinued for more than 6 weeks.	Child can still be infected by breastfeeding. Repeat test once breastfeeding has been discontinued for more than 6 weeks.

TREAT THE CHILD

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

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Follow the instructions below for every oral drug to be given at home.

Also follow the instructions listed with each drug's dosage table.

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

Give an Appropriate Oral Antibiotic

- FOR PNEUMONIA (including HIV-related pneumonia), ACUTE EAR INFECTION:

FIRST-LINE ANTIBIOTIC: Oral Amoxicillin

AGE or WEIGHT	AMOXICILLIN* Give two times daily for 5 days	
	TABLET (dispersible) 250 mg	SYRUP 250mg/5 ml
2 months up to 12 months (4 - <10 kg)	1	5 ml
12 months up to 3 years (10 - <14 kg)	2	10 ml
3 years up to 5 years (14-19 kg)	3	15 ml

* Amoxicillin is the recommended first-line drug of choice in the treatment of pneumonia (including HIV-related pneumonia) due to its efficacy and increasing high resistance to cotrimoxazole.

- FOR PROPHYLAXIS IN HIV INFECTED OR EXPOSED CHILD:

ANTIBIOTIC FOR PROPHYLAXIS: Oral Cotrimoxazole

WEIGHT	COTRIMOXAZOLE (trimethoprim + sulfamethoxazole) Give once a day starting at 6 weeks of age			ISONIAZID Give once daily from 6 weeks of age
	Syrup (40/200 mg/5ml)	Paediatric tablet (Single strength 20/100 mg)	Adult tablet (Single strength 80/400 mg)	Tablet (300mg)
3 - 13.9 kg	2.5 ml	1	-	
14 - 24.9 kg	5 ml	2	1/2	1/2

- FOR DYSENTERY give Ciprofloxacin

FIRST-LINE ANTIBIOTIC: Oral Ciprofloxacin

AGE	CIPROFLOXACIN Give 15mg/kg two times daily for 3 days	
	250 mg tablet	500 mg tablet
Less than 6 months	1/2	1/4
6 months up to 5 years	1	1/2

- FOR CHOLERA:

FIRST-LINE ANTIBIOTIC FOR CHOLERA: _____

SECOND-LINE ANTIBIOTIC FOR CHOLERA: _____

AGE or WEIGHT	ERYTHROMYCIN Give four times daily for 3 days	
	TABLET 250 mg	
4 - < 6kg	1/4	
6 - <10kg	1/2	
10 - <19kg	1	

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

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

Give Inhaled Salbutamol for Wheezing

USE OF A SPACER*

A spacer is a way of delivering the bronchodilator drugs effectively into the lungs. No child under 5 years should be given an inhaler without a spacer. A spacer works as well as a nebuliser if correctly used.

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

Spacers can be made in the following way:

- Use a 500ml drink bottle or similar.
- Cut a hole in the bottle base in the same shape as the mouthpiece of the inhaler. This can be done using a sharp knife.
- Cut the bottle between the upper quarter and the lower 3/4 and disregard the upper quarter of the bottle.
- Cut a small V in the border of the large open part of the bottle to fit to the child's nose and be used as a mask.
- Flame the edge of the cut bottle with a candle or a lighter to soften it.
- In a small baby, a mask can be made by making a similar hole in a plastic (not polystyrene) cup.
- Alternatively commercial spacers can be used if available.

To use an inhaler with a spacer:

- Remove the inhaler cap. Shake the inhaler well.
- Insert mouthpiece of the inhaler through the hole in the bottle or plastic cup.
- The child should put the opening of the bottle into his mouth and breath in and out through the mouth.
- A carer then presses down the inhaler and sprays into the bottle while the child continues to breath normally.
- Wait for three to four breaths and repeat.
- For younger children place the cup over the child's mouth and use as a spacer in the same way.

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

Give Oral Antimalarial for MALARIA

■ If Artemether-Lumefantrine (AL)

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

■ If Artesunate Amodiaquine (AS+AQ)

- Give first dose in the clinic and observe for an hour, if a child vomits within an hour repeat the dose.
- Then daily for two days as per table below using the fixed dose combination.

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

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

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

AGE or WEIGHT	PARACETAMOL	
	TABLET (100 mg)	TABLET (500 mg)
2 months up to 3 years (4 - <14 kg)	1	1/4
3 years up to 5 years (14 - <19 kg)	1 1/2	1/2

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Follow the instructions below for every oral drug to be given at home.

Also follow the instructions listed with each drug's dosage table.

Give Iron*

- Give one dose daily for 14 days.

AGE or WEIGHT	IRON/FOLATE TABLET	IRON SYRUP
	Ferrous sulfate 200 mg + 250 µg Folate (60 mg elemental iron)	Ferrous fumarate 100 mg per 5 ml (20 mg elemental iron per ml)
2 months up to 4 months (4 - <6 kg)		1.00 ml (< 1/4 tsp.)
4 months up to 12 months (6 - <10 kg)		1.25 ml (1/4 tsp.)
12 months up to 3 years (10 - <14 kg)	1/2 tablet	2.00 ml (<1/2 tsp.)
3 years up to 5 years (14 - 19 kg)	1/2 tablet	2.5 ml (1/2 tsp.)

* Children with severe acute malnutrition who are receiving ready-to-use therapeutic food (RUTF) should not be given Iron.

TEACH THE MOTHER TO TREAT LOCAL INFECTIONS AT HOME

- Explain to the mother what the treatment is and why it should be given.
- Describe the treatment steps listed in the appropriate box.
- Watch the mother as she does the first treatment in the clinic (except for remedy for cough or sore throat).
- Tell her how often to do the treatment at home.
- If needed for treatment at home, give mother the tube of tetracycline ointment or a small bottle of gentian violet.
- Check the mothers understanding before she leaves the clinic.

Soothe the Throat, Relieve the Cough with a Safe Remedy

- Safe remedies to recommend:
 - Breast milk for a breastfed infant.

- Harmful remedies to discourage:

Treat Eye Infection with Tetracycline Eye Ointment

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

*Clear the Ear by Dry Wicking and Give Eardrops**

- Dry the ear at least 3 times daily.
 - Roll clean absorbent cloth or soft, strong tissue paper into a wick.
 - Place the wick in the child's ear.
 - Remove the wick when wet.
 - Replace the wick with a clean one and repeat these steps until the ear is dry.
 - Instill quinolone eardrops after dry wicking three times daily for two weeks.

* Quinolone eardrops may include ciprofloxacin, norfloxacin, or ofloxacin.

Treat for Mouth Ulcers with Gentian Violet (GV)

- Treat for mouth ulcers twice daily.
 - Wash hands.
 - Wash the child's mouth with clean soft cloth wrapped around the finger and wet with salt water.
 - Paint the mouth with half-strength gentian violet (0.25% dilution).
 - Wash hands again.
 - Continue using GV for 48 hours after the ulcers have been cured.
 - Give paracetamol for pain relief.

Treat Thrush with Nystatin

Treat thrush four times daily for 7 days

- Wash hands
- Wet a clean soft cloth with salt water and use it to wash the child's mouth
- Instill nystatin 1ml four times a day
- Avoid feeding for 20 minutes after medication
- If breastfed check mother's breasts for thrush. If present treat with nystatin
- Advise mother to wash breasts after feeds. If bottle fed advise change to cup and spoon
- Give paracetamol if needed for pain

GIVE VITAMIN A AND MEBENDAZOLE IN CLINIC

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

Give Vitamin A Supplementation and Treatment

VITAMIN A SUPPLEMENTATION:

- Give first dose any time after 6 months of age to ALL CHILDREN
- Thereafter vitamin A **every six months** to ALL CHILDREN

VITAMIN A TREATMENT:

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

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

Give Mebendazole

- Give 500 mg mebendazole as a single dose in clinic if:
 - hookworm/whipworm are a problem in children in your area, and
 - the child is 1 years of age or older, and
 - the child has not had a dose in the previous 6 months.

GIVE THESE TREATMENTS IN THE CLINIC ONLY

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

Give Intramuscular Antibiotics

GIVE TO CHILDREN BEING REFERRED URGENTLY

- Give Intramuscular Benzyl penicillin (50,000 IU/kg) and Gentamicin (7.5 mg/kg) and **refer child urgently** to hospital.

BENZYL PENICILLIN

- IF REFERRAL IS NOT POSSIBLE OR DELAYED, repeat the Benzyl penicillin injection every 6 hours and Gentamicin once daily.
- Where there is a strong suspicion of meningitis, the dose of Benzyl penicillin can be increased 2 times.

GENTAMICIN

- The dose is 7.5 mg/kg once daily

AGE or WEIGHT	Benzyl Penicillin 50, 000 IU/kg/dose every 6 hours	Gentamicin Give 7.5mg/kg once a day
2 up to 4 months (4 - <6 kg)	250, 000 IU	0.5 - 1.0 ml
4 up to 9 months (6 - < 8kg)	350, 000 IU	1.1 - 1.4 ml
9 up to 12 months (8 - < 10kg)	450, 000 IU	1.5 - 1.8 ml
12 months up to 3 years (10 - < 14kg)	600, 000 IU	1.9 - 2.6 ml
3 years up to 5 years (14 - 19kgs)	800, 000 IU	2.8 - 3.5 ml

Give Diazepam to Stop Convulsions

- Turn the child to his/her side and clear the airway. Avoid putting things in the mouth.
- Give 0.5mg/kg diazepam injection solution per rectum using a small syringe without a needle (like a tuberculin syringe) or using a catheter.
- Check for low blood sugar, then treat or prevent.
- Give oxygen and REFER
- If convulsions have not stopped after 10 minutes repeat diazepam dose

AGE or WEIGHT	DIAZEPAM 10mg/2mls
2 months up to 6 months (5 - 7 kg)	0.5 ml
6 months up to 12months (7 - <10 kg)	1.0 ml
12 months up to 3 years (10 - <14 kg)	1.5 ml
3 years up to 5 years (14-19 kg)	2.0 ml

GIVE THESE TREATMENTS IN THE CLINIC ONLY

Give Artesunate Suppositories or Intramuscular Artesunate or Quinine for Severe Malaria

FOR CHILDREN BEING REFERRED WITH VERY SEVERE FEBRILE DISEASE:

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

IF REFERRAL IS NOT POSSIBLE:

For artesunate injection:

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

For artesunate suppository:

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

For quinine:

- Give first dose of intramuscular quinine.
- The child should remain lying down for one hour.
- Repeat the quinine injection at 4 and 8 hours later, and then every 12 hours until the child is able to take an oral antimalarial. Do not continue quinine injections for more than 1 week.

If low risk of malaria, do not give quinine to a child less than 4 months of age.

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

* quinine salt

Treat the Child to Prevent Low Blood Sugar

■ If the child is able to breastfeed:

- Ask the mother to breastfeed the child.

■ If the child is not able to breastfeed but is able to swallow:

- Give expressed breast milk or a breast-milk substitute.
- If neither of these is available, give sugar water*.
- Give 30 - 50 ml of milk or sugar water* before departure.

■ If the child is not able to swallow:

- Give 50 ml of milk or sugar water* by nasogastric tube.
- If no nasogastric tube available, give 1 teaspoon of sugar moistened with 1-2 drops of water sublingually and repeat doses every 20 minutes to prevent relapse.
- * To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water.

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

(See **FOOD** advice on **COUNSEL THE MOTHER** chart)

PLAN A: TREAT DIARRHOEA AT HOME

Counsel the mother on the 4 Rules of Home Treatment:

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

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

▪ **TELL THE MOTHER:**

- Breastfeed frequently and for longer at each feed.
- If the child is exclusively breastfed, give ORS or clean water in addition to breast milk.
- If the child is not exclusively breastfed, give one or more of the following:
ORS solution, food-based fluids (such as soup, rice water, and yoghurt drinks), or clean water.

▪ **It is especially important to give ORS at home when:**

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

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

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

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

Tell the mother to:

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

2. **GIVE ZINC** (age 2 months up to 5 years)

▪ **TELL THE MOTHER HOW MUCH ZINC TO GIVE (20 mg tab):**

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

▪ **SHOW THE MOTHER HOW TO GIVE ZINC SUPPLEMENTS**

- Infants - dissolve tablet in a small amount of expressed breast milk, ORS or clean water in a cup.
- Older children - tablets can be chewed or dissolved in a small amount of water.

3. **CONTINUE FEEDING** (exclusive breastfeeding if age less than 6 months)

4. **WHEN TO RETURN**

PLAN B: TREAT SOME DEHYDRATION WITH ORS

In the clinic, give recommended amount of ORS over 4-hour period

▪ **DETERMINE AMOUNT OF ORS TO GIVE DURING FIRST 4 HOURS**

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

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

- If the child wants more ORS than shown, give more.
- For infants under 6 months who are not breastfed, also give 100 - 200 ml clean water during this period if you use standard ORS. This is not needed if you use new low osmolarity ORS.

▪ **SHOW THE MOTHER HOW TO GIVE ORS SOLUTION.**

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

▪ **AFTER 4 HOURS:**

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

▪ **IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:**

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

1. **GIVE EXTRA FLUID**

2. **GIVE ZINC** (age 2 months up to 5 years)

3. **CONTINUE FEEDING** (exclusive breastfeeding if age less than 6 months)

4. **WHEN TO RETURN**

GIVE EXTRA FLUID FOR DIARRHOEA AND CONTINUE FEEDING

PLAN C: TREAT SEVERE DEHYDRATION QUICKLY

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

START HERE

Can you give intravenous (IV) fluid immediately?

YES→

NO



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

AGE	First give 30 ml/kg in:	Then give 70 ml/kg in:
Infants (under 12 months)	1 hour*	5 hours
Children (12 months up to 5 years)	30 minutes*	2 1/2 hours

* Repeat once if radial pulse is still very weak or not detectable.

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

Is IV treatment available nearby (within 30 minutes)?

YES→

NO



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

YES→

NO



Can the child drink?

YES→

NO



Refer URGENTLY to hospital for IV or NG treatment

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

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

NOTE:

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

GIVE READY-TO-USE THERAPEUTIC FOOD

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

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

Recommended Amounts of Ready-to-Use Therapeutic Food

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

TREAT THE HIV INFECTED CHILD

Steps when Initiating ART in Children

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

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

STEP 1: DECIDE IF THE CHILD HAS CONFIRMED HIV INFECTION

Child is under 12 months:

HIV infection is confirmed if DNA-PCR test is positive

Child is over 12 months:

- Two different HIV rapid tests are positive
- Send any further confirmatory tests required

If results are discordant, refer

If HIV infection is confirmed, and child is in stable condition, GO TO STEP 2

STEP 3: DECIDE IF ART CAN BE INITIATED IN YOUR FACILITY

If child is less than 3 kg or has TB, Refer for ART initiation.

If child weighs 3 kg or more and does not have TB, **GO TO STEP 4**

STEP 2: DECIDE IF CAREGIVER IS ABLE TO GIVE ART

Check that the caregiver is willing and able to give ART. The caregiver should ideally have disclosed the child's HIV status to another adult who can assist with providing ART, or be part of a support group.

- Caregiver able to give ART: **GO TO STEP 3**
- Caregiver not able: classify as HIV INFECTED but NOT ON ART. Counsel and support the caregiver. Follow-up regularly. Move to the step 3 once the caregiver is willing and able to give ART.

STEP 4: RECORD BASELINE INFORMATION ON THE CHILD'S HIV TREATMENT CARD

Record the following information:

- Weight and height
- Pallor if present
- Feeding problem if present
- Laboratory results (if available): Hb, viral load, CD4 count and percentage. Send for any laboratory tests that are required. Do not wait for results. **GO TO STEP 5**

STEP 5: START ON ART, COTRIMOXAZOLE PROPHYLAXIS AND ROUTINE TREATMENTS

- Initiate ART treatment based on age and weight:
 - Child 3 - 19.9kg: 15PP (ABC/3TC + DTG 10mg) - first-line regimen
 - Child 20.0 - 24.9kg: 15PA (ABC/3TC + DTG 50mg) - another first-line regimen.
- Give co-trimoxazole prophylaxis
- Give other routine treatments, including Vitamin A and immunizations
- Follow-up regularly as per national guidelines

IMMUNIZE EVERY SICK CHILD AS NEEDED

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

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

PNEUMONIA

On day 3:

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

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

} See **ASSESS & CLASSIFY** chart.

Treatment:

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

PERSISTENT DIARRHOEA

On day 5:

Ask:

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

Treatment:

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

DYSENTERY

On day 3:

Assess the child for diarrhoea. > See **ASSESS & CLASSIFY** chart.

Ask:

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

Treatment:

- If the child is **dehydrated**, treat dehydration.
- If **number of stools, amount of blood in stools, fever, abdominal pain, or eating are worse or the same**:
 - Change to second-line oral antibiotic recommended for dysentery in your area. Give it for 5 days. Advise the mother to return in 3 days. If you do not have the second line antibiotic, REFER to hospital.

Exceptions - if the child:

- is less than 12 months old, or
 - was dehydrated on the first visit, or
 - if he had measles within the last 3 months
- } REFER to hospital.

- If **fewer stools, less blood in the stools, less fever, less abdominal pain, and eating better**, continue giving ciprofloxacin until finished.

Ensure that mother understands the oral rehydration method fully and that she also understands the need for an extra meal each day for a week.

MALARIA

On day 3 if fever persists:

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

DO NOT REPEAT the Rapid Diagnostic Test if it was positive on the initial visit.

Treatment:

- If the child has **any general danger sign or stiff neck**, treat as **VERY SEVERE FEBRILE DISEASE**.
- If the child has any **other cause of fever other than malaria**, provide appropriate treatment.
- If there is **no other apparent cause of fever**:
 - If fever has been present for 7 days, refer for assessment.
 - Do microscopy to look for malaria parasites. If parasites are present and the child has finished a full course of the first line antimalarial, give the second-line antimalarial, if available, or refer the child to a hospital.
 - If there is no other apparent cause of fever and you do not have a microscopy to check for parasites, refer the child to a hospital.

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

FEVER: NO MALARIA

On day 2 if fever persists:

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

Repeat the malaria test.

Treatment:

- If the child has **any general danger sign or stiff neck**, treat as VERY SEVERE FEBRILE DISEASE.
- If a child has a **positive malaria test**, give first-line oral antimalarial. Advise the mother to return in 3 days if the fever persists.
- If the child has any **other cause of fever other than malaria**, provide treatment.
- If there is **no other apparent cause** of fever:
 - If the fever has been present for 7 days, refer for assessment.

MEASLES WITH EYE OR MOUTH COMPLICATIONS, GUM OR MOUTH ULCERS, OR THRUSH

On day 3:

Look for red eyes and pus draining from the eyes.

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

Smell the mouth.

Treatment for eye infection:

- If **pus is draining from the eye**, ask the mother to describe how she has treated the eye infection. If treatment has been correct, refer to hospital. If treatment has not been correct, teach mother correct treatment.
- If **the pus is gone but redness remains**, continue the treatment.
- If **no pus or redness**, stop the treatment.

Treatment for mouth ulcers:

- If **mouth ulcers are worse, or there is a very foul smell from the mouth**, refer to hospital.
- If **mouth ulcers are the same or better**, continue using half-strength gentian violet for a total of 5 days.

Treatment for thrush:

- If **thrush is worse** check that treatment is being given correctly.
- If the child has **problems with swallowing**, refer to hospital.
- If **thrush is the same or better**, and the child is feeding well, continue nystatine for a total of 7 days.

EAR INFECTION

On day 5:

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

Measure the child's temperature.

Treatment:

- If there is **tender swelling behind the ear or high fever (38.5°C or above)**, refer URGENTLY to hospital.
- **Acute ear infection:**
 - If **ear pain or discharge** persists, treat with 5 more days of the same antibiotic. Continue wicking to dry the ear. Follow-up in 5 days.
 - If **no ear pain or discharge**, praise the mother for her careful treatment. If she has not yet finished the 5 days of antibiotic, tell her to use all of it before stopping.
- **Chronic ear infection:**
 - Check that the mother is wicking the ear correctly and giving quinolone drops three times a day. Encourage her to continue.

FEEDING PROBLEM

On day 5:

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

Ask about any feeding problems found on the initial visit.

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the child back again.
- If the child is classified as MODERATE ACUTE MALNUTRITION, ask the mother to return 30 days after the initial visit to measure the child's WFH/L, MUAC.

ANAEMIA

On day 14:

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

GIVE FOLLOW-UP CARE FOR ACUTE CONDITIONS

UNCOMPLICATED SEVERE ACUTE MALNUTRITION

On day 14 or during regular follow up:

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

Assess child with the same measurements (WFH/L, MUAC) as on the initial visit.

Check for oedema of both feet.

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

Treatment:

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

MODERATE ACUTE MALNUTRITION

On day 14:

Assess the child using the same measurement (WFH/L or MUAC) used on the initial visit:

- If WFH/L, weigh the child, measure height or length and determine if WFH/L.
- If MUAC, measure using MUAC tape.
- Check the child for oedema of both feet.

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

Treatment:

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

Exception:

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

GIVE FOLLOW-UP CARE FOR HIV EXPOSED AND INFECTED CHILD

HIV EXPOSED

Follow up on day 14, then monthly for 3 months, then every 3 months.

At each follow-up visit follow these instructions:

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

HIV testing:

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

If child is confirmed HIV infected

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

If child is confirmed uninfected

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

HIV INFECTED NOT ON ART

Follow up on day 14, then monthly for 3 months, then every 3 months in the first year then 3 monthly.

At each follow-up visit follow these instructions:

- Ask the mother: Does the child have any problems?
- Do a full assessment including checking for mouth or gum problems, treat, counsel and follow up any new problem
- Counsel and check if mother able or willing now to initiate ART for the child.
- Provide routine child health care: Vitamin A, deworming, immunization, and feeding assessment and counselling
- Continue cotrimoxazole prophylaxis if indicated.
- Initiate or continue isoniazid preventive therapy if indicated.
- If no acute illness and mother is willing, initiate ART (See Box Steps when Initiating ART in children)
- Monitor CD4 count and percentage.
- Ask about the mother's health, provide HIV counselling and testing.
- Home care:
 - Counsel the mother about any new or continuing problems
 - If appropriate, put the family in touch with organizations or people who could provide support
 - Advise the mother about hygiene in the home, in particular when preparing food
- Plan for the next follow-up visit

COUNSEL THE MOTHER

FEEDING COUNSELLING

Assess Child's Appetite

All children aged 6 months or more with **SEVERE ACUTE MALNUTRITION** (oedema of both feet or WFH/L less than -3 z-scores or MUAC less than 115 mm) and no medical complication should be assessed for appetite.

Appetite is assessed on the initial visit and at each follow-up visit to the health facility. Arrange a quiet corner where the child and mother can take their time to get accustomed to eating the RUTF. Usually the child eats the RUTF portion in 30 minutes.

Explain to the mother:

- The purpose of assessing the child's appetite.
- What is ready-to-use-therapeutic food (RUTF).
- How to give RUTF:
 - Wash hands before giving the RUTF.
 - Sit with the child on the lap and gently offer the child RUTF to eat.
 - Encourage the child to eat the RUTF without feeding by force.
 - Offer plenty of clean water to drink from a cup when the child is eating the RUTF.

Offer appropriate amount of RUTF to the child to eat:

- After 30 minutes check if the child was able to finish or not able to finish the amount of RUTF given and decide:
 - Child **ABLE** to finish at least one-third of a packet of RUTF portion (92 g) or 3 teaspoons from a pot within 30 minutes.
 - Child **NOT ABLE** to eat one-third of a packet of RUTF portion (92 g) or 3 teaspoons from a pot within 30 minutes.

FEEDING COUNSELLING

Assess Child's Feeding

Assess feeding if child is **Less Than 2 Years Old, Has MODERATE ACUTE MALNUTRITION, ANAEMIA, CONFIRMED HIV INFECTION, or is HIV EXPOSED**. Ask questions about the child's usual feeding and feeding during this illness. Compare the mother's answers to the **Feeding Recommendations** for the child's age.

ASK - How are you feeding your child?

■ **If the child is receiving any breast milk, ASK:**

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

■ **Does the child take any other food or fluids?**

- What food or fluids?
- How many times per day?
- What do you use to feed the child?

■ **If MODERATE ACUTE MALNUTRITION or if a child with CONFIRMED HIV INFECTION fails to gain weight or loses weight between monthly measurements, ASK:**

- How large are servings?
- Does the child receive his own serving?
- Who feeds the child and how?
- What foods are available in the home?

■ **During this illness, has the child's feeding changed?**

- If yes, how?

In addition, for HIV EXPOSED child:

■ **If mother and child are on ARV treatment or prophylaxis and child breastfeeding, ASK:**

- Do you take ARV drugs? Do you take all doses, miss doses, do not take medication?
- Does the child take ARV drugs (If the policy is to take ARV prophylaxis until 1 week after breastfeeding has stopped)? Does he or she take all doses, missed doses, does not take medication?

■ **If child not breastfeeding, ASK:**

- What milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How are you preparing the milk?
 - Let the mother demonstrate or explain how a feed is prepared, and how it is given to the infant.
- Are you giving any breast milk at all?
- Are you able to get new supplies of milk before you run out?
- How is the milk being given? Cup or bottle?
- How are you cleaning the feeding utensils?

FEEDING COUNSELLING

Feeding Recommendations During Sickness and Health

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

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

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

FEEDING COUNSELLING

Feeding Recommendations for HIV EXPOSED Child on Infant Formula Only

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

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

Up to 6 months



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

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

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

6 up to 12 months



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

■ Give:

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

12 months up to 2 years



- Give 1-2 cups (250 - 500 ml) of boiled, then cooled, full cream milk or infant formula.

■ Give milk with a cup, not a bottle.

■ Give:

- or family foods 3 or 4 times per day. Give 3/4 cup (1 cup = 250 ml) at each meal.
- Offer 1-2 snacks between meals.
- Continue to feed your child slowly, patiently.
- Encourage - but do not force - your child to eat.

Safe preparation of replacement feeding

Infant formula

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

Cow's milk

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

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

FEEDING COUNSELLING

Stopping Breastfeeding

STOPPING BREASTFEEDING means changing from all breast milk to no breast milk.

This should happen gradually over one month. Plan in advance for a safe transition.

1. HELP MOTHER PREPARE:

- Mother should discuss and plan in advance with her family, if possible
- Express milk and give by cup
- Find a regular supply or formula or other milk (e.g. full cream cow's milk)
- Learn how to prepare a store milk safely at home

2. HELP MOTHER MAKE TRANSITION:

- Teach mother to cup feed (See chart booklet Counsel part in Assess, classify and treat the sick young infant aged up to 2 months)
- Clean all utensils with soap and water
- Start giving only formula or cow's milk once baby takes all feeds by cup

3. STOP BREASTFEEDING COMPLETELY:

- Express and discard enough breast milk to keep comfortable until lactation stops

Feeding Recommendations For a Child Who Has PERSISTENT DIARRHOEA

- If still breastfeeding, give more frequent, longer breastfeeds, day and night.
- If taking other milk:
 - replace with increased breastfeeding OR
 - replace with fermented milk products, such as yoghurt OR
 - replace half the milk with nutrient-rich semisolid food.
- For other foods, follow feeding recommendations for the child's age.

EXTRA FLUIDS AND MOTHER'S HEALTH

Advise the Mother to Increase Fluid During Illness

■ **FOR ANY SICK CHILD:**

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

■ **FOR CHILD WITH DIARRHOEA:**

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

Counsel the Mother about her Own Health

- If the mother is sick, provide care for her, or refer her for help.
- If she has a breast problem (such as engorgement, sore nipples, breast infection), provide care for her or refer her for help.
- Advise her to eat well to keep up her own strength and health.
- Check the mother's immunization status and give her tetanus toxoid if needed.
- Make sure she has access to:
 - Family planning
 - Counselling on STD and AIDS prevention.

Give additional counselling if the mother is HIV-positive

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

WHEN TO RETURN

Advise the Mother When to Return to Health Worker

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

If the child has:	Return for follow-up in:
■ PNEUMONIA ■ DYSENTERY ■ MALARIA, if fever persists ● FEVER: NO MALARIA, if fever persists ■ MEASLES WITH EYE OR MOUTH COMPLICATIONS ■ MOUTH OR GUM ULCERS OR THRUSH	3 days
■ PERSISTENT DIARRHOEA ■ ACUTE EAR INFECTION ■ CHRONIC EAR INFECTION ■ COUGH OR COLD, if not improving	5 days
■ UNCOMPLICATED SEVERE ACUTE MALNUTRITION ■ FEEDING PROBLEM	14 days
■ ANAEMIA	14 days
■ MODERATE ACUTE MALNUTRITION	30 days
■ CONFIRMED HIV INFECTION ■ HIV EXPOSED	According to national recommendations

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



WHEN TO RETURN IMMEDIATELY

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

SICK YOUNG INFANT AGE UP TO 2 MONTHS



ASSESS AND CLASSIFY THE SICK YOUNG INFANT

ASSESS

DO A RAPID APPRAISAL OF ALL WAITING INFANTS
ASK THE MOTHER WHAT THE YOUNG INFANT'S
PROBLEMS ARE

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

CLASSIFY

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

IDENTIFY TREATMENT

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

ASK:

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

LOOK, LISTEN, FEEL:

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

YOUNG
INFANT
MUST
BE
CALM

Classify ALL YOUNG INFANTS

Any one of the following signs

- Not able to feed since birth, stopped feeding well or not feeding at all or
- Convulsions or
- Fast breathing (60 breaths per minute or more) or
- Severe chest indrawing or
- Fever (38°C* or above) or
- Low body temperature (less than 35.5°C*) or
- Movement only when stimulated or no movement at all.

Pink:

POSSIBLE
SERIOUS
BACTERIAL
INFECTION OR
VERY SEVERE
DISEASE

- Give first dose of intramuscular Benzyl penicillin and Gentamicin
- Treat to prevent low blood sugar
- Refer URGENTLY to hospital **
- Advise mother how to keep the infant warm on the way to the hospital

Fast breathing (60 breaths per minute or more) in infants 7 to 59 days old

Yellow:

PNEUMONIA

- Give Amoxicillin for 7 days
- advise mother to give home care for the young infant
- Follow up on day 4 of treatment

- Umbilicus red or draining pus
- Skin pustules

Yellow:

LOCAL INFECTION

- Give Amoxicillin for 5 days
- Teach the mother to treat local infections at home
- Advise mother to give home care for the young infant
- Follow up on day 3

No signs of possible serious bacterial infection or very severe disease, pneumonia or local infection

Green:

POSSIBLE
SERIOUS
BACTERIAL
INFECTION OR
VERY SEVERE,
PNEUMONIA OR
LOCAL INFECTION
UNLIKELY

- Advise mother to give home care.

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

** If referral is not possible, management the sick young infant as described in the national referral care guidelines or WHO Pocket Book for hospital care for children.

CHECK FOR JAUNDICE

If jaundice present, ASK:

- When did the jaundice appear first?

LOOK AND FEEL:

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

CLASSIFY JAUNDICE

• Any jaundice if age less than 24 hours <u>or</u> • Yellow palms and soles at any age	Pink: SEVERE JAUNDICE	■ Treat to prevent low blood sugar ■ Refer URGENTLY to hospital ■ Advise mother how to keep the infant warm on the way to the hospital
• Jaundice appearing after 24 hours of age <u>and</u> • Palms and soles not yellow	Yellow: JAUNDICE	■ Advise the mother to give home care for the young infant ■ Advise mother to return immediately if palms and soles appear yellow. ■ If the young infant is older than 14 days, refer to a hospital for assessment Follow-up in 1 day
• No jaundice	Green: NO JAUNDICE	■ Advise the mother to give home care for the young infant

THEN ASK: Does the young infant have diarrhoea*?

IF YES, LOOK AND FEEL:

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

Classify DIARRHOEA for DEHYDRATION

Two of the following signs: • Movement only when stimulated or no movement at all • Sunken eyes • Skin pinch goes back very slowly.	Pink: SEVERE DEHYDRATION	■ If infant has no other severe classification: ◦ Give fluid for severe dehydration (Plan C) OR ■ If infant also has another severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding
Two of the following signs: • Restless and irritable • Sunken eyes • Skin pinch goes back slowly.	Yellow: SOME DEHYDRATION	■ Give fluid and breast milk for some dehydration (Plan B) ■ If infant has any severe classification: ◦ Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way ◦ Advise the mother to continue breastfeeding ■ Advise mother when to return immediately ■ Follow-up in 2 days if not improving
Not enough signs to classify as some or severe dehydration.	Green: NO DEHYDRATION	■ Give fluids to treat diarrhoea at home and continue breastfeeding (Plan A) ■ Advise mother when to return immediately ■ Follow-up in 2 days if not improving

* What is diarrhoea in a young infant?

A young infant has diarrhoea if the stools have changed from usual pattern and are many and watery (more water than faecal matter).

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

THEN CHECK FOR HIV INFECTION

ASK

- Has the mother and/or young infant had an HIV test?

IF YES:

- What is the mother's HIV status?:
 - HIV rapid test POSITIVE or NEGATIVE
- What is the young infant's HIV status?:
 - DNA-PCR test POSITIVE or NEGATIVE
 - HIV rapid test POSITIVE or NEGATIVE

If mother is HIV positive and NO positive DNA-PCR test in child ASK:

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

IF NO test: Mother and young infant status unknown

- Perform HIV test for the mother; if positive, perform virological test for the young infant

Classify
HIV
status

Positive DNA-PCR test in young infant	Yellow: HIV INFECTED	- Give cotrimoxazole prophylaxis from 6 weeks of age - Refer or Start ART and care - Assess the infant's feeding and counsel as necessary - Advise the mother on home care - Follow-up monthly
- Mother HIV positive AND negative DNA-PCR test in young infant breastfeeding or if only stopped less than 6 weeks ago. OR - Mother HIV positive, young infant not yet tested OR - Positive HIV rapid test in young infant	Yellow: HIV EXPOSED	- Give cotrimoxazole prophylaxis from 6 weeks of age - Start or continue ARV prophylaxis* - Do DNA-PCR test at age 6 weeks or repeat 6 weeks after the child stops breastfeeding - Advise the mother on home care - Follow-up regularly
HIV not done for mother or infant	Green: HIV INFECTION STATUS UNKNOWN	Encourage HIV testing where it is available
Negative HIV test in mother or young infant	Green: HIV INFECTION UNLIKELY	Treat, counsel and follow-up existing infections

*Initiate ART for all pregnant and lactating women with HIV infection, and put their infants on ART prophylaxis from birth for 6 weeks if breastfeeding or 6 weeks if on replacement feeding.

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE

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

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

Ask: - Is the infant breastfed? If yes, how many times in 24 hours? - Does the infant usually receive any other foods or drinks? If yes, how often? - If yes, what do you use to feed the infant? LOOK, LISTEN, FEEL: - Determine weight for age. - Look for ulcers or white patches in the mouth (thrush).	Classify FEEDING	- Weight < 1.5kg <u>or</u> - Weight for age < -3 z-score	Pink: VERY LOW WEIGHT	- Treat to prevent low blood sugar - Refer URGENTLY to hospital - Teach the mother to keep the young infant warm on the way to hospital
		- Not well attached to breast <u>or</u> - Not suckling effectively <u>or</u> - Less than 8 breastfeeds in 24 hours <u>or</u> - Receives other foods or drinks <u>or</u> - Low weight for age <u>or</u> - Thrush (ulcers or white patches in mouth).	Yellow: FEEDING PROBLEM OR LOW WEIGHT	- If not well attached or not suckling effectively, teach correct positioning and attachment - If not able to attach well immediately, teach the mother to express breast milk and feed by a cup - If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Advise the mother to breastfeed as often and as long as the infant wants, day and night - If receiving other foods or drinks, counsel the mother about breastfeeding more, reducing other foods or drinks, and using a cup - If not breastfeeding at all*: - Refer for breastfeeding counselling and possible relaxation* - Advise about correctly preparing breast-milk substitutes and using a cup - Advise the mother how to feed and keep the low weight infant warm at home - If thrush, teach the mother to treat thrush at home - Advise mother to give home care for the young infant - Follow-up any feeding problem or thrush in 2 days - Follow-up low weight for age in 14 days
		Not low weight for age and no other signs of inadequate feeding.	Green: NO FEEDING PROBLEM	- Advise mother to give home care for the young infant - Praise the mother for feeding the infant well

ASSESS BREASTFEEDING:

Has the infant breastfed in the previous hour?

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

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

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

TO CHECK ATTACHMENT, LOOK FOR:

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

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

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

not suckling effectively *suckling effectively*

- Clear a blocked nose if it interferes with breastfeeding

* Unless not breastfeeding because the mother is HIV positive.

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

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

Ask: • What milk are you giving? • How many times during the day and night? • How much is given at each feed? • How are you preparing the milk? • Let mother demonstrate or explain how a feed is prepared, and how it is given to the infant. • Are you giving any breast milk at all? • What foods and fluids in addition to replacement feeds is given? • How is the milk being given? • Cup or bottle? • How are you cleaning the feeding utensils? LOOK, LISTEN, FEEL: • Determine weight for age. • Look for ulcers or white patches in the mouth (thrush).	Classify FEEDING	• Milk incorrectly or unhygienically prepared <u>or</u> Giving inappropriate replacement feeds <u>or</u> Giving insufficient replacement feeds <u>or</u> • An HIV positive mother mixing breast and other feeds before 6 months <u>or</u> • Using a feeding bottle <u>or</u> • Low weight for age <u>or</u> • Thrush (ulcers or white patches in mouth).	Yellow: FEEDING PROBLEM OR LOW WEIGHT	■ Counsel about feeding ■ Explain the guidelines for safe replacement feeding ■ Identify concerns of mother and family about feeding. ■ If mother is using a bottle, teach cup feeding ■ Advise the mother how to feed and keep the low weight infant warm at home ■ If thrush, teach the mother to treat thrush at home ■ Advise mother to give home care for the young infant ■ Follow-up any feeding problem or thrush in 2 days ■ Follow-up low weight for age in 14 days
		• Not low weight for age and no other signs of inadequate feeding.	Green: NO FEEDING PROBLEM	■ Advise mother to give home care for the young infant ■ Praise the mother for feeding the infant well

THEN CHECK THE YOUNG INFANT'S IMMUNIZATION AND VITAMIN A STATUS:

IMMUNIZATION SCHEDULE:

AGE	VACCINE				VITAMIN A
Birth	BCG	OPV-0	Hep B0		200 000 IU to the mother within 6 weeks of delivery
6 weeks	DPT+HIB-1	OPV-1	Hep B1	RTV1 PCV1	

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

ASSESS OTHER PROBLEMS

ASSESS THE MOTHER'S HEALTH NEEDS

Nutritional status and anaemia, contraception. Check hygienic practices.

TREAT AND COUNSEL

TREAT THE YOUNG INFANT

GIVE FIRST DOSE OF INTRAMUSCULAR ANTIBIOTICS

- Give first dose of both Intramuscular Benzyl Penicillin and Gentamicin.

Gentamicin: Desired range is 5 -7.5mg/kg once a day. In Low birthweight infants, give 3 - 4mg/kg once daily for 2 days.

To prepare the injection: From an ampoule of 80mg/2ml, get 1ml Gentamicin and add 1ml of water for injection to make 20mg/ml.

Benzyl penicillin: Desired dose is 50, 000 IU/kg twice daily.

To prepare the injection: Dilute a 5 MU vial with 10ml of sterile water.

WEIGHT	Benzyl Penicillin 5 MU	GENTAMICIN Strength of 20mg/ml*
	50,000 Units/kg	7.5mg/kg if >7 days of age or 5mg/kg if < 7days of age
1 - <1.5 kg	60,000 IU	0.3 ml
1.5 - <2.5 kg	100,000 IU	0.4 ml
2.5 - <4 kg	160,000 IU	0.8 ml
4 - <6 kg	250, 000 IU	1.2 ml

* Avoid using undiluted 40 mg/ml Gentamicin.

- Referral is the best option for a young infant classified with POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE. If referral is not possible, reclassify the infant's condition. The infant may end up being treated at home with Gentamicin for 2 days and Amoxicillin for 7 days. Give gentamicin once daily.

TREAT THE YOUNG INFANT TO PREVENT LOW BLOOD SUGAR

- **If the young infant is able to breastfeed:**

Ask the mother to breastfeed the young infant.

- **If the young infant is not able to breastfeed but is able to swallow:**

Give 20-50 ml (10 ml/kg) expressed breast milk before departure. If not possible to give expressed breast milk, give 20-50 ml (10 ml/kg) sugar water (**To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water**).

- **If the young infant is not able to swallow:**

Give 20-50 ml (10 ml/kg) of expressed breast milk or sugar water by nasogastric tube.

TREAT THE YOUNG INFANT

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

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

GIVE AN APPROPRIATE ORAL ANTIBIOTIC FOR LOCAL BACTERIAL INFECTION

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

AGE or WEIGHT	AMOXICILLIN Give 2 times daily for 5 days	
	Tablet 250 mg	Syrup 125 mg in 5 ml
Birth up to 1 month (<4 kg)	1/4	2.5 ml
1 month up to 2 months (4-<6 kg)	1/2	5 ml

TEACH THE MOTHER TO TREAT LOCAL INFECTIONS AT HOME

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

To Treat Skin Pustules or Umbilical Infection

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

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

To Treat Thrush (ulcers or white patches in mouth)

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

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

To Treat Diarrhoea, See TREAT THE CHILD Chart.

TREAT THE YOUNG INFANT

Immunize Every Sick Young Infant, as Needed

GIVE ARV FOR PMTCT PROPHYLAXIS

Initiate triple ART for all pregnant and lactating women with HIV infection, and put their infants on ART prophylaxis*:

Nevirapine or zidovudine are provided to young infant classified as HIV EXPOSED to minimize the risk of mother-to-child HIV transmission (PMTCT).

- **If low risk:** Give NVP fsyrup 24-hourly for 6 weeks beginning at birth. Dispense 2 bottles of 100ml NVP syrup
- **If high risk:** Give AZT/3TC/NVP (2P) 1/4 tablet 12-hourly for 6 weeks beginning at birth. Dispense 1 tin of 60 tablets of 2P

AGE	NEVIRAPINE Give once daily.	2P Give twice daily
Birth up to 6 weeks:		
■ Birth weight <2500g	1.0 ml	NVP 24-hourly
■ Birth weight 2500 - <3000g	1.5 ml	NVP 24-hourly
■ Birth weight 3000g or above	1.5 ml	1/4 tab 12-hourly
■ Unknown	1.5 ml	1/4 tab 12-hourly

*** PREVENTION OF MATERNAL-TO-CHILD-TRANSMISSION (PMTCT) ART PROPHYLAXIS:**

OPTION B+: MOTHER ON LIFELONG TRIPLE ART REGIMEN, YOUNG INFANT ON NVP PROPHYLAXIS FROM BIRTH FOR 6 WEEKS IF BREASTFEEDING OR NVP OR AZT FOR 4-6 WEEKS IF ON REPLACEMENT FEEDING.

OPTION B: MOTHER ON TRIPLE ART REGIMEN TO BE DISCONTINUED ONE WEEK AFTER CESSATION OF BREASTFEEDING, YOUNG INFANT ON NVP PROPHYLAXIS FROM BIRTH FOR 6 WEEKS OR NVP OR AZT FOR 4-6 WEEKS IF ON REPLACEMENT FEEDING.

COUNSEL THE MOTHER

TEACH CORRECT POSITIONING AND ATTACHMENT FOR BREASTFEEDING

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

TEACH THE MOTHER HOW TO EXPRESS BREAST MILK

Ask the mother to:

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

TEACH THE MOTHER HOW TO FEED BY A CUP

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

TEACH THE MOTHER HOW TO KEEP THE LOW WEIGHT INFANT WARM AT HOME

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

COUNSEL THE MOTHER

ADVISE THE MOTHER TO GIVE HOME CARE FOR THE YOUNG INFANT

1. EXCLUSIVELY BREASTFEED THE YOUNG INFANT

Give only breastfeeds to the young infant. Breastfeed frequently, as often and for as long as the infant wants.

2. MAKE SURE THAT THE YOUNG INFANT IS KEPT WARM AT ALL TIMES.

In cool weather cover the infant's head and feet and dress the infant with extra clothing.

3. WHEN TO RETURN:

Follow up visit	
If the infant has:	Return for first follow-up in:
▪ JAUNDICE	1 day
▪ LOCAL BACTERIAL INFECTION ▪ FEEDING PROBLEM ▪ THRUSH ▪ DIARRHOEA	2 days
▪ LOW WEIGHT FOR AGE	14 days
▪ CONFIRMED HIV INFECTION ▪ HIV EXPOSED	According to national recommendations

WHEN TO RETURN IMMEDIATELY:

Advise the mother to return immediately if the young infant has any of these signs:
▪ Breastfeeding poorly ▪ Reduced activity ▪ Becomes sicker ▪ Develops a fever ▪ Feels unusually cold ▪ Fast breathing ▪ Difficult breathing ▪ Palms and soles appear yellow

FOLLOW-UP

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

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

LOCAL BACTERIAL INFECTION

After 2 days:

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

Treatment:

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

DIARRHOEA

After 2 days:

Ask: Has the diarrhoea stopped?

Treatment

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

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

JAUNDICE

After 1 day:

- Look for jaundice. Are palms and soles yellow?

Treatment:

- If palms and soles are yellow, refer to hospital.
- If palms and soles are not yellow, but jaundice has not decreased, advise the mother home care and ask her to return for follow up in 1 day.
- If jaundice has started decreasing, reassure the mother and ask her to continue home care. Ask her to return for follow up at 2 weeks of age. If jaundice continues beyond two weeks of age, refer the young infant to a hospital for further assessment.

FEEDING PROBLEM

After 2 days:

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

Ask about any feeding problems found on the initial visit.

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the young infant back again.
- If the young infant is low weight for age, ask the mother to return 14 days of this follow up visit. Continue follow-up until the infant is gaining weight well.

Exception:

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

LOW WEIGHT FOR AGE

After 14 days:

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

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

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

Exception:

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

GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

THRUSH

After 2 days:

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

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

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

CONFIRMED HIV INFECTION OR HIV EXPOSED

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

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

Annex:



Annex 1: Skin and mouth conditions

IDENTIFY SKIN PROBLEM



IDENTIFY SKIN PROBLEM

If skin is itching

	SIGNS	CLASSIFY AS:	TREATMENT	UNIQUE FEATURES IN HIV
	Itching rash with small papules, scratch marks and dark spots with pale centres	PAPULAR ITCHING RASH (PRURIGO)	■ Treat itching with Calamine lotion or oral Antihistamine ■ If no improvement, 1% hydrocortisone	Can be early sign of HIV and needs assessment for HIV Is a clinical stage 2 defining case
	An itchy circular lesion with a raised edge and fine scaly area in the centre of the body, web of feet and scalp with loss of hair.	RING WORM (TINEA)	Whitfield ointment or other antifungal cream if few patches If extensive refer, if not give: Ketoconazole 6-10mg/kg/day. Alternatively, give Griseofulvin 10mg/kg/day.	Extensive: There is a high incidence of co existing nail infection which has to be treated adequately to prevent recurrence of tinea infections of skin. Fungal nail infection is a clinical stage 2 defining disease
	Rash and excoriations on torso, burrows in web space and wrists. Face spared	SCABIES	Treat itching as above manage with anti scabies: 25% topical Benzyl Benzoate at night, repeat for 3 days after washing and or 1% lindane cream or lotion once wash off after 12 hours	In HIV positive individuals scabies may manifest as crust scabies.

IDENTIFY SKIN PROBLEM

If skin has blisters/sores/pustules

	SIGNS	CLASSIFY AS:	TREATMENT	UNIQUE FEATURES IN HIV
	Vesicles over body. Vesicles appear progressively over days and form scabs after they rupture	CHIKEN POX	Treat itching as above Refer URGENTLY if pneumonia or jaundice appear	Presentation atypical only if child is immunocompromised Duration of disease longer Complications more frequent Chronic infection with continued appearance of new lesions for >1 month; typical vesicles evolve into nonhealing ulcers that become necrotic, crusted, and hyperkeratotic.
	Vesicles in one area on one side of body with intense pain or scars plus shooting pain. Herpes zoster is uncommon in children except where they are immuno-compromised, for example if infected with HIV	HERPES ZOSTER	- Keep lesions clean and dry. Use local antiseptic - If eye involved give acyclovir 20 mg /kg 4 times daily for 5 days - Give pain relief - Follow-up in 7 days	Duration of disease longer Haemorrhagic vesicles, necrotic ulceration Rarely recurrent, disseminated or multi-dermatomal Is a Clinical stage 2 defining disease
	Red, tender, warm crusts or small lesions	IMPETIGO OR FOLLICULITIS	Clean sores with antiseptic Drain pus if fluctuant Start cloxacillin if size >4cm or red streaks or tender nodes or multiple abscesses for 5 days (25-50 mg/kg every 6 hours) Refer URGENTLY if child has fever and / or if infection extends to the muscle.	

IDENTIFY SKIN PROBLEM

Identify Papular lesions

Non-itchy

	SIGNS	CLASSIFY AS:	TREATMENT	UNIQUE FEATURES IN HIV
	Skin coloured pearly white papules with a central umbilication. It is most commonly seen on the face and trunk in children.	MOLLUSCUM CONTAGIOSUM	Can be treated by various modalities: Leave them alone unless superinfected Use of phenol: Pricking each lesion with a needle or sharpened orange stick and dabbing the lesion with phenol Electrodesiccation Liquid nitrogen application (using orange stick) Curettage	Incidence is higher Giant molluscum (>1cm in size), or coalescent Pouple or triple lesions may be seen More than 100 lesions may be seen. Lesions often chronic and difficult to eradicate Extensive molluscum contagiosum is a Clinical stage 2 defining disease
	The common wart appears as papules or nodules with a rough (verrucous) surface	WARTS	Treatment: Topical salicylic acid preparations (eg. Duofilm) Liquid nitrogen cryotherapy. Electrocautery	Lesions more numerous and recalcitrant to therapy Extensive viral warts is a Clinical stage 2 defining disease
	Greasy scales and redness on central face, body folds	SEBBHORREA	Ketoconazole shampoo If severe, refer or provide tropical steroids For seborrheic dermatitis: 1% hydrocortisone cream X 2 daily If severe, refer	Seborrheic dermatitis may be severe in HIV infection. Secondary infection may be common

CLINICAL REACTION TO DRUGS

Drug and Allergic Reactions

	SIGNS	CLASSIFY AS:	TREATMENT	UNIQUE FEATURES IN HIV
	Generalized red, wide spread with small bumps or blisters; or one or more dark skin areas (fixed drug reactions)	FIXED DRUG REACTIONS	Stop medications give oral antihistamines, if peeling rash refer	Could be a sign of reactions to ARVs
	Wet, oozing sores or excoriated, thick patches	ECZEMA	Soak sores with clean water to remove crusts(no soap) Dry skin gently Short time use of topical steroid cream not on face. Treat itching	
	Severe reaction due to cotrimoxazole or NVP involving the skin as well as the eyes and the mouth. Might cause difficulty in breathing	STEVEN JOHNSON SYNDROME	Stop medication refer urgently	The most lethal reaction to NVP, Cotrimoxazole or even Efavirens

Annex 2: WHO Paediatric Staging for HIV

WHO Paediatric Staging for HIV infection

Paediatric HIV staging

	Stage 1 Asymptomatic	Stage 2 Mild Disease	Stage 3 Moderate Disease	Stage 4 Severe Disease (AIDS)
Symptoms/Signs	No symptoms or only Persistent generalized lymphadenopathy (PGL)	■ Persistent unexplained hepatosplenomegaly ■ Lineal gingival erythema ■ Extensive wart virus infection ■ Extensive molluscum contagiosum ■ Persistent unexplained parotid enlargement ■ Upper respiratory tract infections, recurrent (sinusitis, tonsillitis, otitis media, pharyngitis) ■ Herpes zoster ■ Angular cheilitis ■ Oral ulcerations, recurrent ■ Papular pruritic eruptions / Fungal nail infections	■ Moderate unexplained wasting / malnutrition not responding to treatment (weight-for-height/ -age 70-79% or MUAC 11-12cm) ■ Diarrhoea, persistent unexplained (14 days or more) ■ Oral candidiasis (from age 2 months) ■ Acute necrotizing ulcerative gingivitis or periodontitis ■ Lymph node tuberculosis ■ Bacterial pneumonia, severe recurrent ■ Symptomatic lymphoid interstitial pneumonitis ■ Chronic HIV-associated lung disease including bronchiectasis ■ Fever, persistent unexplained, intermittent or constant, >1 month ■ Oral hairy leukoplakia ■ Pulmonary tuberculosis (current) ■ Tuberculosis (PTB or EPTB) within the last 2 years ■ Anaemia, unexplained < 8 g/dl ■ Neutropaenia, unexplained < 500 /mm³ ■ Thrombocytopaenia, chronic < 50,000 /mm³	■ <u>Severe unexplained wasting / malnutrition not responding to treatment (weight-for-height/ -age 1 month or visceral at any site)</u> ■ Cytomegalovirus infection: retinitis or other organ (from age 1 month) ■ <u>Toxoplasmosis of the brain (from age 1 month)</u> ■ Recto-vaginal fistula, HIV-associated ■ <u>Pneumocystis pneumonia</u> ■ <u>Candidiasis of oesophagus, trachea, bronchi or lungs</u> ■ Extrapulmonary tuberculosis ■ Kaposi's sarcoma ■ HIV encephalopathy ■ Cryptococcal meningitis or other Extrapulmonary cryptococcosis ■ Disseminated non-tuberculous mycobacterial infection ■ Cryptosporidiosis, chronic with diarrhoea ■ Isosporiasis >1 month ■ Disseminated mycosis (coccidiomycosis or histoplasmosis) ■ Symptomatic HIV-associated nephropathy or cardiomyopathy ■ Progressive multifocal leukoencephalopathy ■ Cerebral or B-cell non-Hodgkin lymphoma
				Presumed Severe HIV Disease (PSHD) in infants <12 months ■ Positive antibody (rapid) test <u>PLUS</u> one or several of the underlined clinical conditions in the WHO staging list <u>OR</u> ■ combination of at least 2 of the following: ● Oral thrush, Severe sepsis and Severe pneumonia

Annex 3: Where referral is not possible

Possible Serious Bacterial Infection when referral is not possible

When referral of Possible Serious Bacterial Infection is not possible

Assess	Classify	Identify Treatment
Does the young infant have any one of the following? ■ Convulsions ■ Unable to feed at all ■ No movement on stimulation ■ Unable to cry ■ Bulging fontanelle ■ Cyanosis ■ Unconscious ■ Persistent vomiting ■ Apnoea ■ O2 saturation less than 90%	CRITICAL ILLNESS	■ Give first dose of both benzyl penicillin and gentamicin intramuscularly. ■ Explain to the caregiver that the infant is very sick and needs urgent referral for hospital care. ■ Treat to prevent low blood sugar. ■ Teach the mother how to keep the young infant warm on the way to the hospital. ■ Refer URGENTLY to hospital. ■ If referral is still not possible, continue treatment with daily IM gentamicin and twice-daily and IM benzyl penicillin until referral is possible (up to 7 days).
Does the young infant have any one of the following? ■ Not feeding well on observation ■ Temperature 38oC or more ■ Temperature less than 35.5oC ■ Severe chest indrawing ■ Movement only when stimulated	CLINICAL SEVERE INFECTION	■ Explain to the caregiver that the infant is very sick and needs urgent referral for hospital care. ■ Treat to prevent low blood sugar. ■ Teach the mother how to keep the young infant warm on the way to the hospital. ■ Refer URGENTLY to hospital. ■ If referral still is not possible, ● Treat at outpatient clinic with daily intramuscular gentamicin. ● Give oral amoxicillin for 7 days. ● Teach the mother how to give the oral amoxicillin twice daily. ● Advise mother to come for the next injection the following day. ● Treat also for any other classifications that the young infant has. ● Reassess the young infant at each visit (see Follow-up Care, p. 46).
Does the young infant have: Fast breathing (60 breaths per minute or more) in infants less than 7 days old?	SEVERE PNEUMONIA	■ Give oral amoxicillin for 7 days. ■ Teach the mother how to give the oral amoxicillin twice daily. ■ Treat also for any other classifications that the young infant has. ■ Advise the mother to return for follow up on day 4.

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



Name: _____ Age: _____ Weight: _____ kg Height/Length: _____ cm Temp: _____ °C Initial visit? _____ F/up visit? _____

Ask: What are the child's problems? _____

ASSESS (Circle all signs present)

CLASSIFY

Check for General Danger Signs - NOT ABLE TO DRINK OR BREASTFEED - VOMITS EVERYTHING - CONVULSIONS: If yes, - How many times? _____ How long? _____ min - LETHARGIC OR UNCONSCIOUS - CONVULSING NOW		Remember to use Danger sign when selecting classifications																																			
Does the child have cough or difficult breathing? Yes _____ No _____ - For how long? _____ Days - Count the breaths in one minute: _____ breaths per minute. Fast breathing? - Look for chest indrawing - Look and listen for stridor - Look and listen for wheezing																																					
Does the child have diarrhoea? Yes _____ No _____ - For how long? _____ Days - Is there blood in the stool? - Look at the child's general condition. Is the child: - Lethargic or unconscious? Restless and irritable? - Look for sunken eyes. - Offer the child fluid. Is the child: - Not able to drink or drinking poorly? Drinking eagerly, thirsty? - Pinch the skin of the abdomen. Does it go back: - Very slowly (longer than 2 seconds)? Slowly?																																					
Does the child have fever? (by history/feels hot/temperature 37.5°C or above) Yes _____ No _____ For how long? _____ Days - If more than 7 days, has fever been present every day? - Has child had measles within the last 3 months? Do mRDT if NO general danger sign or stiff neck. Test Positive? Negative?																																					
If the child has measles now or within the last 3 months: - Look for mouth ulcers. If yes, are they deep and extensive? - Look for pus draining from the eye. - Look for clouding of the cornea.																																					
Does the child have ear problem? Yes _____ No _____ - Is there ear pain? - Is there ear discharge? - If Yes, for how long? _____ Days - Look for pus draining from the ear - Feel for tender swelling behind the ear																																					
Then check for acute malnutrition - Look for oedema of both feet. - Determine WFH/L z-score: - Less than -3? Between -3 and -2? -2 or more? - For children 6 months or older measure MUAC _____ cm.																																					
If child has MUAC less than 11.5 cm or WFH/L less than -3 Z scores or oedema of both feet: - Is there any medical complication: General danger sign? - Any severe classification? Pneumonia with chest indrawing? - Child 6 months or older: Offer RUTF to eat. Is the child: - Not able to finish? Able to finish? - Child less than 6 months: Is there a breastfeeding problem?																																					
Then check for anaemia - Look for palmar pallor - Severe palmar pallor? - Some palmar pallor? mRDT Positive; mRDT Negative - No palmar pallor?																																					
Then check for HIV infection - Note mother's and/or child's HIV status - Mother's HIV test: Negative or Positive - Child's DNA-PCR test: Negative or Positive - Child's Rapid HIV test: Negative or Positive - If mother is HIV-positive and NO positive DNA-PCR test in child: - Is the child breastfeeding now? - Was the child breastfeeding at the time of test or 6 weeks before? - If breastfeeding: Is the mother and child on ARV prophylaxis?																																					
Check for mouth and gum conditions (If on ART, HIV exposed OR HIV infected) - Look for mouth or gum ulcer - Are they deep or extensive? - Is the child unable to eat due to painful mouth ulcers?																																					
Check the child's immunization, Vitamin A and deworming status (Circle needed today) <table border="0"> <tr> <td colspan="5"></td> <td>Vitamin A</td> <td></td> </tr> <tr> <td>BCG</td> <td>OPV0</td> <td>OPV1</td> <td>OPV2</td> <td>OPV 3 & IPV</td> <td>_____</td> <td></td> </tr> <tr> <td>Scar</td> <td>PCV1</td> <td>PCV2</td> <td>PCV3</td> <td>Measles1</td> <td>6-11 12-17 18-23 24-29 30-35 36-41 42-47 48-53 54-59</td> <td></td> </tr> <tr> <td>Rota1</td> <td>DPT-HepB-Hib1</td> <td>DPT-HepB-Hib2</td> <td>DPT-BepB-Hib3</td> <td>Measles2</td> <td>12-17 18-23 24-29 30-35 36-41 42-47 48-53 54-59</td> <td></td> </tr> <tr> <td>Rota2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>							Vitamin A		BCG	OPV0	OPV1	OPV2	OPV 3 & IPV	_____		Scar	PCV1	PCV2	PCV3	Measles1	6-11 12-17 18-23 24-29 30-35 36-41 42-47 48-53 54-59		Rota1	DPT-HepB-Hib1	DPT-HepB-Hib2	DPT-BepB-Hib3	Measles2	12-17 18-23 24-29 30-35 36-41 42-47 48-53 54-59		Rota2							Return for next immunization on: _____ (Date)
					Vitamin A																																
BCG	OPV0	OPV1	OPV2	OPV 3 & IPV	_____																																
Scar	PCV1	PCV2	PCV3	Measles1	6-11 12-17 18-23 24-29 30-35 36-41 42-47 48-53 54-59																																
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Rota2																																					
Assess feeding if the child is less than 2 years old, has Moderate acute malnutrition, Anaemia, HIVinfected or HIV exposed - Do you breastfeed your child? Yes _____ No _____ - If yes, how many times in 24 hours? _____ times. Do you breastfeed during the night? Yes _____ No _____ - Does the child take any other foods or fluids? Yes _____ No _____ - If Yes, what food or fluids? - How many times per day? _____ times. What do you use to feed the child? - If Moderate acute malnutrition: How large are servings? - Does the child receive his own serving? _____ Who feeds the child and how? - During this illness, has the child's feeding changed? Yes _____ No _____ - If Yes, how?		FEEDING PROBLEMS																																			
ASSESS OTHER PROBLEMS: _____ Ask about mother's own health																																					

Remember to refer any child who has a danger sign and no other severe classification

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ART INITIATION RECORDING FORM



FOLLOW THESE STEPS TO INITIATE ART IF CHILD DOES NOT NEED URGENT REFERRAL

Name: _____ Age: _____ Weight (kg): _____ Temperature (°C): _____ Date: _____

ASSESS (Circle all findings)

TREAT

STEP 1: HIV INFECTED - Child under 12 months: DNA-PCR test - Check that child has not breastfed for at least 6 weeks - Child 12 months and over: HIV Rapid test - Check that child has not breastfed for at least 6 weeks - Send tests that are required - Send confirmation test If HIV infection confirmed, and child is in stable condition, GO TO STEP 2	YES ____ NO ____
STEP 2: CAREGIVER ABLE TO GIVE ART - Caregiver available and willing to give medication - Caregiver has disclosed to another adult, or is part of a support group If yes: GO TO STEP 3. If no: COUNSEL AND SUPPORT THE CAREGIVER.	YES ____ NO ____
STEP 3: DECIDE IF ART CAN BE INITIATED AT FIRST LEVEL - Weight under 3 kg - Child has TB If any present: REFER If none present: GO TO STEP 4	YES ____ NO ____
STEP 4: RECORD BASELINE INFORMATION - Weight: _____ kg - Height/length _____ cm - Feeding problem - WHO clinical stage today: _____ - VL (if available): _____ - Hb: _____ g/dl - Send tests that are required and GO TO STEP 5	
STEP 5: START ART AND COTRIMOXAZOLE PROPHYLAXIS - Less than 3kg: No routine ART. Contact Department of HIV and AIDS (DHA) 3-19.9kg: Paediatric ABC/3TC+ paediatric DTG 10mg (15PP) 20.0 – 24.9kg: Paediatric ABC/3TC tablet + adult DTG 50mg (15PA) 25.0 - 29.9kg: Adult ABC/3TC tablet + adult DTG 50mg (15A) 30kg + : TDF/3TC/DTG 300/300/50mg (13A) RECORD ARVS & DOSAGES HERE: _____ _____ _____	
PROVIDE FOLLOW-UP CARE Follow-up according to national guidelines	NEXT FOLLOW-UP DATE: _____

RECORD ACTIONS AND TREATMENTS HERE:
ALWAYS REMEMBER TO COUNSEL THE MOTHER AND PROVIDE ROUTINE CARE

RECORD ACTIONS AND TREATMENTS HERE:
ALWAYS REMEMBER TO COUNSEL THE MOTHER AND PROVIDE ROUTINE CARE

[illegible]

FOLLOW-UP CARE FOR HIV INFECTED CHILD ON ART: SIX STEPS



Name: _____ Age: _____ Weight (kg): _____ Height/length (cm): _____ Temperature (°C): _____ Date: _____

Circle all findings

STEP 1: ASSESS AND CLASSIFY ASK: does the child have any problems? If yes, record here: _____ ASK: has the child received care at another health facility since the last visit? YES ____ NO ____ • Check for general danger signs: ◦ NOT ABLE TO DRINK OR BREASTFEED ◦ VOMITS EVERYTHING ◦ CONVULSIONS ◦ LETHARGIC OR UNCONSCIOUS ◦ CONVULSING NOW • Check for ART severe side effects: ◦ Severe skin rash ◦ Yellow eyes ◦ Difficulty breathing and severe abdominal pain ◦ Fever, vomiting, rash (only if on Abacavir) • Check for main symptoms: ◦ Cough or difficulty breathing ◦ Diarrhoea ◦ Fever ◦ Ear problem ◦ Other problems If general danger signs or ART severe side effects, provide pre-referral treatment and REFER URGENTLY Assess, classify, treat, and follow-up main symptoms according to IMCI guidelines. Refer if necessary.	RECORD ACTIONS TAKEN:
STEP 2: MONITOR ARV TREATMENT Assess adherence: • Takes all doses - Frequently misses doses - Occasionally misses a dose - Not taking medication • Assess side-effects Nausea - Tingling, numb, or painful hands, feet, or legs - Sleep disturbances - Diarrhoea - Dizziness - Abnormal distribution of fat - Rash - Other • Assess clinical condition: Progressed to higher stage Stage when ART initiated: 1 - 2 - 3 - 4 - Unknown • Monitor blood results: Tests should be sent after 6 months on ARVs, then yearly. Record latest results here: DATE: _____ CD4 COUNT: _____ cells/mm3 CD4%: _____ Viral load: _____ If on LPV/r: LDL Cholesterol: _____ TGs: _____ 1. REFER NON-URGENTLY IF ANY OF THE FOLLOWING ARE PRESENT: • Not gaining weight for 3 months • Loss of milestones • Poor adherence despite adherence counselling • Significant side-effects despite appropriate management • Higher clinical stage than before • CD4 count significantly lower than before • LDL higher than 3.5 mmol/L • Triglycerides (TGs) higher than 5.6 mmol/L 2. MANAGE MILD SIDE-EFFECTS 3. SEND TESTS THAT ARE DUE • CD4 count • Viral load, if available • LDL cholesterol and triglycerides OTHERWISE, GO TO STEP 3	RECORD ACTIONS TAKEN:
STEP 3: PROVIDE ART AND OTHER MEDICATION ABC+3TC+LPV/r ABC+3TC+EFV Cotrimoxazole Vitamin A Other Medication RECORD ART DOSAGES: 1. _____ 2. _____ 3. _____ • COTRIMOXAZOLE DOSAGE: _____ • VITAMIN A DOSAGE: _____ • OTHER MEDICATION DOSAGE: 1. _____ 2. _____ 3. _____	
STEP 4: COUNSEL Use every visit to educate the caregiver and provide support, key issues include: How is child progressing - Adherence - Support to caregiver - Disclosure (to others & child) - Side-effects and correct management RECORD ISSUES DISCUSSED:	DATE OF NEXT VISIT:

[illegible]

MANAGEMENT OF THE SICK YOUNG INFANT AGED UP TO 2 MONTHS



Name: _____ Age: _____ Weight: _____ kg Temperature: _____ °C Initial visit? _____ F/up visit? _____

Ask: What are the infant's problems? _____

ASSESS (Circle all signs present)

CLASSIFY

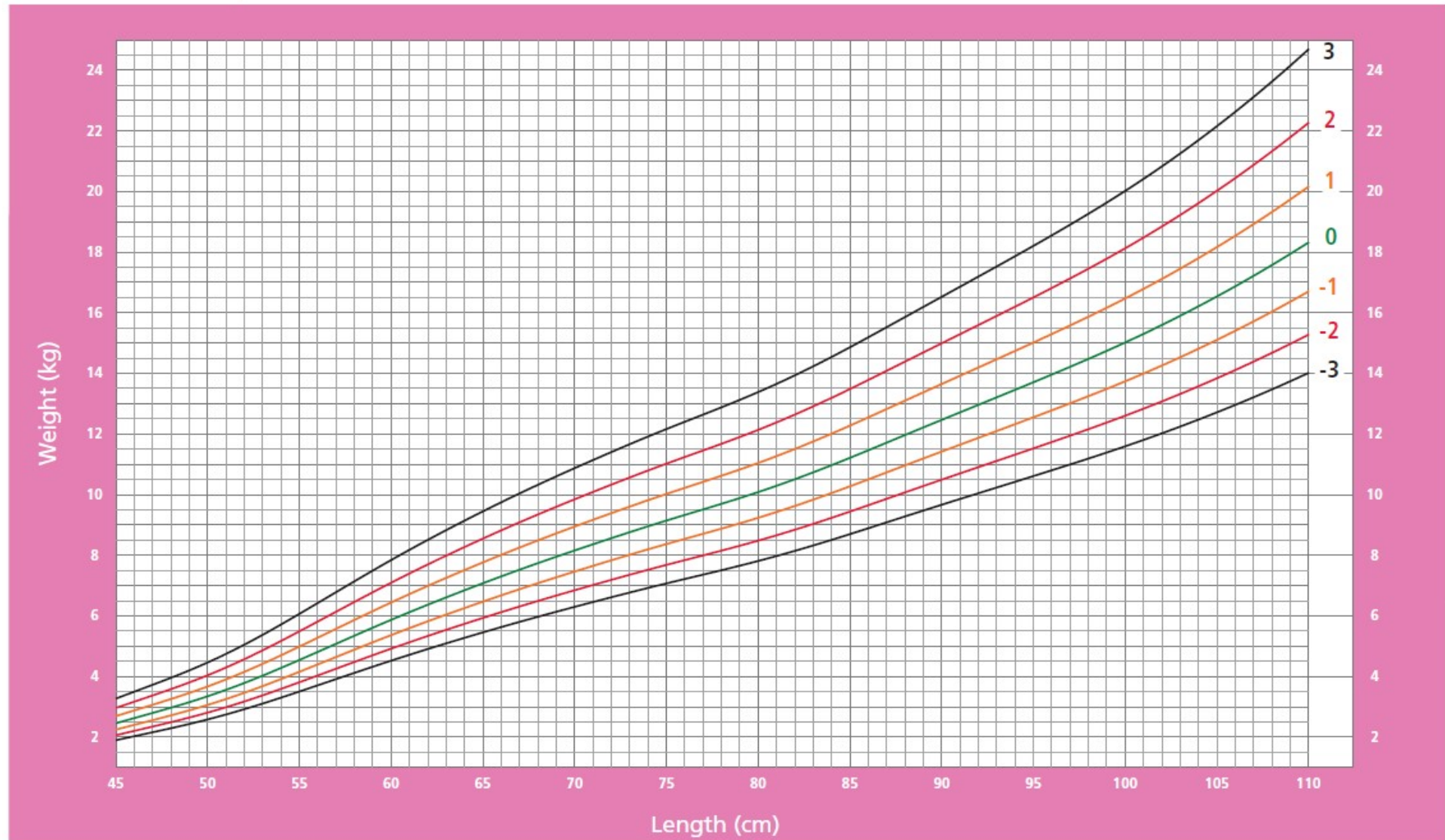
Check for Possible Serious Bacterial Infection or Very Severe Disease, Pneumonia and Local Infection - Is the infant having difficulty in feeding? - Has the infant had convulsions? - Count the breaths in one minute. _____ breaths per minute Repeat if elevated (≥ 60) _____ Fast breathing? - Look for severe chest indrawing. - Look if child is convulsing now. - Fever (temperature $\geq 38^{\circ}\text{C}$) or low body temperature below 35.5°C - Look at young infant's movements - Movement only when stimulated? - No movement at all? - Infant moves on his or her own - Look at the umbilicus. Is it red or draining pus? - Look for skin pustules. Are there many or severe pustules?		
Then check for jaundice - When did the jaundice appear first? - Look for jaundice (yellow eyes or skin) - Look at the young infant's palms and soles. Are they yellow?		
Does the young infant have diarrhoea? Yes _____ No _____ If yes, ASK: - For how long? _____ days - Look at the young infant's general condition. - Does the infant move only when stimulated? - Does the infant not move even when stimulated? - Is the infant restless and irritable? - Look for sunken eyes. - Pinch the skin of the abdomen. Does it go back: - Very slowly (longer than 2 seconds)? - Slowly?		
Check for HIV Infection ASK: - HIV status of the mother? <i>Positive Negative Unknown</i> - HIV rapid test of the infant? <i>Positive Negative Unknown</i> - DNA-PCR test of the infant? <i>Positive Negative Unknown</i> - If mother is HIV positive and DNA-PCR test negative in young infant: - Is the infant breastfeeding now? - Was the infant breastfeeding at the time of test or 6 weeks before it?		
Then check for feeding problem or low weight for age (if there is no indication for urgent referral) - Is the infant breastfed? Yes _____ No _____ If yes, how many times in 24 hours? _____ times - Does the infant usually receive any other foods or drinks? Yes _____ No _____ If yes, how often? _____ times If yes, what do you use to feed the infant? _____ - Determine weight for age. - Very low weight for age _____ - Low weight for age _____ - NOT low weight for age _____ - Look for ulcers or white patches in the mouth (thrush).		
Assess breastfeeding: If the infant has difficult feeding, is feeding less than 8 times in 24 hours, is taking any other food or drinks, or is low weight for age, AND has no indication to refer urgently to the hospital: - Has the infant breastfed in the previous hour? - If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes. - If the infant was fed during the last hour, ask the mother if she can wait and tell you when the infant is willing to feed again. - Is the infant able to attach? To check attachment, look for: - More areola seen above than below the mouth Yes _____ No _____ - Mouth wide open Yes _____ No _____ - Lower lip turned outward Yes _____ No _____ - Chin touching breast Yes _____ No _____ - Good attachment Poor attachment No attachment at all - Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? Suckling effectively Not suckling effectively Not suckling at all		
Assess feeding when the infant does not breastfeed - Is there any difficulty feeding? - What milk are you giving? _____ - How many times during the day and night? _____ - How much is given at each feed? _____ - How are you preparing the milk? _____ - Let the mother demonstrate or explain how a feed is prepared, and how it is given to the infant. - Are you giving any breastmilk at all? - What foods or fluids in addition to the replacement feeding are given? - How is the milk being given? Cup or bottle? - How are you cleaning the feeding utensils? - Determine weight for age: - Very low weight for age (< 1.5 kg or < -3 Z score) _____ - Low weight for age _____ - NOT low weight for age _____ - Look for ulcers or white patches in the mouth (thrush).		
Check the child's Immunization status (Circle immunizations needed today) BCG OPV-1 Rotavirus1 PCV1 DPT-HepB -Hib1 Vitamin A OPV0 200,000 I.U to mother		Return for next immunization on: _____ (Date)
Assess other Problems: Ask about the mother's own health. Counsel the mother about her own health.		

TREAT

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

Weight-for-length GIRLS

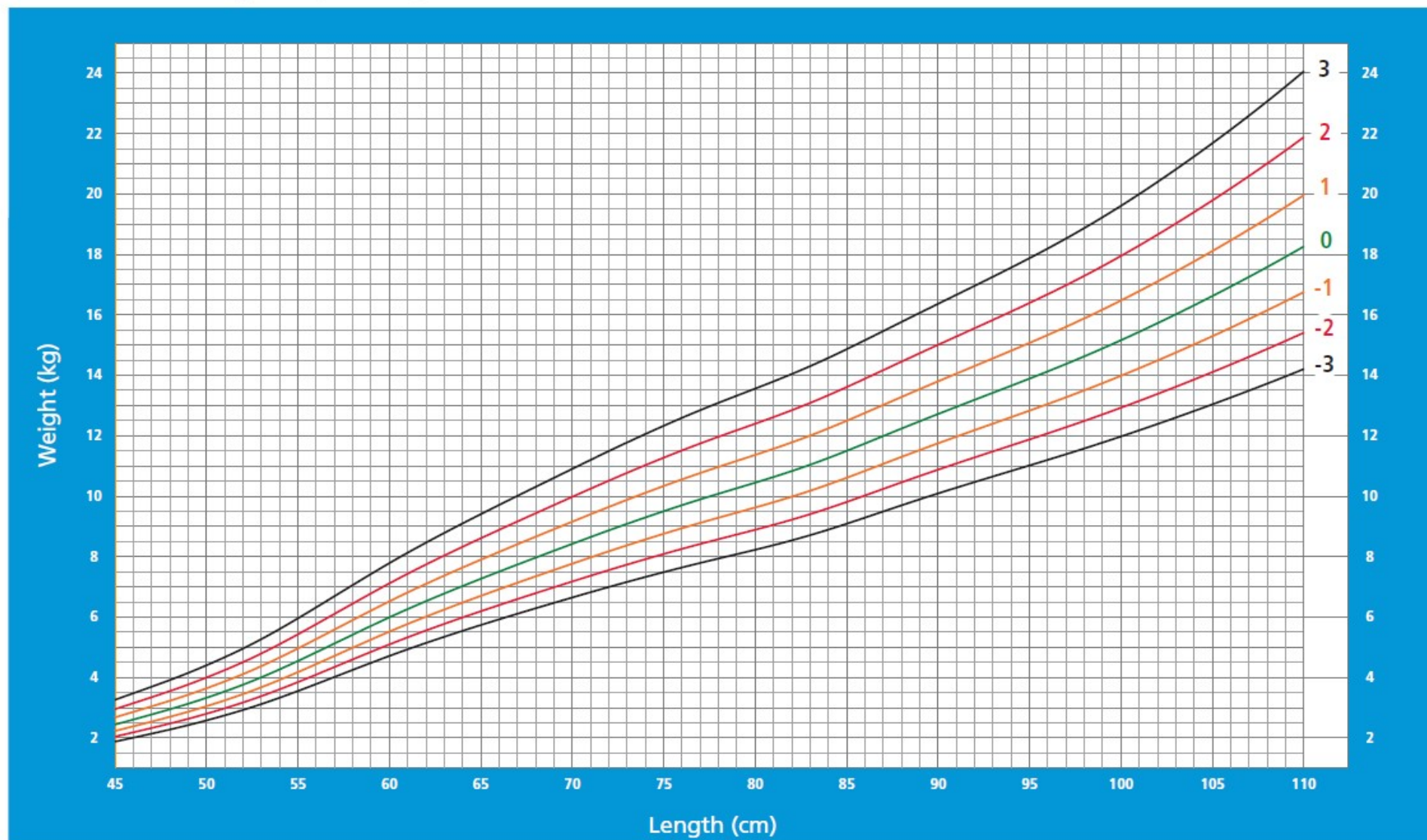
Birth to 2 years (z-scores)



WHO Child Growth Standards

Weight-for-length BOYS

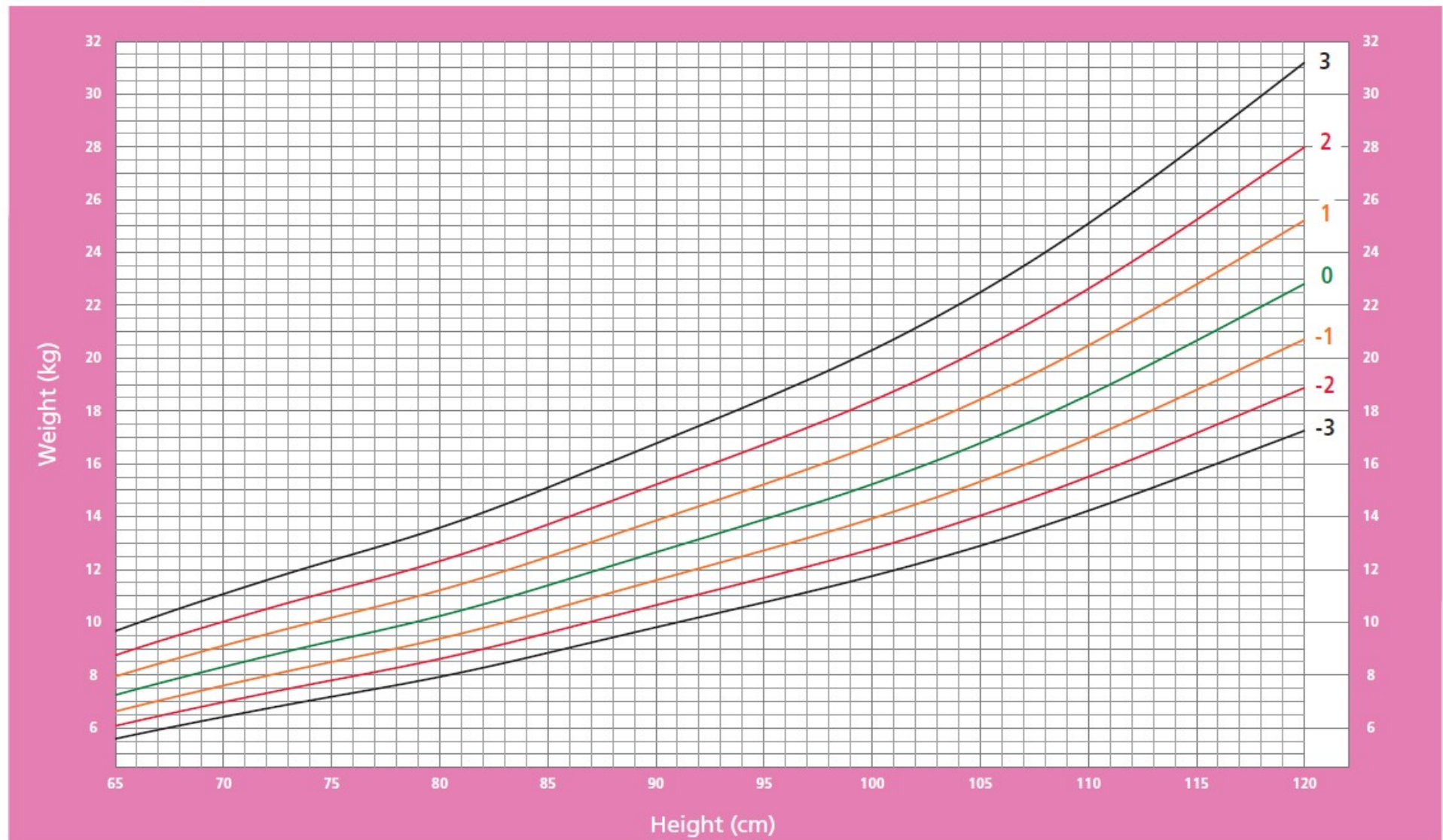
Birth to 2 years (z-scores)



WHO Child Growth Standards

Weight-for-Height GIRLS

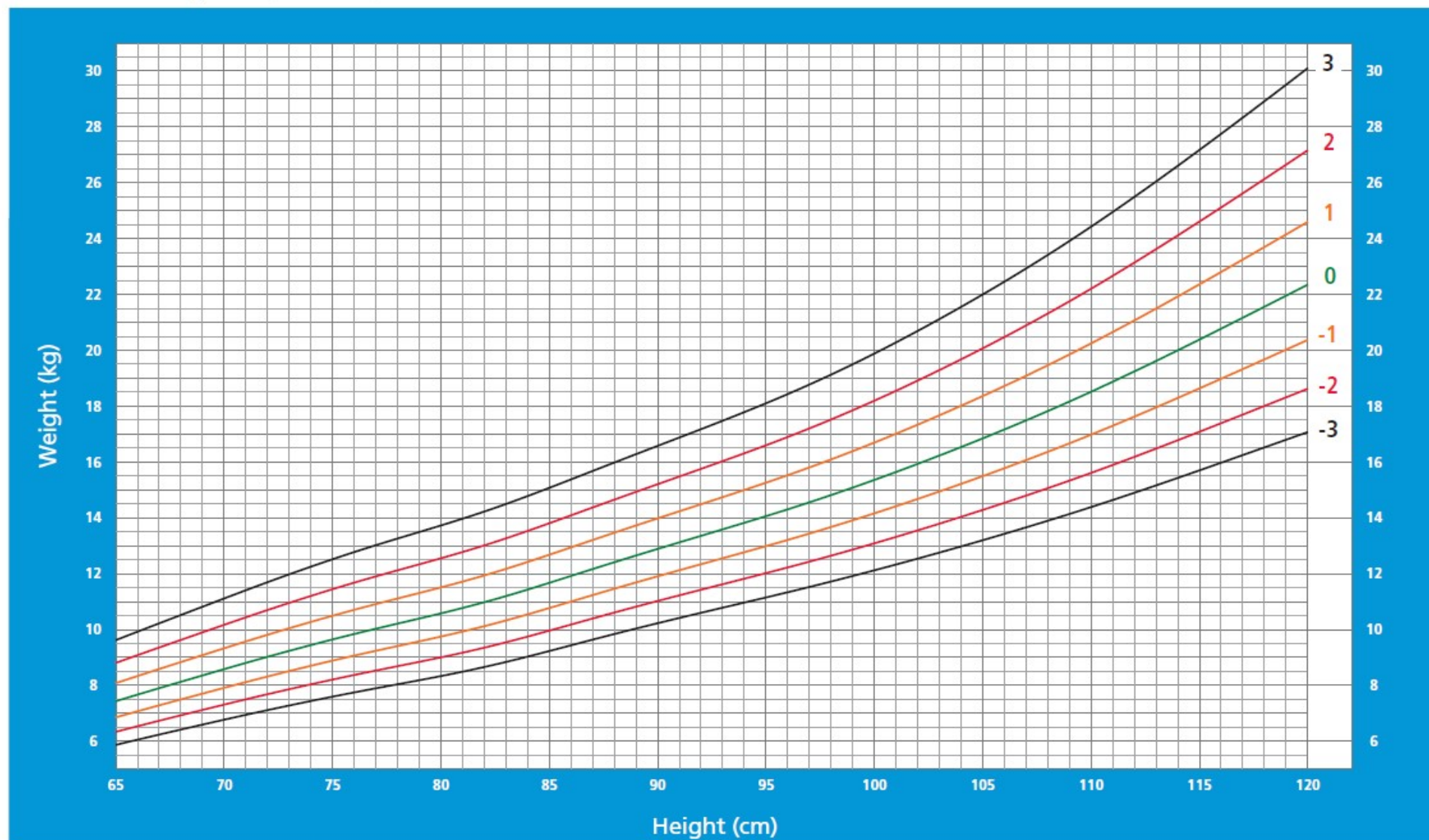
2 to 5 years (z-scores)



WHO Child Growth Standards

Weight-for-height BOYS

2 to 5 years (z-scores)



WHO Child Growth Standards

Weight for length tables birth to 2 years old (WHO, 2006)



Ministry of Health

Weight for length 45.0 - 59.5cm lying down

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
1.9	2.0	2.2	2.4	45.0	2.5	2.3	2.1	1.9
1.9	2.1	2.3	2.5	45.5	2.5	2.3	2.1	2.0
2.0	2.2	2.4	2.6	46.0	2.6	2.4	2.2	2.0
2.1	2.3	2.5	2.7	46.5	2.7	2.5	2.3	2.1
2.1	2.3	2.5	2.8	47.0	2.8	2.6	2.4	2.2
2.2	2.4	2.6	2.9	47.5	2.9	2.6	2.4	2.2
2.3	2.5	2.7	2.9	48.0	3.0	2.7	2.5	2.3
2.3	2.6	2.8	3.0	48.5	3.1	2.8	2.6	2.4
2.4	2.6	2.9	3.1	49.0	3.2	2.9	2.6	2.4
2.5	2.7	3.0	3.2	49.5	3.3	3.0	2.7	2.5
2.6	2.8	3.0	3.3	50.0	3.4	3.1	2.8	2.6
2.7	2.9	3.1	3.4	50.5	3.5	3.2	2.9	2.7
2.7	3.0	3.2	3.5	51.0	3.6	3.3	3.0	2.8
2.8	3.1	3.3	3.6	51.5	3.7	3.4	3.1	2.8
2.9	3.2	3.5	3.8	52.0	3.8	3.5	3.2	2.9
3.0	3.3	3.6	3.9	52.5	3.9	3.6	3.3	3.0
3.1	3.4	3.7	4.0	53.0	4.0	3.7	3.4	3.1
3.2	3.5	3.8	4.1	53.5	4.2	3.8	3.5	3.2
3.3	3.6	3.9	4.3	54.0	4.3	3.9	3.6	3.3
3.4	3.7	4.0	4.4	54.5	4.4	4.0	3.7	3.4
3.6	3.8	4.2	4.5	55.0	4.5	4.2	3.8	3.5
3.7	4.0	4.3	4.7	55.5	4.7	4.3	3.9	3.6
3.8	4.1	4.4	4.8	56.0	4.8	4.4	4.0	3.7
3.9	4.2	4.6	5.0	56.5	5.0	4.5	4.1	3.8
4.0	4.3	4.7	5.1	57.0	5.1	4.6	4.3	3.9
4.1	4.5	4.9	5.3	57.5	5.2	4.8	4.4	4.0
4.3	4.6	5.0	5.4	58.0	5.4	4.9	4.5	4.1
4.4	4.7	5.1	5.6	58.5	5.5	5.0	4.6	4.2
4.5	4.8	5.3	5.7	59.0	5.6	5.1	4.7	4.3
4.6	5.0	5.4	5.9	59.5	5.7	5.3	4.8	4.4

Weight for length tables birth to 2 years old (WHO, 2006)



Weight for length

60.0 - 75.0cm lying down

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
4.7	5.1	5.5	6.0	60.0	5.9	5.4	4.9	4.5
4.8	5.2	5.6	6.1	60.5	6.0	5.5	5.0	4.6
4.9	5.3	5.8	6.3	61.0	6.1	5.6	5.1	4.7
5.0	5.4	5.9	6.4	61.5	6.3	5.7	5.2	4.8
5.1	5.6	6.0	6.5	62.0	6.4	5.8	5.3	4.9
5.2	5.7	6.1	6.7	62.5	6.5	5.9	5.4	5.0
5.3	5.8	6.2	6.8	63.0	6.6	6.0	5.5	5.1
5.4	5.9	6.4	6.9	63.5	6.7	6.2	5.6	5.2
5.5	6.0	6.5	7.0	64.0	6.9	6.3	5.7	5.3
5.6	6.1	6.6	7.1	64.5	7.0	6.4	5.8	5.4
5.7	6.2	6.7	7.3	65.0	7.1	6.5	5.9	5.5
5.8	6.3	6.8	7.4	65.5	7.2	6.6	6.0	5.5
5.9	6.4	6.9	7.5	66.0	7.3	6.7	6.1	5.6
6.0	6.5	7.0	7.6	66.5	7.4	6.8	6.2	5.7
6.1	6.6	7.1	7.7	67.0	7.5	6.9	6.3	5.8
6.2	6.7	7.2	7.9	67.5	7.6	7.0	6.4	5.9
6.3	6.8	7.3	8.0	68.0	7.7	7.1	6.5	6.0
6.4	6.9	7.5	8.1	68.5	7.9	7.2	6.6	6.1
6.5	7.0	7.6	8.2	69.0	8.0	7.3	6.7	6.1
6.6	7.1	7.7	8.3	69.5	8.1	7.4	6.8	6.2
6.6	7.2	7.8	8.4	70.0	8.2	7.5	6.9	6.3
6.7	7.3	7.9	8.5	70.5	8.3	7.6	6.9	6.4
6.8	7.4	8.0	8.6	71.0	8.4	7.7	7.0	6.5
6.9	7.5	8.1	8.8	71.5	8.5	7.7	7.1	6.5
7.0	7.6	8.2	8.9	72.0	8.6	7.8	7.2	6.6
7.1	7.6	8.3	9.0	72.5	8.7	7.9	7.3	6.7
7.2	7.7	8.4	9.1	73.0	8.8	8.0	7.4	6.8
7.2	7.8	8.5	9.2	73.5	8.9	8.1	7.4	6.9
7.3	7.9	8.6	9.3	74.0	9.0	8.2	7.5	6.9
7.4	8.0	8.7	9.4	74.5	9.1	8.3	7.6	7.0
7.5	8.1	8.8	9.5	75.0	9.1	8.4	7.7	7.1

Weight for length tables birth to 2 years old (WHO, 2006)

Weight for length

75.5 - 90.5cm lying down

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
7.6	8.2	8.8	9.6	75.5	9.2	8.5	7.8	7.1
7.6	8.3	8.9	9.7	76.0	9.3	8.5	7.8	7.2
7.7	8.3	9.0	9.8	76.5	9.4	8.6	7.9	7.3
7.8	8.4	9.1	9.9	77.0	9.5	8.7	8.0	7.4
7.9	8.5	9.2	10.0	77.5	9.6	8.8	8.1	7.4
7.9	8.6	9.3	10.1	78.0	9.7	8.9	8.2	7.5
8.0	8.7	9.4	10.2	78.5	9.8	9.0	8.2	7.6
8.1	8.7	9.5	10.3	79.0	9.9	9.1	8.3	7.7
8.2	8.8	9.5	10.4	79.5	10.0	9.1	8.4	7.7
8.2	8.9	9.6	10.4	80.0	10.1	9.2	8.5	7.8
8.3	9.0	9.7	10.5	80.5	10.2	9.3	8.6	7.9
8.4	9.1	9.8	10.6	81.0	10.3	9.4	8.7	8.0
8.5	9.1	9.9	10.7	81.5	10.4	9.5	8.8	8.1
8.5	9.2	10.0	10.8	82.0	10.5	9.6	8.8	8.1
8.6	9.3	10.1	10.9	82.5	10.6	9.7	8.9	8.2
8.7	9.4	10.2	11.0	83.0	10.7	9.8	9.0	8.3
8.8	9.5	10.3	11.2	83.5	10.9	9.9	9.1	8.4
8.9	9.6	10.4	11.3	84.0	11.0	10.1	9.2	8.5
9.0	9.7	10.5	11.4	84.5	11.1	10.2	9.3	8.6
9.1	9.8	10.6	11.5	85.0	11.2	10.3	9.4	8.7
9.2	9.9	10.7	11.6	85.5	11.3	10.4	9.5	8.8
9.3	10.0	10.8	11.7	86.0	11.5	10.5	9.7	8.9
9.4	10.1	11.0	11.9	86.5	11.6	10.6	9.8	9.0
9.5	10.2	11.1	12.0	87.0	11.7	10.7	9.9	9.1
9.6	10.4	11.2	12.1	87.5	11.8	10.9	10.0	9.2
9.7	10.5	11.3	12.2	88.0	12.0	11.0	10.1	9.3
9.8	10.6	11.4	12.4	88.5	12.1	11.1	10.2	9.4
9.9	10.7	11.5	12.5	89.0	12.2	11.2	10.3	9.5
10.0	10.8	11.6	12.6	89.5	12.3	11.3	10.4	9.6
10.1	10.9	11.8	12.7	90.0	12.5	11.4	10.5	9.7
10.2	11.0	11.9	12.8	90.5	12.6	11.5	10.6	9.8

Weight for length tables birth to 2 years old (WHO, 2006)

Weight for length

91.0 - 106.0 cm lying down

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
10.3	11.1	12.0	13.0	91.0	12.7	11.7	10.7	9.9
10.4	11.2	12.1	13.1	91.5	12.8	11.8	10.8	10.0
10.5	11.3	12.2	13.2	92.0	13.0	11.9	10.9	10.1
10.6	11.4	12.3	13.3	92.5	13.1	12.0	11.0	10.1
10.7	11.5	12.4	13.4	93.0	13.2	12.1	11.1	10.2
10.7	11.6	12.5	13.5	93.5	13.3	12.2	11.2	10.3
10.8	11.7	12.6	13.7	94.0	13.5	12.3	11.3	10.4
10.9	11.8	12.7	13.8	94.5	13.6	12.4	11.4	10.5
11.0	11.9	12.8	13.9	95.0	13.7	12.6	11.5	10.6
11.1	12.0	12.9	14.0	95.5	13.8	12.7	11.6	10.7
11.2	12.1	13.1	14.1	96.0	14.0	12.8	11.7	10.8
11.3	12.2	13.2	14.3	96.5	14.1	12.9	11.8	10.9
11.4	12.3	13.3	14.4	97.0	14.2	13.0	12.0	11.0
11.5	12.4	13.4	14.5	97.5	14.4	13.1	12.1	11.1
11.6	12.5	13.5	14.6	98.0	14.5	13.3	12.2	11.2
11.7	12.6	13.6	14.8	98.5	14.6	13.4	12.3	11.3
11.8	12.7	13.7	14.9	99.0	14.8	13.5	12.4	11.4
11.9	12.8	13.9	15.0	99.5	14.9	13.6	12.5	11.5
12.0	12.9	14.0	15.2	100.0	15.0	13.7	12.6	11.6
12.1	13.0	14.1	15.3	100.5	15.2	13.9	12.7	11.7
12.2	13.2	14.2	15.4	101.0	15.3	14.0	12.8	11.8
12.3	13.3	14.4	15.6	101.5	15.5	14.1	13.0	11.9
12.4	13.4	14.5	15.7	102.0	15.6	14.3	13.1	12.0
12.5	13.5	14.6	15.9	102.5	15.8	14.4	13.2	12.1
12.6	13.6	14.8	16.0	103.0	15.9	14.5	13.3	12.3
12.7	13.7	14.9	16.2	103.5	16.1	14.7	13.5	12.4
12.8	13.9	15.0	16.3	104.0	16.2	14.8	13.6	12.5
12.9	14.0	15.2	16.5	104.5	16.4	15.0	13.7	12.6
13.0	14.1	15.3	16.6	105.0	16.5	15.1	13.8	12.7
13.2	14.2	15.4	16.8	105.5	16.7	15.3	14.0	12.8
13.3	14.4	15.6	16.9	106.0	16.9	15.4	14.1	13.0

Weight for length tables birth to 2 years old (WHO, 2006)



Ministry of Health

Weight for length

106.5 - 110.0 cm lying down

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
13.4	14.5	15.7	17.1	106.5	17.1	15.7	14.5	13.4
13.5	14.6	15.9	17.3	107.0	17.3	15.9	14.6	13.5
13.6	14.7	16.0	17.4	107.5	17.4	16.0	14.7	13.6
13.7	14.9	16.2	17.6	108.0	17.6	16.2	14.9	13.7
13.8	15.0	16.3	17.8	108.5	17.8	16.3	15.0	13.8
14.0	15.1	16.5	17.9	109.0	17.9	16.5	15.1	14.0
14.1	15.3	16.6	18.1	109.5	18.1	16.6	15.3	14.1
14.2	15.4	16.8	18.3	110.0	18.3	16.8	15.4	14.2

Weight for height tables for children from 2-5 years old (WHO, 2006)

Weight-for-height

65.0 - 79.5cm Standing up

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
5.9	6.3	6.9	7.4	65.0	7.2	6.6	6.1	5.6
6.0	6.4	7.0	7.6	65.5	7.4	6.7	6.2	5.7
6.1	6.5	7.1	7.7	66.0	7.5	6.8	6.3	5.8
6.1	6.6	7.2	7.8	66.5	7.6	6.9	6.4	5.8
6.2	6.7	7.3	7.9	67.0	7.7	7.0	6.4	5.9
6.3	6.8	7.4	8.0	67.5	7.8	7.1	6.5	6.0
6.4	6.9	7.5	8.1	68.0	7.9	7.2	6.6	6.1
6.5	7.0	7.6	8.2	68.5	8.0	7.3	6.7	6.2
6.6	7.1	7.7	8.4	69.0	8.1	7.4	6.8	6.3
6.7	7.2	7.8	8.5	69.5	8.2	7.5	6.9	6.3
6.8	7.3	7.9	8.6	70.0	8.3	7.6	7.0	6.4
6.9	7.4	8.0	8.7	70.5	8.4	7.7	7.1	6.5
6.9	7.5	8.1	8.8	71.0	8.5	7.8	7.1	6.6
7.0	7.6	8.2	8.9	71.5	8.6	7.9	7.2	6.7
7.1	7.7	8.3	9.0	72.0	8.7	8.0	7.3	6.7
7.2	7.8	8.4	9.1	72.5	8.8	8.1	7.4	6.8
7.3	7.9	8.5	9.2	73.0	8.9	8.1	7.5	6.9
7.4	7.9	8.6	9.3	73.5	9.0	8.2	7.6	7.0
7.4	8.0	8.7	9.4	74.0	9.1	8.3	7.6	7.0
7.5	8.1	8.8	9.5	74.5	9.2	8.4	7.7	7.1
7.6	8.2	8.9	9.6	75.0	9.3	8.5	7.8	7.2
7.7	8.3	9.0	9.7	75.5	9.4	8.6	7.9	7.2
7.7	8.4	9.1	9.8	76.0	9.5	8.7	8.0	7.3
7.8	8.5	9.2	9.9	76.5	9.6	8.7	8.0	7.4
7.9	8.5	9.2	10.0	77.0	9.6	8.8	8.1	7.5
8.0	8.6	9.3	10.1	77.5	9.7	8.9	8.2	7.5
8.0	8.7	9.4	10.2	78.0	9.8	9.0	8.3	7.6
8.1	8.8	9.5	10.3	78.5	9.9	9.1	8.4	7.7
8.2	8.8	9.6	10.4	79.0	10.0	9.2	8.4	7.8
8.3	8.9	9.7	10.5	79.5	10.1	9.3	8.5	7.8

Weight for height tables for children from 2-5 years old (WHO, 2006)



Weight-for-height

80.0 - 95.0 cm Standing up

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
8.3	9.0	9.7	10.6	80.0	10.2	9.4	8.6	7.9
8.4	9.1	9.8	10.7	80.5	10.3	9.5	8.7	8.0
8.5	9.2	9.9	10.8	81.0	10.4	9.6	8.8	8.1
8.6	9.3	10.0	10.9	81.5	10.6	9.7	8.9	8.2
8.7	9.3	10.1	11.0	82.0	10.7	9.8	9.0	8.3
8.7	9.4	10.2	11.1	82.5	10.8	9.9	9.1	8.4
8.8	9.5	10.3	11.2	83.0	10.9	10.0	9.2	8.5
8.9	9.6	10.4	11.3	83.5	11.0	10.1	9.3	8.5
9.0	9.7	10.5	11.4	84.0	11.1	10.2	9.4	8.6
9.1	9.9	10.7	11.5	84.5	11.3	10.3	9.5	8.7
9.2	10.0	10.8	11.7	85.0	11.4	10.4	9.6	8.8
9.3	10.1	10.9	11.8	85.5	11.5	10.6	9.7	8.9
9.4	10.2	11.0	11.9	86.0	11.6	10.7	9.8	9.0
9.5	10.3	11.1	12.0	86.5	11.8	10.8	9.9	9.1
9.6	10.4	11.2	12.2	87.0	11.9	10.9	10.0	9.2
9.7	10.5	11.3	12.3	87.5	12.0	11.0	10.1	9.3
9.8	10.6	11.5	12.4	88.0	12.1	11.1	10.2	9.4
9.9	10.7	11.6	12.5	88.5	12.3	11.2	10.3	9.5
10.0	10.8	11.7	12.6	89.0	12.4	11.4	10.4	9.6
10.1	10.9	11.8	12.8	89.5	12.5	11.5	10.5	9.7
10.2	11.0	11.9	12.9	90.0	12.6	11.6	10.6	9.8
10.3	11.1	12.0	13.0	90.5	12.8	11.7	10.7	9.9
10.4	11.2	12.1	13.1	91.0	12.9	11.8	10.9	10.0
10.5	11.3	12.2	13.2	91.5	13.0	11.9	11.0	10.1
10.6	11.4	12.3	13.4	92.0	13.1	12.0	11.1	10.2
10.7	11.5	12.4	13.5	92.5	13.3	12.1	11.2	10.3
10.8	11.6	12.6	13.6	93.0	13.4	12.3	11.3	10.4
10.9	11.7	12.7	13.7	93.5	13.5	12.4	11.4	10.5
11.0	11.8	12.8	13.8	94.0	13.6	12.5	11.5	10.6
11.1	11.9	12.9	13.9	94.5	13.8	12.6	11.6	10.7
11.1	12.0	13.0	14.1	95.0	13.9	12.7	11.7	10.8

Weight for height tables for children from 2-5 years old (WHO, 2006)

Weight-for-height

95.5- 110.5cm Standing up

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
11.2	12.1	13.1	14.2	95.5	14.0	12.8	11.8	10.8
11.3	12.2	13.2	14.3	96.0	14.1	12.9	11.9	10.9
11.4	12.3	13.3	14.4	96.5	14.3	13.1	12.0	11.0
11.5	12.4	13.4	14.6	97.0	14.4	13.2	12.1	11.1
11.6	12.5	13.6	14.7	97.5	14.5	13.3	12.2	11.2
11.7	12.6	13.7	14.8	98.0	14.7	13.4	12.3	11.3
11.8	12.8	13.8	14.9	98.5	14.8	13.5	12.4	11.4
11.9	12.9	13.9	15.1	99.0	14.9	13.7	12.5	11.5
12.0	13.0	14.0	15.2	99.5	15.1	13.8	12.7	11.6
12.1	13.1	14.2	15.4	100.0	15.2	13.9	12.8	11.7
12.2	13.2	14.3	15.5	100.5	15.4	14.1	12.9	11.9
12.3	13.3	14.4	15.6	101.0	15.5	14.2	13.0	12.0
12.4	13.4	14.5	15.8	101.5	15.7	14.3	13.1	12.1
12.5	13.6	14.7	15.9	102.0	15.8	14.5	13.3	12.2
12.6	13.7	14.8	16.1	102.5	16.0	14.6	13.4	12.3
12.8	13.8	14.9	16.2	103.0	16.1	14.7	13.5	12.4
12.9	13.9	15.1	16.4	103.5	16.3	14.9	13.6	12.5
13.0	14.0	15.2	16.5	104.0	16.4	15.0	13.8	12.6
13.1	14.2	15.4	16.7	104.5	16.6	15.2	13.9	12.8
13.2	14.3	15.5	16.8	105.0	16.8	15.3	14.0	12.9
13.3	14.4	15.6	17.0	105.5	16.9	15.5	14.2	13.0
13.4	14.5	15.8	17.2	106.0	17.1	15.6	14.3	13.1
13.5	14.7	15.9	17.3	106.5	17.3	15.8	14.5	13.3
13.7	14.8	16.1	17.5	107.0	17.5	15.9	14.6	13.4
13.8	14.9	16.2	17.7	107.5	17.7	16.1	14.7	13.5
13.9	15.1	16.4	17.8	108.0	17.8	16.3	14.9	13.7
14.0	15.2	16.5	18.0	108.5	18.0	16.4	15.0	13.8
14.1	15.3	16.7	18.2	109.0	18.2	16.6	15.2	13.9
14.3	15.5	16.8	18.3	109.5	18.4	16.8	15.4	14.1
14.4	15.6	17.0	18.5	110.0	18.6	17.0	15.5	14.2
14.5	15.8	17.1	18.7	110.5	18.8	17.1	15.7	14.4

Weight for height tables for children from 2-5 years old (WHO, 2006)



Ministry of Health

Weight-for-height

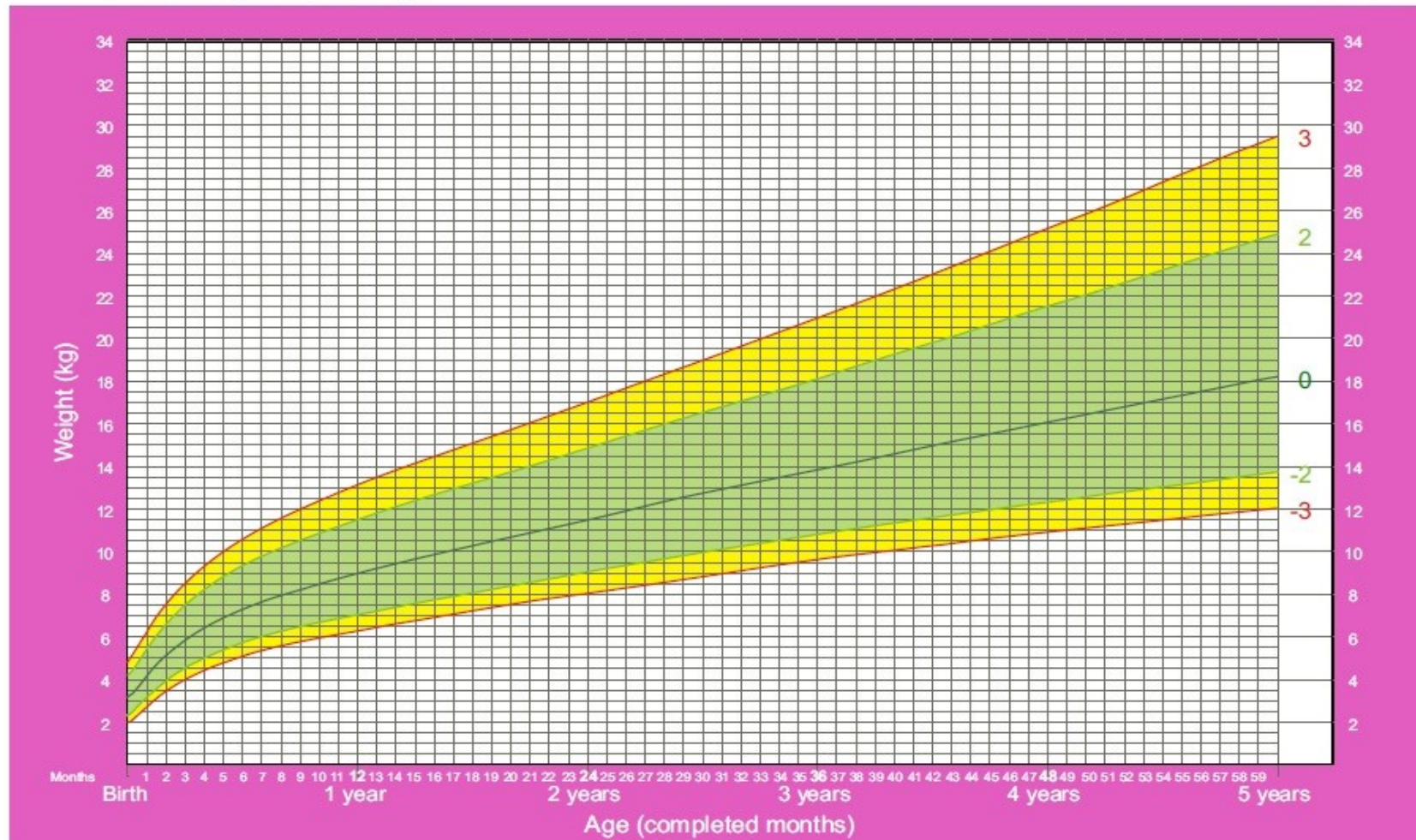
111.0 - 120.0 cm Standing up

BOYS				Height	GIRLS			
-3 Z	-2 Z	-1 Z	Median	cm	Median	-1 Z	-2 Z	-3 Z
14.6	15.9	17.3	18.9	111.0	18.9	17.3	15.9	14.6
14.8	16.0	17.5	19.1	111.5	19.1	17.5	16.0	14.8
14.9	16.2	17.6	19.2	112.0	19.2	17.6	16.2	14.9
15.0	16.3	17.8	19.4	112.5	19.4	17.8	16.3	15.0
15.2	16.5	18.0	19.6	113.0	19.6	18.0	16.5	15.2
15.3	16.6	18.1	19.8	113.5	19.8	18.1	16.6	15.3
15.4	16.8	18.3	20.0	114.0	20.0	18.3	16.8	15.4
15.6	16.9	18.5	20.2	114.5	20.2	18.5	16.9	15.6
15.7	17.1	18.6	20.4	115.0	20.4	18.6	17.1	15.7
15.8	17.2	18.8	20.6	115.5	20.6	18.8	17.2	15.8
16.0	17.4	19.0	20.8	116.0	20.8	19.0	17.4	16.0
16.1	17.5	19.2	21.0	116.5	21.0	19.2	17.5	16.1
16.2	17.7	19.3	21.2	117.0	21.2	19.3	17.7	16.2
16.4	17.9	19.5	21.4	117.5	21.4	19.5	17.9	16.4
16.5	18.0	19.7	21.6	118.0	21.6	19.7	18.0	16.5
16.7	18.2	19.9	21.8	118.5	21.8	19.9	18.2	16.7
16.8	18.3	20.0	22.0	119.0	22.0	20.0	18.3	16.8
16.9	18.5	20.2	22.2	119.5	22.2	20.2	18.5	16.9
17.1	18.6	20.4	22.4	120.0	22.4	20.4	18.6	17.1

GROWTH CHARTS FOR GIRLS

Weight-for-age GIRLS

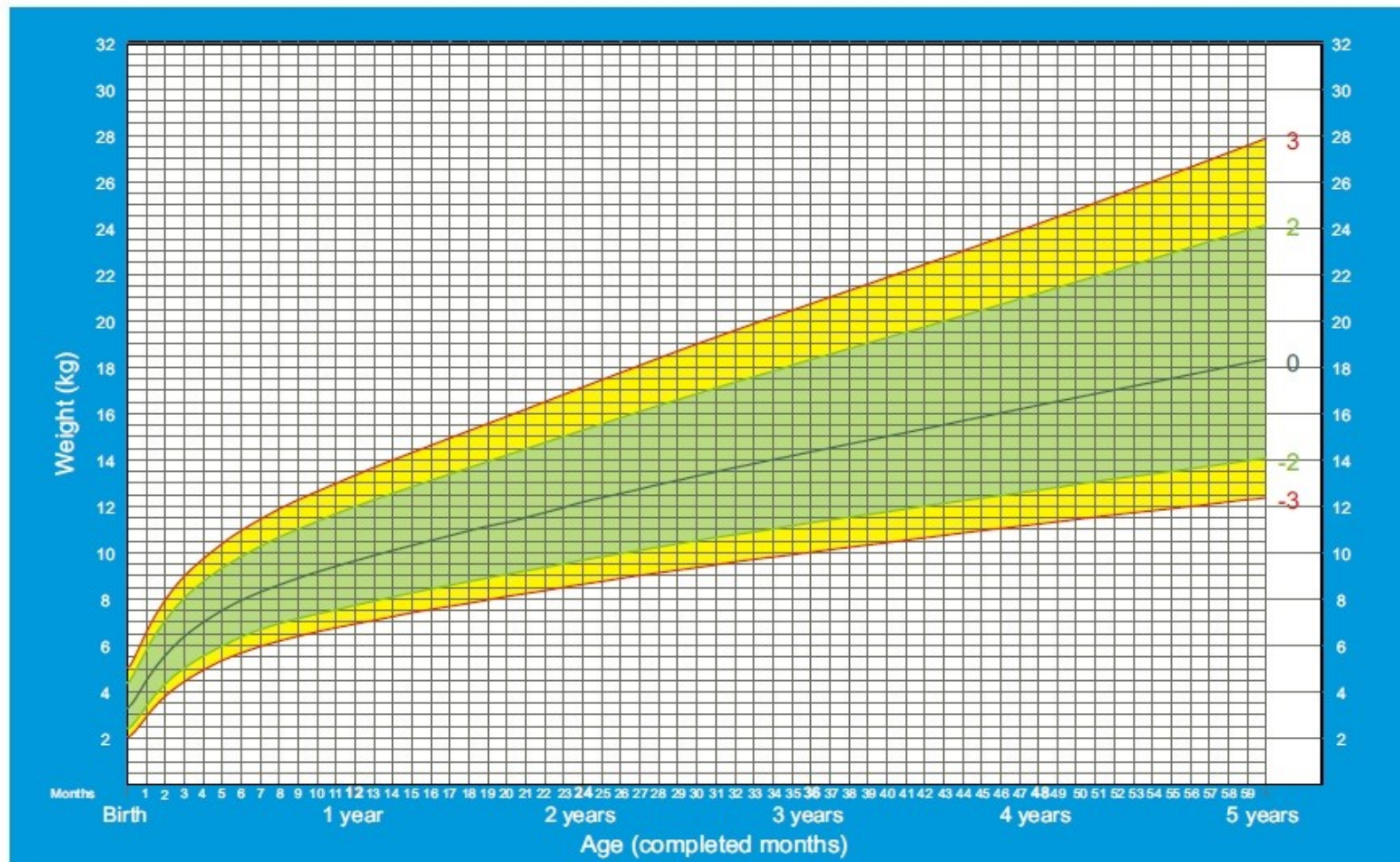
Birth to 5 years (z-scores)



GROWTH CHARTS FOR BOYS

Weight-for-age BOYS

Birth to 5 years (z-scores)



WHEN TO RETURN IMMEDIATELY

BRING ANY SICK CHILD IF



- Not able to drink or breastfeed



- Becomes sicker



- Develops fever

BRING CHILD WITH COUGH IF

- Fast breathing



- Difficult breathing



BRING CHILD WITH DIARRHOEA IF



- Blood in stool



- Drinking poorly

BRING YOUNG INFANT TO CLINIC IF ANY OF ABOVE SIGNS OR



- Breastfeeding poorly



- Feels unusually cold



- Palms and soles appear yellow

GIVE GOOD HOME CARE FOR YOUR CHILD

FOR ANY SICK CHILD :

- If child is breastfed, breastfeed more frequently and for longer at each feed.
- If child is taking breastmilk substitutes, increase the amount of milk given
- Increase other fluids. You may give soup, rice water, yoghurt drinks or clean water. Give these fluids as much as the child will take. Give frequent small sips from a cup.
- If the child vomits, wait 10 minutes then continue – but more slowly



EXCLUSIVELY BREASTFEED THE YOUNG INFANT

- Give only breastfeeds to the young infant
- Breastfeed frequently, as often and for as long as the infant wants



MAKE SURE THAT THE YOUNG INFANT IS KEPT WARM AT ALL TIMES

- In cool weather cover the infant's head and feet and dress the infant with extra clothing



FOR CHILD WITH DIARRHOEA:

- Breastfeed frequently and for longer at each feed
- Give fluids:
 - ☐ ORS
 - ☐ Food based fluids, such as soup, rice water, yogurt drinks
 - ☐ Clean water
- Give zinc supplement, if the child aged more than 2 months and if zinc is given
- Continue giving extra fluid until the diarrhoea stops

PRINCIPLES OF THE INTEGRATED CLINICAL CASE MANAGEMENT

IMCI clinical guidelines are based on the following principles:

- ① **Examining all sick children aged up to five years** of age for **general danger signs** and all young infants for signs of **very severe disease**. These signs indicate severe illness and the need for immediate referral or admission to hospital.
- ② The children and infants are then **assessed for main symptoms**:
 - ◆ In older children the main symptoms include:
 - Cough or difficulty breathing,
 - Diarrhoea,
 - Fever, and
 - Ear infection.
 - ◆ In young infants, the main symptoms include:
 - Local bacterial infection,
 - Diarrhoea, and
 - Jaundice.
- ③ Then in addition, all sick children are **routinely checked** for:
 - Nutritional and immunization status,
 - HIV status in high HIV settings, and
 - Other potential problems.

- ④ Only a **limited number of clinical signs** are used, selected on the basis of their sensitivity and specificity to detect disease through classification.

A combination of individual signs leads to a **child's classification** within one or more symptom groups rather than a diagnosis. The classification of illness is based on a colour-coded triage system:

- ◆ **"PINK"** indicates urgent hospital referral or admission,
- ◆ **"YELLOW"** indicates initiation of specific outpatient treatment,
- ◆ **"GREEN"** indicates supportive home care.

- ⑤ IMCI management procedures use **a limited number of essential drugs** and encourage active participation of caregivers in the treatment of their children.
- ⑥ An essential component of IMCI is the **counselling of caregivers** regarding home care:
 - ◆ Appropriate feeding and fluids,
 - ◆ When to return to the clinic immediately, and
 - ◆ When to return for follow-up