सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESS (IMNCI)





PARTICIPANT MODULE FOR HEALTH WORKERS

Child Health Division
Ministry of Health & Family Welfare
Government of India

2023

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INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESS (IMNCI)

PARTICIPANT MODULE FOR HEALTH WORKERS

2023

डॉ. विनोद कुमार पॉल
सदस्य
Dr. Vinod K. Paul
MEMBER

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आज़ादी का अमृत महोत्सव

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13th November, 2023

MESSAGE

I am pleased to note that the Ministry of Health and Family Welfare has developed the revised version of Integrated Management of Neonatal and Childhood Illness (IMNCI) and developed Facility Based Care of Sick Children as an update of "Facility Based Integrated Management of Neonatal and Childhood Illness (F-IMNCI)" training package which are being released.

National Health Policy (NHP) 2017 provides a framework to strengthen healthcare system for attaining Universal Health Coverage (UHC) and work on Government's philosophy of 'Sabka Sath Sabka Vikas'. Our flagship programme 'Ayushman Bharat' is working towards attainment of UHC as one of the key targets under Sustainable Development Goals. Under this UHC, we are committed to provide appropriate healthcare to newborns and children across the country. Our progress has been steady, despite the COVID-19 pandemic and we are making all efforts to improve children's survival.

There's a continuous need for upskilling and revising training packages, based on recent challenges and new evidence. The training packages developed by the Ministry of Health and Family Welfare are a right step in this direction towards addressing comprehensive management of newborns and sick children in outpatient as well as in-patient settings. These will be helpful in setting up better standards of care in public health facilities for our newborns and children and will help us ensure that each child gets a better start to life and is provided an equal opportunity to survive and thrive.

I extend my best wishes to everyone.

(Vinod Paul)

स्वच्छ भारत
एक कदम स्वच्छता की ओर

सुधांश पंत
सचिव
Sudhansh Pant
Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

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स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

Health systems strengthening over the last decade brought a considerable improvement in the infrastructure, availability of human resources, drugs and equipment along with supportive services all across India. Effective sick newborn and child care is a crucial challenge that is faced by every health care system in low resource settings. While efforts are being made to improve the availability of specialists dealing with sick newborns and children, training of doctors, nurses and peripheral health workers remains key to equip the staff with appropriate knowledge and skills to provide evidence based healthcare to children.

With advances in critical care and based on evidence, the Integrated Management of Neonatal and Childhood Illness (IMNCI) training package has now been revised by the Child Health Division, with updated algorithm and improved training methodology. The revised training package also includes recommendations of the technical expert group on paediatric management of common illness. The package has been bifurcated and rebranded into OPD based Integrated Management of Neonatal and Childhood Illness Modules and Facility Based Care for Sick Children Package for inpatient management.

This revised package provides latest, evidence-based knowledge in improving newborn and child at facilities to provide required care for a newborn and child to identify and manage common conditions, complications, and emergency management of children, including pre-referral management, thereby saving many precious lives.

I hope that these training modules will be rolled out expeditiously across the States and UTs to ensure essential care to the children as a first step towards healthy childhood and adult life.

Date: 15.11.2023
Place: New Delhi

Sudhansh Pant
(Sudhansh Pant)

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FOREWORD

The Ministry of Health and Family Welfare, Government of India has implemented a number of policies and programmes aimed at ensuring universal access to health coverage and reducing child and neonatal mortality. Our country has made sizeable gains in last one decade in Child Mortality and reach to 32 per 1000 Live births in the year 2020. Under National Health Policy (NHP) 2017, the country has set-up ambitious targets of Under 5 Mortality i.e. 23 per 1000 Live births by 2025 and our team is closely working with States/ UTs to achieve these targets in given time frame.

To fulfill the role of providing quality healthcare services for newborns and children, Ministry of Health and Family Welfare, Government of India has developed training package for comprehensive management of illness in newborns and under-five children with distinct outpatient and inpatient components. These target the capacity building needs of pediatricians, medical officers, nurses and peripheral health workers and provide knowledge and skills of high order required for management of common conditions that lead to maximum morbidity and mortality among children in our country.

I would like to express my heartfelt appreciation to all those who contributed to the preparation of these documents. I am sure that these packages will help in equipping our healthcare providers with knowledge and skill to deliver newborn and child health services with quality, all across the country.

With best wishes!

(Ms. L S Changsan)

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राष्ट्रीय स्वास्थ्य मिशन

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भारत सरकार
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GOVERNMENT OF INDIA
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संयुक्त सचिव

Dr. P. Ashok Babu, IAS
Joint Secretary

PREFACE

The Government of India is committed to achieve goals under National Population Policy (2017) and bring down Neonatal Mortality Rate to 16 and Under Five Mortality Rate to 23 by 2025, which are well beyond the Sustainable Development Goals (SDGs) set for 2030. Newborn and Child health are the central pillars in the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy. Inter-linkages between various RMNCAH+N life cycle stages have a significant impact on the mortality and morbidity of children.

The Child Health Division of the Ministry, with support from technical experts and development partners has revised Facility Based Integrated Neonatal and Childhood Illness (F-IMNCI) developed in the year 2009, with updated algorithms and improved training methodology and presented it in a pictorial format which also serves as a job-aid. The F-IMNCI training package has been divided into two packages of "Integrated Management of Newborn and Child Illnesses (IMNCI)" – for outpatient management of both young infants (0-2 months) and children up to five years of age and new package titled, "Facility Based Care of Sick Children" – focusing on appropriate inpatient management of major causes of childhood mortality beyond neonatal age from one month to 59 months old children with common illnesses, like pneumonia, diarrhoea, malaria, meningitis, and severe malnutrition. The training duration has been reduced to make it more practical.

The package emphasizes on the skill imparting techniques by the facilitators and ensures uniform messaging across all the levels. With this revised training package, we hope that the training will be more hands-on and the entire training experience will be enhanced, leading to better learning outcomes. I urge the States and UTs to take this package up to scale and universalize it by the end of 2024-25.

I am hopeful that by adopting this revised training package, the trainers along with service providers will feel more confident in carrying on with their roles and responsibilities. I would also like to place on record my appreciation for the hard work and untiring efforts put in by the Child Health Division in revising and developing the training package. I assure the States and UTs full support, of my team, in taking this important initiative forward.

(Dr. P. Ashok Babu)

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ACKNOWLEDGEMENT

India has witnessed a huge transformation in the scenario of children's health evident by faster reduction in child mortality over the last decade as compared to global rates. This has been made possible by India's continued investments in health systems which are being strengthened further in the wake of threats posed by COVID-19 pandemic through improvement of physical infrastructure and training of health care providers to equip them with suitable skill sets at different levels of care, to deliver quality newborn and child health services.

The Facility Based Integrated Neonatal and Childhood Illness (FIMNCI) package was first launched in India in the year 2009 guiding appropriate inpatient management of major causes of childhood mortality, which has now been bifurcated into two packages based on outpatient and inpatient management:

1. Integrated Management of Newborn and Child Illnesses (IMNCI)- for outpatient management of both young infants (0-2 months) and children up to five years of age with two separate chart booklets for healthcare workers (ANM) and Physicians to be covered over five days.

Cont'd on next page

2. New package titled, "Facility Based Care of Sick Children" - focuses on providing appropriate inpatient management of major causes of childhood mortality beyond neonatal age i.e. one month to 59 months old children with common illnesses, like- pneumonia, diarrhoea, malaria, meningitis, and severe malnutrition also taught over five days.

Other major differences are:

I. Facility based approach dissociated from IMNCI; management is now linked to Emergency signs
II. New chapters added on management of children with shock, management of children presenting with lethargy, unconsciousness or convulsions, supportive care
III. National Guidelines for pediatric management of COVID-19, Malaria, Dengue and Tuberculosis included
IV. Training videos developed by KSCH, Lady Hardinge Medical College

These training packages are a culmination of the work initiated by my previous colleagues Dr Ajay Khera, Ex-Commissioner (MCH); Dr P K Prabhakar, Ex Joint Commissioner (CH) and Dr. Sumita Ghosh, Ex- Additional Commissioner (Child Health), I convey my sincere gratitude for their vision. I would also like to thank Prof. (Dr) Praveen Kumar, Kalawati Saran Children's Hospital (KSCH), New Delhi and his team who worked very hard to develop and revise this package. I also want to acknowledge the contribution of Dr. Ashfaq Bhat (NIPI), Dr. Deepti Agarwal (WHO-India), Vishal Kataria (MoHFW) and Vaibhav Rastogi (MoHFW) who had worked together with KSCH to refine this package further with the support of Academicians, Experts, State Child Health Officers, Development Partners (NIPI, WHO, UNICEF, USAID, IPE Global, PATH) and also supported the pilot testing.

The Child Health Division will provide all the necessary support to the States and UTs to roll out these training packages at the earliest and contribute towards further improving children's health and survival. I wish you the very best for your efforts and look forward to your continued support as we move together on the mission to improve the quality of life of children and attain the national health goals.

(Dr. Shobhna Gupta)

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SECTION 1

INTRODUCTION

SECTION 1

INTRODUCTION

In children under five years of age, neonatal infections, pneumonia, diarrhoea and malaria are the most important causes of death. Malnutrition increases the risk of death and is associated with approximately 50% of all deaths among children. Low birth weight and poor feeding practices are the major reasons for malnutrition in infants and children. Moreover, many children and infants suffer from more than one illness at a time. Children present with overlapping signs and symptoms of diseases; therefore, a single diagnosis can be difficult and may not be feasible or appropriate. An integrated approach is needed to manage these sick children for better outcomes. This approach reduces death and the frequency and severity of illness and disability, and contributes to improved growth and development.

Outpatient management of children is an integrated approach that includes the assessment, classification and management of the major problems in a sick infant or a child aged less than 5 years may have. It also includes assessment of nutritional and immunization status of all sick infants and children.

There will be group discussion on the causes of childhood illness and mortality

THERE ARE TWO PARTS OF THIS COURSE:

- Management of young infants aged upto 2 months (0 to 59 days old)
- Management of sick children 2 months upto 5 years (2 to 59 months). This module will teach you how to do the following:

For young infant upto 2 months

- Assess and classify young infants for possible serious bacterial infection/jaundice
- Assess for diarrhoea
- Assess and classify for feeding problem and low weight for age
- Assess and classify the young infant's immunization status
- Assess other problems
- Assess the mother/caregiver's development supportive practices & counsel for practices to support child's development using MCP card
- Counsel the mother about her own health
- Provide treatment and refer when required
- Correct breastfeeding problems
- Advise the mother on home care to young infant
- Follow-up care

For the sick child 2 months upto 5 years

- Assessment for General Danger Signs
- Assess major symptoms (Cough/Diarrhoea/Fever)
- Check for malnutrition & anemia
- Check for immunization, prophylactic vitamin A & iron-folic acid supplementation status
- Assess other problems
- Assess feeding if age is less than 2 years/ has uncomplicated Severe/ Moderate Acute Malnutrition or Anemia
- Assess the mother/ caregiver's development supportive practices if less than 3 years/ has uncomplicated severe acute malnutrition or anemia
- Classification and identification of treatment
- Provide treatment and refer when required
- Counsel for feeding and development of supportive practices
- Follow-up care

INTRODUCTION TO COLOUR-CODED CHART BOOKLET

Color-coded chart booklet has four columns:

"**Assess**" column lists what signs and symptoms to check and how to do it. "**Signs**" column summarizes the signs and symptoms present. "**Classification**" helps in classifying each illness the young infant or child has.

"**Identify Treatment**" section lists appropriate treatment decisions for each classification.

The 'Assess' and 'Classify' sections are organized in three different colours (pink, yellow and green):

- Conditions included in the boxes with **pink colour** indicate **severe illness**. Children with a severe illness must be **referred** to a hospital or sent to the doctor after giving pre-referral treatment.
- Conditions included in the boxes with a **yellow colour** should be treated with **medicine at home** and home care advice (given) or (provided) to the mother.
- Conditions included in the boxes with **green colour** are to be treated with **home care without the use of medicines.**

SECTION 2

ASSESS AND CLASSIFY THE SICK YOUNG INFANT

SECTION 2

ASSESS AND CLASSIFY THE SICK YOUNG INFANT

Sick young infants **are somewhat different** from older children. Sick young infants frequently have only general signs like lethargy, low body temperature or fever. They can become sick very quickly and may die within a few hours or days unless provided with necessary treatment. These are some of the reasons why young infants have to be managed differently.

Select the case management section for the young infant aged upto 2 months.

- **Greet the mother and give a** friendly smile.
- **Ask the mother what the young infant's** problems are.
- Record what the mother tells you about the infant's problems.

An important reason for asking this question is to open or establish good communication with the mother. Using good communication helps to reassure the mother that her infant will receive good care. When you treat the infant's illness later in the visit, you will need to teach and advise the mother about caring for her sick infant at home.

- **Listen carefully to what the mother tells you**. This will show her that you are taking her concerns seriously.
- **Use words that mother understands**. If she does not understand the questions you asked her, she cannot give the information you need.
- **Give the mother time to answer the questions**. For example, she may need time to decide if a symptom you asked about is present.
- **Ask additional questions when the mother is not sure about her answer**. When you ask about a symptom, the mother may not be sure if it is present. Ask her additional questions to help her give clearer answers.

Other tips for effective communication

- Sit at the mother's level
- Touch appropriately or play with child
- Nod, say hmmm…. when mother is saying something. It makes her feel she is understood.
- Do not appear to be in a hurry

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

If this is the infant's first visit for this episode of the illness or problem, then this is an ***initial*** visit.

If the young infant was seen a few days ago for the same illness, this is a follow-up visit. A follow-up visit has a different purpose than an initial visit. During a follow-up visit, the doctor finds out if the treatment he gave during the initial visit has helped the infant. If the young infant is not improving

or is getting worse after a few days, the doctor refers the infant to a hospital or changes the infant's treatment. You will learn how to carry out a follow-up visit later in the module. If it is an initial visit, follow the sequence of steps on the chart to assess and classify a sick young infant.

Facilitator will conduct a Group Discussion on Steps of Effective Communication

2.1 ASSESS YOUNG INFANT FOR POSSIBLE SERIOUS BACTERIAL INFECTION / JAUNDICE

Every young infant should be checked for possible serious bacterial infection/jaundice.

CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION / JAUNDICE

ASK:	***LOOK, LISTEN & FEEL:***
• Is the infant having difficulty in feeding? • Has the infant had convulsions? • When did jaundice first appear ?	• Count the breaths in one minute. Repeat the count if it is 60 or more breaths per minute. } Young infant must be calm • Look for severe chest indrawing. • Measure axillary temperature (if not possible, feel for fever or low body temperature). • Look at the young infant's movements. If infant is sleeping , ask the mother to wake him/her up. ➢ Does the infant move on his/her own? ➢ Does the infant move only when stimulated but then stops ? ➢ Does the infant not move at all? • Look at the umbilicus. Is it red or draining pus? • Look for skin pustules. • Look for jaundice (yellow skin) • Look at the young infant's palms and soles. Are they yellow?

ASK: Is the infant having difficulty in feeding?

Ask the mother this question. Any difficulty mentioned by the mother is important. A young infant who was feeding well earlier but is not feeding well now may have a serious infection. These infants who are either not able to feed or are not feeding well should be referred urgently to hospital.

The mother may also mention difficulties like: her infant feeds too frequently, or not frequently enough; she does not have enough milk; her nipples are sore; she has flat or inverted nipples. You will assess these difficulties later during breastfeeding assessment**.**

ASK: Has the infant had convulsions?

Ask the mother questions on whether the young infant has suffered from convulsions or not. Use the local term for convulsions. The caregiver may call convulsions "fits" or "spasms."

ASK: When did jaundice first appear?

Ask the mother questions on whether the young infant has palms and soles yellow?

LOOK: Count the breathing rate

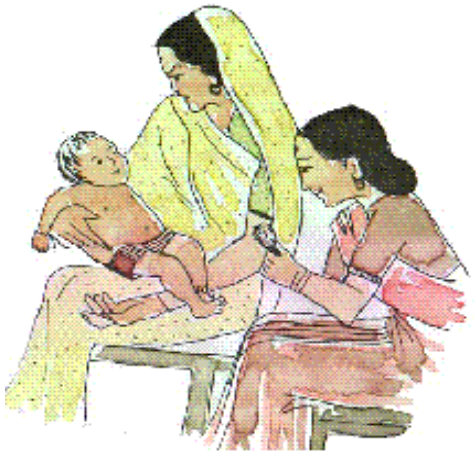
Count the breaths, the young infant takes in one minute. The young infant must be quiet and calm.

If the young infant is frightened, crying or angry, you will not be able to obtain an accurate count of the infant's breaths.

Tell the mother you are going to count her infant's breathing. Tell her to try to keep her infant calm. If the infant is sleeping, ask the mother to wake the baby up.

To count the number of breaths in one minute:

1. Use a watch with a second hand or a digital watch.
2. Put the watch where you can see the second hand and the breathing movements. Glance at the second hand as you count the breaths the young infant takes in one minute.
3. Look for breathing movement anywhere on the infant's chest or abdomen. Usually, you can see breathing movements even on an infant who is dressed. If you cannot see this movement easily, ask the mother to lift the infant's shirt.
4. If you are not sure about the number of breaths you counted (for example, if the young infant was actively moving and it was difficult to watch the chest, or if the young infant was upset or crying), repeat the count.



Counting breathing rate

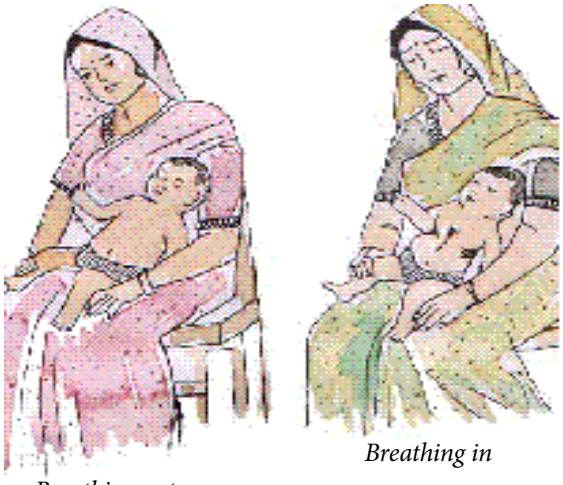
5. Since the breathing rate of the young infant is often irregular, repeat the count if elevated (60 or more breaths per minute or more). The second count is accepted as the final count. If the young infant has fast breath, the young infant may have pneumonia. This is considered serious in a young infant.

If the infant's age is	The infant has fast breathing if you count
Below 2 months	60 or more breaths per minute or more during second count

LOOK: for severe chest indrawing

If you did not lift the young infant's shirt when you counted the infant's breaths, ask the mother to lift it now. Look for chest indrawing when the young infant breathes in. Look at the lower chest wall (lower ribs). The young infant has chest indrawing if ***the lower chest wall goes IN when the infant breathes IN***.

In normal breathing, the whole chest walls (both upper and lower) and the abdomen move OUT when the young infant breathes IN. When chest indrawing is present, the lower chest wall goes IN when the young infant breathes IN.



Breathing out *Breathing in*

Chest Indrawing Present

If you are not sure that chest indrawing is present, look again. If the young infant's body is bent at the waist, it is hard to see the lower chest wall move. Ask the mother to change the infant's position so he is lying flat in her lap. If you still do not see the lower chest wall go IN when the infant breathes IN, the infant does not have chest indrawing. For chest indrawing to be present, it must be clearly visible and present all the time. If you only see chest indrawing when the young infant is crying or feeding, the young infant does not have chest indrawing.

Mild chest indrawing is <u>normal</u> in a young infant because the chest wall is soft. Severe chest indrawing is very deep and easy to see. Severe chest indrawing is a sign of pneumonia and is serious in a young infant.

FEEL: Measure axillary temperature (if not possible, feel for fever or low body temperature).

Fever (axillary temperature 37.5^{0}C /99.5^{0}C or above / feels hot to touch) is **uncommon** in the first two months of life. If a young infant has fever, this may mean the infant has a possible serious bacterial infection. Young infants can also respond to infection by dropping their body temperature to below 35.5^{0}C/95.9^{0}C.

Wash your hands before recording a baby's temperature. And keep the baby warm throughout the procedure.

Using digital thermometer: Switch on the thermometer, till beep is heard. Keep the digital thermometer in the axilla (armpit) and then hold the young infant's arm against his body till beep is heard. Remove the thermometer and note the reading. In case you are using mercury bulb thermometer keep for 5 minutes..

If you do not have a thermometer, feel the infant's abdomen or armpit and determine if it feels hot or cold to touch.

LOOK at the young infant's movements.

Does the young infant move on his/her own? Does the young infant move only when stimulated (touched, flicked at the sole 2-3 times, shaken, or spoken to) but then stops? Are there no movements even after the young infant is stimulated? Young infants often sleep most of the time, and this is not a sign of illness. If a young infant does not wake up during the assessment, ask the mother to wake him. An awake young infant will normally move his arms or legs or turn his head several times in a minute if you watch him closely. Observe the infant's movements while you do the assessment.

If the infant is awake but has no spontaneous movements, gently stimulate the young infant. If the infant moves only when stimulated and then stops moving, or does not move even when stimulated, it is a sign of severe disease.

LOOK at Umbilicus. Is it red or draining pus. There may be some redness of the umbilicus or the umbilicus may be draining pus (The cord usually drops from the umbilicus by one week of age).

LOOK for skin pustules. Examine the skin on the entire body. Skin pustules are red spots or blisters, which contain pus.

LOOK for jaundice

Jaundice is the visible manifestation of increased level of bilirubin in blood. Almost all neonates may have some jaundice known as physiological jaundice during the first week of life due to several physiological changes taking place after birth. Physiological jaundice does not extend to palms and soles, and does not need any treatment. However, if jaundice appears on first day (within first 24 hours of birth) or persists for 14 days/ more or extends to palms and soles then it is severe jaundice and requires urgent attention.

To look for jaundice, press the infant's skin over the forehead with your fingers to blanch, remove your fingers and look for yellow discolouration under natural light. If there is yellow discoloration, the infant has jaundice. To assess for severity, repeat the process over the palms and soles too.

There will be a drill on Checking for possible serious bacterial infection

2.2 CLASSIFY THE YOUNG INFANT FOR POSSIBLE SERIOUS BACTERIAL INFECTION/JAUNDICE

The classification table for Possible Serious Bacterial Infection is shown below:

Signs	Classify as	Identify treatment (Urgent pre-referral treatments are in bold print)
Any one or more of the following signs: • Not able to feed at all or not feeding well or • Convulsions or • Fast breathing (60 or more breaths per minute or more) or • Severe chest indrawing or • Axillary temperature 37.5°C/99.5°F or above (or feels hot to touch) or • Axillary temperature less than 35.5°C/95.9°F (or feels cold to touch) or • Movement only when stimulated or no movement at all	**POSSIBLE SERIOUS BACTERIAL INFECTION**	• ***Give first dose of oral amoxycillin and intramuscular gentamicin.*** • ***Treat to prevent low blood sugar.*** • ***Advise the mother how to keep the young infant warm on the way to the hospital.*** • ***Refer URGENTLY to hospital#***
• Umbilicus red or draining pus or • Skin pustules	**LOCAL BACTERIAL INFECTION**	• ***Give oral amoxycillin for 5 days*** • *Teach the mother how to treat local infections at home.* • *Advise the mother to give home care to the young infant* • *Advise the mother when to return immediately* • *Follow up after 2 days*
• No signs of bacterial infections	**INFECTION UNLIKELY**	• *Advise the mother to give home care to the young infant*

The classification table for jaundice is shown below

Signs	Classify as	Identify treatment (Urgent pre-referral treatments are in bold print)
• Any jaundice in an infant aged less than 24 hours or • Yellow palms or soles	**SEVERE JAUNDICE**	• *Treat to prevent low blood sugar.* • ***Refer URGENTLY to hospital#*** • *Advise mother how to keep baby warm on the way to the hospital*
• Jaundice appearing after 24 hrs of age and • Palms and soles not yellow	**JAUNDICE**	• *Advise the mother to give home care for young infants.* • *Advise the mother to return immediately if the infant's palm or soles appear yellow* • *If the infant is older than 2 weeks, refer to a hospital for assessment.* • *Follow up after 2 days*
• No jaundice	**NO JAUNDICE**	• *Advise the mother to give home care to young infants*

 # If referral is not possible, see the section Where Referral is Not Possible

After assessing the young infant, encircle all the signs that the infant has on the recording form. Compare the signs that the young infant has with the signs listed in each row and choose the appropriate classification.

Remember:

- *All young infants must be assessed for possible serious bacterial infection/jaundice.*
- *A young infant who has even one sign of possible serious bacterial infection has the classification Possible Serious Bacterial Infection (Pink classification). Refer this young infant promptly to hospital.*
- *A young infant who has no sign of Possible Serious Bacterial Infection but has signs of local bacterial infection has the classification Local Bacterial Infection (Yellow classification). This young infant can be treated at home with medicines.*
- *A young child with no symptoms of bacterial infection has the classification Infection Unlikely. The mother of this infant should be advised for proper home care.*
- *If the infant has jaundice, choose an additional classification from the jaundice classification table.*
- *If the infant has signs in the pink row for Jaundice, classify as SEVERE JAUNDICE. If the infant has none of the signs in the pink row, but has the sign in the yellow row, classify him as JAUNDICE.*
- *A young infant with no jaundice symptoms will be classified as No Jaundice. The mother of this infant should be advised for proper home care.*

There will be a demonstration on how to classify a sick young infant

PRACTICE CASE STUDIES

Case 1

1. Rekha is 20 days old. She has a breathing rate of 66 per minute, moves only when stimulated. Select the classification for the infant based on the signs given in the table below.

Any one or more of the following signs: • Not able to feed at all or not feeding well or • Convulsions or • Fast breathing (60 or more breaths per Minute or more) or • Severe chest indrawing or • Axillary temperature 37.5^{0}C/99.5^{0}F or above (or feels hot to touch) or • Axillary temperature less than 35.5^{0}C/95.9^{0}F (or feels cold to touch) or • Movement only when stimulated or no movement at all	**POSSIBLE SERIOUS BACTERIAL INFECTION**	• ***Give first dose of oral amoxycillin and intramuscular gentamicin.*** • ***Treat to prevent low blood sugar.*** • ***Advise the mother how to keep the young infant warm on the way to the hospital.*** • ***Refer URGENTLY to hospital***
• Umbilicus red or draining pus or • Skin pustules	**LOCAL BACTERIAL INFECTION**	• *Give oral amoxycillin for 5 days* • *Teach mother how to treat local infections at home.* • *Advise the mother to give home care to the young infant* • *Advise mother when to return immediately* • *Follow up after 2 days*
• No signs of bacterial infections	**INFECTION UNLIKELY**	• *Advise the mother to give home care to the young infant*

Answer

Since she has two signs present in the pink classification box and none in the yellow classification box. So, you will select the pink classification- POSSIBLE SERIOUS BACTERIAL INFECTION

Case 2

2. Amit is 45 days old. He has skin pustules over his abdomen.

Any one or more of the following signs: • Not able to feed at all or not feeding well or • Convulsions or • Fast breathing (60 or more breaths per minute or more) or • Severe chest indrawing or • Axillary temperature 37.5^{0}C/99.5^{0}F or above (or feels hot to touch or • Axillary temperature less than 35.5^{0}C/95.9^{0}F (or feels cold to touch) or • Movement only when stimulated or no movement at all	**POSSIBLE SERIOUS BACTERIAL INFECTION**	• ***Give first dose of oral amoxycillin and intramuscular gentamicin.*** • ***Treat to prevent low blood sugar.*** • ***Advise the mother how to keep the young infant warm on the way to the hospital.*** • ***Refer URGENTLY to hospital***
• Umbilicus red or draining pus or • Skin pustules	**LOCAL BACTERIAL INFECTION**	• *Give oral amoxycillin for 5 days* • *Teach mother how to treat local infections at home.* • *Advise the mother to give home care to the young infant* • *Advise mother when to return immediately* • *Follow up after 2 days*
• No signs of bacterial infections	**INFECTION UNLIKELY**	• *Advise the mother to give home care to the young infant*

Answer

He has no signs in the pink classification box. Has one sign in the yellow classification box, so you will select the yellow box classification – LOCAL BACTERIAL INFECTION.

Case 3

3. Meena is 15 days old. She feels hot to touch, has no movements even when stimulated and has pus draining from the umbilicus.

Any one or more of the following signs: • Not able to feed at all or not feeding well or • Convulsions or • Fast breathing (60 or more breaths per minute or more) or • Severe chest indrawing or • Axillary temperature 37.5^{0}C/99.5^{0}F or above (or feels hot to touch) or • Axillary temperature less than 35.5^{0}C/95.9^{0}F (or feels cold to touch) or • Movement only when stimulated or no movement at all	**POSSIBLE SERIOUS BACTERIAL INFECTION**	• ***Give first dose of oral amoxycillin and intramuscular gentamicin.*** • ***Treat to prevent low blood sugar.*** • ***Advise the mother how to keep the young infant warm on the way to the hospital.*** • ***Refer URGENTLY to hospital***
• Umbilicus red or draining pus or • Skin pustules	**LOCAL BACTERIAL INFECTION**	• *Give oral amoxycillin for 5 days.* • *Teach the mother to treat local infections at home.* • *Advise the mother to give home care to the young infant* • *Advise the mother when to return immediately* • *Follow up after 2 days*
• No signs of bacterial infections	**INFECTION UNLIKELY**	• *Advise the mother to give home care to the young infant*

Answer

She has two signs in the pink classification box and one sign in the yellow classification box. She has signs in both the classification boxes but you have to choose only one classification for possible serious bacterial infection. Whenever you use a classification table, start with the top row. In each classification table, a young infant receives classifications in one colour only. If the infant has signs from more than one row, always select the more serious classification. So, you will select the classification from the pink box- POSSIBLE SERIOUS BACTERIAL INFECTION.

You will watch a video of young infants. This will demonstrate how to assess a young infant for possible serious bacterial infection.

Video: Fast breathing and chest indrawing

There will be a group discussion of photographs of a young Infant

Discuss the following photographs with your facilitator in a group discussion.

Photograph 1: Normal umbilicus in a newborn

Photograph 2: This is an umbilicus with redness

Photograph 6: This infant has skin pustules.

Now write your answers for following photographs:

Umbilicus	Normal	Redness or draining pus
Photograph 3		
Photograph 4		
Photograph 5		

Facilitator will introduce Recording Forms.

2.3 ASSESS YOUNG INFANT FOR DIARRHOEA

All young infants with diarrhoea should be assessed for: (a) duration of diarrhoea; (b) blood in the stool; and (c) signs of dehydration.

Ask: Does the young infant have diarrhoea

If the mother says that the young infant has diarrhoea, assess and classify for diarrhoea. Breastfed babies normally have frequent loose stools but they are not watery. This is not diarrhoea. If the stools have changed from the usual pattern and are many and watery, the young infant has diarrhoea. If mother tells you that there is visible blood in stool then this baby should be referred to hospital. **Blood in stool in young infant, needs investigations and treatment of underlying medical or surgical condition**.

If Yes:

- Look at the young infant's general condition.
  - Look at Infant's movements:
    - Does the infant move on his/her own?
    - Does the infant move only when stimulated and 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)?
  - Slowly?

Check for signs of dehydration

LOOK: at the young infant's general condition

You have already checked if the young infant is lethargic or unconscious.

Does the young infant move only when stimulated (touched, flicked at the sole 2-3 times, shaken, or spoken to)? Are there no movements even after the young infant is stimulated? Young infants often sleep most of the time, and this is not a sign of illness. If a young infant does not wake up during the assessment, ask the mother to wake him. An awake young infant will normally move his arms or legs or turn his head several times in a minute if you watch him closely. Observe the infant's movements while you do the assessment.

If the infant is awake but has no spontaneous movements, gently stimulate the young infant. If the infant moves only when stimulated and then stops moving, or does not move even when stimulated, it is a sign of severe disease.

A young infant has the sign of restlessness and irritability if the young infant is restless and irritable all the time or every time he is touched and handled. If the young infant is calm while breastfeeding but is again restless and irritable when s/he stops breastfeeding is also considered as restless and irritable. This can be a sign of some dehydration.

LOOK: for sunken eyes.

The eyes of a young infant who is dehydrated may look sunken. Decide if the eyes are sunken. If you think that the eyes are sunken, ask the mother if she thinks that her infant's eyes look unusual. Her opinion helps you confirm that the young infant's eyes are sunken.

PINCH the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?

Ask the mother to hold the young infant in her lap so that the infant is lying flat on its back. Locate an area half way between the infant's navel and the side of the tummy. Now pinch the skin with the thumb and the first finger by lifting it for one second and then releasing it. Do not pinch with the tip of the finger or the thumb since this will cause pain to the infant. After leaving the skin, check to see how soon the skin returns to normal. If the skin comes back very slowly, that is, it takes more than 2 seconds, the skin pinch is very slow. **Very slow skin pinch is one of the signs of severe dehydration.**

If the skin does not return to normal immediately, the skin pinch is slow and this means that dehydration is present. A **very short tenting of the skin lasting less than 2 seconds is considered as slow skin pinch**.

If the skin returns to normal immediately after being pinched, the skin pinch is normal.

2.4. CLASSIFY DIARRHOEA IN YOUNG INFANT FOR DEHYDRATION

Classify young infant for dehydration. Here is the classification table for dehydration:

<table>
<tr><th>Signs</th><th>Classify as</th><th>Identify treatment
(Urgent pre-referral treatments are in bold print)</th></tr>
<tr><td>Two of the following signs:
• Movements only when stimulated or no movement at all
• Sunken eyes
• Skin pinch goes back very slowly</td><td>SEVERE DEHYDRATION</td><td rowspan="2">• Give first dose of oral amoxycillin and intramuscular gentamicin.
• Refer URGENTLY to hospital[#] with the mother giving frequent sips of ORS on the way.
• Advise the mother to continue breastfeeding.
• Advise the mother how to keep the young infant warm on the way to the hospital.</td></tr>
<tr><td>Two of the following signs:
• Restless, irritable
• Sunken eyes
• Skin pinch goes back slowly</td><td>SOME DEHYDRATION</td></tr>
<tr><td>• Not enough signs to classify as some or severe dehydration</td><td>NO DEHYDRATION</td><td>• Give fluids and breastfeeds to treat diarrhoea at home (Plan A).
• Advise mother when to return immediately.
• Follow-up up after 2 days if no improvement</td></tr>
</table>

[#]***If referral is not possible, see the section Where Referral is Not Possible***

Compare the signs that the young infant has to the signs listed in each row and choose the appropriate classification.

Remember:

- *Classify all cases of diarrhoea for dehydration.*
- *Infants with signs of severe or some dehydration should be referred to hospital.*
- *A infant who is not dehydrated should be treated at home.*

Exercise: Assess and classify for diarrhoea

Case 1: Neera

Neera is 7 weeks old female. Her weight is 3.0 kg. Her temperature is 37°C. Her mother has brought her because she has diarrhoea. The health worker first assesses her for signs of possible serious bacterial infection. The mother says that Neera has not had convulsions. The health worker counts her breaths and finds she is breathing 58 breaths per minute. She was sleeping in her mother's arms but awoke when her mother unwrapped her. She has slight chest indrawing. Her umbilicus is not red or no draining pus. There are no pustules.

She is crying and moving her arms and legs. When the health worker asks the mother about Neera's diarrhoea, the mother replies that it began 3 days ago. Neera is still crying. She stopped once when her mother put her to the breast. She began crying again when she stopped breastfeeding. Her eyes look normal, not sunken. When the skin of her abdomen is pinched, it goes back slowly. What is her classification?

MANAGEMENT OF THE SICK YOUNG INFANT AGE UPTO 2 MONTHS

Name: Neera **Age:** 7 weeks **Gender:** Female **Weight:** 3 kg **Temperature:** 37 ℃/ °F **Date:** 13/02/2023
ASK: What are the infant's problems? Diarrhoea **Initial visit?** √ **Follow up visit?** _____

ASSESS (Circle all signs present) **CLASSIFY**

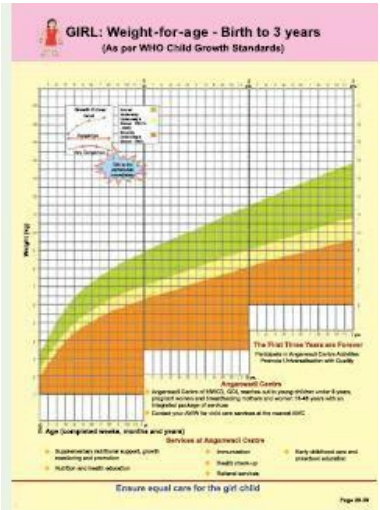
CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION/JAUNDICE • Is the infant having difficulty in feeding? • Has the infant had convulsions? • Count the breaths in one minute 58 breaths per minute Repeat if elevated _____Fast breathing? • Look for severe chest indrawing • Measure axillary temperature (if not possible, feel for fever or low body temperature) - Is it < 35.5℃/ 37.5 ℃(95.9°F/99.5°F) or above? • Look at young infant's movements. If infant is sleeping, ask the mother to wake him/her ⇨ Does the infant move only when stimulated but then stops? ⇨ Does the infant not move at all? • Look at the umbilicus. Is it red or draining pus? • Look for skin pustules • Look for jaundice (yellow skin), If present • Look at the young infant's palms and soles. Are they yellow? • Ask when did jaundice appeared – First 24 hours / After 24 hours	***Infection Unlikely***
DOES THE YOUNG INFANT HAS DIARRHOEA? Yes √ No ____ • Look at the young infant's general condition. ➢ Look at infant's movements: ⇨ Does the infant move only when stimulated and 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 ⇨ Slowly	***Some Dehydration***

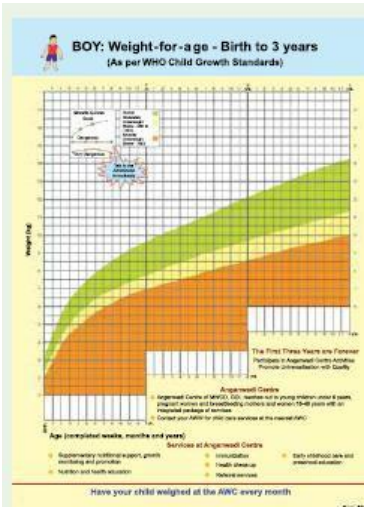
2.5 CHECK FOR FEEDING PROBLEM AND LOW WEIGHT FOR AGE

- Every sick young infant should be checked for feeding problem and low weight for age

Assessment of feeding problem and low weight for age. Assessment of feeding in young infants has two parts. You determine weight and weight for age. ***All Young Infants are weighed. Young infants*** whose weight is **less than 1800 gm in an infant less than 7 days/ weight for age <- 3SD in infants 7-59 days old (red on MCP card) are** classified as ***VERY LOW WEIGHT***.

Take weight of the infant with minimum acceptable clothes and record. The Mother and Child Protection (MCP) Card is a familiar tool being used by most of you for over a decade now. The shape and form of the card may vary according to your states and you may have a different name for the card in your region such as 'Mamta Card' or 'Jaccha-Baccha Card'.





MCP Weight-for-Age Chart

In the weight-for-age chart, the horizontal line at the bottom of the Chart is the X Axis. This is for recording the age of the child and is called 'month axis'. The vertical line at the far left of the Chart is the Y Axis. This is for recording the weight of the child from birth onwards and is called 'weight axis'.

The month axis of each Growth Chart has three boxes, representing three years. Each box contains 12 small squares representing 12 months i.e. each small square on month axis represents 1 month. Age is recorded in completed weeks/ months/years. It is recorded in completed weeks only for a infant below 1 month. Similarly, on the weight axis, lines are marked for recording weight in kilograms and grams. Each thick extended line represents 1 kg, each line extended from a small square represents 500 gms. and very thin and small extended lines represent 100 gms. White rectangles below the 'month axis' are for writing months and years as per the date of birth of the child. On each visit, weight of the child taken is recorded under the relevant rectangle. A point on a Growth Chart, where a line extended from a measurement on the 'month axis' i.e. age, intersects with a line extended from a measurement on the 'weight axis' i.e. weight, is called a plotted point.

A Growth Curve is formed by joining the plotted points on a Growth Chart. The direction of the growth curve indicates whether the child is growing or not and is more important than the actual weight of the child at any point.

On each Growth Chart, there are 3 pre-printed Growth Curves. These are called Reference Lines or Z Score Lines and are used to compare and interpret the growth pattern of the child and assess her/ his nutritional status. The 1st/ top curve line on the growth chart is the median which generally speaking is the average. The other two curve lines are below the average and are at a distance.

Weight of all normal and healthy children plotted on the Growth Chart, fall above 2nd curve (dark green band); weight of moderately underweight children falls between the 2nd curve and to the 3rd curve (yellow band); and weight of severely underweight children fall below the 3rd curve (red band). A plotted point or a growth curve of a child, which is much above or far below from the 1st pre-printed curve indicates a growth problem.

MCP card is also a counselling and family empowerment tool which would ensure tracking of mother and child cohort for health, nutrition and development purpose. Use this card for assessing nutritional status, feeding counseling and counseling for development supportive practices.

The *LOW WEIGHT infant* includes those with weight between 1800 to 2500 gm or weight-for-age <-2SD (yellow on MCP card) line. Infants who are Very Low Weight should be referred to a hospital. Infants who are Low Weight need special attention to how they are fed and on keeping them warm.

You can also check weight for age by checking SD scores in the table given below.

Weight for age Birth to 6 months

Boy's (wt-for-age)				Age*	Girl's (wt-for-age)			
-3 SD	**-2 SD**	**-1 SD**	**Median**		**Median**	**-1 SD**	**-2 SD**	**-3 SD**
2.1	2.5	2.9	3.3	**0 weeks**	3.2	2.8	2.4	2.0
2.2	2.6	3.0	3.5	**1 weeks**	3.3	2.9	2.5	2.1
2.4	2.8	3.2	3.8	**2 weeks**	3.6	3.1	2.7	2.3
2.6	3.1	3.5	4.1	**3 weeks**	3.8	3.3	2.9	2.5
2.9	3.3	3.8	4.4	**4 weeks**	4.1	3.6	3.1	2.7
3.1	3.5	4.1	4.7	**5 weeks**	4.3	3.8	3.3	2.9
3.3	3.8	4.3	4.9	**6 weeks**	4.6	4.0	3.5	3.0
3.5	4.0	4.6	5.2	**7 weeks**	4.8	4.2	3.7	3.2
3.7	4.2	4.8	5.4	**8 weeks**	5.0	4.4	3.8	3.3
3.8	4.4	5.0	5.6	**9 weeks**	5.2	4.6	4.0	3.5
4.0	4.5	5.2	5.8	**10 weeks**	5.4	4.7	4.1	3.6
4.2	4.7	5.3	6.0	**11 weeks**	5.5	4.9	4.3	3.8
4.3	4.9	5.5	6.2	**12 weeks**	5.7	5.0	4.4	3.9
4.4	5.0	5.7	6.4	**13 weeks/ 3 months**	5.8	5.1	4.5	4.0
4.9	5.6	6.2	7.0	**4 months**	6.4	5.7	5.0	4.4
5.3	6.0	6.7	7.5	**5 months**	6.9	6.1	5.4	4.8
5.7	6.4	7.1	7.9	**6 months**	7.3	6.5	5.7	5.1

** Age (in completed weeks and months)*

You also ask the mother questions to determine if she is having difficulty in feeding the infant; what the young infant is fed and how often.

ASK: Is the infant breastfed? If yes, how many times in 24 hours?

The young infant should be breastfed as often and for as long as the infant wants, day and night. This should be 8 or more times in 24 hours.

ASK: Does the infant usually receive any other foods or drinks? If yes, how often?

A young infant should be exclusively breastfed. Find out if the young infant is receiving ***any*** other foods or drinks such as other milk, juice, tea, thin porridge, dilute cereal, or even water. Ask how often he/she receives it and the amount.

ASK: What do you use to feed the infant?

If a young infant takes other foods or drinks, find out if the mother uses a feeding bottle, cup or any other device.

IF AN INFANT HAS NO INDICATION OF EARLY REFERRAL

Assess breastfeeding

If the infant has a serious problem (for e.g.: diarrhoea, dehydration and jaundice) requiring urgent referral to a hospital, do not assess breastfeeding.

ASK: Has the infant breastfed in the previous hour?

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

(If the infant was fed during the previous hour, ask the mother if she can wait and tell you when the infant is willing to feed again.) In the meantime, complete the assessment by checking the infant's immunization status. You may also decide to begin any treatment that the infant needs, such as giving an antibiotic for local bacterial infection or ORS solution for some dehydration.

ASK: Does the mother have pain while breastfeeding?

Pain while breastfeeding may indicate sore nipples, breast engorgement or breast abscess.

LOOK: Is the infant able to attach?

The four signs of good attachment are:

- chin touching breast
- mouth wide open
- lower lip turned outward
- more areola visible above than below the mouth

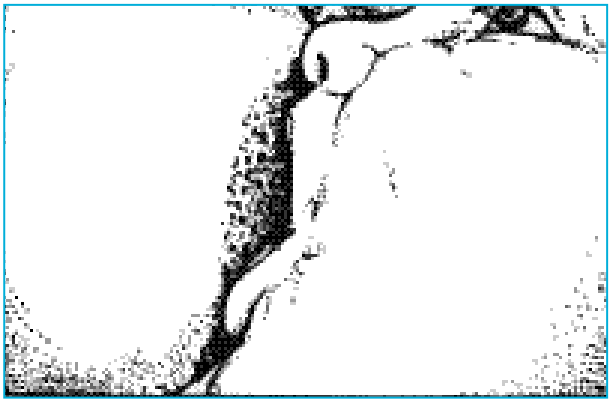
All of these signs should be present if the attachment is good.

If attachment is not good, you may see:

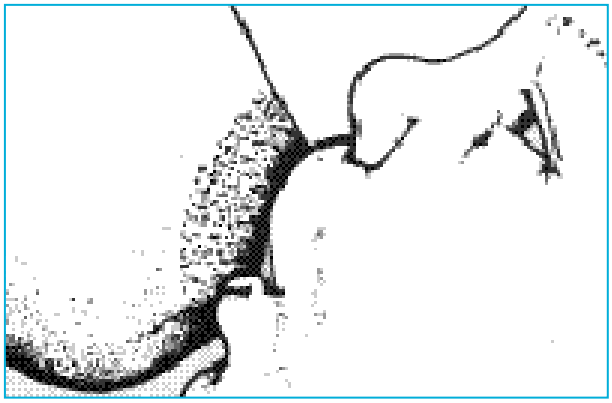
- chin not touching breast
- mouth not wide open, lips pushed forward
- lower lip turned in, or
- more areola (or equal amount) visible below infant's mouth than above it

If you see any of these signs of poor attachment, the infant is ***not well attached***.

If a very sick infant cannot take the nipple into his mouth and keep it there to suck, he has ***no attachment at all.*** He is not able to breastfeed at all.



Good attachment



Poor attachment

If an infant is not well attached, it may cause pain or damage to the nipples. Or the infant may not suckle breast milk effectively, which may cause engorgement of the breast.

The infant may be unsatisfied after breastfeeds and want to feed very often or for a very long time. The infant may get too little milk and not gain weight, or the breastmilk may dry up. All these problems may improve if attachment can be improved.

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

The infant is **suckling effectively** if he suckles with slow deep sucks and sometimes pauses. You may see or hear the infant swallowing. If you can observe how the breastfeed finishes, look for signs that the infant is satisfied. If satisfied, the infant releases the breast spontaneously (that is, the mother does not cause the infant to stop breastfeeding in any way). The infant appears relaxed, sleepy, and loses interest in the breast.

An infant is **not suckling effectively** if he is taking only rapid, shallow sucks. You may also see indrawing of the cheeks. You do not see or hear swallowing. The infant is not satisfied at the end of the feed, and may be restless. He may cry or try to suckle again, or continue to breastfeed for a long time.

An infant who is ***not suckling at all*** is not able to suck breastmilk into his mouth and swallow. Therefore, he is not able to breastfeed at all.

If a blocked nose seems to interfere with breastfeeding, clear the infant's nose. Then check whether the infant can suckle more effectively.

LOOK: for ulcers or white patches in the mouth (thrush)

Look inside the mouth at the tongue and inside of the cheek. It is important to treat these infections so that the young infant feeds well.

Thrush looks like milk curds on the inside of the cheek, or a thick white coating of the tongue. Try to wipe the white off with a clean gauge or cloth. The white patches of thrush will remain.

LOOK: for flat or inverted nipples, or sore nipples

for engorged breast or breast abscess

The nipples may be sore and cracked. Engorged breasts are swollen, hard and tender. Presence of a breast abscess is indicated additionally by localized redness and warmth.

2.6 CLASSIFY FOR FEEDING PROBLEM AND LOW WEIGHT FOR AGE

Here is the classification table for feeding problem:

SIGN	CLASSIFIED AS	PRE-REFERRAL TREATMENT
• Weight <1800 gm in infants less than 7 days • Weight for age less than-3SD in infants 7-59 days old (red on MCP card)	**VERY LOW WEIGHT**	• ***Refer URGENTLY to hospital***[#] • *Treat to prevent low blood sugar.* • *Warm the young infant by skin-to-skin contact if temperature less than 36.5°C/97.7°F (or feels cold to touch) while arranging referral.* • *Advise mother how to keep the young infant warm on the way to hospital.*
• Not well attached to breast or • Not suckling effectively or • Less than 8 breastfeeds in 24 hours or • Receives other foods or drinks or • Thrush (ulcers or white patches in mouth) or • Low weight for age (weight between 1800-2500 gm or weight for age yellow on MCP card i.e <- 2SD) or • Breast or nipple problems	**FEEDING PROBLEM AND/OR LOW WEIGHT**	• *If receiving other foods or drinks, counsel the mother about breastfeeding more, reducing other foods or drinks.* • *If not well attached or not suckling effectively, teach correct positioning and attachment.* • *If breastfeeding less than 8 times in 24 hours, advise to increase frequency of breastfeeding.* • *If not breastfeeding at all* - *refer for breastfeeding counseling and relactation.* - *advise mother about giving locally appropriate animal milk and teach the mother to feed with a cup and spoon* • *If thrush, teach the mother to treat thrush at home.* • *If low weight for age:* - *teach the mother how to keep the young infant warm at home.* - *advise to increase frequency of breastfeeding* • *If breast or nipple problem, teach the mother to treat breast or nipple problems.* • *Advise mother to give home care to the young infant.* • *Advise mother when to return immediately* • *Follow-up any feeding problem or thrush after 2 days.* • *Follow-up low weight for age after 14 days*
• Not low weight for age ≥-2SD (green on MCP card) and no other signs of inadequate feeding.	**NO FEEDING PROBLEM**	• *Praise the mother for feeding the infant well.* • *Advise mother to give home care to the young infant.* • *Advise mother when to return immediately*

[#]*If referral is not possible, see the section , where referral is not possible*

Compare the signs that the young infant has to the signs listed in each row and choose the appropriate classification.

Why 'Not Able to Feed' is not mentioned in this classification chart?

The first and most severe classification, NOT ABLE TO FEED, was assessed when you checked for signs of serious disease or possible local infection. As such, this classification is not included on the classification chart for feeding problem or low weight for age.

If the infant was **NOT ABLE TO FEED**, it was a severe classification (PINK) because this infant has a life-threatening problem. The infant requires the same urgent pre-referral as SEVERE DISEASE, and then must be urgently referred.

Remember:

- *A young infant who weighs less than 1800 gm in first seven days or has W/A <-3SD (orange classification on MCP card) has the classification VERY LOW WEIGHT and should be urgently referred to hospital*
- *The mother of a young infant with the classification FEEDING PROBLEM or LOW WEIGHT FOR AGE (yellow classification) should be counselled for feeding.*
- *A young infant who has no feeding problem has the classification NO FEEDING PROBLEM (green classification). The mother should be praised & should be advised for home care.*

This video will show how to check for a feeding problem and assess breastfeeding.

***

There will be a discussion on photographs on attachment to breast

Photo	Signs of Good Attachment				Assessment	Comments
	Chin Touching Breast	Mouth Wide Open	Lower Lip Turned Outward	More Areola Showing Above		
13						
14						
15						
16						
17						
18						
19						
20						
21						

2.7 CHECK IMMUNIZATION STATUS

Immunization helps protect young infants from infections that can be especially dangerous at their young age. The immunization status of all children, who are seen by you, should be checked. If any immunization is due, advise the mother to get the immunization at the earliest opportunity. You should give vaccination as per your local authorities guidelines as few vaccines are available in only few districts.

THEN CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS

IMMUNIZATION SCHEDULE:

AGE	VACCINE
Birth	BCG OPV-0 Hep B-0
6 weeks	Penta-1 OPV-1 Rotavirus-1 fIPV-1 PCV-1

Remember *that you should not give OPV 0 to an infant who is more than 14 days old. Therefore, if an infant has* ***not*** *received OPV 0 by the time he is 15 days old, you should wait to give OPV until he is 6 weeks old. Then give OPV 1 together with Penta 1. HEP-B 0 should be given at birth or as early as possible within 24 hours of birth.*

Administer any immunization that the young infant needs today. Tell the caregiver when to bring the infant for the next immunization, and record this on your recording form. **If the young infant is going to be referred, do not immunize before referral**.

2.8. ASSESS OTHER PROBLEMS

Assess any other problems mentioned by the mother or observed by you. If you think the young infant has a serious problem, or you do not know how to help the young infant, refer the young infant to a hospital.

2.9. ASSESS THE MOTHER/CAREGIVER'S DEVELOPMENT SUPPORTIVE PRACTICES & COUNSEL FOR PRACTICES TO SUPPORT CHILD'S DEVELOPMENT USING MCP CARD

Assess the mother/caregiver's usual practices & counsel for practices to support Child's Development using MCP Card. Compare mother's answers to the **Recommendations** for child's development

Case 1: Neera

Neera is 7 weeks old female. Her weight is 3.0 kg. Her temperature is 37°C. Her mother has brought her because she has diarrhoea. The health worker first assesses her for signs of possible serious bacterial infection. The mother says that Neera has not had convulsions. The health worker counts her breaths and finds she is breathing 58 breaths per minute. She was sleeping in her mother's arms but awoke when her mother unwrapped her. She has slight chest indrawing. Her umbilicus is not red or no draining pus. There are no pustules.

She is crying and moving her arms and legs. When the health worker asks the mother about Neera's diarrhoea, the mother replies that it began 3 days ago. Neera is still crying. She stopped once when her mother put her to the breast. She began crying again when she stopped breastfeeding. Her eyes look normal, not sunken. When the skin of her abdomen is pinched, it goes back slowly.

The mother says that she has no difficulty feeding her. She breastfeeds about 5 times in 24 hours. She gives her cow's milk 3 times by bottle for last 10 days. The worker uses the weight-for-age chart and determines that Neera has very low weight.

Answer

Since Neera's mother is feeding less than 8 times in 24 hours and is taking other foods or drinks, there is feeding problem. However there is an indication for urgent referral so breastfeeding assessment was not done.

MANAGEMENT OF THE SICK YOUNG INFANT AGE UPTO 2 MONTHS

Name: Neera **Age:** 7 weeks **Gender:** Female **Weight:** 3 kg **Temperature:** 37 ℃/ °F **Date:** 13/02/2023

ASK: What are the infant's problems? Diarrhoea **Initial visit?** √ **Follow up visit?** _____

ASSESS (Circle all signs present)	**CLASSIFY**
CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION/JAUNDICE • Is the infant having difficulty in feeding? • Has the infant had convulsions? • Count the breaths in one minute 58 breaths per minute Repeat if elevated _____Fast breathing? • Look for severe chest indrawing • Measure axillary temperature (if not possible, feel for fever or low body temperature) - Is it < 35.5℃/ 37.5 ℃℃(95.9°F/99.5°F) or above? • Look at young infant's movements. If infant is sleeping, ask the mother to wake him/her ⇨ Does the infant move only when stimulated but then stops? ⇨ Does the infant not move at all? • Look at the umbilicus. Is it red or draining pus? • Look for skin pustules • Look for jaundice (yellow skin), If present • Look at the young infant's palms and soles. Are they yellow? • Ask when did jaundice appeared – First 24 hours / After 24 hours	*Infection Unlikely*
DOES THE YOUNG INFANT HAS DIARRHOEA? Yes √ No ____ • Look at the young infant's general condition. ➢ Look at infant's movements: ⇨ Does the infant move only when stimulated and 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 ⇨ Slowly	*Some Dehydration*
THEN CHECK FOR FEEDING PROBLEM & VERY LOW WEIGHT • Has the infant breastfed in the previous hour? Yes _____ No √ If yes, how many times in 24 hours? 5 times • Does the infant usually receive any other foods or drinks? **Yes** √ **No** _____ ⇨ If yes, how often? 3 ⇨ What do you use to feed the infant? cow's milk, feeding bottle • Measure Weight ⇨ Is it less than 1800 gm? ⇨ Is it 1800 – 2500 gm? • Determine weight for age by plotting weight on MCP card ⇨ Red (<- 3 SD) ⇨ Yellow (<- 2 SD to -3SD) ⇨ Green (≥ -2SD) • Look for ulcers or white patches in the mouth (thrush) Is there any indications for urgent Referral-Yes/No? If no **ASSESS BREASTFEEDING**	*Feeding Problem*
ASSESS BREASTFEEDING: • Has the infant breastfed in the previous hour? • If infant has not breastfed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfed for 4 minutes. • Check for attachment ⇨ Chin touching breast Yes__No_____ ⇨ Mouth wide open Yes__No_____ ⇨ Lower lip turned outward Yes__No_____ ⇨ More areola above than below the mouth Yes__No_____ • Is the infant able to attach? ⇨ no attachment at all ⇨ not well attached ⇨ good attachment • Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? ⇨ not suckling at all ⇨ not suckling effectively ⇨ suckling effectively • Does the mother have pain while breastfeeding? If yes, then look for: ⇨ Flat or inverted nipples or sore nipples	
CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS Circle immunization needed today Birth _____ BCG _____ OPV 0 _____ HEP-B 0 6 weeks _____ Penta-1 _____ OPV-1 _____ Rotavirus-1 _____ fIPV-1 _____ PCV-1	Circle immunization needed today Return for next immunization on: _____(Date)

SECTION 3

IDENTIFY TREATMENT

SECTION 3

IDENTIFY TREATMENT

The "Identify Treatment" column lists the treatments for the classification that the young infant has.

If the infant has more than one classification, strike out wherever there are duplicate instructions. For example, if the young infant has a pink classification Possible Serious Bacterial Infection and also has another pink classification Severe Dehydration, strike out **Refer to the hospital** from the treatments listed in one of the two boxes.

- A young infant with a PINK classification should be referred to hospital after giving appropriate pre-referral treatments listed.
- A young infant with a YELLOW classification should be provided all the listed treatments.
- The mother of a young infant with a GREEN classification should be advised to give home care.

There will be a demonstration for identifying treatment

EXERCISE ON IDENTIFYING TREATMENT

In this exercise you will decide whether or not urgent referral is needed. Tick the appropriate answer.

1. Sarla is an 11-day-old girl. She has the classification:
   LOCAL BACTERIAL INFECTION, NO FEEDING PROBLEM
   Does Sarla need urgent referral? YES__NO___
   Identify the treatment she needs:
2. Neena is a 6-week-old girl. She has the classification:
   POSSIBLE SERIOUS BACTERIAL INFECTION
   Does Neena need urgent referral? YES_NO ___
   What is the pre-referral treatment that she needs?
3. Hanif is a 7-day-old boy. He has the classification:
   Diarrhoea with NO DEHYDRATION and FEEDING PROBLEM
   Does Hanif need urgent referral? YES_NO ___
4. Habib is a 19-day-old boy. He has:
   POSSIBLE SERIOUS BACTERIAL INFECTION
   Does Habib need urgent referral? YES_NO ___

HOW DO YOU URGENTLY REFER THE CHILD?

Children with PINK Classification require urgent pre referral treatment and referral. These classifications indicate very serious illness

There are four steps to referring a child or a sick young infant to hospital:

1. **EXPLAIN to the caregiver the need for referral, and get her agreement to take the child.**

   If you suspect that she does not want to take the child, find out why. Possible reasons might be:

   - She thinks hospitals are places where people often die. She fears her infant will die there too.
   - She does not think that the hospital will help the infant.
   - She cannot leave home and stay in the hospital to care for her infant, if there is no one to take care of her other children, or she is needed for farming, or she may lose a job.
   - She does not have money to pay for transportation, hospital bills, medicines, or food for herse. lf during the hospital stay.

2. **CALM the caregiver's fears and help her resolve any problems.**

   For example: if the caregiver fears that her infant will die at the hospital, reassure her that the hospital has physicians, supplies, and equipment that can help cure her baby.

   - Explain what will happen at the hospital and how that will help her baby.
   - If the caregiver needs help at home while she is at the hospital, ask questions and make suggestions about who could help. For example, ask whether her husband, sister or caregiver could help with the other children or with meals while she is away.
   - Discuss how she can travel to the hospital. Help arrange transportation if necessary.
   - You may not be able to help the caregiver solve her problems and be sure that she goes to the hospital. However, it is important to do everything you can to help.

3. **WRITE A REFERRAL NOTE for the caregiver to carry.**

   Tell her to give it to the health worker there. The note should include:

   - The name and age of the infant or child. The date and time of referral, description of the child's problems.
   - The reason for referral (signs/symptoms for classification). Treatment that you have given
   - Any other information that the hospital needs to know in order to care for the infant, such as earlier treatment of the illness or immunizations needed.
   - Your name and the name of your clinic.

4. **GIVE SUPPLIES AND INSTRUCTIONS NEEDED to care for her infant on the way to the hospital:**

   If the hospital is far, give the caregiver additional doses of antibiotic and tell her when to give them during the trip (according to dosage schedule on the **TREAT** chart). *If you think the caregiver will not actually go to the hospital, give her the full course of antibiotics, and teach her how to give them.*

   - Tell the caregiver how to keep the young infant warm during the trip. Advise the caregiver to continue breastfeeding.
   - If the infant has some or severe dehydration and can drink, give the caregiver some ORS solution for the infant to sip frequently on the way.

   REMEMBER: any infant with a general danger sign or a serious classification requires urgent referral.

   Separate section will describe the steps, if referral is not possible/refused

SECTION 4

TREAT THE YOUNG INFANT

SECTION 4

TREAT THE YOUNG INFANT

Facilitator will tell you how to use the TREAT section. TREAT section is organized into many subsections. Review various sub sections in the job-aid.

4.1 REFER THE INFANT

Write on the referral card the name, age and sex of the young infant; date and time of referral; include all problems that were identified and the classification, the treatment that has been given. Any other information that the staff at the referral hospital need to know about. Do not forget to write your name and the clinic. A referral card is shown in the illustration below.

REFERRAL CARD

Name Age: Gender: Date:

Signs

Classification

Treatment advice

Signatures

Designation & SC

Young infants with a PINK classification require referral. The following steps are necessary for a successful referral:

1. Explain to the mother the need for referral and get her agreement to take the young infant. If she appears reluctant then find out the reasons for this.
2. Solve the problems and calm her fears. Some common problems and their possible solutions are summarized in the table.
3. Write a referral card for the mother to take to the hospital, tell her to give this card to the doctor in the hospital.
4. Give any urgent treatment before the mother leaves you and provide any instructions that the mother should follow while on her way to the hospital.
   (a) If it has been determined that the young infant should be given antibiotics then make sure to give the first dose of antibiotic in your presence. Give an extra dose of this medicine if it is going to take a long time before the infant reaches the hospital. (If you are certain that the mother will not take the infant to the hospital then it is advisable that the entire course of antibiotic should be given).
   (b) Advise the mother to continue to breastfeed the baby while transporting the baby.
   (c) If the young infant has severe dehydration and the infant can feed then the mother must continue to give sips of ORS once every minute or two minutes throughout when she is travelling to the referral facility.

There will be Role Play followed by a Group Discussion

Give a single dose of amoxycillin and injection gentamicin as pre-referral treatment to infants with POSSIBLE SERIOUS BACTERIAL INFECTION or DEHYDRATION.

Administer injection gentamicin along with oral amoxycillin to young infants suspected with sepsis under the following situations;

- Pre-referral dose - The ANM will give the first dose of each antibiotic before referral to a health facility.
- Completion of antibiotic treatment - If the infant has not completed a course of either of the antibiotics following discharge from a health facility, the ANM will complete the course of the treatment as prescribed by the Medical Officer.
- Referral not possible or refused - Under this special situation where referral is not possible or is refused, the ANM will continue to give treatment for 7 days.

When referral is not possible, see the section ***Where Referral is Not Possible.***

Giving Injection Gentamicin

Dosage: 5-7.5 mg/kg

- Route of administration: intramuscular
- Site of Injection: Antero-Lateral aspect of the thigh
- Preparation: Prefer to use 20 mg/ ml strength (may be prepared by adding 2 ml sterile water in 80 mg/ 2 ml vial i.e. total volume 4 ml giving strength of 20 mg/ml).

Choose the dose from the row of the table that is closest to the infant's age and weight. Storage: Gentamicin is a heat stable drug and can be maintained at room temperature. **There is no need for refrigerator/cold chain maintenance for the storage of the drug.**

- Syringe and needle: 1 ml disposable syringe with 23 gauge needle should be used. Alternatively, insulin syringe could be used. ***Auto disposable syringes provided for immunization should not be used*** because of varying dosage marking.
- Duration of treatment: Total duration of treatment is 7 days. In cases of follow up treatment, the ANM may follow the advice as per the discharge ticket/ doctor's prescription.

Give the full course of amoxycillin to infants with LOCAL BACTERIAL INFECTION at home. Give amoxycillin by mouth every morning and every night for five days.

- Give oral amoxycillin and intramuscular gentamicin.
- ***Give one dose for possible serious bacterial infection or diarrhoea with dehydration or very low weight.***
- ***Give oral amoxycillin twice daily for 5 days in cases with local bacterial infection.***
- Determine the dose appropriate for the infant's weight (or age).
- Use a sterile needle and sterile syringe. Measure the dose accurately.
- Give the drugs as an intramuscular injection.

Weight	**Amoxycillin oral**			**Gentamicin[$] Dose: 5 - 7.5 mg /kg /day**	
	Syrup (125 mg/5 ml) per dose in ml	**Tab 125 mg (per dose)**	**Tablet 250 mg (per dose)**	**Strength 80 mg/ 2 ml vial (40 mg / ml)**	**Strength 20 mg/ ml[#]**
<1.5kg	2 ml	½	¼	0.2 ml	0.4 ml
1.5kg upto 2.0 kg	2 ml	½	¼	0.2 ml	0.4 ml
2kg upto 3.0 kg	2.5 ml	½	¼	0.3 ml	0.6 ml
3kg upto 4.0 kg	3.5 ml	1	½	0.4 ml	0.8 ml
4kg upto 5.0 kg	5.0 ml	1	½	0.5 ml	1.0 ml

[$]Explain to the mother why the drug is given

[#]Prefer to use 20 mg/ ml strength (may be prepared by adding 2 ml sterile water in 80 mg/ 2 ml vial i.e. total volume 4 ml giving strength of 20 mg/ml).

If referral is not possible:

- Referral is the best option for a young infant classification with POSSIBLE SERIOUS BACTERIAL INFECTION, DIARRHEA WITH SEVERE/SOME DEYDRATION AND LOW WEGHT FOR AGE/VERY LOW WEIGHT
- If referral is not possible or refused, give oral amoxycillin (25-30 mg/kg) every 12 hrs and intramuscular gentamicin once daily. Teach the mother how to keep the young infant warm at home and how to prevent low blood sugar. At each contact for injection of antibiotics, explain again to the caregiver that the infant is very sick and should urgently be referred for hospital. Continue giving once-daily intramuscular gentamicin and twice-daily oral amoxycillin until referral is feasible or for 7 days.
- Urgent referral is also needed in SEVERE JAUNDICE. Explain and counsel for urgent referral at each visit.

Treat the Young Infant 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 20-50 ml (10 ml/kg) of expressed breastmilk or locally appropriate animal milk (with added sugar) before departure. If neither of these is available, give 20- 50 ml (10 ml/kg) of sugar water.

To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200 ml cup of clean water.

If the child is not able to swallow:

- Give 20-50 ml (10 ml/kg) of expressed breastmilk or locally appropriate animal milk (with added sugar) or sugar water by nasogastric tube.

Teach the mother how to give oral drugs to the infant at home

STEPS IN TEACHING THE MOTHER TO GIVE ORAL DRUGS AT HOME

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

Ask the mother checking questions to make sure that she has understood all the steps of preparing the medicine for giving it to the young infant.

There will be an exercise on asking good checking questions followed by a demonstration role play on teaching the mother how to give oral drugs at home.

Teach the mother how to keep the young infant with low weight warm at home

It is important to keep the young infant warm. Low temperature has an adverse impact on the sick young infant and increases the risk of death. Maintaining temperature is especially important in low weight babies.

Teach the mother how to keep the young infant with low weight warm at home:

- Do not bathe young infant with low weight or low body temperature; instead sponge with lukewarm water to clean.
- Provide skin-to-skin contact (Kangaroo Mother Care) as much as possible, day and night.
- When skin-to-skin contact not possible:
  - Keep the room warm (>25°C/77°F) with a home heating device.
  - Clothe the baby in 3-4 layers; cover the head, hands and feet with cap, gloves and socks,
  - respectively.
  - Let the baby and mother lie together on a soft, thick bedding
  - Cover the baby and the mother with additional quilt, blanket or shawl, especially in cold weather.

FEEL THE FEET OF THE BABY PERIODICALLY– BABY'S FEET SHOULD BE ALWAYS WARM TO TOUCH

KEEP THE YOUNG INFANT WARM

The best way to maintain temperature warm a baby with low temperature is by placing the baby in skin-to-skin contact with the mother (or any adult). Skin-to-skin contact can also be used to keep a baby warm during transport and at home.

Warm the young infant using skin-to-skin contact (Kangaroo Mother Care):

- Provide privacy to the mother. If mother is not available, skin-to-skin contact may be provided by the father or any other adult.
- Request the mother to sit or recline comfortably.
- Undress the baby gently, except for cap, nappy and socks.
- Place the baby prone on mother's chest in an upright and extended posture, between her breasts, in skin-to-skin contact; turn baby's head to one side to keep airways clear
- Cover the baby with mother's blouse, 'pallu' or gown; wrap the baby-mother duo with an added blanket or shawl.
- Breastfeed the baby frequently.
- If possible, warm the room (>25°C/77°F) with a heating device.

Skin-to-skin contact is the most practical, preferred method of warming a hypothermic infant in a primary health care facility. If not possible: Clothe the baby in 3-4 layers, cover head with a cap, put gloves, socks and cover body with a soft, dry cloth and then by a blanket or a shawl; hold baby close to caregiver's body.

- **Keep the young infant warm on the way to the hospital**
  - By skin-to-skin contact OR
  - Clothe the baby in 3-4 layers, cover head with a cap and body with a blanket or a shawl; hold the baby close to the caregiver's body.

Small childern must be kept warm

Young Infant must be kept warm

Teach the mother to treat local infection at home

Teach mother to give local treatment for skin pustules and umbilical infection in addition to giving oral amoxycillin. Also teach the mother to treat young infants with thrush (mouth ulcers).

- Explain how the treatment is given at home
- Watch her as she gives the first treatment in the clinic
- She should return to the clinic if the infection worsens
- Check the mother's understanding before she leaves the clinic

Follow the following instructions to treat local infection at home:

To Treat Skin Pustules or Umbilical	***To Treat Thrush (ulcers or white patches in mouth)***
• Apply gentian violet paint twice daily The mother should: - Wash hands - Gently wash off pus and crusts with soap and water - Dry the area and paint with gentian violet 0.5% or antibacterial ointment - Wash hands again	• Tell the mother to do the treatment twice daily The mother should: - Wash hands - Wash mouth with clean soft cloth wrapped around the finger and wet with salt water - Paint the mouth (ulcers/ patches) with gentian violet 0.25% - Wash hands again

4.2 TREATMENT OF DIARRHOEA

Plan A: Treat diarrhoea at home

The best way to treat diarrohea at home includes giving the young infant extra fluid and continue feeding. If an infant is exclusively breastfed, breastfeed frequently and for longer at each feed. If passing frequent watery stools, give ORS and clean water in addition to breast milk in infant less than 6 months. Remind the mother to stop giving ORS solution after the diarrhoea has stopped.

If the infant is not exclusively breastfed: Give one or more of the following home fluids; ORS solution, or plain clean water.

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:

- <2 months- 5 spoons after each loose stool.
- 2 months upto 2 years- 1/4 cup to 1/2 cup after each loose stool.
- 2 years or more- 1/2 cup to 1 cup after each loose stool.

Tell the mother to:

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

4.3 COUNSEL THE MOTHER OF A YOUNG INFANT WITH THE CLASSIFICATION 'FEEDING PROBLEM'

Locate the following sections in the chart booklet and counsel the mother using good communication skills.

Teach correct positioning and attachment for breastfeeding.

- Show the mother how to hold her infant
  - with the infant's head and body straight
  - facing her breast, with infant's nose opposite her nipple
  - with infant's body close to her body
  - supporting infant's whole body, not just neck and shoulders
- Show the mother 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.

	
Correct breastfeeding position	**Incorrect breastfeeding position**
• Baby's body should be straight, not bent or twisted. His head can be slightly extended at the neck, which helps his or her chin to be close to the breast. • Baby should be facing the breast with nose opposite to the nipple. • Baby's body should be close to the mother which enables the baby to be close to the breast, and to take a large mouthful. • Baby's whole body should be supported.	• Infant's neck is twisted or bend forward • Baby's body turned away from mother. • Baby's whole body not well supported • No mother baby eye contact.

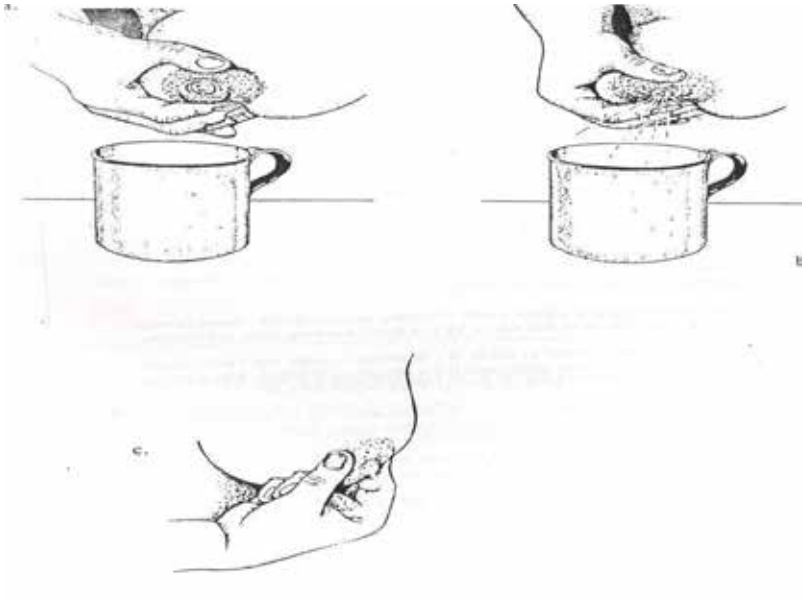
	
Good Attachment	**Poor Attachment**
• The baby's chin touches the breast • The baby's mouth is wide open • The baby's lower lip is turned outwards • Most of the areola is inside baby's mouth and small part of it is seen above the baby's mouth only.	• The baby's chin does not touch the breast. • The baby's mouth is not wide open. • The baby's lower lip is not turned outwards. • The same area of areola is seen above and below the baby's mouth.

Teach the mother to treat breast and nipple problems

- If the nipple is flat or inverted, evert the nipple several times with fingers before each feed and put the baby to the breast.
- If nipple is sore, apply breast milk for soothing effect and ensure correct positioning and attachment of the baby. If mother continues to have discomfort, feed expressed breast milk with a cup.
- If breasts are engorged, let the baby continue to suck if possible. If the baby cannot suckle effectively, help the mother to express milk and then put the young infant to the breast. Putting a warm compress on the breast may help.
- If breast abscess, advise mother to feed from the other breast and refer to a surgeon. If the young infant wants more milk, feed undiluted animal milk with added sugar by cup and spoon.

Teach the mother how to express breast milk

- The mother should wash hands, sit comfortably and hold a cup or 'katori' under the nipple and areola.
- Place her finger on the top of the breast and the first finger on the underside of the breast so that they are opposite to 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 round the breast, keeping her fingers the same distance from the nipple.
- She should be careful not to squeeze the nipple, to rub the skin or move her thumb or finger on the skin.
- Express one breast until the milk just drips, and then express the other breast until the milk just drips.
- Alternate 5-6 times between breasts for at least 20-30 minutes.



Teach the mother to feed with a cup and spoon (donor human milk/ animal milk)

- Place the young infant in upright posture (feeding him in lying position can cause aspiration)
- Keep a soft cloth napkin or cotton on the neck and upper trunk to mop the spilled milk.
- Gently stimulate the young infant to wake him up
- Put a measured amount of milk in the cup
- Hold the cup so that it rests lightly on young infant's lower lip
- Tilt the cup so that the milk just reaches the infant's lips
- Allow the infant to take the milk himself and swallows it. DO NOT pour the milk into the infant's mouth.

Principles of Communication while Counselling

ASK and LISTEN	As you have learnt earlier
PRAISE	It is likely that the mother has done something helpful for the baby, for example, seeking care for the current illness episode. Praise the mother ONLY for something helpful she has done. Be sure that the praise is genuine, and only praise actions that are indeed helpful to the child.
ADVISE	Limit your advice to what is relevant to the mother at this time. If possible, use pictures or real objects to help explain. Advise against any harmful practices that the mother may have reported, for example giving honey or sugar water. Do not make the mother feel guilty but explain why the practice is harmful.
CHECK UNDERSTANDING	Ask questions to find out what the mother understands and what needs further explanation. Avoid asking questions that can be answered with a simple yes or no. Examples of good checking questions are: "How often will you breastfeed the baby?" or "Why is it important not to give the baby anything other than breast milk?" If you get an unclear response, ask another checking question. Praise the mother for correct understanding or clarify your advice as necessary.

Common breastfeeding problems and possible solutions

Breastfeeding problem	Counsel the mother
Mother feels her milk is not enough for the baby	• Increase your food and fluid intake • Breastfeed in a relaxed environment free from any mental stress • Take some rest during the day • Breastfeed frequently including at night, at least 8 times during 24 hours • Breastfeed until the breast is completely empty. Then feed from the other breast
Young infant is being fed with a bottle, cotton or dropper	• If possible, stop other foods and fluids and give only breast milk upto 6 months of age • If not possible, give undiluted animal milk with a katori and spoon
Mother works outside home	• Breastfeed frequently before going to work and after returning home, including at night • Express breastmilk before leaving for work and ask the caretaker to feed the young infant with a katori and spoon • If necessary, supplement with top milk. Ask the caretaker to give undiluted animal milk with a katori and spoon

Teach the mothers how to feed with a cup and spoon (donor human milk/ animal milk) in case of no prospects of breastfeeding

Mother/caregiver feeds infant with cup, and does not use bottles, teats, or spouted cups.

Assess readiness for cup feeding:

- Rest the cup against the infant's lips, with milk touching infant's top lip.
- Wait and watch for infant response. If no response, try at next feed.

Counsel the mother or caregiver to:

- Put a cloth on the infant's front to protect his clothes as some milk can spill.
- Hold the infant upright or semi-upright on the lap. Put a measured amount of milk in the cup.
- Hold the cup resting on the lower lip and tilt the cup so that the milk touches the infant's upper lip.
- Wait for the infant to draw in or suck in the milk. Allow the infant to take the milk himself.
- DO NOT pour the milk into the infant's mouth. Caregiver should pause and let infant rest after every few sucks.
- Caregiver should pay attention to infant, look into infant's eyes and be responsive to infant's cues for feeding.
- Do not reuse any milk the infant does not drink for another feeding.

Teach the mother/ caregiver where there is no prospects of breastfeeding or has to give replacement feeds temporarily

- Prepare milk correctly & hygienically.

You will now watch a video on how to teach Correct Positioning and Attachment

***

Facilitator will conduct a Group Discussion of photographs – Recognizing signs of good positioning.

Comment on the following photographs:

Photo	Signs of Good Positioning				Comments on Attachment
	Infant's Head and Body Straight	Head and Body Facing Breast	Infant's Body Close to Mother's	Supporting Infant's Whole Body	
24					
25					
26					
27					
28					
29					

Advise Mother to Give Home Care

- Immediately after birth, baby should be put on the mother's abdomen for skin-to-skin contact.
- Initiate breastfeeding within one hour of birth.
- 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 him or her at least every 2-3 hours. Wake the baby for feeding after 3 hours, if she or he does not wake-up self.
- Breastfeed as often as your baby wants. Look for signs of hunger, such as beginning to fuss, sucking fingers, or moving lips.
- DO NOT give other foods or fluids. Breastmilk is all your baby needs.
- Make sure the young infant stays warm at all times. In cool weather, cover the infant's head and feet and dress the infant with extra clothing.
- Wash hands with soap and water after defecation and after cleaning bottom of the baby.
- Do not apply anything on the cord and keep the umbilicus cord dry.

Advise the mother to return immediately if the young infant has any of these danger signs. Use local terms that the mother can understand. Circle the signs that the mother must remember. Ask her checking questions to be sure she knows when to return immediately.

When to Return Immediately:

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

- Breastfeeding or drinking poorly
- Becomes sicker
- Develops a fever or feels cold to touch
- Fast breathing
- Difficult breathing
- Yellow palms and soles (if the infant has jaundice)
- Blood in stool

4.4 COUNSEL THE MOTHER ABOUT HER OWN HEALTH

After the assessment, classification and treatment of the young infant has already been performed, listen for any problems that the mother herself may be having. The mother may need treatment or referral for her own health problem.

- Follow-up visit and regular postnatal visits should be coordinated. Try and schedule the visit of the young infant and mother together.
- Emphasize that postnatal visit is a good opportunity to provide advice and care to the mother and young infant.
- If the mother is sick, provide care for her or refer her for help. Also, if the sick young infant is still breastfed, help the mother to breastfeed her young infant.
- Advise her to eat well to keep up her own strength and health. Advise her to take one additional energy dense meal to meet requirements for good lactation.
- Give iron folic acid (1 tab 60 mg elemental iron daily + 500 microgram folic acid) & Calcium tablets (500 mg elemental calcium with 250 IU Vitamin D twice daily). Advise her to continue it for a total of 180 days.
- Make sure she has access to:
  - Contraceptives
  - Counselling on STD and AIDS prevention

4.5 ASSESS AND COUNSEL THE MOTHER /CAREGIVER FOR DEVELOPMENT SUPPORTIVE PRACTICES

First thousand days are period of rapid brain growth. Stimulation and development supportive practices are important for achieving child full development potential.

If the mother does not breastfeed, counsel the mother to:

- Hold the baby close when feeding, look at the baby, and talk or sing to the baby.

If caregivers do not know what the baby does to play or communicate:

- Remind caregivers that babies play and communicate from birth.
- First thousand days are period of rapid brain growth. Stimulation and development supportive practices are important for achieving child full development potential.
- Demonstrate how the baby responds to activities.

If caregivers feel too burdened or stressed to play and communicate with the baby:

- Listen to the caregiver's feelings, and help them identify a key person who can share their feelings and help them with their baby.
- Build their confidence by demonstrating their ability to carry out a simple activity.
- Refer caregivers to a local service, if needed and available.

If caregivers feel that they do not have time to play and communicate with the baby:

- Encourage them to combine play and communication activities with other care for the child.
- Ask other family members to help care for the baby or help with chores.

If caregivers have no toys for the baby to play with, counsel them to:

- Use any household objects that are clean and safe.
- Make simple toys.
- Play with the baby. The baby will learn by playing with the caregivers and other people.

If the baby is not responding, or seems slow :

- Encourage the family to do extra play and communication activities with the baby.
- Check to see whether the baby is able to see and to hear.
- Refer the baby with difficulties to special services.
- Encourage the family to play and communicate with the baby through touch and movement, as well as through language.

If the mother or father has to leave the baby with someone else for a period of time:

- Identify at least one person who can care for the baby regularly, and give the baby love and attention.
- Get the baby used to being with the new person gradually.
- Encourage the mother and father to spend time with the baby when possible.

If it seems that the baby is being treated harshly:

- Recommend better ways of dealing with the baby.
- Encourage the family to look for opportunities to praise the baby for good behaviour.
- Respect the baby's feelings. Try to understand why the baby is sad or angry.
- Give the baby choices about what to do, instead of saying "don't"

Counsel the mother /caregiver for practices to support child's development:

- **If the mother reports she does not play with baby:** Discuss ways to help baby see, hear, feel and move, appropriate for baby's age and Ask caregiver to do play or communication activity, appropriate for age.
- **If the mother reports she does not talk to child or talks harshly to child:** Ask caregiver to looks into baby's eye, gently hold and talk to the baby.

4.6 FOLLOW-UP CARE

Advise the mother when to return for follow-up visit as per the schedule given in the box below:

	When to Return
• Feeding problem • Jaundice • Diarrhoea • Any local infection • Low weight for age	2 days 2 days 2 days 2 days 14 days

What are you going to do when the young infant comes for follow-up visit?

Jaundice:

An infant with Jaundice should be seen after 2 days

- If the sole and palm are yellow now **Refer to a hospital URGENTLY**
- If the infant is more than 2 weeks now and jaundice is persisting , **refer to a hospital**
- If the sole and palm are not yellow and less than 2 weeks of age , call after 2 days for FU

Feeding problems:

When a young infant returns for follow-up, reassess feeding.
Review with the mother the changes that the mother has been able to bring about in the infant's feeding.

• Have her attempts been successful?	• If successful, reassure the mother and ask her to continue
• If the mother has not been able to follow the advice	• Find out the reasons and try to correct them • Ask her to come back after 2 days

If you do not think that feeding will improve, refer the infant.

Diarrhoea:

A young infant with diarrhoea should be seen after 2 days.

Assess dehydration as described in chart booklet, and review the feeding.

Assessment Findings	**Treatment**
• If young infant has some or severe dehydration or blood in stool or any sign of possible serious bacterial infection or if duration of diarrhoea is 14 days or more	• ***Refer urgently to hospital***
• If duration of diarrhoea less than 14 days, no blood in the stool and young infant has no dehydration	• Continue breastfeeding and ORS with clean, preferably boiled water

Any Local Infection:

If the young infant is getting better, continue the treatment. However, if the young infant becomes worse or the baby has the same condition, refer to a doctor/hospital.

Low Weight for Age:

If the infant is gaining weight and feeding well, praise the mother and continue treatment. However, if the young infant becomes worse or the baby has the same condition, refer to doctor/ hospital.

SECTION 5

ASSESS AND CLASSIFY THE SICK CHILD AGE 2 MONTHS UPTO 5 YEARS

SECTION 5

ASSESS AND CLASSIFY THE SICK CHILD

The process to assess and classify the sick child aged 2 months upto 5 years is very similar to the one you learnt for the young infant.

Begin by asking the Child's **Name** and **Age**. Ask The Mother, **What the Child's Problems Are**. Select the case management section, Assess and Classify the Sick Child aged 2 Months upto 5 Years and follow the steps.

5.1. CHECK FOR GENERAL DANGER SIGNS

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

ASK:	*LOOK:*	*SIGNS:*
• Is the child able to drink or feed? • Does the child vomit everything? • Has the child had convulsions?	• See if the child is lethargic or unconscious. • Is the child convulsing now?	• Not able to drink or feed or • Vomits everything or • Lethargic or unconscious or • Convulsions/ convulsing now

Danger signs indicate serious illness. These can occur in many illnesses. Some danger signs may occur without any relationship to the type of illness. For example, fever, diarrhoea, pneumonia, meningitis or malaria can all produce lethargy or unconsciousness. These illnesses can also make the child so sick that the child is not able to drink any fluids. These are called **general danger signs.** The presence of even one general danger sign is enough to indicate a severe disease.

Every child who is seen for an illness should be checked for the presence of the following general danger signs:

- Not able to drink or breastfeed
- Vomits everything
- Lethargic or unconscious
- Convulsions

ASK: Is the child able to drink or feed?

A child has the sign "not able to drink or breastfeed" if the child is not able to suck or swallow when offered a drink or breastmilk.

If the mother says that the child is not able to drink or feed, ask her to describe what happens when she offers the child something to drink. For example, is the child able to take fluid into his mouth and swallow it? If you are not sure about the mother's answer, ask her to offer the child a clean water or breastmilk to drink. Look to see if the child is swallowing the water or breastmilk.

A child who is breastfed may have difficulty sucking when his nose is blocked. If the child's nose is blocked, clear it. If the child can breastfeed after his nose is cleared, the child does not have the danger sign: "not able to drink or feed."

Child not able to drink

ASK: Does the child vomit everything?

A child who is not able to hold anything down at all has the sign: "vomits everything." What goes down comes back up. A child who vomits everything will not be able to hold down food, fluids or oral drugs. A child who vomits several times but can hold down some fluids does not have this general danger sign.

LOOK: See if the child is lethargic or unconscious.

The lethargic child is sleepy when the child should be awake. A child who stares blankly and does not appear to notice what is happening around is also lethargic.

The unconscious child does not awaken at all. This child does not respond to touch, loud noise or pain.

Note: If the child is sleeping and has cough or difficult breathing, count the number of breaths first before you try to wake the child.

ASK: Has the child had convulsions?

Ask the mother questions on whether the child has suffered from convulsions or not (use local term for convulsion).

Remember:

- All sick children must be assessed for general danger signs
- A child who has even one general danger sign has a severe problem. **Refer this child urgently to hospital**.
- Complete the rest of the assessment and any pre-referral treatment immediately so that referral is not delayed.

You will now watch a video on how to assess a child for general danger signs.

At the end of video answer the following questions:

	Is the child lethargic or unconscious?	
	YES	**NO**
Child 1		
Child 2		
Child 3		
Child 4		

5.2. ASSESS AND CLASSIFY COUGH OR DIFFICULT BREATHING

THEN ASK ABOUT MAIN SYMPTOMS:
Does the child have cough or difficult breathing?

IF YES, ASK:
- For how long?

LOOK, LISTEN:
- Count the breaths in one minute.
- Look for chest indrawing.
- Check oxygen saturation: <90% or >90%

} **CHILD MUST BE CALM**

Ask the mother if the child has cough or difficult breathing. **If the child has no cough or difficult breathing, do not assess for the same.** If the mother says that the child has cough or difficult breathing:

ASK: For how long?

A child who has had cough for more than 14 days needs to be **referred to hospital** for further assessment.

COUNT the breaths in one minute.

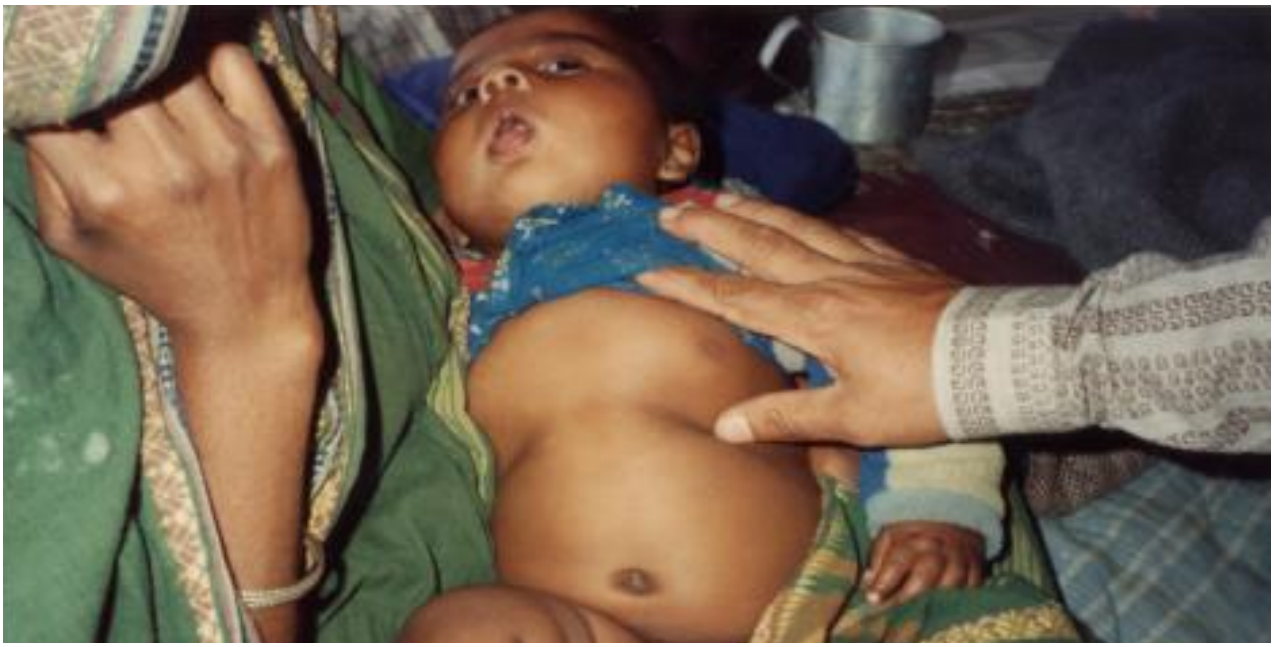
Count the breaths the child takes in one minute as you have learnt earlier. Decide whether the child has normal breathing or fast breathing.

If the child is:	The child has fast breathing if you count:
2 months upto 12 months	**50** breaths per minute or more
12 months upto 5 years	**40** breaths per minute or more

Note: The child who is exactly 12 months old has fast breathing if you count 40 breaths per minute or more.

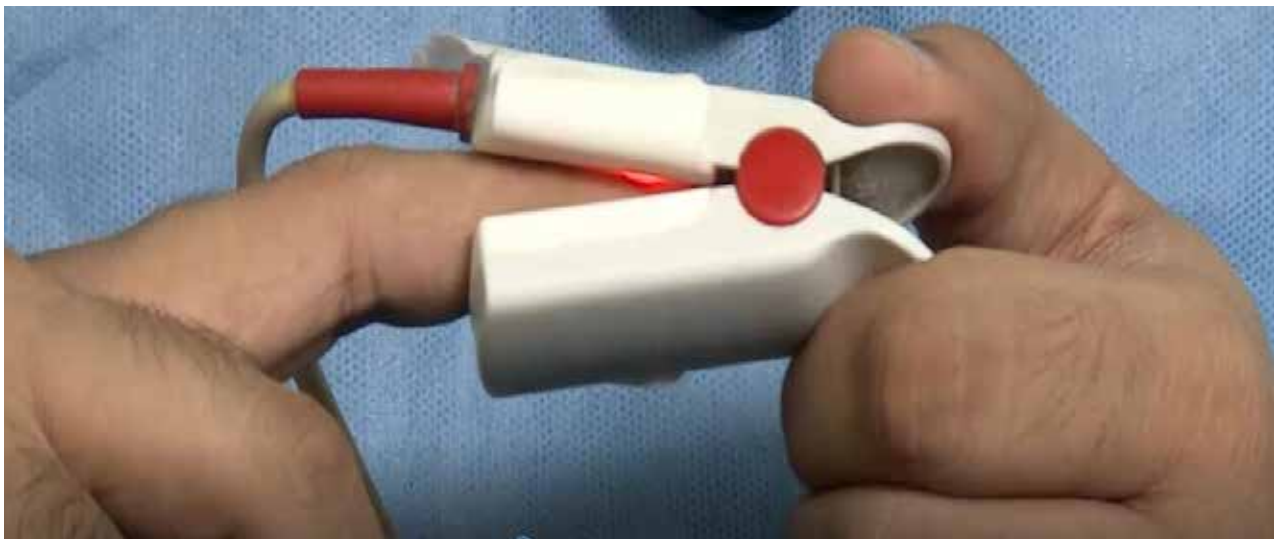
LOOK for Chest Indrawing

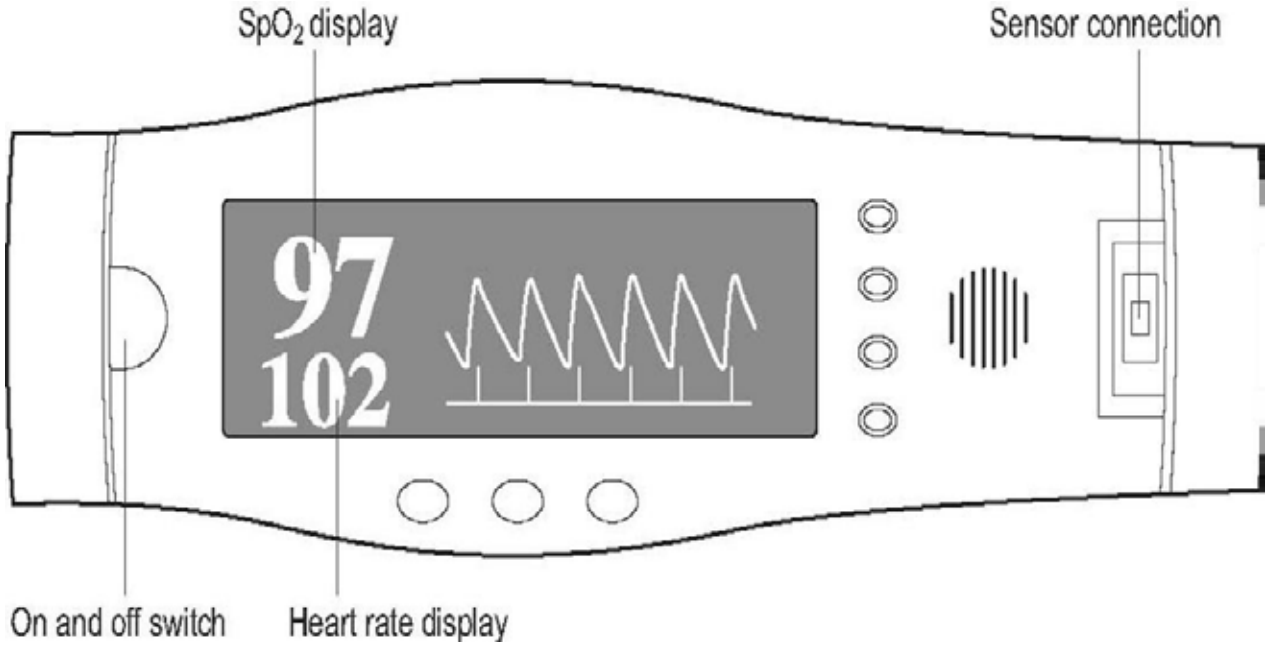
Chest indrawing in a child with cough or difficult breathing indicates that the child has severe pneumonia. Unlike young infants, mild chest indrawing is **NOT** normal in a child. A child with any chest indrawing should be referred to hospital.



CHECK Oxygen saturation (SpO_2)

Oxygen saturation of blood is checked with a device called pulse oximeter. There are several types of pulse oximeter - finger probe type is most commonly used. Use whichever is supplied to you after cleaning probe with alcohol swab. A normal child has oxygen saturation between 95-100%. If oxygen saturation is less than 90% in a child with cough or difficult breathing, this is sign of severe pneumonia and child will need oxygen supplementation. **Reading should be taken when child is not moving and there is proper wave formation on the display.**




SpO2 display
Sensor connection
97
102
On and off switch
Heart rate display

CLASSIFY COUGH OR DIFFICULT BREATHING

Given below is the classification table for cough or difficult breathing.

Signs	Classify as	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
• General danger signs (inability to breastfeed or drink, lethargy or unconsciousness, persistent vomiting) or • Chest indrawing or • Oxygen saturation < 90%	**SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	• ***Give pre-referral dose of oral amoxycillin and IM gentamicin*** • ***Refer URGENTLY to hospital.***[#]
• Fast breathing Respiratory rate: - 2-11 months - ≥ 50/min - 12-59 months - ≥ 40/min	**PNEUMONIA**	• ***Give amoxycillin for 5 days.*** • *Advise home care for cough and cold.* • *Follow-up after 2 days.*
• No signs of severe pneumonia or pneumonia	**NO PNEUMONIA: COUGH or COLD**	• *Advise home care for cough and cold.* • *If coughing for more than 14 days, refer for assessment.* • *Follow up after 5 days, if not improving*

[#]*If referral is not possible, see the section where referral is not possible.*

Remember:

- *A child with any danger sign or chest indrawing has SEVERE PNEUMONIA OR VERY SEVERE DISEASE (pink classification) and needs urgent referral to hospital.*
- *A child who has no general danger signs and no chest indrawing but has fast breathing has PNEUMONIA (yellow classification). This child should be treated with medicine at home.*
- *A child who has no general danger signs, no chest indrawing and no fast breathing has NO PNEUMONIA: COUGH OR COLD (green classification). The mother of this child should be advised on how to give home care.*

You will now watch a video on how to assess a child for cough or difficult breathing

1. For each of the children shown in the video, answer the question:

			Does the child have fast breathing?	
	Age	**Breaths per minute**	**YES**	**NO**
Mano	**4 years**			
Wambai	**6 months**			

2. For each of the children shown in the video, answer the questions:

	Does the child have chest indrawing?	
	YES	**NO**
Mary		
Jenna		
Ho		
Anna		
Lo		

Video Case Study - Ben

MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UPTO 5 YEARS

Name:_____ **Age:**_____ **Gender:** _____ **Weight:**_____ **kg** **Temperature:**_____**°C** **ate:**_____

ASK: What are the infant's problems?_____ **Initial visit?**_____ **Follow up visit?**_____

ASSESS (Circle all signs present) **CLASSIFY**

CHECK FOR GENERAL DANGER SIGNS • NOT ABLE TO DRINK OR BREASTFEED • LETHARGIC OR UNCONSCIOUS • VOMITS EVERYTHING • CONVULSIONS/ CONVULSING NOW	General danger sign present? Yes _____ No_____ 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 • Check oxygen saturation- <90%/≥90%	

5.3 ASSESS AND CLASSIFY DIARRHOEA

Ask the mother if her child has diarrhoea. If the mother says the child has diarrhoea:

Ask for how long the child has had diarrhoea. If the **diarrhoea is of 14 days or more** duration, the child has **persistent diarrhoea**. This child should be referred to hospital.

Ask if there is blood in the stools. The child who is passing blood in the stools has **dysentery**. Children with dysentery should be referred to a hospital.

DOES THE CHILD HAVE DIARRHOEA?	
IF YES, ASK:	***LOOK AND FEEL:***
• For how long? • 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: - Slowly? - Very slowly (longer than 2 seconds)?

Assess every child with diarrhea for ***dehydration. Look for the following:***

LOOK and **FEEL** for the following signs:

LOOK at the child's general condition. Is the child lethargic or unconscious? restless and irritable?

LOOK for sunken eyes.

OFFER the child fluid to drink. Is the child not able to drink or drinking poorly? drinking eagerly, thirsty?

Ask the mother to offer the child some water in a cup or spoon. Watch the child drink.

A child is ***not able to drink*** if he is not able to suck or swallow when offered a drink. A child may not be able to drink because he is lethargic or unconscious.

A child is ***drinking poorly*** if the child is weak and cannot drink without help. He may be able to swallow only if fluid is put in his mouth.

A child has the sign ***drinking eagerly, thirsty*** if it is clear that the child wants to drink. Look to see if the child reaches out for the cup or spoon when you offer him water. When the water is taken away, see if the child is unhappy because he wants to drink more.

Drinks eagerly

If the child takes a drink only with encouragement and does not want to drink more, he does not have the sign "drinking eagerly, thirsty."

PINCH the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?

CLASSIFY DIARRHOEA FOR DEHYDRATION

Given below is the classification table for diarrhoea

Signs	**Classify as**	**IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)**
Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly.	**SEVERE DEHYDRATION**	• ***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, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly.	**SOME DEHYDRATION**	• Give fluid, zinc supplements and food for some dehydration (Plan B). • Follow-up after 2 days if not improving. • Advice when to return immediately
• Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	• Give fluid, zinc supplements and food to treat diarrhoea at home (Plan A). • Follow-up after 5 days if not improving. • Advice when to return immediately

[#]*If referral is not possible, see the section where referral is not possible.*

Remember:

- **Classify all cases of diarrhoea for dehydration.**
- *Children with signs of some and severe dehydration should be referred to hospital.*
- *Children with blood in stool should also be referred to hospital to rule out surgical or medical causes.*
- *Children with diarrhoea which is persisting for 14 days or more should also be referred to hospital.*
- **Children who are not dehydrated and have no blood in stool should be managed at home.**

You will now watch a video on how to assess a child for dehydration.

1. For each of the children shown, answer the question:

	Does the child have sunken eyes?	
	YES	**NO**
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		
Child 6		

2. For each of the children shown, answer the question:

	Does the skin pinch go back:		
	Very slowly?	**Slowly?**	**Immediately?**
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			

Video Case Study "JOSH":

MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UPTO 5 YEARS

Name:_____ Age:_____ Gender: _____ Weight:_____ kg Temperature:_____°C ate:_____

ASK: What are the infant's problems?_____ Initial visit?_____ Follow up visit?_____

ASSESS (Circle all signs present) **CLASSIFY**

CHECK FOR GENERAL DANGER SIGNS • NOT ABLE TO DRINK OR BREASTFEED • LETHARGIC OR UNCONSCIOUS • VOMITS EVERYTHING • CONVULSIONS/ CONVULSING NOW	General danger sign present? Yes _____ No_____ 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 • Check oxygen saturation- <90%/≥90%	
DOES THE CHILD HAVE DIARRHOEA? Yes____ No____ • For how long?_____ Days? • Is there blood in 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: ⇨ Slowly? ⇨ Very slowly (longer than 2 seconds)?	

Your Facilitator will conduct a Photograph Exercise on Skin Pinch

Photograph	Skin Pinch assessment
Photograph 30:	
Photograph 31:	
Photograph 32:	
Photograph 33:	
Photograph 34:	
Photograph 35:	
Photograph 36:	

5.4 ASSESS AND CLASSIFY FEVER

Fever is a common problem among young children. A child with fever may have malaria or another disease such as simple cough or cold or other viral infection.

DOES THE CHILD HAVE FEVER? (By history or feels hot or temperature 37.5^{0}C/99.5^{0}F* or above)	
IF YES: Is it a PF (p. falciparum) predominant area? Yes/ No ***THEN ASK:*** • Fever for how long? ▫ If more than 7 days, has fever been present every day?	***LOOK AND FEEL:*** • Look or feel for stiff neck • Look for any other focus of fever

** This cut-off is for axillary temperature.*

ASK: Does the child have fever?

Ask the mother if the child has fever. To check temperature, wash your hands before recording a baby's temperature. And keep the baby warm throughout the procedure.

Using digital thermometer: Switch on the thermometer, till beep is heard. Keep the digital thermometer in the axilla (armpit) and then hold the baby's arm against his body till beep is heard. Remove the thermometer and note the reading. If you are using mercury thermometer, keep it for 5 minutes.

If you do not have a thermometer, place the back of your hand in the armpit or on the tummy of the child to decide if the child feels hot to touch.

Fever is present if the mother is sure that her child has had fever or if you have determined that the child feels hot to touch.

ASK: For how long? If more than 7 days, has fever been present every day?

Ask the mother how long the child has had fever. If the fever has been present every day for more than 7 days, refer this child for further assessment.

LOOK or FEEL for stiff neck.

A child with fever and stiff neck may have meningitis. A child with meningitis needs urgent treatment with injectable antibiotics and referral to a hospital.

While you talk with the mother during the assessment, look to see if the child moves and bends his neck easily as he looks around. If the child is moving and bending his neck, he does not have a stiff neck.

If you did not see any movement, or if you are not sure, draw the child's attention to his umbilicus or toes.

For example, you can shine a flashlight on his toes or umbilicus or tickle his toes to encourage the child to look down. Look to see if the child can bend his neck when he looks down at his umbilicus or toes.

Before classifying fever, check for other focus of fever (e.g. cough, diarrhoea, skin infection etc.). The National Anti-Malaria Program in some areas has provided health workers rapid diagnostic kits and anti-malarials (including ACT) for early diagnosis and treatment of Falciparum cases.

Therefore, before treating a child with fever, you will determine whether the child has malaria by doing an RDT. The fever box (below) on the recording form reminds you to do the RDT before you treat the child for malaria

Classify Fever

Given below is the classification table for fever

Signs	Classify as	IDENTIFY TREATMENT • **(Urgent pre-referral treatments are in bold print.)**
• Any general danger sign or • Stiff neck	**VERY SEVERE FEBRILE DISEASE**	• ***Give first dose of oral amoxycillin and IM gentamicin*** • ***Treat the child to prevent low blood sugar*** • *Give one dose of paracetamol for high fever (temp. 38.5°C/101.3°F or above).* • ***Refer URGENTLY to hospital#*** .
• Positive RDT or • RDT not available and no other obvious cause of fever	**MALARIA/ SUSPECTED MALARIA**	• ***Give oral antimalarial as per national guidelines after making a smear*** • *Give one dose of paracetamol in clinic for high fever (temp. 38.5°C/101.3°F* or above).* • *Advise mother when to return immediately.* • *Follow-up after 2 days*
• Negative RDT and/or other causes of fever PRESENT**	**FEVER- MALARIA UNLIKELY**	• *Give one dose of paracetamol in clinic for high fever (temp. 38.5°C/101.3°F or above)* • *Give appropriate treatment for an identified cause of fever* • Advise mother when to return immediately. • *Follow-up after 2 days if fever persists* • *If fever is present every day for more than 7 days, refer for assessment*

*# If referral is not possible, see the section **Where referral is not possible** in the **treat the child***

***This cut-off is for axillary temperature**

**** Other causes of fever include no pneumonia: cough or cold, pneumonia, diarrhoea, dysentery, skin infections, dengue and measles**

Remember:

- *Remember to classify a child with fever who has a general danger sign as VERY SEVERE FEBRILE DISEASE*
- *Do not assess for fever if the child does not have fever*
- *If fever has been present every day for 7 days or more, refer to hospital*

***

You will now watch a video on "Does the Child have Stiff Neck"

Exercise
For each of the children shown, answer the question:

	Does the child have a stiff neck?	
	YES	**NO**
Child 1		
Child 2		
Child 3		
Child 4		

5.5. CHECK FOR MALNUTRITION

Check **ALL** sick children for signs suggesting malnutrition.

THEN CHECK FOR MALNUTRITION
LOOK AND FEEL
• Measure weight, length/height, plot WFL/H on MCP card and determine WFL/H SD score (color)*
• Look for oedema of both feet.
• Measure MUAC if child is 6 months or older.

** Look for visible severe wasting if unable to measure length/height. Classify severe acute malnutrition in presence of visible severe wasting.*

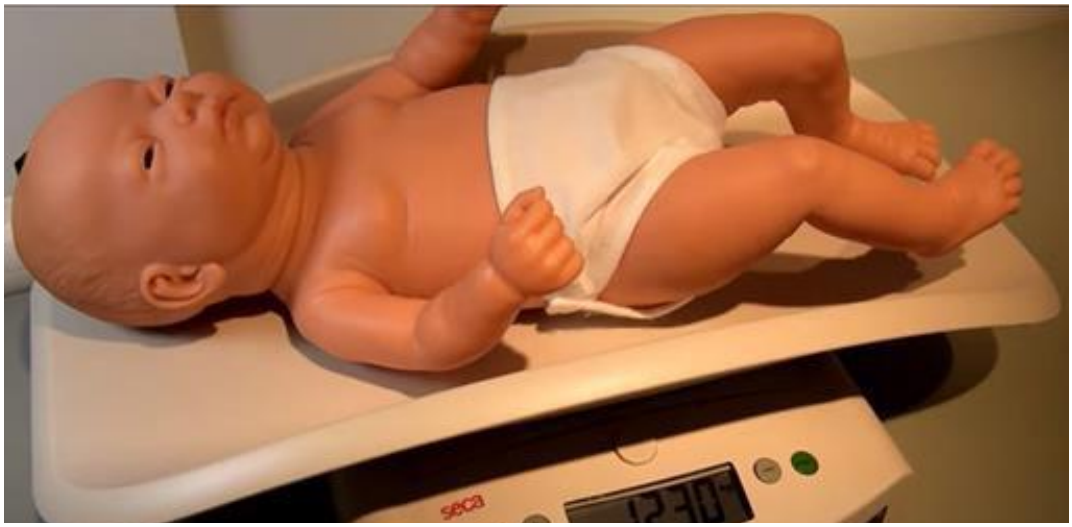
WEIGHT MEASUREMENT:

- Weight is vital anthropometric measurement and should be recorded for all children during all health contacts.
- Infants and children should be weighed at least once every month during first 5 years of life.

Weight Measurement through Salter Scale

Measurement of weight by digital weighing machine

- Remove the child's clothes to minimal clothes, but keep the child warm by covering him with a blanket or cloth while carrying to the scale.
- Turn on the scale by pressing the START button (or follow instructions for that scale).
- Adjust the scale to zero.
- Place the child gently in the pan.
- Wait for the child to settle and the weight to stabilize.



Weight measurement through digital weighing scale

- Measure weight to the nearest 0.01 kg (10 g) or as precisely as possible & record immediately.
- Wrap the child immediately to re-warm

MEASUREMENT OF LENGTH/HEIGHT:

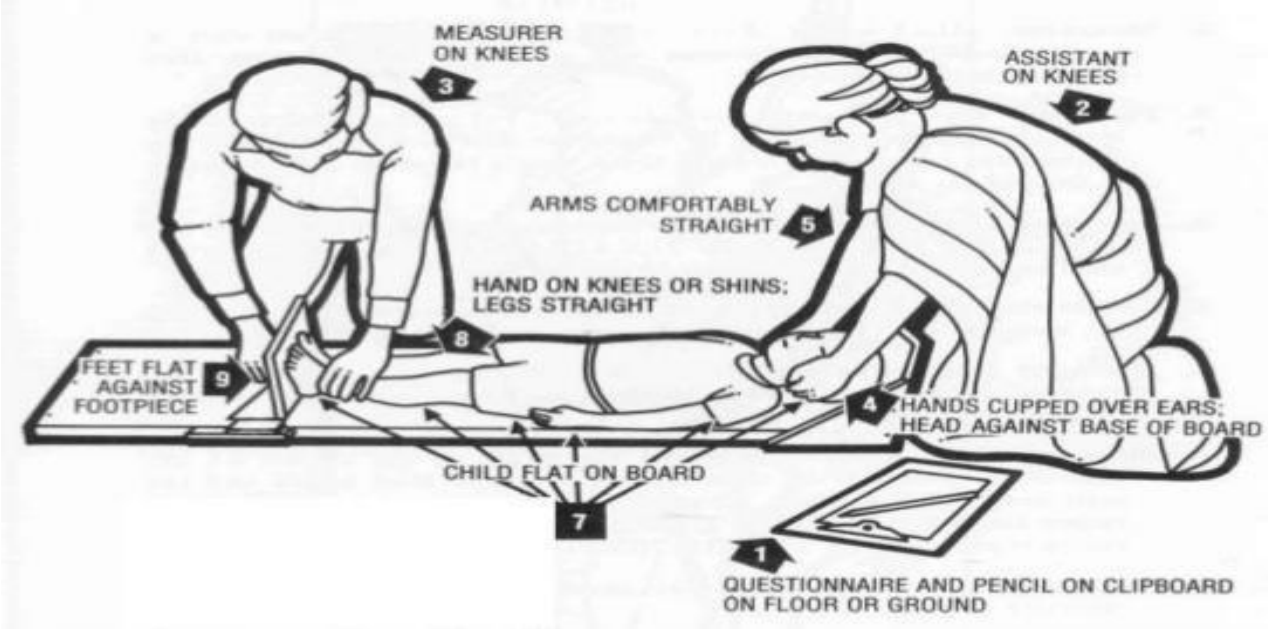
Depending on a child's age and ability to stand, measure the child's length or height. A child's length is measured lying down (recumbent). Height is measured standing upright. You have to keep the following points into consideration while deciding whether to measure child's height or length:

- If a child is less than 2 years old (less than 87 cm), measure recumbent length.
- If the child is aged 2 years (more than 87cm) or older and able to stand, measure standing height.

If a child less than 2 years old will not lie down for measurement of length, measure standing height and add 0.7 cm to convert it to length. If a child aged 2 years or older cannot stand, measure recumbent length and subtract 0.7 cm to convert it to height.

Measure the length (if child is less than 2 years of age or less than 87cm)

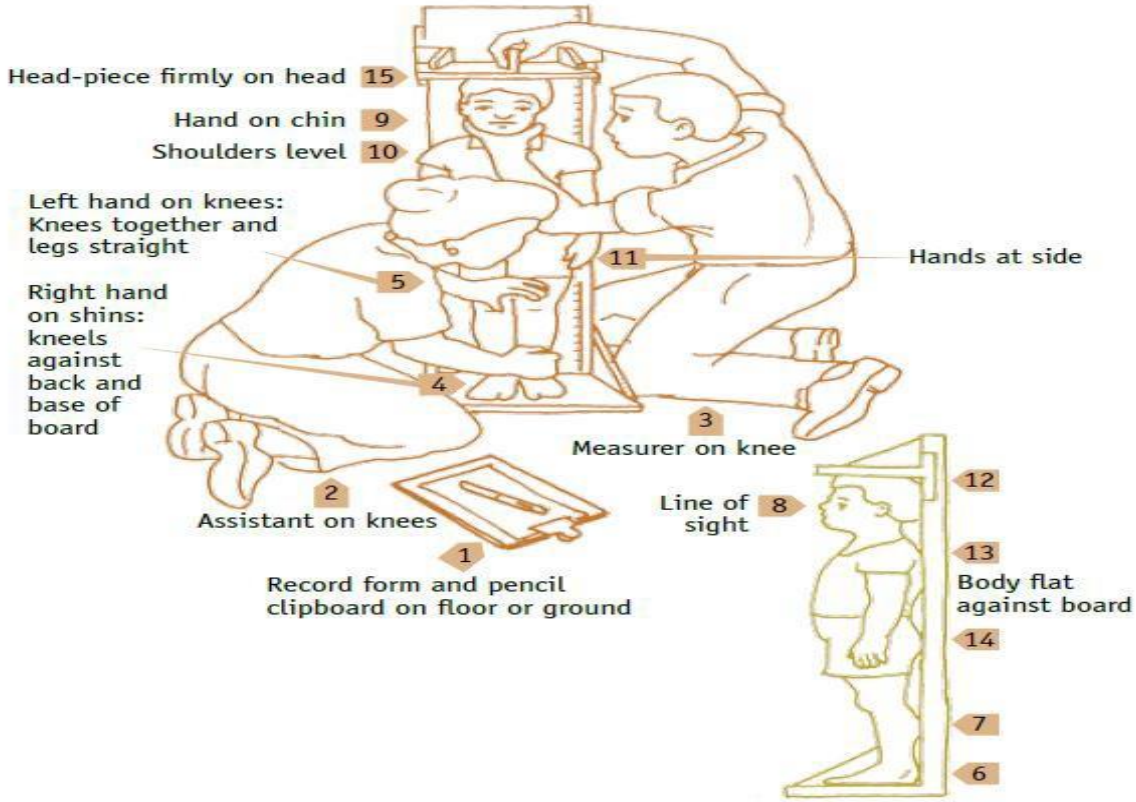
Infantometer (with a fixed head piece and horizontal backboard, and an adjustable foot piece).



Length Measurement

- Place the Infantometer on a hard, flat, level surface, such as the ground, floor or a solid table.
- One health worker or mother should stand or kneel behind the headboard and position the child lying on his back on the measuring board, supporting the head and placing it against the headboard.
- Position the crown of the head against the headboard, compressing the hair.
- Hold the head with two hands and tilt upwards until the eyes look straight up, and the line of sight is perpendicular to the measuring board.
- Check that the child lies straight along the centre line of the measuring board and does not change position.
- The ANM/AWW should stand alongside the measuring board and with the help of mother/ caretaker, support the child's trunk as the child is positioned on the board.
- Place one hand on the shins or knees and press gently but firmly. Straighten the knees as much as possible without hurting the child with the other hand; place the foot piece firmly against the feet.
- Soles of the feet should be flat on the foot piece, toes pointing up. If the child curls the toes and prevents the foot piece from touching the soles, scratch the soles gently and slide in the foot piece, when child straightens the toes.
- Read the measurement aloud to the nearest 0.1 cm and record it immediately on MCP card or on recording form.
- Child should be lifted off the board.

Measure the Height (if child is 2 years or more of age or more than 87 cm)



Height Measurement

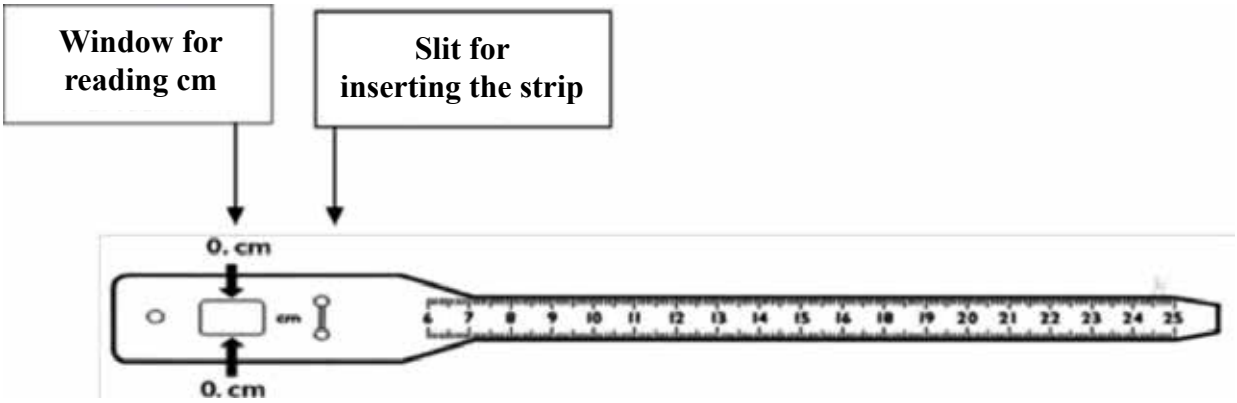
- Place stadiometer on a hard, flat level surface against a wall. Make sure it is stable.
- Ask the mother/caretaker to bring the child on the stadiometer and to kneel in front of the child so that the child will look forward at the mother.
- Make sure the child's arms hang down at his/her sides and the shoulders are level.
- Mother or a HW should kneel or crouch near the child's feet and help the child stand with back of the head, shoulder blades, buttocks, calves and heels touching the vertical board.
- Prevent children from standing on their toes.
- If necessary, gently push the child's tummy to help him stand straight to full height.
- The ANM/AWW should bend to level of the child's face and position the head so that the child is looking straight ahead (line of sight is parallel to the base of the board).
- Place thumb and forefinger over the child's chin to help keep the head in an upright position.
- With the other hand, pull down the head board to rest firmly on top of the head and compress hair.
- Measure height to the last completed 0.1 cm and record it immediately on MCP card & recording form.
- Help child to get off the board.

MID UPPER ARM CIRCUMFERENCE (MUAC) MEASUREMENT

Measure MUAC (only for children 6–59 months)

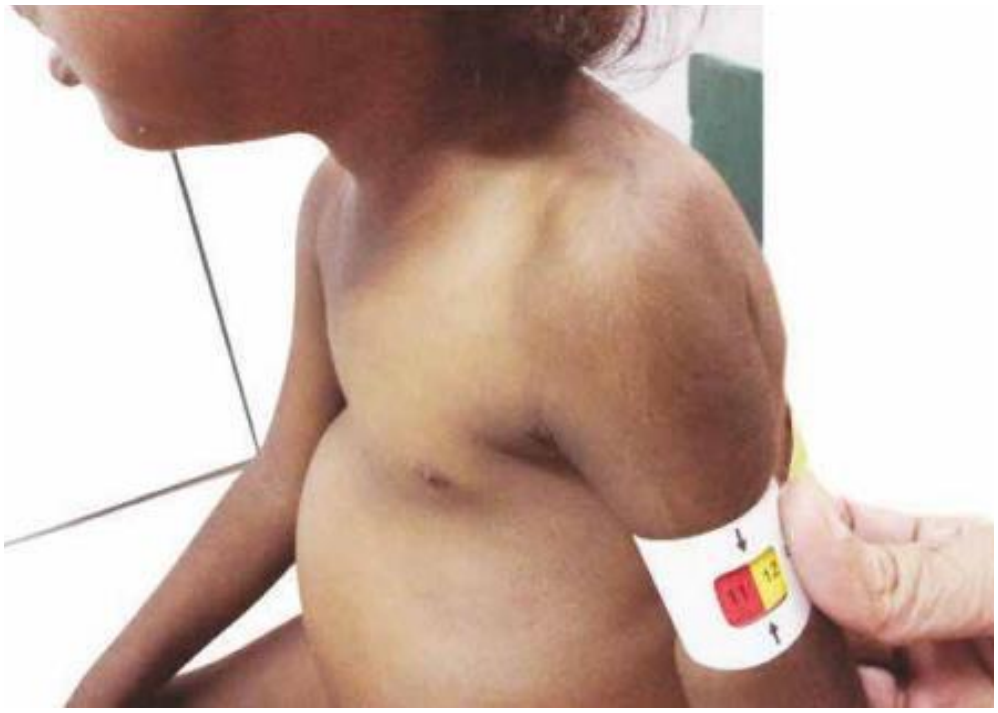
MUAC the measurement around the middle of a child's left upper arm is an important indicator of acute malnutrition in a child. This is called mid-upper arm circumference (MUAC). The MUAC strip is a flexible measuring tape that measures in centimeter (cm). MUAC measurement is used to identify wasted and severely wasted children between 6–59 months.

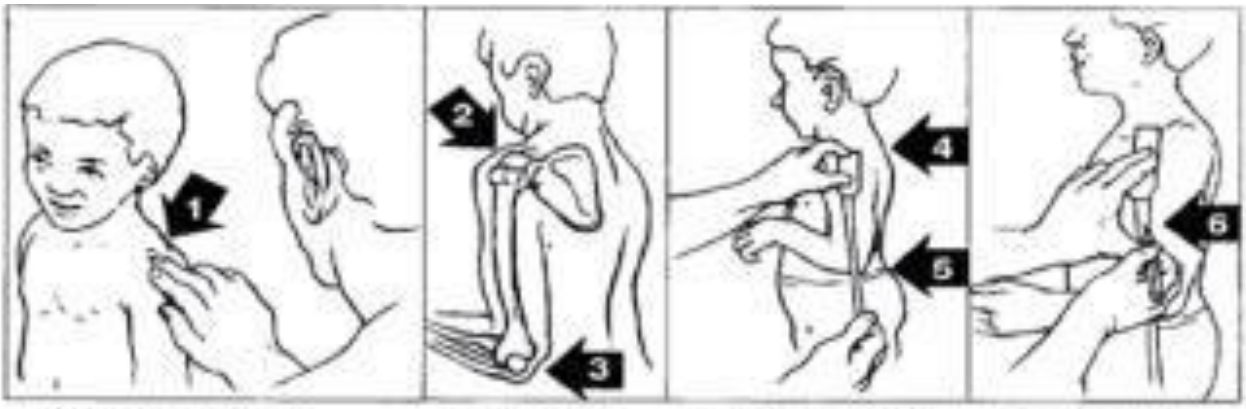
Examine your own MUAC strip, and refer to the picture below. The first thing you should note about your MUAC strip is that there are three different colours: green, yellow, and red to note danger of child's MUAC.



There are two important pieces of the MUAC strip you should note in the picture. The first is the slit where you will insert the MUAC strip. The next is the window where you will read the child's MUAC in cm.

Children with a MUAC less than 11.5 cm have severe acute malnutrition. This measurement is red on the MUAC strip. These children need special treatment.





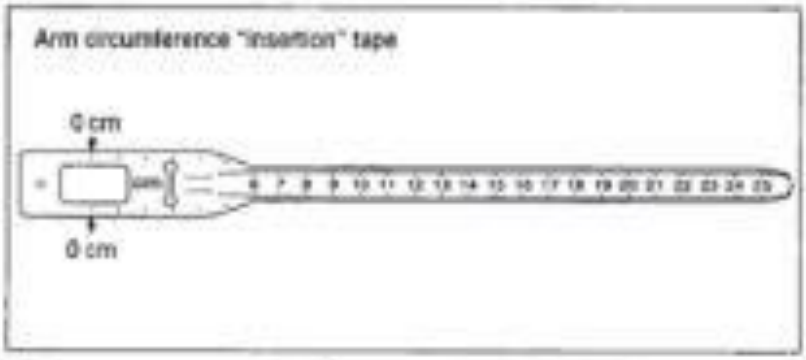
1 Locate tip of shoulder

2 Tip of shoulder
3 Tip of elbow

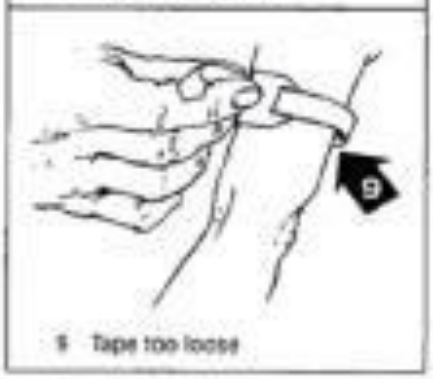
4 Place tape at tip of shoulder
5 Pull tape past tip of bent elbow

6 Mark midpoint

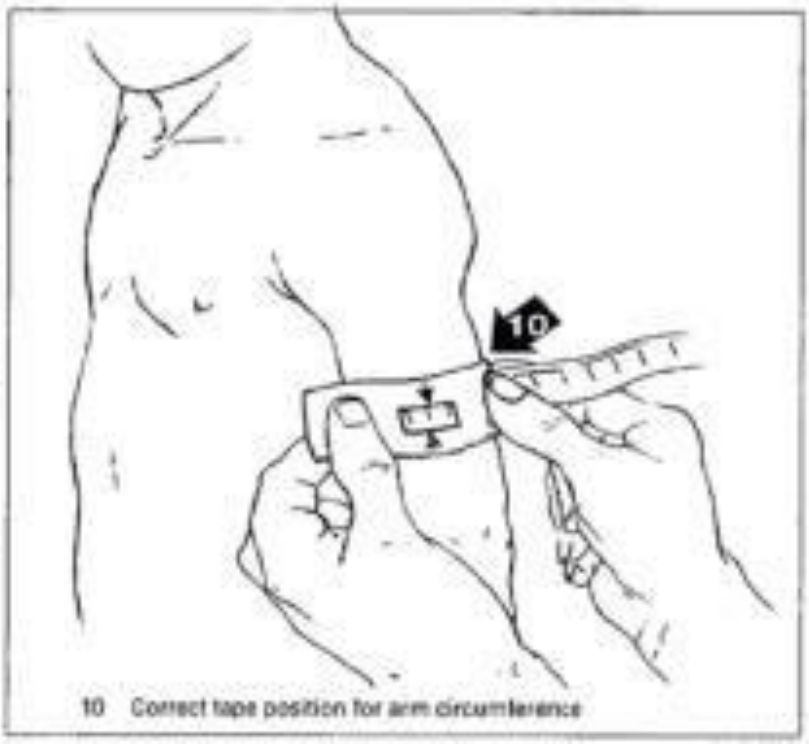
7 Correct tape tension



8 Tape too tight



9 Tape too loose



10 Correct tape position for arm circumference

The steps to measure the child's MUAC.

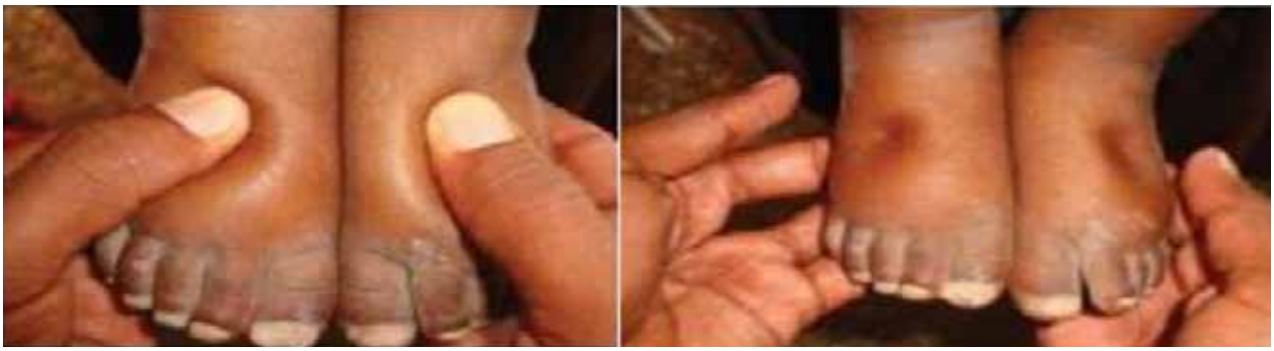
- Find the mid-point of the child's upper arm between the shoulder and elbow.
- Use MUAC tape to mark the mid-point on the child's arm.
- Hold the large end of the tape against the arm at the mid-point of the arm.
- Put the other end of the tape around the child's arm. Thread the end up through the second small slit in the tape. The end will come from behind.
- Pull both ends until the tape fits closely. It should not be so tight that it makes folds in the skin. It should also not be too loose.
- Gently press the window. At the marks note the measurement and colour.

ASSESSMENT OF BILATERAL PITTING OEDEMA

What is Bilateral Pitting Oedema?

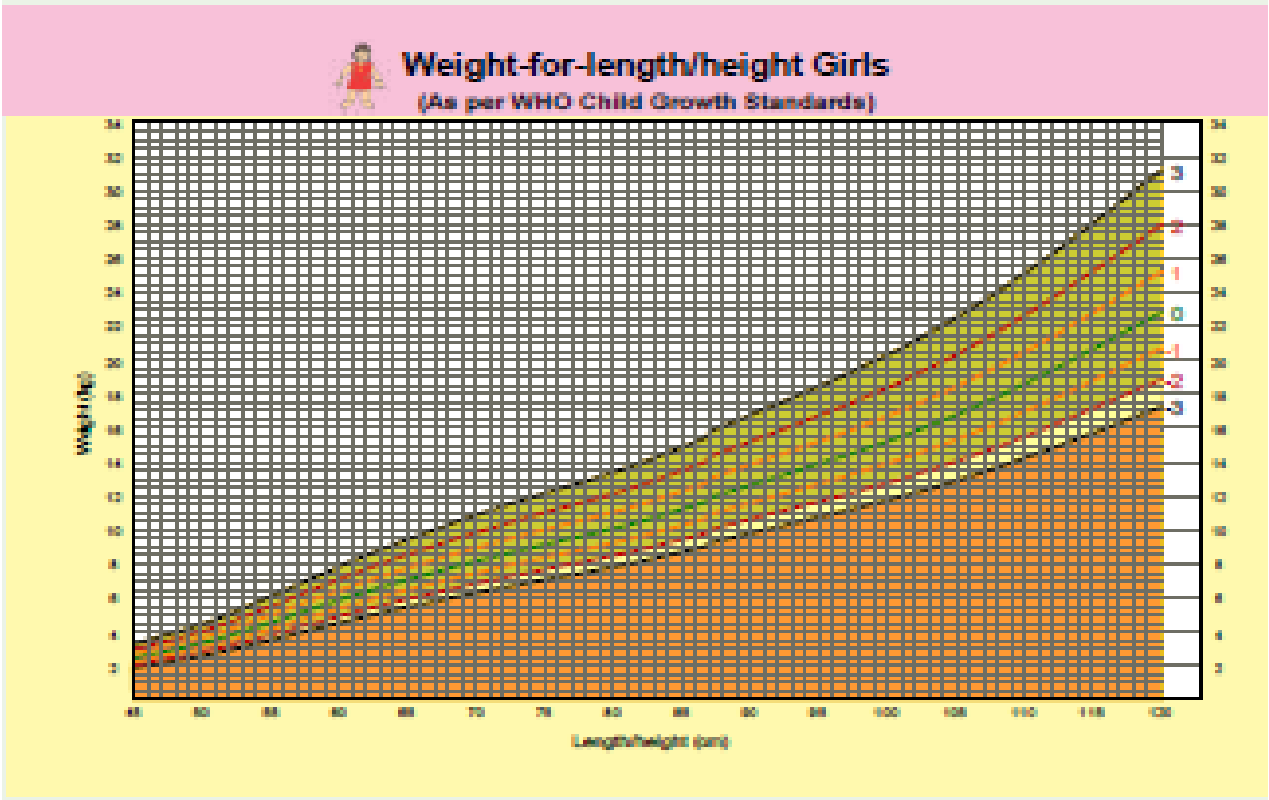
Imbalance in energy and protein intake in children with SAM causes low protein in the body and physiological changes lead to accumulation of excessive fluid in the tissues or oedema. These children are at high risk of mortality and need to be treated urgently.

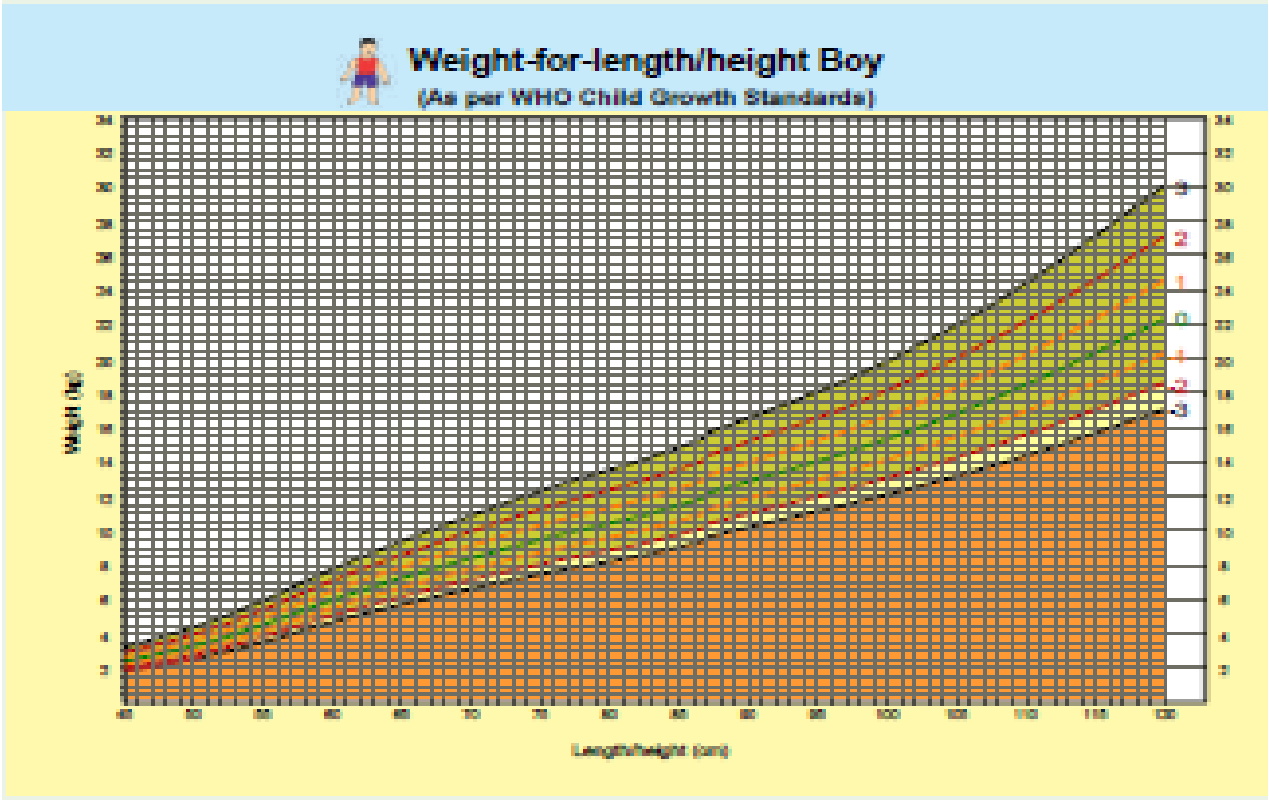
- In order to determine the presence of oedema, apply normal thumb pressure on both feet for three seconds (count the numbers 1001, 1002, 1003 in order to estimate three seconds without using a watch).
- The child has oedema if a pit (dent) remains in the feet when you lift your thumb, it can be seen and felt. (Please see figure below)



Assessment of oedema

Determining Weight-for-Height/Length SD score & Nutritional status





- ✓ Low weight in child may happen due to wasting (malnutrition of shorter duration) or stunting (malnutrition of long duration) or both together. Plotting parameters on weight for length chart helps us to differentiate wasted and stunted children.
- ✓ The horizontal line at the bottom of the Chart is the X Axis. This is for recording the length/ height of the child for five years. The vertical line at the far left of the Chart is the Y Axis. This is for recording the weight of the child from birth onwards and is called 'weight axis'.
- ✓ On each Growth Chart, there are 3 pre-printed Growth Curves. These are called Reference Lines or Z Score Lines and are used to compare and interpret the growth pattern of the child and assess her/ his nutritional status. The 1st/ top curve line on the growth chart is the median which generally speaking is the average. The other two curve lines are below the average and are at a distance.
- ✓ Weight of all normal and healthy children according to their length/height, plotted on the Growth Chart, falls above 2nd curve (dark green band); weight of children with moderate acute malnutrition fall between 2nd curve to 3rd curve (yellow band); and weight of children with severe acute malnutrition fall below the 3rd curve (orange band). A plotted point or a growth curve of a child, which is much above or far below from the 1st pre-printed curve indicates a growth problem**.**

LOOK FOR VISIBLE SEVERE WASTING

A child with visible severe wasting is very thin, has less or no fat, and looks like skin and bones. Some children are thin but do not have visible severe wasting. This assessment step helps you identify children with visible severe wasting who need urgent treatment and **referral to a hospital particularly in situations where length or MUAC measurement is not possible.**

To look for visible severe wasting, remove the child's clothes. Look for severe wasting of the muscles of the shoulders, arms, buttocks and legs. Look at the child from the side to see if the fat of the buttocks is missing. When wasting is extreme, there are many folds of skin on the buttocks and thigh.

5.6. CLASSIFY MALNUTRITION

Here is the classification table for malnutrition

Signs	Classify as	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print)
• WFL <-3 SD score (red color on MCP card)* and/or • MUAC <11.5 cm and/or • Oedema of both feet	**SEVERE ACUTE MALNUTRITION**	• ***Give first dose of oral amoxycillin and IM gentamicin*** • ***Treat the child to prevent low blood sugar.*** • ***Refer URGENTLY to hospital#*** • ***Keep the child warm on the way to hospital.***
• WFL <-2 SD score (yellow color on MCP card) and/or • MUAC 11.5–12.4 cm and • No Oedema of both feet	**MODERATE ACUTE MALNUTRITION**	• *Assess feeding and counsel the mother on how to feed the child* • *Advise mother when to return immediately* • *Follow-up after 30 days*
• WFL ≥ -2SD score and • MUAC ≥ 12.5 cm and • No Oedema of both feet	**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 FOOD box on the COUNSEL THE MOTHER chart.* • *If feeding problem, follow-up in 5 days.* • *Advise mother when to return immediately.*

****Look for visible severe wasting if unable to measure length/height. Classify severe acute malnutrition in presence of visible severe wasting.***
#If referral is not possible, See the section where Referral is not possible

Remember:

- *A child with severe acute malnutrition has a serious problem and should be urgently referred to hospital*
- *Children with moderate acute malnutrition should be assessed and counselled for feeding*
- *All children less than 2 years of age should also be assessed and counselled for feeding*

Your Facilitator will conduct a Group Activity and Photograph Exercise

Photograph 67: This is an example of visible severe wasting. The child has small hips and thin legs relative to the abdomen. Notice that there is still cheek fat on the child's face.

Photograph 68: This is the same child as in photograph 67 showing loss of ribs fat.

Photograph 69: This is the same child as in photograph 67 showing folds of skin ("baggy pants") due to loss of buttock fat. Not all children with visible severe wasting have this sign. It is an extreme sign.

Photograph 70: This child has oedema of both feet.

Now look at photographs numbered 71 through 79. For each photograph, tick whether the child has visible severe wasting. Also look at photograph 79 and tick whether the child has oedema of both feet.

	Does the child have visible severe wasting	
	Yes	**No**
Photograph 71		
Photograph 72		
Photograph 73		
Photograph 74		
Photograph 75		
Photograph 76		
Photograph 77		
Photograph 78		
	Does the child have bilateral pitting oedema	
	Yes	**No**
Photograph 79		

Your Facilitator will conduct a Demonstration of 'How to measure MUAC'

5.7. CHECK FOR ANEMIA

Check all sick children for signs suggestive of anemia.

THEN CHECK FOR ANEMIA
LOOK AND FEEL: • Look for palmar pallor. Is it: - Severe palmar pallor? - Some palmar pallor?

LOOK for Palmar Pallor

Pallor is unusual paleness of the skin. It is a sign of anemia.

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

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

5.8. CLASSIFY ANEMIA

Here is the classification table for anemia:

Signs	Classify as	IDENTIFY TREATMENT (Urgent pre-referral treatments are in bold print.)
Severe palmar pallor	**SEVERE ANEMIA**	• ***Refer URGENTLY to hospital.***
Some palmar pallor	**ANEMIA**	• Give iron folic acid therapy for 14 days. • Assess the child`s feeding and counsel the mother on feeding. If feeding problem, follow-up after 5 days. • Follow-up after 14 days.
No palmar pallor	**NO ANEMIA**	• Give prophylactic iron folic acid if child is 6 months or older

Remember:

A child with severe anemia should be referred to hospital

Your Facilitator will conduct a Photograph Exercise

Photograph 80: This child's skin is normal. There is no palmar pallor.

Photograph 81a: The hands in this photograph are from two different children. The child on the left has some palmar pallor.

Photograph 81b: The child on the right has no palmar pallor.

Photograph 82a: The hands in this photograph are from two different children. The child on the left has no palmar pallor.

Photograph 82b: The child on the right has severe palmar pallor.

	Does the child have signs of		
	Severe pallor	**Some pallor**	**No pallor**
Photograph 83			
Photograph 84			
Photograph 85a			
Photograph 85b			
Photograph 86			
Photograph 87			
Photograph 88			

CHECK THE CHILD'S IMMUNIZATION*, PROPHYLACTIC VITAMIN A, IRON-FOLIC ACID SUPPLEMENTATION

CHECK THE CHILD'S IMMUNIZATION STATUS

The immunization status of all children, who are seen by you, should be checked.

	AGE	VACCINE
IMMUNIZATION SCHEDULE:	At Birth	BCG + OPV-0 + Hep B 0
	6 weeks	OPV-1 + Penta-1 +Rota Virus-1* + fIPV –1 + PCV –1
	10 weeks	OPV-2+ Penta-2+ Rota Virus –2*
	14 weeks	OPV-3+ Penta-3 +fIPV-2 + RVV-3* + PCV-2
	9-12 months	Measles-rubella (MR-1) + JE–1#+ PCV booster + fIPV-3
	16-24 months	MR-2, JE-2#, DPT booster-1, OPV booster
	60 months	DPT booster-2

***A child who needs to be immunized should be advised to go for immunization , the day vaccines are available at AWC/ PHC**

#JE in states where it is included in their immunization schedule

PROPHYLACTIC IRON-FOLIC ACID SUPPLEMENTATION

Prophylactic supplementation of iron folic acid twice every week is recommended under the ANEMIA MUKT BHARAT PROGRAMME for all children above 6 months of age. You will be the main vehicle for supply and promotion of IFA to all children and will be given a regular supply of IFA syrup for easy administration to children.

The recommended schedule for iron and folic acid supplementation is as follows:

PROPHYLACTIC IFA/ DEWORMING/ PROPHYLACTIC VITAMIN A

- Give IFA syrup (1ml; 2 times a week with auto dispenser) containing 20 mg of elemental iron + 100 mcg of folic acid after the child has recovered from acute illness if the child is 6 months of age or older. Supplement IFA in LBW after 6 weeks of age
- Give anthelminthic if child is one year or older and has not received deworming agents in last 6 months (1-2 years; 1/2 tablet albendazole and for 2 years above; 1 tablet)
- Give Vitamin A supplementation as per state guidelines

Method of giving IFA

- The cap/dispenser/dropper provided with the IFA syrup should be filled up to the mark of 1 ml and the content given to the child twice a week.
- Fix the days for giving the IFA dose so that mother can remember the days. e.g. Monday and Thursday of each week.
- A child should be given 1 ml of IFA one hour after food. Do **NOT** give IFA with milk since milk hinders the absorption of Iron in the body.
- Ensure that mother measures the dose correctly. The child must be held in the mother's lap. Encourage the child to open the mouth. If the child does not open the mouth, you may need to press the cheeks gently together for the mouth to open. Mother must pour the dose entirely into the child's mouth and watch the child swallow the entire dose.
- Child should not be given IFA on an empty stomach.
- Convey to the mother that child may get black stools after IFA and this is normal.
- If a child has high fever, omit the dose on that day and continue subsequent doses
- Keep the IFA bottle out of reach of children in a clean and safe place.

DEWORMING

If the child is more than 1 year and has not received de-worming (in last 6 months), give tablet Albendazole. The tablet should be broken and crushed, then safe water/breast milk can be added to help administer the Albendazole tablet

Drug	**Doses by age**		
	Below 1 year	**1-2 year**	**2 years onwards**
Albendazole (400 mg tablet)	Not to be given (safety not established)	Half tablet	One tablet

5.9. ASSESS OTHER PROBLEMS

The last box on the ASSESS side of the jobaid reminds you to assess any other problems that the child may have.

Since the *ASSESS & CLASSIFY* section does not address all the problems of a sick child, you will now assess other problems the mother told you about. Identify and treat any other problems according to your training and experience. Refer the child for any other problem you cannot manage.

5.10. ASSESS THE MOTHER/CAREGIVER'S DEVELOPMENT SUPPORTIVE PRACTICES

Ask following questions about the mother/caregiver's usual practices to support child's development. Compare the mother's answers to the recommendations for the child's development on MCP card.

ASK -

Infant age less than 6 months

- How do you play with your baby?
- How do you talk to your baby?
- How do you get your baby to smile?

Child age 6 months and older

- How do you play with your child?
- How do you talk to your child?
- How do you think your child is learning?

LOOK– All children

- How does caregiver show he or she is aware of child's movements?
- How does caregiver comfort the child and show love?

5.11. COUNSEL THE MOTHER ABOUT HER OWN HEALTH

After the assessment, classification and treatment of the young infant has already been performed listen for any problems that the mother herself may be having. The mother may need treatment or referral for her own health problem.

- Follow-up visit and regular postnatal visits should be coordinated. Try and schedule the visit of the young infant and mother together.
- Emphasize that postnatal visit is a good opportunity to provide advice and care to the mother and young infant.
- If the mother is sick, provide care for her, or refer her for help. Also, if the sick young child is still breastfed, help the mother to breastfeed her baby.
- Advise her to eat well to keep up her health. Counsel the breastfeeding mother to have at least three meals per day of balanced diet rich in protein, vegetables and fruits.

SECTION 6

IDENTIFY TREATMENT AND TREAT THE CHILD

SECTION 6

IDENTIFY TREATMENT AND TREAT THE CHILD

"Identify Treatment" is on the same lines as for a young infant.

If the child has any general danger sign or a pink classification, REFER THE CHILD after giving appropriate treatments.

6.1. GIVE AN APPROPRIATE ANTIBIOTIC

- Give pre-referral dose of oral amoxycillin and IM gentamicin to children presenting with general danger signs, severe pneumonia, severe febrile disease and SAM with medical complications
- Give oral amoxycillin to children (**FOR PNEUMONIA, SEVERE ACUTE MALNUTRITION)**

AGE or WEIGHT	Amount of Gentamicin to be given IM as injection (vial contains 80 mg in 2 ml)	Amount of amoxicillin to be given per-orally as Syrup (contains 125 mg/5 ml)	Amount of amoxycillin to be given per-orally as tablet (contains 250 mg)
2 months upto 4 months (4 - <6 kg)	0.5-1.0 ml	5 ml	½
4 months upto 12 months (6- <10 kg)	1.1-1.8 ml	10 ml	1
12 months upto 3 years (10 - <14 kg)	1.9-2.7 ml	15 ml	1 ½
3 years upto 5 years (14-19 kg)	2.8—3.5 ml	20 ml	2

IF REFERRAL IS NOT POSSIBLE

- Referral is the best option for children classification with General danger signs, severe pneumonia, very severe febrile disease, severe dehydration, severe acute malnutrition and severe anemia.
- If referral is not possible or refused in children with general danger signs, severe pneumonia, very severe febrile disease, severe acute malnutrition then give oral amoxycillin (25-30 mg/kg) every 12 hrs and intramuscular gentamicin once daily.
- At each contact for injection of antibiotics, explain again to the caregiver that the infant is very sick and should urgently be referred for hospital care. Continue giving once-daily intramuscular gentamicin and twice-daily oral amoxycillin until referral is feasible or for 7 days
- For severe dehydration, rehydrate with ORS till the time referral is possible
- For severe anemia, explain need for blood transfusion at each visit till referral is possible
- **Give Zinc:** For acute diarrhoea and severe acute malnutrition, give zinc supplements for 14 days.
  - Give 10 mg (1/2 tab of 20 mg tablet) to infants aged 2-<6 months.
  - Give 20 mg (1 tab of 20 mg tablet)to children 6-59 months

6.2. TREAT DIARRHOEA WITH DEHYDRATION WITH ORAL REHYDRATION SALT (ORS) SOLUTION (PLAN B)

The child with diarrhoea of less than 14 days duration who has signs of some dehydration should be treated under your supervision with ORS for 4 hours. For this, keep the mother and child under observation, either at the health centre or at the home of the child.

Teach the mother how to prepare ORS.

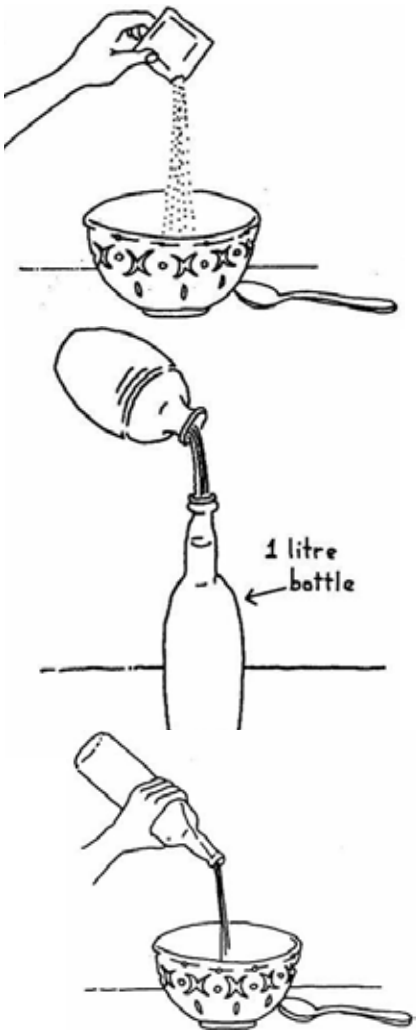
1. Wash your hands with soap and water.

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

3. Measure 1 litre of clean portable water. Use the cleanest drinking water available.

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

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



Ask the mother to give one teaspoon of the solution to the child. This should be repeated every 1-2 minutes (An older child who can drink it in sips should be given one sip every 1-2 minutes). If the child vomits the ORS tell the mother to wait for 10 minutes and resume giving the ORS but this time more slowly than before.

Breastfed babies should be continued to be given breast milk in between ORS. Any ORS which is left over after 24 hours should be thrown away.

Use the table to determine the amount of ORS that should be given to the child in 4 hours.

AGE*	Up to 4 months	4 months up to 12 months	12 months up to 2 years	2 years up to 5 years
WEIGHT	< 6 kg	6 - < 10 kg	10 - < 12 kg	12 - 19 kg
In ml	200 - 400	400 - 700	700 - 900	900 – 1400
Cups	2	3	5	7

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.

After 4 hours

- Reassess the child and classify the child for dehydration.
- Select the appropriate plan to continue treatment. When there are no signs of dehydration, the child is put on Plan A. If there is still some dehydration, Plan B should be repeated. If the child now has severe dehydration, the child should be put on Plan C at facility level.
- Begin feeding the child in clinic.
- After about 4 hours of giving ORS, reassess the child for dehydration. If the child is no longer dehydrated, tell the mother to give home available fluids the same way as she gave ORS. Details of what home available fluids to give are given in the next section. Begin feeding the child even if dehydration persists, continue ORS. If the child is still dehydrated, refer. On the way mother should continue to give ORS to the child.

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:

- **GIVE EXTRA FLUID**
- **GIVE ZINC SUPPLEMENT**
- **CONTINUE FEEDING**
- **WHEN TO RETURN**

The signs that she must look for are:

- Child becomes sicker;
- Not able to drink or breast feed or drinking poorly;
- Blood in stool;
- Develops a fever.

Your Facilitator will conduct a drill followed by Demonstration of 'Preparation of ORS solution'

6.3. TREAT HIGH FEVER WITH PARACETAMOL

Fever whatever the cause should be treated with paracetamol. If the axillary temperature is 38.5ºC/101.3°F or above, give paracetamol. The dose of paracetamol is given in the table below. Paracetamol may be repeated every 6 hours if fever is high or ear pain gone.
Give 3 additional doses of paracetamol for use at home every 6 hours until high fever or ear pain is gone.

If fever persists for seven days or more refer the child to a hospital.

PARACETAMOL		
AGE or WEIGHT	**TABLET** (100 mg)	**TABLET** (500 mg)
2 months upto 1 year (4 - <10 kg)	1	1/4
1 year upto 3 years (10 - <15kg)	1 1/2	1/4
3 years upto 5 years (15-20 kg)	2	1/2

6.4. TREAT ANEMIA WITH IRON FOLIC ACID

Treat some pallor with iron. The dose of iron is given in the table. Do not give iron with tea since this reduces the absorption of the medicine and makes it less effective. Also advise mother to feed the child according to the age specific feeding recommendations. These are described later.

Give Vitamin A

Give single dose to all children with Severe Malnutrition or for prophylaxis as per guidelines

AGE	**VITAMIN A SYRUP**
	100,000 IU/ml
Upto 6 months	0.5 ml
6 months upto 12 months or weight < 8 kg	1 ml
More than 12 months or weight ≥ 8 kg	2 ml

Give Iron & Folic Acid therapy: *Give one dose daily for 60 days*

AGE or WEIGHT	**IFA PEDIATRIC TABLET** (20 mg elemental iron)	**IFA SYRUP** (20 elemental iron + 100 mcg Folic acid per ml)	**IFA DROPS** 20 mg of elemental iron per 1 ml
2 months upto 4 months (4 - <6 kg)		0.5 ml	0.5 ml
4 months upto 12 months (6 - <10kg)	1 tablet	1ml	1 ml
12 months upto 3 years (10 - 14 kg)	1.5 tablets	1.5 ml	1.5 ml
3 years upto 5 years (14 -19 kg)	2 tablets	2 ml	

Give Iron for 14 days initially and ask mother to return for follow up at that time. If the child is doing well give iron therapy again till the child has consumed iron for 60 days. Inform mother that the stools of the child will become black. This is not a cause of worry.

6.5. GIVE ANTIMALARIALS AS PER NATIONAL GUIDELINES

Once a suspected case is diagnosed malaria positive by RDT or microscopy, treatment is started. The first dose is always taken in the presence of the health volunteer/worker. The blister pack with remaining tablets is given to the patient/caretaker to take home with clear instructions.

Caution: If the patient is a child under 5 years, ask the patient to wait for 15 minutes after taking the first dose. If it is vomited within this period, let the patient rest for 15 minutes, and then give the first dose again i.e. open a new blister-pack and discard what remains of the old. If the patient vomits the first dose again, it is considered a case of severe malaria, refer the patient immediate to the nearest Block PHC/ CHC/ Hospital.

Explain to the patient/caretaker:

- That if the treatment is not completed as prescribed, the disease may manifest again with more serious features and become more difficult to treat.
- To come back immediately, if there is no improvement after 24 hours, if the situation gets worse or the fever comes back.
- That regular use of a mosquito net (preferably insecticide treated net) is the best way to prevent malaria.

Give Oral Antimalarials as per National guidelines (other than NE-States)

FALCIPARUM MALARIA: If RDT or blood smear Pf positive

Age group (years) / color of blister pack	Day 1		Day 2		Day 3
	Artesunate (AS)	Sulphadoxine Pyramethamine (SP)	Artesunate (AS)	Primaquine (PQ)	Artesunate (AS)
0-1* Pink Blister	1 (25 mg)	1 (250+12.5 mg)	1 (25 mg)	Nil	1 (25 mg)
1-4 Yellow Blister	1 (50 mg)	1 (500+25 mg)	1 (50 mg)	1 (7.5 mg base)	1 (50 mg)

*__NOTE:__ ACT-SP (Artesunate based combination therapy-Sulfadoxine Pyremethamine) Artesunate 4 mg per kg daily for 3 days and Sulfadoxine (25 mg/kg)-Pyremethamine 1.25 mg per kg on first day. Give Primaquine 0.75 mg per kg on day-2. SP is not to be prescribed for infants <5 months of age and should be treated with alternate Artesunate Combination Therapy (ACT)

- **Vivax malaria: If blood smear positive for PV, give Chloroquine for 3 days and Primaquine for 14 days**
  - Chloroquine for P. Vivax: 25 mg/kg divided over 3 days i.e. 10mg/kg on day 1 and 2 and 5 mg/kg on day 3
  - Primaquine: 0.25 mg/kg daily for 14 days

Age group	Chloroquine						Primaquine
	Day 1		Day 2		Day 3		Give daily for 14
	Tablet (150 mg)	Syrup 50 mg base per ml	Tablet	Syrup	Tablet	Syrup	Tablet (2.5 mg)
2 months upto 12 months	1/2	7.5 ml	1/2	7.5 ml	1/4	4 ml	0
12 months upto 5 years	1	15 ml	1	15 ml	1/2	7.5 ml	1

Give Oral Antimalarials as per National guidelines (for NE- States)
FALCIPARUM MALARIA: If blood smear positive for PF, give ACT-AL (ARTEMETHER AND LUMEFANTRINE) Co-formulated tablet

Age group **(weight)**	**Co-formulated ACT-AL**				
	Dose	Times	No of days	Total dose	Availability under National programme
> 5 months to < 3 years (5-14 kg)	1 tab (20 mg)	Twice/day	3	120 mg	Yellow colored pack with 6 tablets
≥ 3 months to < 8 years (15-24 kg)	2 tab (40 mg)	Twice/day	3	240 mg	Green colored pack with 12 tablets

NOTE: If blood smear or RDT positive for both P. Vivax + P. falciparum, give ACT-AL as above and Primaquine.

6.6. TEACH THE MOTHER TO TREAT LOCAL INFECTIONS AT HOME

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 20-50 ml (10 ml/kg) of expressed breastmilk or locally appropriate animal milk (with added sugar) before departure. If neither of these is available, give 20-50 ml (10 ml/kg) of sugar water.

If the child is not able to swallow: Give 20-50 ml (10 ml/kg) of expressed breastmilk or locally appropriate animal milk (with added sugar) or sugar water by nasogastric tube.

Advise Home Care for Cough or Cold

Children having no signs of either pneumonia or severe pneumonia are classified as 'NO PNEUMONIA: COUGH OR COLD' and health worker will advise on home care.

1. **An infant below 6 months who is exclusively breastfed should not be given any home remedy.**
2. Breastfeeding should be continued. The other advise is to continue feeding the child during the illness.
3. Mother is advised to give home available fluids as much as the child would take. This would help in the relief of cough.
4. Mother is advised to give the child a safe home-made cough remedy if the child is more than 6 months of age like honey, tulsi, ginger, herbal concoctions and other safe home remedies. Avoid cough syrups.
5. The mother is advised to keep the nose clean by putting in nasal drops (boiled and cooled water with salt mixed in it) and by cleaning the nose with a soft cotton cloth. Mothers can also prepare

saline nasal drops at the home by adding 1/2 teaspoon of common salt (2.5 gm) to 250 ml (1 glass) of clean drinking water. Fresh solutions should be prepared daily.

6. The mother should also be advised on how to give drugs at home.
7. She should look for signs of worsening of illness, like child becomes sicker or is not able to drink or breastfeed, fast breathing, difficult breathing or if child develops fever. If any of these signs appear, mother should immediately contact ASHA or ANM for referral to the nearest health facility.

Your Facilitator will conduct a Group Discussion on 'Home Made Safe Cough Remedies'

Home Care for Child with fever

For the child with fever who does not have severe disease advice the mother to, treat with home care:

1. Advise the mother to continue feeding the child during the illness. Continue breastfeeding.
2. Advise the mother to continue giving home available fluids as much as the child would take. The sick child who has fever needs more fluids.
3. Teach the mother to look for signs of illness when to return to you immediately.
   - Child becomes sicker;
   - Not able to drink or breast feed.

Home care for the child with diarrhoea and no dehydration (Plan A)

Home care for treatment of diarrhoea and no dehydration includes the following:

1. **THE CHILD SHOULD BE GIVEN EXTRA FLUIDS TO DRINK (AS MUCH AS THE CHILD WILL TAKE).**

Tell the mother:

If the child is exclusively breastfed: Breastfeed frequently and for longer duration at each feed. If passing frequent watery stools, give ORS in addition to breastmilk.

- **If the child is 6 months or older:** Give one or more of the following home fluids; ORS solution,buttermilk drink, milk, lemon drink, rice or pulses-based drink, vegetable soup, green coconut water or plain clean water.

Advise the mother to give fluids available at home. Some examples of useful and harmful fluids available at home fluids are given in the table below:

Useful	Harmful
1. Breast Milk	Soft drinks
2. Yoghurt drink	Fruit juices (sweetened)
3. Lemon drink	Coffee
4. Rice Water	
5. 'Dal' (lentil)	
6. Vegetable soup	
7. Plain clean water	
8. Coconut water	

How much extra fluid to give after each loose stool

Age		
Up to 2 months	**2 months upto 2 years**	**2 years or more**
5 SPOONS	1/4 - 1/2 cup (50-100 ml)	1/2 - 1 cup (100-200 ml)
Give more if the child wants.		

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.

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 SUPPLEMENT FOR 14 DAYS

Zinc supplement

Zinc is an important part of the treatment of diarrhoea. Zinc helps to lessen the amount of fluid loss during diarrhoea so that the diarrhoea is less severe. Zinc shortens the number of days of diarrhoea. It increases the child's appetite and makes the child stronger. Zinc also helps prevent diarrhoea in the future. Giving zinc for the full 14 days can help prevent diarrhoea for up to the next three months.

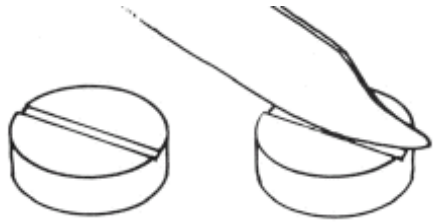
For these reasons, we now give zinc to children with diarrhoea. The diarrhoea treatment box tells how much zinc to give—the dose. It also tells how many tablets (tabs) the child should take in 14 days. You will give the caregiver the total number of tablets for the 14 days, and help her as she gives the first dose now.

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

For acute diarrhea and severe acute malnutrition give zinc supplements for 14 days.

- Give 10 mg (1/2 tab of 20 mg tablet) to infants aged 2-<6 months
- Give 20 mg (1 tab of 20 mg tablet) to infants and children aged 6-59 months

Help the caregiver give the first dose now



If the dose is half of a tablet (For infants below 6 months), help the caregiver cut it into two parts.

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

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

Give the caregiver enough zinc for 14 days. Explain how much zinc to give, once a day. Emphasize that it is important to give the zinc for the full 14 days, even if the diarrhoea stops. This will help her child have less diarrhoea in the months to come. The child will have a better appetite and will become stronger.

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

3. CONTINUE FEEDING

The child should continue to be fed as much as the child would take. If the child is reluctant to eat, then feed more often than before (smaller amounts of food). As soon as the child recovers, child's appetite would return and the mother should feed extra foods to make up for the excessive losses during the disease or illness.

4. ADVISE THE MOTHER WHEN TO RETURN

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 fever
If child has NO PNEUMONIA: COUGH OR COLD, also return if:	• Fast breathing • Difficult breathing
If child has Diarrhoea, also return if:	• Blood in stool • Drinking poorly

PROMOTE THE HEALTH OF THE CHILD

1. Update Immunizations
2. Give vitamin A
3. Give Prophylactic IFA
4. For a child older than 6 months, give IFA Paediatric Syrup for 100 days during the year. Give iron therapy for 14 days at a time and call the mother again after 14 days to repeat the supply.
5. Counsel for child's feeding and development support care

The assessment of the child's feeding & development supportive care is necessary if the child is very low weight for age or has anemia or if the child is less than 2 years age.

The brain develops most rapidly before birth and during the first two years of life. Good nutrition and good health are especially important during this time. Breast milk plays a special role in the development of the brain. Breast milk also helps young children stay free from illness so that they are strong and can explore and learn.

Children can see and hear at birth. Starting when they are very young, children need opportunities to use their eyes and ears, in addition to good nutrition. For their brains to develop, children also need to move, to have things to touch and explore, and to play with others. Children also need love and affection. All these experiences help the brain to develop.

6.7. ASSESS THE CHILD'S FEEDING

Ask the following 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 in the box below.

ASK

- **Do you breast feed the child?**
  - How many times during the day?
  - Do you breastfeed during the night?

- **Does the child take any other foods or fluids?**
  - What foods or fluids?
  - How many times per day?
  - What do you use to feed the child?
  - How large are the servings? Does the child receive his own serving? Who feeds the child and how?
- **During this illness, has the child's feeding changed? If yes, how?**

Compare feeding practices with feeding recommendations and counsel.

FEEDING RECOMMENDATIONS DURING SICKNESS AND HEALTH

Age: Birth upto 6 months

- Give exclusive breast feeding. This means that the infant should not be given anything else by mouth; not even water.
- Remember that no extra water is required for an exclusively breastfed baby even if the weather outside is very hot.
- There is always enough water in breastmilk to protect the baby from getting dehydrated.
- Breastfeed the baby as often as the baby wants. The baby should be breastfed even at night.
- Most babies need to be fed at least 8 times during a day. Do not give water, food or other fluids for any reason unless advised specially by a medical doctor.

Birth upto 6 months

- Immediately after birth, put your baby in skin to skin contact with you.
- Breastfeed as often as the infant wants, day and night, at least 8 times in 24 hours.

- Do not give any other foods or fluids not even water
- If baby is small (low birth weight), feed at least every 2 to 3 hours. Wake the baby for feeding after 3 hours, if the baby does not wake-up by him/herself.

Remember:

- Continue breastfeeding if the baby is sick

Age: 6 months upto 9 months

The child should continue to be breastfed during this age. Breastfeed as often as the child wants.
The first foods given to the baby in addition to breastmilk are called complementary foods.

- Child should also take 2-3 meals a day.
- Always give breastmilk first before giving other foods.
- Start giving 2–3 teaspoons of soft porridge or mashed food, and begin to introduce vegetables and fruit twice daily.
- Gradually increase the amount to ½ cup (250ml) and frequency of feeds.
- Give a variety of locally available food.
- A child who is not breast fed may be given animal milk undiluted by a cup.
- Never use a feeding bottle.

6 months upto 9 months

- Breastfeed as often as the child wants.
- **Start by giving 2 to 3 tablespoons of food. Gradually increase to 1/2 cups (1 cup = 250 ml).**

  - Mashed roti/ rice mixed in undiluted milk OR thick dal with added ghee/oil or khichri with added oil/ghee. Add cooked vegetables also in the servings, or
  - Sevian/dalia/halwa/kheer prepared in milk or any cereal porridge cooked in milk, or
  - Mashed boiled/fried potatoes.
  - *Give 2 to 3 meals each day.
  - Offer 1 or 2 snacks each day between meals when the child seems hungry.

Remember:

- Keep the child in your lap and feed with your own hands
- Wash your own and child's hands with soap and water every time before feeding

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

Age: 9 months upto 12 months

- The child should continue to be breast fed during this age.
- Breast feed as often as the child wants.
- Child should also take 3-4 meals a day. Always give breastmilk first before giving other foods. Start giving at least ½ cup (250ml) of soft porridge or mashed food, and begin to introduce snacks.
- Give a variety of locally available food.
- Remember to keep the child in your lap and feed with your own hands and wash yours own and child's hands with soap and water every time before feeding.

Age: 9 months upto 12 months

- Breastfeed as often as the child wants.

- Give at least ½ katori serving* at a time of:
  - Mashed roti/ rice mixed in undiluted milk, OR
  - Mashed roti/rice mixed in thick dal with added ghee/oil or khichri with added oil/ghee add cooked vegetables also in the servings

    OR
  - Sevian/dalia/halwa/kheer prepared in milk, or any cereal porridge cooked in milk, OR
  - Mashed boiled/fried potatoes

  *3 times per day if breastfed; 5 times per day if not breastfed.

Remember:

- Keep the child in your lap and feed with your own hands
- Wash your own and child's hands with soap and water every time before feeding

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

Age: 12 months upto 2 years

- Breastfeeding should be continued. Continue breastfeeding as often as the child wants.
- Increase the amount to ¾ cup per feed. The variety in the diet should be increased by including the family foods in the diet of the child. Family foods should be chopped so that they are easy for the child to take. They must not be spicy.
- If possible at least once in the day the child should be given a food that is made especially for the child.

Age: 12 months upto 2 years

- Breastfeed as often as the child wants.
- Offer food from the family pot
- Give at least 3/4 cup servings 5 times a day. The following food options can be considered:
  - Mashed roti/rice mixed in thick dal with added ghee/oil or khichri with added oil/ghee. Add cooked vegetables also in the servings OR
  - Mashed roti/ rice mixed in undiluted milk, OR
  - Sevian/dalia/halwa/kheer prepared in milk, or any cereal porridge cooked in milk, OR
  - Mashed boiled/fried potatoes
  - Offer banana/cheeko/ mango/ papaya
  - *5 times per day

Remember:

- Sit by the side of child and help him to finish the serving
- Wash your child's hands with soap and water every time before feeding

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

Age: 2 years and older

- The family foods should be given to the child 3 to 4 times in the day.
- The focus should be on adding variety and food rich in calories and vitamin contents such as animal source foods.
- Child should be given at least 1 full cup at each meal.
- Two extra feedings should be given to the child. These can be family foods or other foods that are especially cooked for the child or some snacks.

Age: 2 years and older

- Give a variety of family foods to your child, including animal source and vitamin A-rich fruits and vegetables.
- Give at least one cup (250ml) serving at a time.
- Give family foods at 3-4 meals each day.
- Also, twice daily, give nutritious food between meals, such as: banana/ cheeko/ mango/ papaya as snacks.
- If child refuses a new food, offer "tastes" several times. Be patient.

Remember:

- Ensure that the child finishes the serving
- Teach your child to wash his hands with soap and water every time before eating

IDENTIFY FEEDING PROBLEMS

The differences between what is recommended for age and what the child is fed are the feeding problems.

You should identify all the feeding problems before advising on feeding. Common feeding problems that are observed include the following:

- Difficulty in breast feeding
- Giving sugar water or tea before 6 months age
- Breast milk is not considered to be enough
- Feeding bottle is used for giving milk
- Lack of active feeding (If a young child is left to feed himself, or if he has to compete with siblings for food, he may not get enough to eat. By asking, "Who feeds the child and how?" you should be able to find out if the child is actively being encouraged to eat.)
- The child does not feed well during the illness

There may be other feeding problems that you may identify. These are summarized on the job-aid. If there are other feeding problems not listed, consult supervisor for finding solutions.

Give feeding advice according to age

Ask the mother to describe how the child is being fed. This can be done by asking the questions that are listed on the job-aid.

Determine the feeding problems that you have identified on the basis of mother's description and matching it with feeding recommendations.

Give only the feeding advice that is needed for the child's age and situation. To avoid confusion, advise not more than 2 changes in feeding. Try to select two most important ones which may have direct bearing on the child's health.

To make the changes in the child's diet that you have suggested, discuss and negotiate with the mother if she feels she can try these at home. In case she has problems, support her in solving these problems.

COUNSEL THE MOTHER ABOUT FEEDING PROBLEMS

If the child is not being fed as described in the above recommendations, counsel the mother accordingly. In addition:

- If the mother reports difficulty with breastfeeding, assess breastfeeding. (See YOUNG INFANT chart.)

As needed, show the mother correct positioning and attachment for breastfeeding.

If the infant is less than 6 months old and is taking other milk or foods:

- Build mother's confidence that she can produce all the breastmilk that the child needs.
- Suggest giving more frequent, longer breastfeeds day or night, and gradually reducing other milk or foods.

If other milk needs to be continued, counsel the mother to:

- Breastfeed as much as possible, including at night.
- Make sure that other milk is a locally appropriate dairy/animal milk .
- Make sure other milk is correctly and hygienically prepared and given in adequate amounts.
- Finish prepared milk within an hour.

If the mother is using a bottle to feed the child:

- Recommend substituting a cup for bottle.
- Show the mother how to feed the child with a cup.

If the child is not being fed actively, counsel the mother to:

- Sit with the child and encourage eating.
- Give the child an adequate serving in a separate plate or bowl.

If the child is not feeding well during illness, counsel the mother to:

- Breastfeed more frequently and for longer if possible.
  - Use soft, varied, appetizing, favourite foods to encourage the child to eat as much as possible, and offer frequent small feedings.
  - Clear a blocked nose if it interferes with feeding.

COUNSEL THE MOTHER ON HOW TO FEED THE CHILD WITH MODERATE ACUTE MALNUTRITION

- Tell mother about child's nutritional status
- Tell them to avail nutritional services for malnourished children in that area through anganwadi centers.
- Tell mothers, young children have a small stomach size, which can accommodate limited quantity at a time, so each meal must be made energy dense and should be given at least 5-6 times daily.
- Meals may be made energy dense by preparing porridge in milk; adding butter/ghee/which makes food item tasty and also helps in absorption of vitamins.
- Foods can also be enriched by adding flours of sprouted and roasted grains.
- Encourage them to use milk and milk products like curd, paneer which are good source of protein, calcium and also provide energy.

- Encourage mothers to give animal origin food items like egg, fish etc. wherever culturally acceptable which are also good source of protein.
- Easily available uncooked seasonal fruits and vegetables are useful source of vitamins and minerals. They should be given daily as snacks in between meals.

Your Facilitator will conduct a group discussion on 'Complementary foods available locally for different age groups'

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6.8. ASSESS THE MOTHER/CAREGIVER'S PRACTICE'S TO SUPPORT CHILD'S DEVELOPMENT

The care that children receive has powerful effects on their survival, growth, and development. The key risk factors for development include issues like stunting, iron deficiency, iodine deficiency, frequent illness and difficulty in learning new skills, understanding the world around them, solving problems and communicating with others. Care for child care development begins with improving the skills of health workers and others who work with families.

Next, there are tools for health workers to use while counselling families on play and communication activities with their child. One such tool is the child feeding with **play** and **communication** steps in chart booklet. This section includes recommended activities for children and caregivers for specific age groups.

Ask the following questions:

ASK

Child age less than 6 months

- How do you play with your baby?
- How do you talk to your baby?
- How do you get your baby to smile?

Child age 6 months and older

- How do you think your child is learning?

LOOK: ALL CHILDREN

- How does caregiver show he or she is aware of child's movement?
- How does caregiver comfort the child and show love?

This section describes an important piece of child development, the bonding and attachment between a caregiver and child. We will begin by defining these concepts.

There are two important concepts to understand about strong interactions between a caregiver and a child. These concepts are sensitivity and responsiveness.

CONCEPT OF SENSITIVITY AND RESPONSIVENESS

WHAT IS 'BONDING'?

Bonding is the process of a mother forming a relationship with her new infant. It begins during the first few hours after birth. The connection is mother-to-child.

WHAT IMPACTS BONDING?

It is important to remember that bonding occurs early in the child's life, and can have a lasting impact on his or her development. Bonding is a process that happens very quickly after birth. Therefore, some actions might affect the bonding between a mother and child. For example:

- Mother is separated from infant for a long period after birth, like many days.
- Mother has poor health.
  - Mother is depressed after delivery, which happens to many women. This depression often goes undetected and many mothers do not seek help.
- The mother or someone else is abusing or neglecting the child.
- The infant is a low weight baby and therefore need even more attention and care.
- The infant is ill.

WHAT IS 'ATTACHMENT'?

Attaching is primarily a process of the infant forming a relationship with his or her mother or the primary caregiver, and reinforced by the responses. It occurs during the first two years of life, but especially between **2 and 7 months of age**. During attachment, the child develops a **personal communication system** with the primary caregiver. The connection is **child-to-caregiver**.

WHAT ARE THE CONSEQUENCES OF POOR ATTACHMENT?

Poor attachment between a child and the caregiver can have very serious impact on development. Some of the known complications of poor attachment include:

- Child might have difficulty trusting others in their life.
- Child can experience increasing depression or rage.
- Child fails to thrive as a child that is physically and emotionally healthy, curious about the world around him/her, active, and happy.
- Child can have difficulty adapting to change. As child grows older, he or she will have more behavioral problems and worse peer relations compared to their peers.
- Older children may also have poor problem-solving abilities, and low self-esteem.

SENSITIVITY

Is the ability of the caregiver to be **aware of the infant**. This includes the infant's acts and vocalizations that communicate the infant's needs and wants. If the caregiver is sensitive, this means the caregiver:

- Is aware of the infant's signals, and interprets them accurately
- Accepts the child's interests
- Regards the child as an individual, separate person
- Sees things from the child's point of view

RESPONSIVENESS

Is the ability of the caregiver to respond appropriately to the infant's signals. The response is triggered by the child's signal. It happens quickly after the signal, and is the appropriate level of response.

A caregiver must be **sensitive** in order to be **responsive**. That means that the caregiver must be aware of the infant's signals in order to appropriately respond to them. A caregiver would for example be able to see the child's signs of discomfort, recognize that the child is hungry, and feed the child.

Your Facilitator will conduct an exercise

Are the following actions examples of a caregiver's sensitivity or responsiveness? Tick your answer.

A mother, Deepti, takes the following actions with her son Rajat	S	R
1. Deepti hears Rajat crying		
2. Deepti picks up Rajat to soothe his crying		
3. Deepti is giving Rajat a bath and notices a rash on his leg		
4. Deepti sees Rajat watching the tree's branches blowing in the wind		
5. Deepti asks Rajat, "Do you see the wind blowing? The leaves are blowing!"		
6. Deepti notices that Rajat is not feeding as much as usual		
7. Deepti offers Rajat a food he likes to see if he will eat		

6.9. PLAY AND COMMUNICATE

For Infant, upto 6 months

From birth, babies can see and hear.
The mother's face is the favourite thing the young baby wants to look at. The baby sees her mother's face and loves to respond to her smiles and sounds.
A mother should begin to talk to her child from birth—and even before birth

Play: Infants at this age like to reach for and grab fingers and other objects. They look at their hands and feet, as if they are just discovering them. They put things into their mouths because their mouths are sensitive. The mouth helps them learn warm and cool, and soft and hard, by taste and touch.

Help the baby follow an object. For example, ask the caregiver to show a colourful cup to the baby, just out of reach. When she is sure the baby sees the cup, ask her to move it slowly from one side to the other and up and down, in front of the baby. Then, to move the cup closer.

Encourage the baby to reach for the cup and grab the handle.

Clean, safe, and colourful things from the household, such as a wooden spoon or plastic bowl, can be given to the baby to reach for and touch. A simple, homemade toy, like a shaker rattle, can attract the child's interest by the sounds it makes. Babies at this age also continue to love to see people and faces. Encourage family members to hold and carry the baby.

Communicate*:* Babies enjoy making new sounds, like squeals and laughs. They respond to someone's voice with more sounds, and they copy sounds they hear. They start to learn about how to make a conversation with another person before they can say words.

All family members can smile, laugh, and talk to the baby. They can "coo" and copy the baby's sounds. Copying the baby's sounds and movements helps the persons who care for the baby pay close attention to the baby. They learn to understand what the baby is communicating, and respond to the interests and needs of the baby.

These are important caregiving skills—being sensitive to the baby's signs and responding appropriately to them. These caregiving skills help family members notice when the baby is hungry, or sick, or unhappy, or at risk of getting hurt. They are better able to respond to the child's needs.

For the baby, this practice in communicating helps the baby prepare for talking later. The family will also enjoy the reactions they get from the baby and the attempts at communicating.

For the child, from 6 months upto 9 months

***Play**:* Children enjoy making noises by hitting or banging with a cup and other objects. They may pass things from hand to hand and to other family members, dropping them to see where they fall, what sounds they make, or if someone will pick them up.

This may be frustrating for busy mothers and fathers. Caregivers can be more patient if you help them understand that their child is learning through this play. "Your child is being a little scientist. She is experimenting with how objects fall, how to make a noise, how the force of her arm sends the object across the table."

***Communicate**:* Even before children say words, they learn from what family members say to them, and can understand a lot. They notice when people express strong anger, and may be upset by it. Children copy the sounds and actions of older brothers and sisters and adults. Children like other persons to respond to the sounds they are making and to show an interest in the new things they notice. A child can recognize his name before he can say it. Hearing his name helps him know that he is a special person in the family. When he hears his name, he will look to see who is saying it. He will reach out to the person who kindly calls his name.

For the child, from 9 months upto 12 months

***Play**:* Play continues to be a time for the child to explore and learn about himself, the people around him, and the world. As a child discovers his toes, he may find them as interesting to touch as a toy. When a box disappears under a cloth, where does it go? Is it still there? Can he find it?

A child also enjoys playing peek-a-boo. When his father disappears behind a tree, he laughs as father reappears. He enjoys hiding under a cloth and giggles when his father "finds" him.

***Communicate**:* Even though the child cannot yet speak, she shows that she understands what her family members say. She hears the name of things, and delights in knowing what they are. She begins to connect the word bird to the bird in the tree, and the word nose to her nose.

All members of the family can enjoy sharing new things with the young child. They can play simple hand games together, like "bye-bye", and clap to the beat of music.

A child may become afraid when he loses sight of a familiar caregiver. The adult helps him feel safe, responds when he cries or is hungry, and calms him by her presence and the sound of her voice. Encourage the caregiver to tell her child when she is leaving and to reassure her child that she will soon return. She can leave a safe, comfortable object with the child—one that reminds the child of the caregiver and assures the child that she will return.

For the child, 12 months upto 2 years

***Play**:* If children of this age are healthy and well nourished, they become more active. They move around and want to explore. They enjoy playing with simple things from the household or from nature, and do not need store-bought toys. They like to put things into cans and boxes, and then take them out. Children like to stack things up until they fall down. Families can use safe household items to play with their children.

Children need encouragement as they try to walk, play new games, and learn new skills.

Families can encourage their children to learn by watching what they do and naming it: "You are filling the boxes." Adults should play with the children and offer help: "Let's do it together. Here are more stones to put into your box."

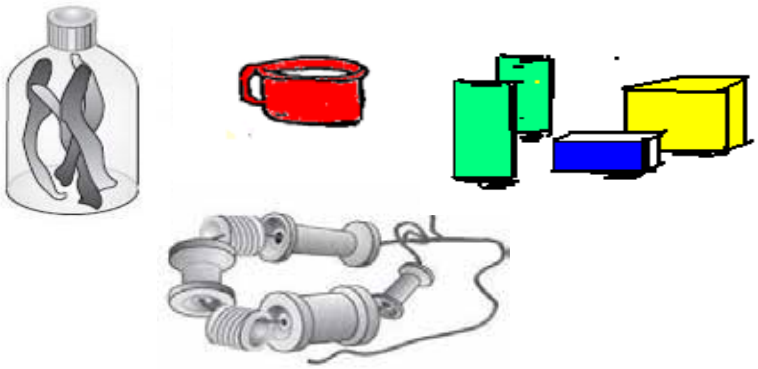
When children learn a new game or skill, they repeat it over and over again. These discoveries make them happy and more confident. They are especially happy when they see that they are making the adults around them happy, too. Encourage family members to notice and praise their young children for what they are learning to do.

***Communicate**:* At this age, children learn to understand words and begin to speak. Mothers and fathers should use every opportunity to make conversations with the child, when feeding and bathing the child, and when working near the child.

Children are beginning to understand what others are saying and can follow simple directions. They often can say some words, such as "water" or "ball." Family members should try to understand the child's words and check to see whether they understand what the child says: "Would you like some water?" "Do you want to play with the ball?"

Families can play simple word games, and ask simple questions: "Where is your toe?", or "Where is the bird?" Together they can look at pictures and talk about what they see.

Adults should use kind words to soothe a hurt child and praise the child's efforts.



A child enjoys playing with homemade toys, and will learn by grabbing, shaking, banging, and stacking them.

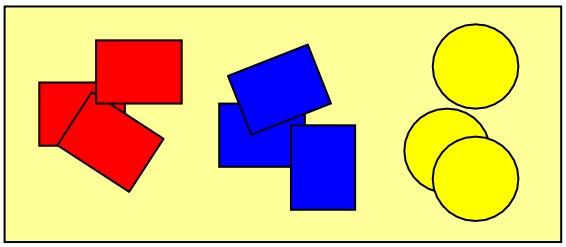
Children can learn to match colours, shapes, and sizes with simple objects, such as bottle caps. They can compare and sort circles and other shapes cut from coloured paper.

For the child, 2 years and older

***Play**:* Children 2 years and older learn to name things and to count.

A caregiver can help her child to learn to count by asking "how many" and counting things together. Children make mistakes at first, but learn from repeating the games many times.

Children still enjoy playing with simple, homemade toys. They do not need store-bought toys. They can learn to draw with chalk on a stone or with a stick in the sand. Picture puzzles can be made by cutting magazine pictures or simple drawings into large pieces.



***Communicate**:* By age 2 years, children can listen and understand. Asking simple questions and listening to the answers encourages children to talk: "What is this?" "Where is your brother?" "Which ball is bigger?" "Would you like the red cup?"

Looking at picture books and reading stories to children prepares them for reading. Stories, songs, and games also help children improve how they speak.

Answering a child's questions encourages the child to explore the world. Family members should try—with patience—to answer a young child's many questions.

Children who are learning to talk make many mistakes. Correcting them, however, will discourage talking. They will learn to speak correctly by copying—by listening to others who speak correctly.

Children this age can understand what is right and wrong. Traditional stories, songs, and games help teach children how to behave. Children also copy their older brothers and sisters and other family members as they learn what is right and wrong.

Children learn better if they see and are told what is correct first. They should be corrected gently so that they do not feel ashamed.

Group Discussion: WHAT ARE GOOD TOYS TO MAKE AT HOME?

Advise the caregiver to strengthen the skills of the persons who care for young children.

When you counsel a family you have an opportunity to strengthen the skills of the persons who care for young children.

The assessment identifies some common problems and what you can suggest to help families in caring for their children. You will guide the caregiver and child in practising the play and communication activities with you. For example:

To help a caregiver respond to the child

You might find that a caregiver does not move easily with her child and does not know how to comfort her child. You do not see the close connection between what the child does and how the caregiver responds.

This connection is the basis for sensitive and responsive caregiving. Where it is missing, you can help the caregiver learn to look closely at what a young child is doing and to respond directly to it.

Ask the caregiver to:

1. Look into the child's face until their eyes meet.
2. Notice the child's every movement and sound.
3. Copy the child's movements and sounds.

Soon, most young children also begin to copy the caregiver.

One time is not enough. Encourage the caregiver and child to play this communication game every day. Help the caregiver see how the child enjoys it. Notice how satisfied the caregiver is with the attention the child gives her.

> It is important that you do not do the activities directly with the child. Connecting with you, the counsellor, will interfere with the child making the connection with her caregiver.
>
> Instead, teach or coach the caregiver through the activity with her child.

To help a caregiver speak less harshly to a child

Sometimes, children annoy adults as they try new skills. For example, a father might think his child is misbehaving when he drops things again and again. He scolds his child and perhaps spanks him.

You can help the father see what the child might be thinking in a more positive way: "See what I can do. I can make it fall, and it makes a noise. The harder I push, the farther it goes. I am strong. When I drop it near Daddy, I am asking him to play with me, and we laugh and have fun together. He loves me very much."

To introduce a new play or communication activity

In general, introduce a play or communication activity on the counselling card by following these steps:

Get the child's attention

Before you start, help the caregiver get the child's attention. She can look into the child's eyes, smile, and make sounds until the child begins to respond to her. She can also move a container or other object in front of the child until the child reaches for it.

Respond to the child

Help the caregiver follow the child's lead. She can copy the child's sounds, or respond to the child's hand or leg movements. Often the child will then repeat the activity, in order to get the caregiver to respond again. This increases the child's attempts to make sounds and move, and the caregiver's pleasure. Both are important to help the child learn.

Introduce a play or communication activity recommended on the counselling card. When the caregiver and child are responding together, it is now easier to introduce a new activity.

For example, give stones (large enough not to swallow) and a plastic jar to a caregiver who takes care of her 14-month-old grandson. Ask her to try to teach her grandchild to put the stones into the jar. Help him to get started, if necessary. Point out any success, and help her find ways to show her grandchild that she is pleased.

Also, help her see how much her grandchild seems to enjoy playing with her. Often children want to repeat this activity many times, once they have learned it.

Note again that it is important that, as the counsellor, you do not do this activity directly with the child. Instead help—or coach—the caregiver to do the activity with the child.

Then, state the recommendations on play or communication for the child.

Recommend that the caregiver continue this activity at home to help her child learn: "Give your child things to put into containers and take out, and to stack up. This will help your child learn new skills. This will help him grow and be ready for school."

If the child is almost at the end of an age group—or the child already knows how to do the activities for her age group, you may introduce the recommendations for the next, older age group.

Check understanding

Before the caregiver and child leave, be sure you have seen them do the recommended play or communication activities. This will show you that the caregiver is able to do the activity. Encourage the caregiver to continue the activities at home.

Also, ask the caregiver questions about how he will do the activity at home. For example, "What do you have at home to use to teach your boy how to stack things?"

"What would you like your child to learn to name?" "When is a good time to read to your child?"

Finally, explain to the caregiver the importance of stimulating the child's development. One of the following reasons might be important to the child's family:

- Play and communication, as well as good feeding, will help your child grow healthy and learn. These activities are especially important in the first years of life.
- Play and communication activities help the brain to grow and make your child smart and happy.
- Good care for the child's development will help your child be ready to go to school and to contribute one day to the family and community.
- Playing and communicating with your child will help build a strong relationship with your child for life.

SELF-ASSESSMENT EXERCISE

Practice using the care for child development section

The following children are in your Health Centre for a visit. What activities would you recommend to their caregivers for play and communication? Take quick notes on the activities below.

Age of the child	Play?	Communication?
17 days		
2 months		
7 months		
10 months		
17 months		

6.10. FOLLOW UP CARE

To decide whether antibiotic is working in the treatment of pneumonia or iron is helping in correcting the anemia or the feeding advice is being followed, the mother should be asked to come back after specified period of time.

If the child has:	Return for follow-up after:
PNEUMONIA MALARIA/SUSPECTED MALARIA FEVER-MALARIA UNLIKELY (if fever persists),	2 days
DIARRHOEA, if not improving PERSISTENT DIARRHOEA FEEDING PROBLEM ANY OTHER ILLNESS , if not improving	5 days
UNCOMPLICATED SEVERE ACUTE MALNUTRITION	7 days
ANEMIA	14 days
MODERATE ACUTE MALNUTRITION	30 days

Consult the immunization schedule to advise the mother about when she should return for next immunization.

Do not confuse the mother with too many instructions about return visit. Advise her about the next visit only.

Follow-up Care

- **Pneumonia**

After 2 days of treatment review with the mother if she has given the treatment as advised. Then assess the child by checking for general danger signs, chest indrawing and count the breathing rate for one minute.

Assessment findings	Treatment
• If chest indrawing **or** general danger signs	• ***Refer urgently to hospital***
• If fast breathing persists and the child has been given the medicines as advised	• Refer to a doctor
• If breathing is slower and the child is feeding better	• Continue the antibiotic for 3 days

- **Diarrhoea**

A child with diarrhoea having some or no dehydration should be seen after 2 days. Assess the child's diarrhoea and review the feeding.

Assessment Findings	Treatment
• If very slow skin pinch or drinks poorly or general danger sign	• ***Refer urgently to hospital***
• If child has some dehydration (slow skin pinch and drinks eagerly)	• Treat with ORS • Reassess after 4 hours
• If child has no dehydration (skin pinch normal and drinks normally)	• Continue home available fluids. Review feeding and solve problems

- **Malaria/Malaria Unlikely**

After 2 days of treatment review fever:

Assessment Findings	Treatment
• Child with a general danger sign or stiff neck	• ***Refer urgently to hospital***
• If the child has any obvious cause of fever other than malaria	• Provide treatment or Refer
• If malaria is the only apparent cause of fever	• Continue antimalarial/start antimalarial if not given and see again in 2 days till fever settles
• If fever has been present for 7 days	• Refer for assessment

- **Moderate Acute Malnutrition**

After 30 days:

- Assess the child using the same measurement (weight, length/height, MUAC) used on the initial visit:
- Check the child for oedema of both feet.
- Reassess feeding. See questions in the COUNSEL THE MOTHER section. 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 weight for height >=-2SD/ MUAC is 12.5 cm 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.

- **Anemia**

Review whether the child is getting the iron as advised. Is the child feeling better? Is the child eating better?

- Give iron supplement for another 14 days and continue for a total of 60 days. Advise to return after 14 days.
- Assess pallor/haemoglobin estimation.
- Refer if the child has not improved after 2 months of treatment with Iron.

- **Feeding problems**

When a child returns for follow-up after 2 days reassess feeding. Use "counsel the mother on feeding" section.

Review with the mother the changes that the mother has been able to bring about in the child's feeding.

• Have her attempts been successful?	• If successful, reassure the mother and ask her to continue • Advise her about one or two more foods if appropriate • Ask her to come back after 14 days • Praise her if the child has started to eat more
• If the mother has not been able to follow the advice	• Find out the reasons and try to correct them • Ask her to come back after 14 days

Ask the mother to come back after **2 weeks** to assess whether the child has improved. However, if after 1 month of monitoring there is no improvement, you should refer the child to a doctor.

RECORDING FORMS

MANAGEMENT OF THE SICK YOUNG INFANT AGE UPTO 2 MONTHS FOR HW

Name:_____ **Age:**_____ **Gender:** _____ **Weight:**_____ **kg** **Temperature:**_____ **°C / °F** **Date:** _____

ASK: What are the infant's problems?_____ **Initial visit?**_____ **Follow up visit?**_____

ASSESS (Circle all signs present) **CLASSIFY**

CHECK FOR POSSIBLE SERIOUS BACTERIAL INFECTION/JAUNDICE

- Is the infant having difficulty in feeding?
- Has the infant had convulsions?
- Count the breaths in one minute_____ breaths per minute
  Repeat if elevated _____Fast breathing?
- Look for severe chest indrawing
- Measure axillary temperature (if not possible, feel for fever or low body temperature) - Is it < 35.5°C / 37.5 °C (95.9°F/ 99.5°F) or above?
- Look at young infant's movements.
  If infant is sleeping, ask the mother to wake him/her
  - ⇨ Does the infant move only when stimulated but then stops?
  - ⇨ Does the infant not move at all?
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules
- Look for jaundice (yellow skin). If present
- Look at the young infant's palms and soles. Are they yellow?
- Ask when did jaundice appeared – First 24 hours / After 24 hours

DOES THE YOUNG INFANT HAS DIARRHOEA? **Yes___ No___**

- Look at the young infant's general condition.
  - Look at infant's movements:
  - ⇨ Does the infant move only when stimulated and 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:
  - ⇨ Slowly?
  - ⇨ Very slowly (longer than 2 seconds)?

THEN CHECK FOR FEEDING PROBLEM & VERY LOW WEIGHT

- Has the infant breastfed in the previous hour?
  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? ____
  - ⇨ What do you use to feed the infant?_____

Yes _____ No _____

- Measure Weight
  - ⇨ Is it less than 1800 gm?
  - ⇨ Is it 1800 – 2500 gm?
- Determine weight for age by plotting weight on MCP card
  - ⇨ Red (<- 3 SD)
  - ⇨ Yellow (<- 2 SD)
  - ⇨ Green (≥ -2SD)
- Look for ulcers or white patches in the mouth (thrush)

Is there any indications for urgent Referral-Yes/No?

If no ASSESS BREASTFEEDING

ASSESS BREASTFEEDING:

- Has the infant breastfed in the previous hour?
- If infant has not breastfed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfed for 4 minutes.

- Check for attachment
  - ⇨ Chin touching breast Yes_____No____
  - ⇨ Mouth wide open Yes_____No____
  - ⇨ Lower lip turned outward Yes_____No____
  - ⇨ More areola above than below the mouth Yes____No____
- Is the infant able to attach?
  - ⇨ no attachment at all
  - ⇨ not well attached
  - ⇨ good attachment
- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  - ⇨ not suckling at all
  - ⇨ not suckling effectively
  - ⇨ suckling effectively
- Does the mother have pain while breastfeeding?
  If yes, then look for:
  - ⇨ Flat or inverted nipples or sore nipples

CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS
Circle immunization needed today

Birth	BCG	OPV 0	HEP-B 0		
6 weeks	Penta-1	OPV-1	Rotavirus-1	fIPV-1	PCV-1

Circle immunization needed today
Return for next immunization on:
_____(Date)

ASSESS CAREGIVER'S PRACTICES TO SUPPORT CHILD'S DEVELOPMENT
ASK:
How do you play with your baby?
How do you talk to your baby?
How do you get your baby smile?

- Look how does caregiver show he/she is aware of child's movement?
- Look how does caregiver comfort the child and show love?

ASSESS OTHER PROBLEMS

	TREAT
• **Advise Mother to Give Home Care to the Young Infant** ➢ Immediately after birth, baby should be put on the mother's abdomen for skin to skin contact. ➢ Initiate breastfeeding within one hour of birth. ➢ 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 him or her at least every 2-3 hours. Wake the baby for feeding after 3 hours, if she or he does not wake self. ➢ Breastfed as often as your child wants. Look for signs of hunger, such as beginning to fuss, sucking fingers, or moving lips. ➢ DO NOT give other foods or fluids. Breast milk is all your baby needs. ➢ Make sure the young infant stays warm at all times. In cool weather, cover the infant's head and feet and dress the infant with extra clothing. ➢ Advise mother to wash hands with soap and water after defecation and after cleaning bottom of the baby ➢ Do not apply anything on the cord and keep the umbilical cord dry.	
• **Advise the mother to return immediately if the young infant has any of these danger signs:** ➢ Not able to drink or breastfeed ➢ Becomes sicker ➢ Develops a fever or feels cold to touch ➢ Fast breathing ➢ Difficult breathing ➢ Yellow palms and soles (if infant has jaundice) ➢ Blood in stool	**Counsel mother about feeding** **Counsel mother about development supportive practices** **Advise mother when to return immediately.** **Give any immunization needed today _____** **Counsel the mother about her own health** **Return to follow up in:**

MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UPTO 5 YEARS FOR HW

Name:_____ **Age:**_____ **Gender:** _____ **Weight:**_____ **kg** **Temperature:**_____°C / °F **Date:**_____

ASK: What are the infant's problems?_____ **Initial visit?**_____ **Follow up visit?**_____

ASSESS (Circle all signs present)	**CLASSIFY**
CHECK FOR GENERAL DANGER SIGNS • NOT ABLE TO DRINK OR BREASTFEED • LETHARGIC OR UNCONSCIOUS • VOMITS EVERYTHING • CONVULSIONS/ CONVULSING NOW	General danger sign present? Yes _____ No_____ **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 • Check oxygen saturation- <90%/≥90%	
DOES THE CHILD HAVE DIARRHOEA? **Yes**___ **No**___ • For how long?_____ Days? • Is there blood in stools? Yes/ No • 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: ⇨ Slowly? ⇨ Very slowly (longer than 2 seconds)?	
DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5 °C or above) **Yes**___ **No**___ Is it a PF (P. falciparum predominant area) **Yes/ No** • Fever for how long? _____ Days? • If more than 7 days, has fever been present every day? • Look or feel for stiff neck • Look for any other focus of fever	
THEN CHECK FOR MALNUTRITION Weight_____(kg) Length/Height_____ (cm) • If child is 6 months or older, measure MUAC _____cm • Determine WFH/L SD score by plotting on MCP card: ⇨ Red (<-3SD) ⇨ Yellow (<-2 SD) ⇨ Green (≥-2SD) • Look for oedema of both feet • Look for visible severe wasting	
THEN CHECK FOR ANEMIA • Look for palmar pallor ⇨ Severe palmar pallor ⇨ Some palmar pallor ⇨ No pallor	
CHECK THE CHILD'S IMMUNIZATION, PROPHYLACTIC VITAMIN A & IRON-FOLIC ACID STATUS Circle immunizations and Vitamin A or IFA supplements needed today. BCG, PENTA 1, PENTA 2, PENTA 3, MR-1, MR-2 OPV 0, OPV 1, OPV 2, OPV 3, VITAMIN A+ IFA, OPV- Booster Hep B 0, Rota-1, Rota-2, Rota-3, JE-1, JE-2 PCV-1, PCV-2, PCV Booster, DPT Booster-1, DPT Booster-2 fIPV-1, fIPV-2, fIPV-3, Deworming	Return for next immunization or Vitamin A or IFA supplement or Deworming: _____ (Date)
ASSESS CHILD'S FEEDING • 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 food or fluids? Yes_____ No___ If yes, what foods of fluids? _____ • How many times per day? _____ . What do you use to feed the child and how? _____ • How large are the 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?	
ASSESS CAREGIVER'S PRACTICES TO SUPPORT CHILD'S DEVELOPMENT ASK: • How do you play with your baby? • How do you talk to your baby? • How do you get your baby smile? • Look how does caregiver show he/she is aware of child's movement? • Look how does caregiver comfort the child and show love?	
ASSESS OTHER PROBLEMS:	

TREAT

	Remember to refer any child who has a general danger sign and/or has another severe classification.
	Give any immunization. Vitamin A or IFA supplement needed today _______________
	Counsel the mother about feeding
	Counsel the mother about development supportive practices
	Advise mother when to return immediately.
	Counsel the mother about her own health.
	Return to follow up in: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