Integrated Management of Newborn and Childhood Illnesses (IMNCI)
This primary IMNCI protocol was developed based on the World Health Organization (WHO) Integrated Management of Childhood Illness: Chart Booklet 2014 and fully adapted for the needs of the primary healthcare system of DPR Korea. The adapted protocol is a joint product of the Ministry of Public Health (MoPH), United Nations Children’s Fund (UNICEF), World Health Organization (WHO) and the United Nations Population Fund (UNFPA) in Democratic People’s Republic of Korea.

UNICEF, WHO and UNFPA IMNCI team in DPR Korea:

<table>
<thead>
<tr>
<th>UNICEF</th>
<th>WHO</th>
<th>UNFPA</th>
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<tbody>
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<tr>
<td>Health Officer</td>
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</tbody>
</table>

MoPH team of experts:

<table>
<thead>
<tr>
<th>Dr. Choe Suk Hyon</th>
<th>Focal Point for UNICEF, MoPH</th>
</tr>
</thead>
<tbody>
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<td>IMNCI Project Manager</td>
</tr>
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</tbody>
</table>

The Protocol was developed and printed with the technical and financial support of UNICEF in DPR Korea and GAVI.

Graphic design and layout: Jesús Alés (www.sputnix.es)
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TREAT THE YOUNG INFANT

- Give first dose of intramuscular antibiotics
- Treat the young infant to prevent low blood sugar
- Teach the mother how to keep the young infant warm on the way to the hospital
- Give an appropriate oral antibiotic for local bacterial infection
- Teach the mother to treat local infections at home
- Give follow-up care for acute conditions
- When to return

FOLLOW UP

- Give follow-up care for the young infant
- Feeding counselling
- Supplementary feeding
- Counsel the mother
- Counsel the mother
- Extra fluids and mother's health

IDENTIFY SKIN PROBLEM

- If skin is itching
- If skin has blisters / sores / pustules
- If skin is non-itchy
- Drug and allergic reactions

SEXUAL AND REPRODUCTIVE HEALTH MESSAGES

- Message for prevention of STI
- Preparing for childbirth
- Danger signs during delivery/childbirth
- Principles of the integrated clinical case management
Foreword

To: Ms. Oyunsaihan Dendevnoro,
   UNICEF Representative, DPR Korea

Subject: Approval of Protocol on Integrated Management of Newborn and Childhood Illnesses (IMNCI)

Dear Ms. Oyunsaihan Dendevnoro,

Acknowledging the efforts of UNICEF in developing the protocol on IMNCI in active collaboration with WHO and UNFPA, the Ministry of Public Health approves the developed protocol with acknowledgment of its technical value and contents.

We hope that this protocol is utilized fully by the health professionals, pediatricians and household doctors as training material and practical guideline in implementing IMNCI program in the country.

Thank you for your usual cooperation and best regards.

Dr. Pak Jong Min,
Director, Department of External Affairs
Ministry of Public Health, DPR Korea
Sick child

age

2 months

up to 5 years
**ASSESS AND CLASSIFY THE SICK CHILD**

### ASSESS

**ASK** THE MOTHER WHAT THE CHILD’S PROBLEMS ARE

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

### CLASSIFY

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

### IDENTIFY TREATMENT

**CHECK FOR GENERAL DANGER SIGNS**

<table>
<thead>
<tr>
<th>Ask:</th>
<th>Look:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the child able to drink or breastfeed?</td>
<td>• See if the child is lethargic or unconscious.</td>
</tr>
<tr>
<td>• Does the child vomit everything?</td>
<td>• Is the child convulsing now?</td>
</tr>
<tr>
<td>• Has the child had convulsions?</td>
<td></td>
</tr>
</tbody>
</table>

**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?

<table>
<thead>
<tr>
<th>Look, listen, feel*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count the breaths in one minute.</td>
</tr>
<tr>
<td>Look for chest indrawing.</td>
</tr>
<tr>
<td>Look and listen for stridor</td>
</tr>
<tr>
<td>Look and listen for wheezing.</td>
</tr>
</tbody>
</table>

**CHILD MUST BE CALM**

<table>
<thead>
<tr>
<th>Classify COUGH or DIFFICULT BREATHING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pink: Any general danger sign or Stridor in calm child.</td>
</tr>
<tr>
<td>Green: Cough or Cold</td>
</tr>
<tr>
<td>Yellow: Pneumonia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest indrawing or Fast breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give oral Amoxicillin for 5 days***</td>
</tr>
<tr>
<td>If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****</td>
</tr>
<tr>
<td>If chest indrawing in HIV exposed/infected child, give first dose of amoxicillin and refer.</td>
</tr>
<tr>
<td>Advise mother when to return immediately</td>
</tr>
<tr>
<td>Follow-up in 3 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fast breathing is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 breaths per minute or more</td>
</tr>
<tr>
<td>40 breaths per minute or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No signs of pneumonia or very severe disease.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give oral Amoxicillin for 5 days***</td>
</tr>
<tr>
<td>If wheezing (or disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days****</td>
</tr>
<tr>
<td>Soothe the throat and relieve the cough with a safe remedy</td>
</tr>
<tr>
<td>If coughing for more than 14 days or recurrent wheeze, refer for possible TB or asthma assessment</td>
</tr>
<tr>
<td>Advise mother when to return immediately</td>
</tr>
<tr>
<td>Follow-up in 5 days if not improving</td>
</tr>
</tbody>
</table>

* 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, listen, 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?

**Pink: SEVERE DEHYDRATION**
- Two of the following signs:
  - Lethargic or unconscious
  - Sunken eyes
  - Not able to drink or drinking poorly
  - Skin pinch goes back very slowly.
- 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

**Yellow: SOME DEHYDRATION**
- Two of the following signs:
  - Restless, irritable
  - Sunken eyes
  - Drinks eagerly, thirsty
  - Skin pinch goes back slowly.
- 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

**Green: NO DEHYDRATION**
- Not enough signs to classify as some or severe dehydration.
- Give fluid, zinc supplements, and food to treat diarrhoea at home (Plan A)
- Advise mother when to return immediately
- Follow-up in 5 days if not improving

### Dehydration present.
- Dehydration present.

**Pink: SEVERE PERSISTENT DIARRHOEA**
- Two of the following signs:
  - Restless, irritable
  - Sunken eyes
  - Drinks eagerly, thirsty
  - Skin pinch goes back slowly.
- Treat dehydration before referral unless the child has another severe classification
- Refer to hospital

**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

### Blood in the stool.
- Blood in the stool.

**Yellow: DYSENTERY**
- Give ciprofloxacin for 3 days
- Follow-up in 3 days
### Assess and Classify the Sick Child

**Does the child have fever?**
(by history or feels hot or temperature 37.5°C* or above)

<table>
<thead>
<tr>
<th>If yes, ask:</th>
<th>High or low malaria risk</th>
<th>Look, listen, feel*:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Decide malaria risk: high or low</td>
<td><strong>Any general danger signs or</strong></td>
<td><strong>Pink:</strong></td>
<td><strong>Suspect malaria</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Stiff neck</strong></td>
<td><strong>Very severe febrile disease</strong></td>
<td><strong>Give first dose of an appropriate antibiotic</strong></td>
</tr>
<tr>
<td>Then ask:</td>
<td><strong>Pink:</strong></td>
<td></td>
<td><strong>Treat the child to prevent low blood sugar</strong></td>
</tr>
<tr>
<td>For how long?</td>
<td><strong>Suspected malaria</strong></td>
<td></td>
<td><strong>Give one dose of the appropriate NSAID</strong>* in the clinic for high fever (38.5°C or above)**</td>
</tr>
<tr>
<td>• If more than 7 days, has fever been present every day?</td>
<td><strong>Pink:</strong></td>
<td></td>
<td><strong>Refer URGENTLY to hospital</strong></td>
</tr>
<tr>
<td>• Has the child had measles within the last 3 months?</td>
<td><strong>Clear cause of fever present</strong></td>
<td><strong>Green:</strong></td>
<td><strong>Give one dose of the appropriate NSAID</strong>* in clinic for high fever (38.5°C or above)**</td>
</tr>
<tr>
<td></td>
<td><strong>Suspected malaria</strong></td>
<td><strong>Fever: no malaria</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Advise mother when to return immediately</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Follow up in 3 days if fever persists</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>If fever is present every day for more than 7 days, refer for assessment</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No general danger sign</strong></td>
<td><strong>Pink:</strong></td>
<td><strong>Give one dose of NSAID</strong>* in clinic for high fever (38.5°C or above)**</td>
</tr>
<tr>
<td>No malaria risk and no travel to malaria risk area</td>
<td><strong>Stiff neck</strong></td>
<td><strong>Fever: no malaria</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>No general danger sign</strong></td>
<td><strong>Pink:</strong></td>
<td><strong>Give first dose of an appropriate antibiotic</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No stiff neck</strong></td>
<td><strong>Very severe febrile disease</strong></td>
<td><strong>Treat the child to prevent low blood sugar</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Give one dose of NSAID</strong>* in clinic for high fever (38.5°C or above)**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Refer URGENTLY to hospital</strong></td>
</tr>
</tbody>
</table>

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* 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.

*** NSAID: Non-Steroid Anti-Inflammatory Drug (example: paracetamol, ibuprofen)
Does the child have an ear problem?

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

### Look, listen, feel:
- Look for pus draining from the ear.
- Feel for tender swelling behind the ear.

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

<table>
<thead>
<tr>
<th>CHECK FOR ACUTE MALNUTRITION</th>
<th>LOOK AND FEEL</th>
<th>Classify NUTRITIONAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOOK AND FEEL</strong></td>
<td>Look for signs of acute malnutrition</td>
<td><strong>Pink:</strong> SEVERE PNEUMONIA OR VERY SEVERE DISEASE</td>
</tr>
</tbody>
</table>
| | • Look for oedema of both feet. | • Give first dose of an appropriate antibiotic  
| | • Determine WFH/L\(^*\) ______ z-score. | • Refer URGENTLY to hospital**  
| | • 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 | **Yellow:** UNCOMPROMISED SEVERE ACUTE MALNUTRITION |
| | » Any severe classification | • Give oral antibiotics for 5 days  
| | » Pneumonia with chest indrawing | • Give RUTF for a child aged 6 months or more  
| | • If no medical complications present:  
| | » Child is 6 months or older, offer RUTF*** to eat. Is the child:  
| | » Not able to finish RUTF portion? | • Counsel the mother on how to feed the child.  
| | » Able to finish RUTF portion?  
| | » If child is less than 6 months, assess breastfeeding: | • Assess for possible TB infection  
| | Does the child have a breastfeeding problem? | • Advise mother when to return immediately  
| **Oedema of both feet** | |  
| **WFH/L less than -3 z-scores** | |  
| **OR** | |  
| **MUAC less than 115 mm** | |  
| **AND any one of the following:** | |  
| » Medical complication present | |  
| » Not able to finish RUTF | |  
| » Breastfeeding problem. | |  
| **Yellow:** MODERATE ACUTE MALNUTRITION | |  
| **WFH/L between -3 and -2 z-scores** | |  
| **OR** | |  
| **MUAC 115 up to 125 mm.** | |  
| **Green:** NO ACUTE MALNUTRITION | |  
| **WFH/L - 2 z-scores or more** | |  
| **OR** | |  
| **MUAC 125 mm or more.** | |  |

* 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 an appetite test and feeding children with severe acute malnutrition.
Check for anaemia

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

Classify ANAEMIA Classification arrow

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

* 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 THE CHILD’S IMMUNIZATION, VITAMIN A AND DEWORMING STATUS**

<table>
<thead>
<tr>
<th>Immunization schedule:</th>
<th>Vaccine</th>
<th>1st dose</th>
<th>2nd dose</th>
<th>3rd dose</th>
<th>Vitamin A supplementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>Birth</td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bOPV</td>
<td>6 weeks</td>
<td>10 weeks</td>
<td>14 weeks</td>
<td></td>
<td>Routine worm treatment</td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Give every child a deworming drug (mebendazole/albendazole) from the age of 1 year. Record the dose on the child’s card.</td>
</tr>
<tr>
<td>DTP-Hib-HepB (PENTA)</td>
<td>6 weeks</td>
<td>10 weeks</td>
<td>14 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>9 months</td>
<td>15 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vitamin A 100,000 IU for children 6 months to 1 year
Vitamin A 200,000 IU for children 12 to 59 months
Deworming tablet for children 12 to 59 months (Mebendazole: 500mg; Albendazole 400 mg)

Assess other problems

Make sure child with any general danger sign is referred after the first dose of an appropriate antibiotic and other urgent treatment. Treat all children with a general danger sign to prevent low blood sugar.

**Please do not forget to inform a mother about:**

1. Importance of the vaccination
2. The diseases that the vaccines prevent
3. Expected or potential adverse events,
4. What to do if there will be any adverse event

Please ensure that a mother understood you well.
Sick young infant age up to 2 months
ASSESS AND CLASSIFY THE SICK CHILD

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
# Assess and Classify the Sick Child

## Sick Young Infant Age up to 2 Months

### Check for Very Severe Disease 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?

### Classify all young infants

#### Pink: Very Severe Disease
- Not feeding well or
- Convulsions or
- Fast breathing (60 breaths per minute or more) or
- Severe chest indrawing or
- Fever (37.5°C* or above) or
- Low body temperature (less than 35.5°C) or
- Movement only when stimulated or no movement at all.

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

#### Yellow: Local Bacterial Infection
- Umbilicus red or draining pus
- Skin pustules

- Give an appropriate oral antibiotic
- Teach the mother to treat local infections at home
- Advise mother to give home care for the young infant
- Follow up in 2 days

#### Green: Severe Disease or Local Infection Unlikely
- None of the signs of very severe disease or local bacterial infection

- 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, manage 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**

<table>
<thead>
<tr>
<th>Jaundice</th>
<th>Pink: SEVERE JAUNDICE</th>
<th>Yellow: JAUNDICE</th>
<th>Green: NO JAUNDICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any jaundice if age less than 24 hours or Yellow palms and soles at any age</td>
<td>Treat to prevent low blood sugar</td>
<td>Advise the mother to give home care for the young infant</td>
<td>Advise the mother to give home care for the young infant</td>
</tr>
<tr>
<td>Jaundice appearing after 24 hours of age and Palms and soles not yellow</td>
<td>Refer URGENTLY to hospital</td>
<td>Advise mother to return immediately if palms and soles appear yellow.</td>
<td>Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way</td>
</tr>
<tr>
<td>No jaundice</td>
<td>Advise mother how to keep the infant warm on the way to the hospital</td>
<td>If the young infant is older than 14 days, refer to a hospital for assessment</td>
<td>Advise mother how to keep the infant warm on the way to the hospital</td>
</tr>
</tbody>
</table>

**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 move when stimulated but then stops?
    » 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**

<table>
<thead>
<tr>
<th>Two of the following signs: Movement only when stimulated or no movement at all Sunken eyes Skin pinch goes back very slowly</th>
<th>Pink: SEVERE DEHYDRATION</th>
<th>Yellow: SOME DEHYDRATION</th>
<th>Green: NO DEHYDRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>If infant has no other severe classification:</td>
<td>Give fluid for severe dehydration (Plan C)</td>
<td>Give fluid and breast milk for some dehydration (Plan B)</td>
<td>Give fluids to treat diarrhoea at home and continue breastfeeding (Plan A)</td>
</tr>
<tr>
<td><em>If infant also has another severe classification:</em></td>
<td>OR</td>
<td>If infant has any severe classification:</td>
<td>OR</td>
</tr>
<tr>
<td>RefeR URGENTLY to hospital with mother giving frequent sips of ORS on the way</td>
<td>Advise the mother to continue breastfeeding</td>
<td>Advise the mother to continue breastfeeding</td>
<td>Advise the mother to continue breastfeeding</td>
</tr>
<tr>
<td>Advise the mother when to return immediately</td>
<td>Follow-up in 2 days if not improving</td>
<td>Follow-up in 2 days if not improving</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Two of the following signs: Restless and irritable Sunken eyes Skin pinch goes back slowly.</th>
<th>Yellow: SOME DEHYDRATION</th>
<th>Green: NO DEHYDRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give fluid and breast milk for some dehydration (Plan B)</td>
<td>Give fluids to treat diarrhoea at home and continue breastfeeding (Plan A)</td>
<td></td>
</tr>
<tr>
<td>If infant has any severe classification:</td>
<td>Advise the mother to return immediately</td>
<td></td>
</tr>
</tbody>
</table>

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

---

*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 FEEDING PROBLEM OR LOW WEIGHT FOR AGE**

<table>
<thead>
<tr>
<th><strong>Ask:</strong></th>
<th><strong>Look, listen, feel:</strong></th>
<th><strong>Classify FEEDING</strong></th>
</tr>
</thead>
</table>
| • 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? | • Determine weight for age.  
• Look for ulcers or white patches in the mouth (thrush). | **Yellow:**  
**FEEDING PROBLEM OR LOW WEIGHT**  
• Not well attached to breast or  
• Not suckling effectively or  
• Less than 8 breastfeeds in 24 hours or  
• Receives other foods or drinks or  
• Low weight for age or  
• Thrush (ulcers or white patches in mouth). |
| **Green:**  
**NO FEEDING PROBLEM**  
• Not low weight for age and no other signs of inadequate feeding. | **Classify FEEDING**  
• 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.
## Assess and Classify the Sick Child

### 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

<table>
<thead>
<tr>
<th>Yellow: Feeding Problem or Low Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk incorrectly or unhygienically prepared or</td>
</tr>
<tr>
<td>Giving inappropriate replacement feeds or</td>
</tr>
<tr>
<td>Giving insufficient replacement feeds or</td>
</tr>
<tr>
<td>An HIV positive mother mixing breast and other feeds before 6 months or</td>
</tr>
<tr>
<td>Using a feeding bottle or</td>
</tr>
<tr>
<td>Low weight for age or</td>
</tr>
<tr>
<td>Thrush (ulcers or white patches in mouth).</td>
</tr>
<tr>
<td>• Counsel about feeding</td>
</tr>
<tr>
<td>• Explain the guidelines for safe replacement feeding</td>
</tr>
<tr>
<td>• Identify concerns of mother and family about feeding.</td>
</tr>
<tr>
<td>• If mother is using a bottle, teach cup feeding</td>
</tr>
<tr>
<td>• Advise the mother how to feed and keep the low weight infant warm at home</td>
</tr>
<tr>
<td>• If thrush, teach the mother to treat thrush at home</td>
</tr>
<tr>
<td>• Advise mother to give home care for the young infant</td>
</tr>
<tr>
<td>• Follow-up any feeding problem or thrush in 2 days</td>
</tr>
<tr>
<td>• Follow-up low weight for age in 14 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Green: No Feeding Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not low weight for age and no other signs of inadequate feeding.</td>
</tr>
<tr>
<td>• Advise mother to give home care for the young infant</td>
</tr>
<tr>
<td>• Praise the mother for feeding the infant well</td>
</tr>
</tbody>
</table>

### WHEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN NON-BREASTFEEDING INFANTS
THEN CHECK THE YOUNG INFANTS’ IMMUNIZATION AND VITAMIN-A STATUS

Please refer to “THEN CHECK THE CHILD’S IMMUNIZATION, VITAMIN A AND DEWORMING STATUS” in the chapter above.

In addition:
- 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 (refer to the SRH module of the protocol)
Nutritional status and anemia, conception (SRH). Check hygienic practices.
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, ACUTE EAR INFECTION:
FIRST-LINE ANTIBIOTIC: Oral Amoxicillin

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>AMOXICILLIN*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give two times daily for 5 days</td>
</tr>
<tr>
<td>TABLET</td>
<td>SYRUP</td>
</tr>
<tr>
<td>250 mg</td>
<td>250mg/5 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>AMOXICILLIN*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months up to 12 months (4 - &lt;10 kg)</td>
<td>1</td>
</tr>
<tr>
<td>12 months up to 3 years (10 - &lt;14 kg)</td>
<td>2</td>
</tr>
<tr>
<td>3 years up to 5 years (14-19 kg)</td>
<td>3</td>
</tr>
</tbody>
</table>

Amoxicillin is the recommended first-line drug of choice in the treatment of pneumonia due to its efficacy and increasing high resistance to cotrimoxazole.

FOR DYSENTERY give Ciprofloxacin
FIRST-LINE ANTIBIOTIC: Oral Ciprofloxacin

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>CIPROFLOXACINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give 15mg/kg two times daily for 3 days</td>
</tr>
<tr>
<td>TABLET</td>
<td></td>
</tr>
<tr>
<td>tablet 250 mg</td>
<td>tablet 500 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>CIPROFLOXACINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months up to 12 months (4 - &lt;10 kg)</td>
<td>1/2</td>
</tr>
<tr>
<td>12 months up to 3 years (10 - &lt;14 kg)</td>
<td>1</td>
</tr>
</tbody>
</table>

FOR CHOLERA:

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>ERYTHROMYCIN</th>
<th>TETRACYCLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Give four times daily for 3 days</td>
<td>Give four times daily for 3 days</td>
</tr>
<tr>
<td>TABLET</td>
<td>TABLET</td>
<td></td>
</tr>
<tr>
<td>250 mg</td>
<td>250 mg</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>ERYTHROMYCIN</th>
<th>TETRACYCLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years up to 5 years (10 - 19 kg)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
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 instruction 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 (100μg/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 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**

<table>
<thead>
<tr>
<th>WEIGHT</th>
<th>&lt; 6 kg</th>
<th>6 - &lt;10 kg</th>
<th>10 - &lt;12 kg</th>
<th>12 - 19 kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 4 months</td>
<td>200 - 450</td>
<td>450 - 800</td>
<td>800 - 960</td>
<td>960 - 1600</td>
</tr>
<tr>
<td>4 months up to 12 months</td>
<td>200 - 450</td>
<td>450 - 800</td>
<td>800 - 960</td>
<td>960 - 1600</td>
</tr>
<tr>
<td>12 months up to 2 years</td>
<td>200 - 450</td>
<td>450 - 800</td>
<td>800 - 960</td>
<td>960 - 1600</td>
</tr>
<tr>
<td>2 years up to 5 years</td>
<td>200 - 450</td>
<td>450 - 800</td>
<td>800 - 960</td>
<td>960 - 1600</td>
</tr>
</tbody>
</table>

* 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

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

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:

<table>
<thead>
<tr>
<th>AGE</th>
<th>First give 30 ml/kg in:</th>
<th>Then give 70 ml/kg in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (under 12 months)</td>
<td>1 hour*</td>
<td>5 hours</td>
</tr>
<tr>
<td>Children (12 months up to 5 years)</td>
<td>30 minutes*</td>
<td>2 1/2 hours</td>
</tr>
</tbody>
</table>

* 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.

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.

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.
TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME
Follow the instructions listed with each drug’s dosage table.

**Give Iron***
Give one dose daily for 14 days.

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>IRON/FOLATE TABLELET</th>
<th>IRON SYRUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months up to 4 months (4 – &lt;6 kg)</td>
<td>Ferrous sulphate PJ–J Folate (60 mg elemental iron)</td>
<td>1.00 ml (&lt; 1/4 tsp.)</td>
</tr>
<tr>
<td>4 months up to 12 months (6 – &lt;10 kg)</td>
<td>Ferrous fumarate 100 mg per 5 ml (20 mg elemental iron per ml)</td>
<td>1.25 ml (1/4 tsp.)</td>
</tr>
<tr>
<td>12 months up to 3 years (10 – &lt;14 kg)</td>
<td>1/2 tablet</td>
<td>2.00 ml (&lt;1/2 tsp.)</td>
</tr>
<tr>
<td>3 years up to 5 years (14 – 19 kg)</td>
<td>1/2 tablet</td>
<td>2.5 ml (1/2 tsp.)</td>
</tr>
</tbody>
</table>

* 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 mother’s 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.
  » Instil 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

- Wash hands.
  » Wash a clean soft cloth and use it to wash the child’s mouth.
  » Instil nystatin 1 ml four times a day.
  » Avoid feeding for 20 minutes after medication.
  » If breastfed check mother’s breast 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.

<table>
<thead>
<tr>
<th>AGE</th>
<th>VITAMIN A DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 up to 12 months</td>
<td>100 000 IU</td>
</tr>
<tr>
<td>One year and older</td>
<td>200 000 IU</td>
</tr>
</tbody>
</table>

**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.
TREAT THE CHILD / CARRY OUT THE TREATMENT STEPS IDENTIFIED ON THE ASSESS AND CLASSIFY CHART

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 Ampicillin (50 mg/kg) and Gentamicin (7.5 mg/kg).

AMPICILLIN
- Dilute 500mg vial with 2.1ml of sterile water (500mg/2.5ml).
- If REFERRAL IS NOT POSSIBLE OR DELAYED, repeat the ampicillin injection every 6 hours.
- Where there is a strong suspicion of meningitis, the dose of ampicillin can be increased 4 times.

GENTAMICIN
- 7.5 mg/kg/day once daily

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

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>AMPICILLIN 500 mg vial</th>
<th>GENTAMICIN 2ml/40 mg/ml vial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 up to 4 months (4 - &lt;6 kg)</td>
<td>1 ml</td>
<td>0.5-1.0 ml</td>
</tr>
<tr>
<td>4 up to 12 months (6 - &lt;10 kg)</td>
<td>2 ml</td>
<td>1.1-1.8 ml</td>
</tr>
<tr>
<td>12 months up to 3 years (10 - &lt;14 kg)</td>
<td>3 ml</td>
<td>1.9-2.7 ml</td>
</tr>
<tr>
<td>3 years up to 5 years (14-19 kg)</td>
<td>5 ml</td>
<td>2.8-3.5 ml</td>
</tr>
</tbody>
</table>

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.
Treat the young infant
### GIVE FIRST DOSE OF INTRAMUSCULAR ANTIBIOTICS

- Give first dose of both ampicillin and gentamicin intramuscularly.

<table>
<thead>
<tr>
<th>WEIGHT</th>
<th>AMPICILLIN</th>
<th>GENTAMICIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose: 50 mg per kg To a vial of 250 mg</td>
<td>Undiluted 2 ml vial containing 20 mg = 2 ml at 10 mg/ml OR Add 6 ml sterile water to 2 ml vial containing 80 mg* = 8 ml at 10 mg/ml</td>
</tr>
<tr>
<td></td>
<td>Add 1.3 ml sterile water = 250 mg/1.5ml</td>
<td>AGE &lt;7 days Dose: 5 mg per kg</td>
</tr>
<tr>
<td>1-&lt;1.5 kg</td>
<td>0.4 ml</td>
<td>0.6 ml*</td>
</tr>
<tr>
<td>1.5-&lt;2 kg</td>
<td>0.5 ml</td>
<td>0.9 ml*</td>
</tr>
<tr>
<td>2-&lt;2.5 kg</td>
<td>0.7 ml</td>
<td>1.1 ml*</td>
</tr>
<tr>
<td>2.5-&lt;3 kg</td>
<td>0.8 ml</td>
<td>1.4 ml*</td>
</tr>
<tr>
<td>3-&lt;3.5 kg</td>
<td>1.0 ml</td>
<td>1.6 ml*</td>
</tr>
<tr>
<td>3.5-&lt;4 kg</td>
<td>1.1 ml</td>
<td>1.9 ml*</td>
</tr>
<tr>
<td>4-&lt;4.5 kg</td>
<td>1.3 ml</td>
<td>2.1 ml*</td>
</tr>
</tbody>
</table>

Avoid using undiluted 40 mg/ml gentamicin.

- Referral is the best option for a young infant classified with VERY SEVERE DISEASE. If referral is not possible, continue to give ampicillin and gentamicin for at least 5 days.
  - Give ampicillin two times daily to infants less than one week of age and 3 times daily to infants one week or older. 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.
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

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>AMOXICILLIN: Give 2 times daily for 5 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tablet: 250 mg</td>
</tr>
<tr>
<td>Birth up to 1 month (&lt;4 kg)</td>
<td>1/4</td>
</tr>
<tr>
<td>1 month up to 2 months (4-&lt;6 kg)</td>
<td>1/2</td>
</tr>
</tbody>
</table>

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.
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**

After 3 days
- 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?

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 antibiotics.

**PERSISTENT DIARRHOEA**

After 5 days
- 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**

After 3 days:
Assess the child for diarrhoea. > See ASSESS & Classify chart.

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

Treatment:
- If the child is dehydrated, treat 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, is dehydrated on the first visit, or if he had measles within the last 3 month

- 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.
**FEVER: NO MALARIA**

If fever persists after 3 days:
- 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 lives in malaria endemic area refer the child to malaria hospital.
- If the child has any other cause of fever other than malaria, provide treatment.
  » If the fever has been present for 7 days, refer for assessment

**EARD INFECTION**

After 5 days:
- 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.

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

After 3 days:
- 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 nystatin for a total of 7 days.

**FEEDING PROBLEM**

After 7 days:
- 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**

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

After 14 days or during regular follow up:

• Do a full reassessment of the child. > See ASSESS & CLASSIFY chart.
• Assess child with the same measurements (WFH/L, MUAC) as on the initial visit.
• Check for oedema of both feet.
• Check the child’s appetite by offering ready-to use therapeutic food if the child is 6 months or older.

Treatment:
• If the child has COMPLICATED SEVERE ACUTE MALNUTRITION (WFH/L less than -3 z-scores or MUAC is less than 115 mm or oedema of both feet AND has developed a medical complication or oedema, or fails the appetite test), refer URGENTLY to hospital.
• If the child has UNCOMPROMISED 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) please refer to the hospital for verification and treatment.
• If the child has MODERATE ACUTE MALNUTRITION without any additional disease (WFH/L between -3 and -2 z-scores or MUAC between 115 and 125 mm), please counsel the mother and encourage her to follow recommitted child feeding practices, include her to the SFP (Supplementary Feeding Programme) if available and ask her to return in 14 days. Continue to see the child every 14 days until the child’s WFH/L us -2z score or more and/or MUAC is 125 mm.
• 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 and counsel her about age-appropriate feeding recommendations (see COUNSEL THE MOTHER chart).

MODERATE ACUTE MALNUTRITION

After 30 days:
• Assess the child using the same measurement (WFH/L or MUAC) used on the initial visit:
  » If WFH/L, weigh the child, measure height or length and determine if WFH/L.
  » If MUAC, measure using MUAC tape.
  » Check the child for oedema of both feet.
• Reassess feeding. See questions in the COUNSEL THE MOTHER chart.

Treatment:
• If the child is no longer classified as MODERATE ACUTE MALNUTRITION, praise the mother and encourage her to continue.
• If the child is still classified as MODERATE ACUTE MALNUTRITION, counsel the mother about any feeding problems 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.
WHEN TO RETURN

Advising 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.

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

WHEN TO RETURN IMMEDIATELY

Advise the 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 diarrhea, also return if:

| Blood in stool | Drinking poorly                    |
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.

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 within 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.

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.
FEEDING COUNSELLING

Assess Child’s Feeding
Assess feeding if child is Less Than 2 Years Old, Has MODERATE ACUTE MALNUTRITION, ANAEMIA.
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 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,
• 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 Recommendations**

**Feeding recommendations FOR ALL CHILDREN during sickness and health**

<table>
<thead>
<tr>
<th>Newborn, birth up to 1 week</th>
<th>1 week up to 6 months</th>
<th>6 up to 9 months</th>
<th>9 up to 12 months</th>
<th>12 months up to 2 years</th>
<th>2 years and older</th>
</tr>
</thead>
</table>

- **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.

- **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 or 2 snacks between meals.

- **Breastfeed as often as your child wants.** Also give a variety of 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.
**SUPPLEMENTARY FEEDING**

**Assess Child’s Feeding**
Stop breastfeeding means changing from all breast milk to no breast milk. This should be happened gradually over one months. Plan in advance for a safe transition.

1. **Help mother prepare:**
   - Mother should discuss and plan in advance with her family, if possible
   - Express mild 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
   - Clean all utensils with soap and water
   - Start giving only formula or cow’s mild 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 diarrhea**
- If still breastfeeding, give more frequent, longer breastfeeding, day and night
- If taken other milk:
  - Replace with increased breastfeeding
  - OR
  - Replace with fermented milk products, such as yogurt
  - OR
  - Replace half the milk with nutrient-rich semisolid food
- For other foods, follow feeding recommendations for the child’s age
FOLLOW UP / FEEDING COUNSELLING

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 underside 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 a home heating device and make sure 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:

<table>
<thead>
<tr>
<th>Follow up visit</th>
<th>Return for first follow-up in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the infant has:</td>
<td></td>
</tr>
<tr>
<td>• JAUNDICE</td>
<td>1 day</td>
</tr>
<tr>
<td>• LOCAL BACTERIAL INFECTION</td>
<td>2 days</td>
</tr>
<tr>
<td>• FEEDING PROBLEM</td>
<td></td>
</tr>
<tr>
<td>• THRUSH</td>
<td></td>
</tr>
<tr>
<td>• DIARRHOEA</td>
<td></td>
</tr>
<tr>
<td>• LOW WEIGHT FOR AGE</td>
<td>14 days</td>
</tr>
<tr>
<td>• CONFIRMED HIV INFECTION</td>
<td></td>
</tr>
<tr>
<td>• HIV EXPOSED</td>
<td>According to national recommendations</td>
</tr>
</tbody>
</table>

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
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 STIs
Identify skin problem
# IF SKIN IS ITCHING

<table>
<thead>
<tr>
<th>PICTURE</th>
<th>SIGNS</th>
<th>CLASSIFY AS:</th>
<th>TREATMENT</th>
</tr>
</thead>
</table>
| ![Image](image1.png) | Itching rash with small papules and scratch marks. Dark spots with pale centres. | PAPULAR ITCHING RASH (PRURIGO) | Treat itching:  
- Calamine lotion  
- Antihistamine oral  
- If not improved 1% hydrocortisone. |
| ![Image](image2.png) | An itchy circular lesion with a raised edge and fine scaly area in the centre with loss of hair. May also be found on body or web on feet. | RING WORM (TINEA) |  
- Whitfield ointment or other antifungal cream if few patches  
- If extensive refer, if not give:  
  - Ketoconazole  
    - for 2 up to 12 months (6-10 kg) 40mg per day  
    - for 12 months up to 5 years give 60 mg per day or give griseofulvin 10mg/kg/day  
  - If in hair shave hair and treat itching as above. |
| ![Image](image3.png) | 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. |
## IF SKIN HAS BLISTERS / SORES / PUSTULES

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Vesicles over body" /></td>
<td>Vesicles over body. Vesicles appear progressively over days and form scabs after they rupture</td>
<td><strong>CHICKEN POX</strong></td>
<td>Treat itching as above. Refer <strong>URGENTLY</strong> if pneumonia or jaundice appear.</td>
</tr>
</tbody>
</table>
| ![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 immunocompromised, for example if infected with HIV](image2.png) | 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 immunocompromised, 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. |
| ![Red, tender, warm crusts or small lesions](image3.png) | 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. |
## IF SKIN IS NON-ITCHY

<table>
<thead>
<tr>
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<th>TREATMENT</th>
</tr>
</thead>
</table>
| ![Image](image1.png) | 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 |
| ![Image](image2.png) | The common wart appears as papules or nodules with a rough ( verrucous) surface | **WARTS** | Treatment:  
- Topical salicylic acid preparations (e.g. Duofilm)  
- Liquid nitrogen cryotherapy.  
- Electrocautery |
| ![Image](image3.png) | Greasy scales and redness on central face, body folds | **SEBORRHEA** |  
- Ketoconazole shampoo  
- If severe, refer or provide topical steroids  
- For seborrheic dermatitis: 1% hydrocortisone cream X 2 daily  
- If severe, refer |
## DRUG AND ALLERGIC REACTIONS

<table>
<thead>
<tr>
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<th>CLASSIFY AS:</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.jpg" alt="Image" /></td>
<td>Generalized red, wide spread with small bumps or blisters; or one or more dark skin areas (fixed drug reactions)</td>
<td><strong>FIXED DRUG REACTIONS</strong></td>
<td>Stop medications give oral antihistamines, if peeling rash refer</td>
</tr>
</tbody>
</table>
| ![Image](image2.jpg) | Wet, oozing sores or excoriated, thick patches | **ECZEMA** | • Soak sores with clean water to remove crusts (no soap)  
• Dry skin gently  
• Short-term use of topical steroid cream, not on face  
• Treat itching |
| ![Image](image3.jpg) | 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 and refer **urgently** |
Sexual and reproductive health messages
MESSAGE FOR PREVENTION OF STI

• All pregnant women should be tested for syphilis during early antenatal care and if they test serum positive, all of them should be timely treated for syphilis with all sexual partners because syphilis during pregnancy can cause spontaneous abortion, prematurity, stillbirth, neonatal death or serious sequelae in live-born infants.

• If there is untreated gonorrhea or chlamydia infection during pregnancy, these infections can cause septic abortion or PROM, or preterm labour; and neonates that pass through an infected birth canal can develop conjunctivitis, nasopharyngeal infection, infections or pneumonia. Especially, if there is untreated neonatal conjunctivitis with Neisseria gonorrhea, the infant may develop blindness; and if untreated chlamydia infection, the child may develop visual dysfunction or apnea, asthma, obstructed respiratory dysfunction.

• STIs such as syphilis, gonorrhea, chlamydia, vaginal trichomoniasis and genital herpes increase the risk of HIV co-infection and mother-to-child transmission of HIV.

• Therefore all pregnant women should be tested and receive the appropriate treatment for these infections.
PREPARING FOR CHILDBIRTH

- Pick up a birthing kit
- Plan to use a skilled birth attendant and, if possible, to give birth in a facility
- Plan for emergency transportation
- Talk with family to plan for an emergency
DANGER SIGNS DURING DELIVERY / CHILDBIRTH

If this happens to you, go to a health facility immediately:

- Hand or foot before head
- Severe bleeding
- Seizure
- Umbilical cord first
- More than one infant
- Prolonged labor

Pictures were taken from "Inter-Agency Working Group for RH: Universal and Adaptable Information, Education and Communication Templates on the MISP"
PRINCIPLES OF THE INTEGRATED CLINICAL CASE MANAGEMENT

IMNCI 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 indicated 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 symptoms 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 encourages active participation of caregivers in the treatment of their children.

(6) An essential component of IMNCI is the counselling of caregivers regarding home care:
- Appropriate feeding and fluids
- When to return to the clinical immediately, and
- When to return for follow-up
5 FACTS ON VACCINES

There's a lot of conflicting information out there about vaccines. Question what you read and hear – and understand the facts.

1. Vaccines are safe and effective.
Any licensed vaccine is rigorously tested before it is approved for use, regularly reassessed and constantly monitored for side effects. In the rare event a serious side effect is reported, it is immediately investigated.

2. Vaccines prevent deadly illnesses.
Vaccination protects children from diseases like diphtheria, measles, mumps and pertussis (whooping cough). Failure to vaccinate leaves children and adults vulnerable to diseases, complications or even death.

3. Vaccines provide better immunity than natural infections.
The immune response to vaccines is similar to the one produced by natural infection but less risky. For example: natural infection can lead to cognitive impairments from *Haemophilus influenzae* type b (Hib), birth defects from congenital rubella infection or irreversible paralysis from polio.

4. Combined vaccines are safe and beneficial.
Giving several vaccines at the same time has no negative effect on a child's immune system, reduces discomfort for the child and saves time and money. Children are exposed to more antigens from a common cold than they are from vaccines.

5. If we stop vaccination, diseases will return.
Even with better hygiene, sanitation and access to safe water, infections still spread. When people are not vaccinated, infectious diseases that have become uncommon – diphtheria, measles, mumps and polio – quickly reappear.
#VACCINESWORK TO PROTECT INDIVIDUALS AND COMMUNITIES

Immunization is our shield against serious diseases.

When immunization rates are high, the wider community is protected including:

- Infants who are too young to receive their vaccines.
- Older adults at risk of serious diseases.
- People who take medication that lowers their immune systems.

Check with your doctor that you are fully vaccinated.

World Health Organization