INTTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS FOR HIGH HIV SETTINGS

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**ASSESS AND CLASSIFY THE SICK CHILD Aged 2 Months up to 5 Years**

**ASK THE MOTHER WHAT THE CHILD’S PROBLEMS ARE**
- Determine whether this is an initial or follow-up visit for this problem.
  - if follow-up visit, use the follow-up instructions on TREAT THE CHILD chart (p.11)
  - if initial visit, assess the child as follows:

**CHECK FOR GENERAL DANGER SIGNS**

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

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

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

**IF YES, ASK:**

- For how long?
  - Count the breaths in one minute.
  - Look for chest indrawing.
  - Look and listen for stridor or wheezing.

**LOOK, LISTEN, FEEL:**

- CHILD MUST BE CALM

**Signs**
- Any general danger sign
  - Chest indrawing
  - Stridor in calm child
- Fast breathing
- No signs of pneumonia or very severe disease

**Classify As**
- SEVERE PNEUMONIA OR VERY SEVERE DISEASE
- PNEUMONIA
- COUGH OR COLD

**TREATMENT**

- Give first dose of an appropriate antibiotic IM
- Give oral antibiotic for 5 days
- If wheezing give a trial of rapid acting bronchodilator for up to three times before classifying severe pneumonia*
- If wheezing give an inhaled bronchodilator for five days*
- If recurrent wheezing refer for an assessment
- Advise mother when to return immediately

* In settings where inhaler is not available, oral salbutamol may be the second choice

---

**IF NO, ASK:**

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

IF YES, ASK:
• For how long?
• Is there blood in the stool?

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

Classify

for DEHYDRATION

and if diarrhoea for 14 days or more

and if blood in stool

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

SEVERE DEHYDRATION

➢ If child has no other severe classification:
  - Give fluid for severe dehydration (Plan C)
  OR
  - If child also has another severe classification:
    - Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way
    - Advise the mother to continue breastfeeding

➢ If child is 2 years or older and there is cholera in your area, give antibiotic for cholera

Two of the following signs:
• Restless, irritable
• Sunken eyes
• Drinks eagerly, thirsty
• Skin pinch goes back slowly.

SOME DEHYDRATION

➢ Give fluid, zinc supplements and food for some dehydration (Plan B)

➢ If child also has a severe classification:
  - Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way
  - Advise the mother to continue breastfeeding

➢ Advise mother when to return immediately

Not enough signs to classify as some or severe dehydration

NO DEHYDRATION

➢ Give fluid, zinc supplements and food to treat diarrhoea at home (Plan A)

➢ Advise mother when to return immediately

Dehydration present

SEVERE PERSISTENT DIARRHOEA

➢ Treat dehydration before referral unless the child has another severe classification

➢ Refer to hospital

➢ Check for HIV Infection

➢ Advise the mother on feeding a child who has PERSISTENT DIARRHOEA

➢ Give multivitamins and Zinc for 14 days

➢ Follow up in 5 days

➢ No dehydration

PERSISTENT DIARRHOEA

➢ Give ciprofloxacin for 3 days

➢ Follow-up in 2 days

Blood in the stool

DYSENTERY

➢ If referral is not possible, manage the child as described in Integrated Management of Childhood Illness, Treat the Child, Annex: Where Referral Is Not Possible, and WHO guidelines for inpatient care.
Does the child have fever?
(by history or feels hot or temperature 37.5°C** or above)

IF YES:
Decide Malaria Risk: high or low

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

LOOK AND FEEL:
• Look or feel for stiff neck.
• Look for runny nose.
• Look for signs of MEASLES
  • Generalized rash and
  • One of these: cough, runny nose, or red eyes.

Classify FEVER

High Malaria Risk

• Any general danger sign or
  Stiff neck.

FEVER - MALARIA UNLIKELY

• Any general danger sign or
  Clouding of cornea or
  Deep or extensive mouth ulcers

MEASLES WITH EYE OR MOUTH COMPLICATIONS***

MEASLES

LOW MALARIA RISK

• Any general danger sign or
  Stiff neck

SEVERE COMPLICATED MEASLES***

MEASLES

• Pus draining from the eye or
  Mouth ulcers

MEASLES WITH EYE OR MOUTH COMPLICATIONS***

MEASLES

• Running nose PRESENT or
  Measles PRESENT or
  Other cause of fever PRESENT

FEVER - MALARIA UNLIKELY

• No runny nose and
  No measles and
  No other cause of fever

MALARIA

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

MALARIA

• Give quinine for severe malaria (first dose)
  Give first dose of an appropriate antibiotic
  Treat the child to prevent low blood sugar
  Give one dose of paracetamol in clinic for high fever (38.5°C or above)
  Refer URGENTLY to hospital

• Give oral co-artemether or other recommended antimalarial
  Give one dose of paracetamol in clinic for high fever (38.5°C or above)
  Advise mother when to return immediately
  Follow-up in 2 days if fever persists
  If fever is present every day for more than 7 days, refer for assessment

• Give one dose of paracetamol in clinic for high fever (38.5°C or above)
  Advise mother when to return immediately
  Follow-up in 2 days if fever persists
  If fever is present every day for more than 7 days, refer for assessment

• Give Vitamin A for treatment
  Give first dose of an appropriate antibiotic
  If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment
  Refer URGENTLY to hospital

• Give Vitamin A for treatment
  If pus draining from the eye, treat eye infection with tetracycline eye ointment
  If mouth ulcers, treat with gentian violet
  Follow-up in 2 days.

• Give Vitamin A for treatment

** These temperatures are based on axillary temperature. Rectal temperature readings are approximately 0.5°C higher.
*** Other important complications of measles - pneumonia, stridor, diarrhoea, ear infection, and malnutrition - are classified in other tables.
### Does the child have an ear problem?

**IF YES, ASK:**
- Is there ear pain?
- Is there ear discharge? If yes, for how long?

**LOOK AND FEEL:**
- Look for pus draining from the ear.
- Feel for tender swelling behind the ear.

**Classify EAR PROBLEM**

<table>
<thead>
<tr>
<th>Tender swelling behind the ear.</th>
<th>MASTOIDITIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pus is seen draining from the ear and discharge is reported for less than 14 days, or</td>
<td>• Give first dose of an appropriate antibiotic.</td>
</tr>
<tr>
<td>• Ear pain.</td>
<td>• Give first dose of paracetamol for pain.</td>
</tr>
<tr>
<td></td>
<td>• Refer URGENTLY to hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACUTE EAR INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give an antibiotic for 5 days.</td>
</tr>
<tr>
<td>• Give paracetamol for pain.</td>
</tr>
<tr>
<td>• Dry the ear by wicking.</td>
</tr>
<tr>
<td>• If ear discharge, check for HIV Infection</td>
</tr>
<tr>
<td>• Follow-up in 5 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHRONIC EAR INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pus is seen draining from the ear and discharge is reported for 14 days or more.</td>
</tr>
<tr>
<td>• Dry the ear by wicking.</td>
</tr>
<tr>
<td>• Treat with topical quinolone eardrops for 2 weeks</td>
</tr>
<tr>
<td>• Check for HIV Infection</td>
</tr>
<tr>
<td>• Follow-up in 5 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NO EAR INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No ear pain and no pus seen draining from the ear.</td>
</tr>
<tr>
<td>• No treatment.</td>
</tr>
</tbody>
</table>
THEN CHECK FOR MALNUTRITION AND ANAEMIA

CHECK FOR MALNUTRITION

LOOK AND FEEL:

- For all children
  - Determine weight for age
  - Look for oedema of both feet
- For children up to 6 months
  - Look for visible severe wasting
- For children aged 6 months or more
  - Determine if MUAC* less than 110 mm
  - If MUAC less than 110 mm, or oedema, assess appetite**

CLASSIFY NUTRITIONAL STATUS

- If age up to 6 months:
  - and visible severe wasting
  - or oedema of both feet
- If age 6 months and above and:
  - MUAC less than 110 mm or
  - oedema of both feet
  - and poor appetite or pneumonia or persistent diarrhea or dysentery

SEVERE COMPLICATED MALNUTRITION

- Treat the child to prevent low sugar
- Refer URGENTLY to hospital

SEVERE UNCOMPROMICATED MALNUTRITION

- Counsel the mother on how to feed a child with RUTF***, if available, or refer to OTP**** or hospital (see box on p 21)
- Check for HIV infection
- Give mebendazole (if child aged 1 year or above), and first line oral antibiotic
- Assess the child’s feeding
- Advise mother when to return immediately
- Follow-up in 7 days

VERY LOW WEIGHT

- Assess the child’s feeding and counsel the mother on feeding according to the feeding recommendations (page 24)
- Check for HIV infection
- Advise mother when to return immediately
- Follow-up in 30 days

NOT VERY LOW WEIGHT

- If child is less than 2 years old, assess the child’s feeding and counsel the mother on feeding according to the feeding recommendations (page 24)
  - If feeding problem, follow-up in 5 days
  - Advise mother when to return immediately

CHECK FOR ANAEMIA

LOOK and FEEL:

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

CLASSIFY ANAEMIA

- Severe palmar pallor
- Some palmar pallor
- No palmar pallor

SEVERE ANAEMIA

- Refer URGENTLY to hospital

ANAEMIA

- Give iron
- Give oral antimalarial if high malaria risk
- Check for HIV infection
- Give mebendazole if child is 1 year or older and has not had a dose in the previous six months
- Advise mother when to return immediately
- Follow up in 14 days

NO ANAEMIA

- If child is less than 2 years old, assess the child’s feeding and counsel the mother on feeding according to the feeding recommendations (page 24)
  - If feeding problem, follow-up in 5 days

* MUAC is mid-upper arm circumference. If tapes are not available, look for visible severe wasting
** Appetite is assessed by observing the child eating RUTF***, where available. A spoon is needed to assess child feeding the paste
*** RUTF- Ready-To-Use Therapeutic Food
**** OTP - outpatient therapeutic feeding point
## THEN CHECK FOR HIV INFECTION*

- Has the mother or child had an HIV test? **OR**
- Does the child have one or more of the following conditions?:
  - Pneumonia **
  - Persistent diarrhoea **
  - Ear discharge (acute or chronic)
  - Very low weight for age**

### NOTE OR ASK:
- PNEUMONIA ?
- PERSISTENT DIARRHOEA?
- EAR DISCHARGE?
- VERY LOW WEIGHT?

### LOOK and FEEL:
- Oral thrush
- Parotid enlargement
- Generalized persistent lymphadenopathy

HIV test result available for mother/child?

---

*A child who has already been put on ART does not need to be assessed with this HIV box

** Includes severe forms such as severe pneumonia. In the case of severe forms, complete assessment quickly and refer child URGENTLY

### SIGNS

<table>
<thead>
<tr>
<th>CLASSIFY</th>
<th>IDENTIFY TREATMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONFERMED HIV INFECTION</strong></td>
<td></td>
</tr>
<tr>
<td>• Positive HIV antibody test for child 18 months and above OR</td>
<td></td>
</tr>
<tr>
<td>• Positive HIV virological test</td>
<td></td>
</tr>
<tr>
<td><strong>HIV EXPOSED/ POSSIBLE HIV</strong></td>
<td></td>
</tr>
<tr>
<td>One or both of the following:</td>
<td></td>
</tr>
<tr>
<td>• Mother HIV positive and no test result for child OR</td>
<td></td>
</tr>
<tr>
<td>• Child less than 18 months with positive antibody test</td>
<td></td>
</tr>
<tr>
<td><strong>SUSPECTED SYMPTOMATIC HIV INFECTION</strong></td>
<td></td>
</tr>
<tr>
<td>• 2 or more conditions AND</td>
<td></td>
</tr>
<tr>
<td>• No test results for child or mother</td>
<td></td>
</tr>
<tr>
<td><strong>SYMPTOMATIC HIV INFECTION UNLIKELY</strong></td>
<td></td>
</tr>
<tr>
<td>• Less than 2 conditions AND</td>
<td></td>
</tr>
<tr>
<td>• No test result for child or mother</td>
<td></td>
</tr>
<tr>
<td><strong>HIV INFECTION UNLIKELY</strong></td>
<td></td>
</tr>
<tr>
<td>• Negative HIV test in mother or child AND not enough signs to classify as suspected symptomatic HIV infection</td>
<td></td>
</tr>
</tbody>
</table>

**TREAT, COUNSEL AND FOLLOW-UP EXISTING INFECTIONS**

- Give co-trimoxazole prophylaxis
- Give Vitamin A supplements from 6 months of age every 6 months
- Assess the child’s feeding and provide appropriate counselling to the mother
- Refer for further assessment including HIV care/ART

**FOLLOW-UP IN 14 DAYS, THEN MONTHLY FOR 3 MONTHS AND THEN EVERY 3 MONTHS OR AS PER IMMUNIZATION SCHEDULE**
THEN CHECK THE CHILD’S IMMUNIZATION STATUS

<table>
<thead>
<tr>
<th>IMMUNIZATION SCHEDULE:</th>
<th>AGE</th>
<th>VACCINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth</td>
<td>BCG*</td>
</tr>
<tr>
<td></td>
<td>6 weeks</td>
<td>DPT+HIB-1</td>
</tr>
<tr>
<td></td>
<td>10 weeks</td>
<td>DPT+HIB-2</td>
</tr>
<tr>
<td></td>
<td>14 weeks</td>
<td>DPT+HIB-3</td>
</tr>
<tr>
<td></td>
<td>9 months</td>
<td>Measles 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPV-0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPV-1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPV-2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPV-3</td>
</tr>
</tbody>
</table>

VITAMIN A PROPHYLAXIS
Give every child a dose of Vitamin A every six months from the age of 6 months. Record the dose on the child’s card.

ROUTINE WORM TREATMENT
Give every child mebendazole every 6 months from the age of one year. Record the dose on the child’s card.

ASSESS OTHER PROBLEMS:

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

*BCG could be given* any time after birth to all infants born to women of unknown HIV status or born to HIV infected women but with no signs or reported symptoms of suggestive HIV infection. *BCG should NOT be given* any time after birth to infants known to be HIV infected or born to HIV infected women and HIV status unknown but who have signs or reported symptoms suggestive of HIV infection.
### WHO Paediatric Clinical Staging for HIV

<table>
<thead>
<tr>
<th>Has the child been confirmed HIV Infected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If yes, perform clinical staging: any one condition in the highest staging determines stage. If no, you cannot stage the patient)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>WHO Paediatric Clinical Stage 1 - Asymptomatic</th>
<th>WHO Paediatric Clinical Stage 2 - Mild Disease</th>
<th>WHO Paediatric Clinical Stage 3 - Moderate Disease</th>
<th>WHO Paediatric Clinical Stage 4 - Severe Disease (AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth</td>
<td><img src="image" alt="Growth Stage" /></td>
<td><img src="image" alt="Growth Stage" /></td>
<td><img src="image" alt="Growth Stage" /></td>
<td><img src="image" alt="Growth Stage" /></td>
</tr>
<tr>
<td>Symptoms/ signs</td>
<td><img src="image" alt="Symptoms/ signs" /></td>
<td><img src="image" alt="Symptoms/ signs" /></td>
<td><img src="image" alt="Symptoms/ signs" /></td>
<td><img src="image" alt="Symptoms/ signs" /></td>
</tr>
<tr>
<td>ARV Therapy</td>
<td><img src="image" alt="ARV Therapy" /></td>
<td><img src="image" alt="ARV Therapy" /></td>
<td><img src="image" alt="ARV Therapy" /></td>
<td><img src="image" alt="ARV Therapy" /></td>
</tr>
</tbody>
</table>

#### ART is indicated:
Irrespective of the CD4 count, and should be started as soon as possible

If HIV infection is NOT confirmed in infants<18 months, presumptive diagnosis of severe HIV disease can be made on the basis of:

- HIV antibody positive
- One of the following:
  - AIDS defining condition OR
  - Symptomatic with two or more of:
    - Oral thrush
    - Severe pneumonia
    - Severe sepsis

---

*Note that these are interim recommendations and may be subject to change.*
HIV TESTING FOR THE HIV EXPOSED CHILD

Encourage HIV testing for:
- All children born to an HIV positive mother
- All sick children with symptomatic suspected HIV infection

For children > 18 months, a positive HIV antibody test result means the child is infected.

For HIV exposed children <18 months of age,
- If PCR or other virological test is available, test from 6 weeks of age
  - A positive result means the child is infected
  - A negative result means the child is not infected, but could become infected if they are still breastfeeding
- If PCR or other virological test not available, use HIV antibody test.
  - A positive result is consistent with the fact that the child has been exposed to HIV, but does not tell us if the child is definitively infected.
  - A negative test usually means the child is not infected.

If PCR or other virological test is not available, use HIV antibody test.
- If the child becomes sick, recommend HIV antibody test.
- If the child remains well, recommend HIV antibody test at 9–12 months.
- If child > 12 month has not yet been tested, recommend HIV antibody test.

### Interpreting the HIV antibody test results in a child < 18 months of age

<table>
<thead>
<tr>
<th>Test result</th>
<th>HIV antibody test is positive</th>
<th>HIV antibody test is negative</th>
</tr>
</thead>
</table>
| Not breastfeeding or not breastfed in last 6 weeks | **HIV exposed and/or HIV infected**  
Manage as if they could be infected. Repeat test at 18 months | **HIV negative**  
Child is not HIV infected |
| Breast feeding                                   | **HIV exposed and/or HIV infected**  
Manage as if they could be infected. Repeat test at 18 months or once breastfeeding has been discontinued for more than 6 weeks | **Child can still be infected by breastfeeding.**  
Repeat test once breastfeeding has been discontinued for more than 6 weeks. |

1. The older the child is the more likely the HIV antibody is due to their own infection and not due to maternal antibody
2. Very exceptionally a very severely sick child who is HIV infected will have HIV antibody test results that are negative. If the clinical picture strongly suggests HIV, then virological testing will be needed.
Give Co-trimoxazole to Children with Confirmed or Suspected HIV Infection or Children who are HIV Exposed

- Co-trimoxazole should be given starting at 4-6 weeks of age to:
  - All infants born to mothers who are HIV infected until HIV is definitively ruled out
  - All infants with confirmed HIV infection aged <12 months or those with stage 2,3 or 4 disease or
  - Asymptomatic infants or children (stage 1) if CD4 <25%
- Give co-trimoxazole once daily.

Give Co-trimoxazole to Children with Confirmed or Suspected HIV Infection or Children who are HIV Exposed

TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

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

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

Give an Appropriate Oral Antibiotic

- **FOR PNEUMONIA, ACUTE EAR INFECTION:**
  - **FIRST-LINE ANTIBIOTIC:** __________________________________________________________
  - **SECOND-LINE ANTIBIOTIC:** __________________________________________________________

  *Amoxycillin should be used if there is high co-trimoxazole resistance. Amoxycillin can be given twice daily instead of three times at 25mg/kg/dose. Duration of treatment can be reduced to 3 days in low HIV prevalence areas.*

For dysentery give Ciprofloxacin

15mg/kg/day—2 times a day for 3 days

<table>
<thead>
<tr>
<th>CO-TRIMOXAZOLE dosage—single dose per day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>Less than 6 months</td>
</tr>
<tr>
<td>6 months up to 5 years</td>
</tr>
<tr>
<td>5 - 14 years</td>
</tr>
<tr>
<td>&gt; 15 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>250 mg TABLET</strong></th>
<th><strong>500 mg TABLET</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE</strong></td>
<td><strong>DOSE/ tabs</strong></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>1/2 tablet</td>
</tr>
<tr>
<td>6 months up to 5 years</td>
<td>1 tablet</td>
</tr>
</tbody>
</table>

TREAT THE CHILD
CARRY OUT THE TREATMENT STEPS IDENTIFIED ON THE ASSESS AND CLASSIFY CHART
TEACH THE MOTHER TO GIVE ORAL DRUGS AT HOME

Give pain relief

- Safe doses of paracetamol can be slightly higher for pain. Use the table and teach mother to measure the right dose.
- Give paracetamol every 6 hours if pain persists.
- Stage 2 pain is chronic severe pain as might happen in illnesses such as AIDS:
  - Start treating Stage 2 pain with regular paracetamol.
  - In older children, ½ paracetamol tablet can replace 10 ml syrup.
  - If the pain is not controlled, add regular codeine 4 hourly.
  - For severe pain, morphine syrup can be given.

<table>
<thead>
<tr>
<th>WEIGHT</th>
<th>AGE (If you do not know the weight)</th>
<th>PARACETAMOL 120mg / 5mls</th>
<th>Add CODEINE 30mg tablet</th>
<th>ORAL MORPHONE 5mg/5ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - &lt;6kg</td>
<td>2 months up to 4 months</td>
<td>2 ml</td>
<td>1/4</td>
<td>0.5ml</td>
</tr>
<tr>
<td>6 - &lt;10kg</td>
<td>4 months up to 12 months</td>
<td>2.5 ml</td>
<td>1/4</td>
<td>2ml</td>
</tr>
<tr>
<td>10 - &lt;12kg</td>
<td>12 up to 2 years</td>
<td>5 ml</td>
<td>1/2</td>
<td>3ml</td>
</tr>
<tr>
<td>12 - &lt;14kg</td>
<td>2 years up to 3 years</td>
<td>7.5 ml</td>
<td>1/2</td>
<td>4ml</td>
</tr>
<tr>
<td>14 - 19kg</td>
<td>3 to 5 years</td>
<td>10 ml</td>
<td>3/4</td>
<td>5ml</td>
</tr>
</tbody>
</table>

Give Iron

- Give one dose daily for 14 days.

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>IRON/FOLATE TABLET</th>
<th>IRON SYRUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ferrous sulfate 200 mg + 250 mcg Folate (60 mg elemental iron)</td>
<td>Ferrous fumarate 100 mg per 5 ml (20 mg elemental iron per ml)</td>
</tr>
<tr>
<td>2 months up to 4 months (4 - &lt;6 kg)</td>
<td>1.0 ml (&lt;1/4 tsp)</td>
<td></td>
</tr>
<tr>
<td>4 months up to 12 months (6 - &lt;10kg)</td>
<td>1.25 ml (1/4 tsp)</td>
<td></td>
</tr>
<tr>
<td>12 months up to 3 years (10 - &lt;14 kg)</td>
<td>1/2 tablet</td>
<td>2.0 ml (&lt;1/2 tsp)</td>
</tr>
<tr>
<td>3 years up to 5 years (14 - 19 kg)</td>
<td>1/2 tablet</td>
<td>2.5 ml (1/2 tsp)</td>
</tr>
</tbody>
</table>

GIVE INHALED SALBUTAMOL for WHEEZING

USE OF A SPACER*

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

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

Spacers can be made in the following way:

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

To use an inhaler with a spacer:

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

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

Give Oral Co-artemether

- Give the first dose of co-artemether in the clinic and observe for one hour. If child vomits within an hour repeat the dose. 2nd dose at home after 8 hours.
- Then twice daily for further two days as shown below.

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>Co-artemether tablets (20mg artemether and 120mg lumefantrine)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WEIGHT (age)</td>
</tr>
<tr>
<td>5-15kg (&lt;3 years)</td>
<td>1</td>
</tr>
<tr>
<td>15-24kg (4-8 years)</td>
<td>2</td>
</tr>
<tr>
<td>25-34 kg (9-14 years)</td>
<td>3</td>
</tr>
<tr>
<td>&gt;34 kg (&gt;14 years)</td>
<td>4</td>
</tr>
</tbody>
</table>
### TEACH THE MOTHER TO TREAT LOCAL INFECTIONS AT HOME

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

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

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

#### Treat for Mouth Ulcers with Gentian Violet (GV)

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

#### Treat for Thrush with Nystatin

- Treat for thrush four times daily for 7 days
  - Wash hands
  - Wet a clean soft cloth with salt water and use it to wash the child’s mouth
  - Instill nystatin 1ml four times a day
  - Avoid feeding for 20 minutes after medication
  - If breastfed check mother’s breasts for thrush. If present treat with nystatin
  - Advise mother to wash breasts after feeds. If bottle fed advise change to cup and spoon
  - If severe, recurrent or pharyngeal thrush consider symptomatic HIV (p. 7)
  - Give paracetamol if needed for pain (p.12)

#### Treat Eye Infection with Tetracycline Eye Ointment

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

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*Quinolone eardrops may include ciprofloxacin, norfloxacin, or ofloxacin* ear-drops.

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#### Soothe the Throat, Relieve the Cough with a Safe Remedy

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

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GIVE VITAMIN A AND MEBENDAZOLE IN CLINIC

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

Give Vitamin A to all children from 6 months of age every 6 months

PREVENTION:
- Give Vitamin A to all children to prevent severe illness:
  - First dose at 6 weeks in a child that is not being breastfed
  - First dose in breastfed children to be given any time after 6 months of age
  - Thereafter Vitamin A should be given every six months to ALL CHILDREN

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

<table>
<thead>
<tr>
<th>Age</th>
<th>VITAMIN A DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 months</td>
<td>50 000IU</td>
</tr>
<tr>
<td>6 up to 12 months</td>
<td>100 000IU</td>
</tr>
<tr>
<td>One year and older</td>
<td>200 000IU</td>
</tr>
</tbody>
</table>

Give Mebendazole
- Give 500 mg mebendazole as a single dose in clinic if:
  - hookworm/whipworm is a problem in your area
  - the child is 1 year of age or older, and
  - has not had a dose in the previous 6 months
GIVE THESE TREATMENTS IN THE CLINIC ONLY

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

Give An Intramuscular Antibiotic

**GIVE TO CHILDREN BEING REFERRED URGENTLY**

- Give Ampicillin (50 mg/kg) and Gentamicin (7.5mg/kg)

**AMPICILLIN**

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

**GENTAMICIN**

- 7.5mg/kg/day once daily

<table>
<thead>
<tr>
<th>AGE</th>
<th>WEIGHT</th>
<th>AMPICILLIN 500 mg vial</th>
<th>Gentamicin 2ml/40 mg/ml vial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 up to 4 months</td>
<td>4 - &lt;6kg</td>
<td>1 ml</td>
<td>0.5 - 1.0 ml</td>
</tr>
<tr>
<td>4 up to 12 months</td>
<td>6 - &lt;10kg</td>
<td>2 ml</td>
<td>1.1 - 1.8 ml</td>
</tr>
<tr>
<td>1 up to 3 years</td>
<td>10 - &lt;15kg</td>
<td>3 ml</td>
<td>1.9 - 2.7 ml</td>
</tr>
<tr>
<td>3 up to 5 years</td>
<td>15 - 20kg</td>
<td>5 ml</td>
<td>2.8 - 3.5 ml</td>
</tr>
</tbody>
</table>

**GIVE DIAPZEPAM TO STOP A CONVULSION**

- Turn the child to his/her side and clear the airway. Avoid putting things in the mouth
- Give 0.5mg/kg diazepam injection solution per rectum using a small syringe without a needle (like a tuberculin syringe) or using a catheter
- Check for low blood sugar, then treat or prevent (p.16)
- Give oxygen and REFER
- If convulsions have not stopped after 10 minutes repeat diazepam dose

<table>
<thead>
<tr>
<th>WEIGHT</th>
<th>AGE</th>
<th>DOSE OF DIAZEPAM (10mg/2mls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5kg</td>
<td>&lt;6 months</td>
<td>0.5 mls</td>
</tr>
<tr>
<td>5 - &lt; 10kg</td>
<td>6 - &lt; 12 months</td>
<td>1.0 mls</td>
</tr>
<tr>
<td>10 - &lt; 15kg</td>
<td>1 - &lt; 3 years</td>
<td>1.5mls</td>
</tr>
<tr>
<td>15 - 19 kg</td>
<td>4 - &lt; 5 years</td>
<td>2.0 mls</td>
</tr>
</tbody>
</table>

**GIVE QUININE FOR SEVERE MALARIA**

**FOR CHILDREN BEING REFERRED WITH VERY SEVERE FEBRILE DISEASE:**

- Check which quinine formulation is available in your clinic
- Give first dose of intramuscular quinine and refer child urgently to hospital

**IF REFERRAL IS NOT POSSIBLE:**

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

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>INTRAMUSCULAR QUININE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months up to 4 months (4 - &lt; 6 kg)</td>
<td>150 mg/ml* (in 2 ml)</td>
</tr>
<tr>
<td>4 months up to 12 months (6 - &lt; 10 kg)</td>
<td>300 mg/ml* (in 2 ml)</td>
</tr>
<tr>
<td>12 months up to 2 years (10 - &lt; 12 kg)</td>
<td>0.4 ml</td>
</tr>
<tr>
<td>2 years up to 3 years (12 - &lt; 14 kg)</td>
<td>0.6 ml</td>
</tr>
<tr>
<td>3 years up to 5 years (14 - 19 kg)</td>
<td>1.0 ml</td>
</tr>
</tbody>
</table>

*quinine salt
Treat the Child to Prevent Low Blood Sugar

If the child is able to breastfeed:
Ask the mother to breastfeed the child

If the child is not able to breastfeed but is able to swallow:
• Give expressed breast milk or breast-milk substitute
• If neither of these is available give sugar water
• Give 30-50 ml of milk or sugar water before departure

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

If the child is not able to swallow:
• Give 50ml of milk or sugar water by nasogastric tube
Plan A: Treat for Diarrhoea at Home

Counsel the mother on the 4 Rules of Home Treatment:
1. Give Extra Fluid,
2. Give Zinc Supplements,
3. Continue Feeding,
4. When to Return

1. **GIVE EXTRA FLUID** (as much as the child will take)
   - **TELL THE MOTHER:**
     - Breastfeed frequently and for longer at each feed
     - If the child is exclusively breastfed, give ORS or clean water in addition to breast milk
     - If the child is not exclusively breastfed, give one or more of the following:
       food-based fluids (such as soup, rice water, and yoghurt drinks), or ORS
   - It is especially important to give ORS at home when:
     - the child has been treated with Plan B or Plan C during this visit
     - the child cannot return to a clinic if the diarrhoea gets worse
   - **TEACH THE MOTHER HOW TO MIX AND GIVE ORS. GIVE THE MOTHER 2 PACKETS OF ORS TO USE AT HOME.**
   - **SHOW THE MOTHER HOW MUCH FLUID TO GIVE IN ADDITION TO THE USUAL FLUID INTAKE:**
     - Up to 2 years: 50 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**
   - **TELL THE MOTHER HOW MUCH ZINC TO GIVE (20 mg tab):**
     - Up to 6 months ——— 1/2 tablet daily for 14 days
     - 6 months or more ——— 1 tablet daily for 14 days
   - **SHOW THE MOTHER HOW TO GIVE ZINC SUPPLEMENTS**
     - Infants—dissolve tablet in a small amount of expressed breast milk, ORS or clean water in a cup
     - Older children - tablets can be chewed or dissolved in a small amount of clean water in a cup

3. **CONTINUE FEEDING**

4. **WHEN TO RETURN**

Plan B: Treat for Some Dehydration with ORS

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

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

<table>
<thead>
<tr>
<th>AGE*</th>
<th>Up to 4 months</th>
<th>4 months up to 12 months</th>
<th>12 months up to 2 years</th>
<th>2 years up to 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHT</td>
<td>&lt; 6 kg</td>
<td>6 - &lt; 10 kg</td>
<td>10 - &lt; 12 kg</td>
<td>12 - &lt;20 kg</td>
</tr>
<tr>
<td>Amount of fluid (ml) over 4 hours</td>
<td>200 - 450</td>
<td>450 - 800</td>
<td>800 - 960</td>
<td>960 - 1600</td>
</tr>
</tbody>
</table>

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

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

- **SHOW THE MOTHER HOW TO GIVE ORS SOLUTION:**
  - Give frequent small sips from a cup
  - If the child vomits, wait 10 minutes then continue - but more slowly
  - Continue breastfeeding whenever the child wants

- **AFTER 4 HOURS:**
  - Reassess the child and classify the child for dehydration
  - Select the appropriate plan to continue treatment
  - Begin feeding the child in clinic

- **IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT:**
  - Show her how to prepare ORS solution at home
  - Show her how much ORS to give to finish 4-hour treatment at home
  - Give her instructions how to prepare salt and sugar solution for use at home
  - Explain the 4 Rules of Home Treatment:
    1. **GIVE EXTRA FLUID**
    2. **GIVE ZINC**
    3. **CONTINUE FEEDING**
    4. **WHEN TO RETURN**
Plan C: Treat for Severe Dehydration Quickly

**FOLLOW THE ARROWS. IF ANSWER IS “YES”, GO ACROSS. IF “NO”, GO DOWN**

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

<table>
<thead>
<tr>
<th>AGE</th>
<th>First give 30ml/kg in:</th>
<th>Then give 70ml/kg in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (under 12 months)</td>
<td>1 hour</td>
<td>5 hours</td>
</tr>
<tr>
<td>Children (12 months up to 5 years)</td>
<td>30 minutes</td>
<td>2½ hours</td>
</tr>
</tbody>
</table>

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

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

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

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

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**IMMUNIZE EVERY SICK CHILD, AS NEEDED**
GIVE FOLLOW-UP CARE

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

**PNEUMONIA**

After 2 days:
Check the child for general danger signs.  
Assess the child for cough or difficult breathing.  
See ASSESS & CLASSIFY chart.

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

Assess for HIV infection

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

**DYSENTERY:**

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

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

Treatment:
- If the child is dehydrated, treat for dehydration.
- If number of stools, blood in the stools, fever, abdominal pain, or eating is worse or the same REFER.

Change to second-line oral antibiotic recommended for shigella in your area. Give it for 5 days. Advise the mother to return in 2 days.

Exceptions: if the child is less than 12 months old or was dehydrated on the first visit, or if he had measles within the last 3 months, REFER TO HOSPITAL.

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

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

**PERSISTENT DIARRHOEA**

After 5 days:
- Has the diarrhoea stopped?
- How many loose stools is the child having per day?

Assess for HIV infection

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

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

**MALARIA (Low or High Malaria Risk)**

*If fever persists after 2 days, or returns within 14 days:*

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

**Treatment:**

- If the child has *any general danger sign or stiff neck*, treat as VERY SEVERE FEBRILE DISEASE.
- If the child has any *cause of fever other than malaria*, provide treatment.
- If *malaria is the only apparent cause of fever:*
  - Treat with the first-line oral antimalarial. Advise the mother to return again in 2 days if the fever persists.
  - If fever has been present for 7 days, refer for assessment.

**FEVER-MALARIA UNLIKELY (Low Malaria Risk)**

If fever persists after 2 days:

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

**Treatment:**

- If the child has *any general danger sign or stiff neck*, treat as VERY SEVERE FEBRILE DISEASE.
- If the child has any *cause of fever other than malaria*, provide treatment.
- If *malaria is the only apparent cause of fever:*
  - Treat with the second-line oral antimalarial (if no second-line antimalarial is available, refer to hospital.) Advise the mother to return again in 2 days if the fever persists.
  - If fever has been present for 7 days, refer for assessment.

**MEASLES WITH EYE OR MOUTH COMPLICATIONS**

*After 2 days:*

Look for red eyes and pus draining from the eyes. Look at mouth ulcers. Smell the mouth.

**Treatment for Eye Infection:**

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

**Treatment for Mouth Ulcers:**

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

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

**EAR INFECTION**

After 5 days:

- Reassess for ear problem. > See ASSESS & CLASSIFY chart.
- Measure the child’s temperature.
- Check for HIV infection.

**Treatment:**

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

**FEEDING PROBLEM**

After 5 days:

- Reassess feeding. > See questions at the top of the COUNSEL chart.
- Ask about any feeding problems found on the initial visit.

**Treatment:**

- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the child back again.
- If the child is very low weight for age, ask the mother to return 30 days after the initial visit to measure the child’s weight gain.

**PALLOR**

After 14 days:

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

**VERY LOW WEIGHT**

After 30 days:

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

**Treatment:**

- If the child is no longer very low weight for age, praise the mother and encourage her to continue.
- If the child is still very low weight for age, counsel the mother about any feeding problem found. Ask the mother to return again in one month. Continue to see the child monthly until the child is feeding well and gaining weight regularly or is not longer very low weight for age.

**Exception:**

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

**SEVERE UNCOMPROMICATED MALNUTRITION**

Every 7 days for 2 months:

- Weigh the child, assess MUAC

**Treatment:**

- If the child gained weight, praise the mother and give a weekly supply of ready-to-use therapeutic food (RUTF)
- If no weight gain during the first 2 weeks or weight loss when MUAC less than 110 mm or weight loss for 2 consecutive weeks when MUAC 110 mm or above, refer for assessment.
### GIVE FOLLOW-UP CARE FOR THE CHILD WITH POSSIBLE HIV INFECTION / HIV EXPOSED OR SUSPECTED SYMPTOMATIC OR CONFIRMED HIV INFECTION

**GENERAL PRINCIPLES OF GOOD CHRONIC CARE FOR HIV-INFECTED CHILDREN**
- Develop a treatment partnership with the mother and infant or child
- Focus on the mother and child’s concerns and priorities
- Use the ‘5 As’: Assess, Advise, Agree, Assist, Arrange to guide you the steps on chronic care consultation. Use the 5As at every patient consultation
- Support the mother and child’s self-management
- Organize proactive follow-up
- Involve “expert patients”, peer educators and support staff in your health facility
- Link the mother and child to community-based resources and support
- Use written information – registers, Treatment Plan and treatment cards - to document, monitor and remind
- Work as a clinical team
- Assure continuity of care

**IF POSSIBLE HIV INFECTION / HIV EXPOSED**
- Follow-up: in 14 days, then monthly for 3 months, then every 3 months or as per immunization schedule
- Do a full re-assessment at each follow-up visit and reclassify for HIV on each follow-up visit
- Counsel about feeding practices (page 25 in chart booklet and according to the recommendations in Module 3)
- Follow co-trimoxazole prophylaxis as per national guidelines
- Follow national immunization schedule
- Follow Vitamin A supplements from 6 months of age every 6 months
- Monitor growth and development
- Virological Testing for HIV infection as early as possible from 6 weeks of age
- Refer for ARVs if infant develops severe signs suggestive of HIV
- Counsel the mother about her own HIV status and arrange counselling and testing for her if required

* Any child with confirmed HIV infection should be enrolled in chronic HIV care, including assessment for eligibility of ART – refer to subsequent sections of the chart booklet.

**IF SUSPECTED SYMPTOMATIC HIV INFECTION**
- Follow up in 14 days, then monthly for 3 months and 3 monthly or as per immunization schedule
- Do a full assessment – classify for common childhood illnesses, for malnutrition and feeding, skin and mouth conditions and for HIV on each visit
- Check if diagnostic HIV test has been done and if not, test for HIV as soon as possible
- Assess feeding and check weight and weight gain
- Encourage breastfeeding - mothers to continue exclusive breastfeeding
- Advise on any new or continuing feeding problems
- Initiate or follow up co-trimoxazole prophylaxis according to national guidelines
- Give immunizations according to schedule. Do not give BCG
- Give Vitamin A according to schedule
- Provide pain relief if needed
- Refer for confirmation of HIV infection and ART, if not yet confirmed

**IF CHILD IS CONFIRMED HIV INFECTED**
- Follow-up: in 14 days, monthly for 3 months and then 3-monthly or as per national guideline
- Continue co-trimoxazole prophylaxis
- Follow-up on feeding
- Home care:
  - Counsel the mother about any new or continuing problems
  - If appropriate, put the family in touch with organizations or people who could provide support
  - Explain the importance of early treatment of infections or refer
  - Advise the mother about hygiene in the home, in particular when preparing food
- Reassess for eligibility for ART or REFER

**IF CHILD CONFIRMED UNINFECTED**
- Stop co-trimoxazole only if no longer breastfeeding and more than 12 months of age
- Counsel mother on preventing HIV infection and about her own health

**IF HIV TESTING HAS NOT BEEN DONE**
- Re-discuss the benefits of HIV testing
- Identify where and when HIV testing including virological testing can be done
- If mother consents arrange HIV testing and follow-up visit

**IF MOTHER REFUSES TESTING**
- Provide ongoing care for the child, including routine monthly follow-up
- Discuss and provide co-trimoxazole prophylaxis
- On subsequent visits, re-counsel the mother on preventing HIV and on benefits of HIV testing
COUNSEL THE MOTHER

➢ Assess the Feeding of Sick Infants under 2 years 
(or if child has very low weight for age)

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

ASK — How are you feeding your child?

If the infant is receiving any breast milk, ASK:
- How many times during the day?
- Do you also breastfeed during the night?

If infant is receiving replacement milk, ASK:
- What replacement milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How is the milk prepared?
- How is the milk being given? Cup or bottle?
- How are you cleaning the utensils?
- If still breastfeeding as well as giving replacement milk could the mother give extra breast milk instead of replacement milk (especially if the baby is below 6 months)

Does the infant take any other food or fluids?
- What food or fluids?
- How many times per day?
- What do you use to feed the child?

If low weight for age, ASK:
- How large are servings?
- Does the child receive his own serving?
- Who feeds the child and how?

During this illness, has the infant’s feeding changed?
- If yes, how?
FEEDING RECOMMENDATIONS DURING SICKNESS AND HEALTH

NOTE: These feeding recommendations should be followed for infants of HIV negative mothers. Mothers who DO NOT KNOW their HIV status should be advised to breastfeed but also to be HIV tested so that they can make an informed choice about feeding.

Feeding recommendations for a child who has SEVERE UNCOMPLICATED MALNUTRITION
- If still breast feeding, give more frequent, longer breast feeds, day and night
- Feed the child with RUTF (ready-to-use therapeutic food) per day (corresponding to 40 g/kg/day) for 2 months. Usually comes in sachets of 500 gms. NOTE: RUTF is a special food for malnourished children aged more than 6 months and should not be shared with other family members. Offer plenty of clean water to drink with RUTF

Feeding Recommendations for a child who has PERSISTENT DIARRHOEA
- If still breastfeeding, give more frequent, longer breastfeeds, day and night.
- If taking other milk:
  - replace with increased breastfeeding OR
  - replace with fermented milk products, such as yoghurt OR
  - replace half the milk with nutrient-rich semisolid food

Up to 6 Months of Age
- Breastfeed as often as the child wants, day and night, at least 8 times in 24 hours.
- Do not give other foods or fluids.

6 Months up to 12 Months
- Breastfeed as often as the child wants.
- Give adequate servings of:
  __________________________ __________________________ __________________________ __________________________

  - 3 times per day if breastfed plus snacks
  - 5 times per day if not breastfed.

12 Months up to 2 Years
- Breastfeed as often as the child wants.
- Give adequate servings of:
  __________________________ __________________________ __________________________ __________________________ __________________________

  or family foods 3 or 4 times per day plus snacks.

2 Years and Older
- Give family foods at 3 meals each day. Also, twice daily, give nutritious food between meals, such as:
  __________________________ __________________________ __________________________ __________________________
Feeding advice for the mother of a child with CONFIRMED HIV INFECTION

- The child with confirmed HIV infection needs the benefits of breastfeeding and should be encouraged to breastfeed. She is already HIV infected therefore there is no reason for stopping breastfeeding or using replacement feeding.
- The child should be fed according to the feeding recommendations for his age.
- Children with confirmed HIV infection often suffer from poor appetite and mouth sores, give appropriate advice.
- If the child is being fed with a bottle encourage the mother to use a clean cup as this is more hygienic and will reduce episodes of diarrhoea.
- Inform the mother about the importance of hygiene when preparing food because her child can easily get sick. She should wash her hands after going to the toilet and before preparing food. If the child is not gaining weight well, the child can be given an extra meal each day and the mother can encourage him to eat more by offering him snacks that he likes if these are available.
- Advise her about her own nutrition and the importance of a well balanced diet.

“AFASS” CRITERIA FOR STOPPING BREASTFEEDING for HIV exposed

Acceptable:
Mother perceives no problem in replacement feeding.

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

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

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

Safe:
Replacement foods are correctly and hygienically prepared and stored.

Counsel the mother about Stopping Breastfeeding (for HIV exposed)

- While you are breastfeeding teach your infant to drink expressed breast milk from a cup. This milk may be heat-treated to destroy HIV.
- Once the infant is drinking comfortably, replace one breastfeed with one cup feed using expressed breast milk.
- Increase the number of cup-feeds every few days and reduce the number of breastfeeds. Ask an adult family member to help with cup feeding.
- Stop putting your infant to your breast completely as soon as your baby is accustomed to frequent cup feeding. From this point on it is best to heat-treat your breast milk.
- If your infant is receiving milk only check that your baby has at least 6 wet nappies in a 24 hour period. This means he is getting enough milk.
- Gradually replace the expressed breast milk with commercial infant formula or another milk after 6 months.
- If your infant needs to suck, give him/her one of your clean fingers instead of the breast.
- To avoid breast engorgement (swelling) express a little milk whenever your breasts feel full. This will help you feel more comfortable. Use cold compresses to reduce inflammation. Wear a firm bra to prevent discomfort.
- Do not begin breastfeeding again once you have stopped. If you do you can increase the chances of passing HIV to your infant. If your breasts become engorged express breast milk by hand.
- Begin using a family planning method of your choice, if you have not already done so, as soon as you start reducing breastfeeds.
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 child is less than 6 months old and is taking other milk or foods*:
  - Build mother’s confidence that she can produce all the breast milk that the child needs.
  - Suggest giving more frequent, longer breastfeeds day or night, and gradually reducing other milk or foods.

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

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

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

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

- If the child has a poor appetite:
  - Plan small, frequent meals.
  - Give milk rather than other fluids except where there is diarrhoea with some dehydration.
  - Give snacks between meals.
  - Give high energy foods.
  - Check regularly.

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

* if child is HIV exposed, counsel the mother about the importance of not mixing breastfeeding with replacement feeding.
Breastfeed exclusively as often as the child wants, day and night. Feed at least 8 times in 24 hours.
Do not give other foods or fluids (mixed feeding increases the risk of HIV transmission from mother to child when compared with exclusive breastfeeding).
Stop breastfeeding as soon as this is AFASS.

OR (if feasible and safe)
Formula feed exclusively (no breast milk at all)
Give formula. Other foods or fluids are not necessary.
Prepare correct strength and amount just before use. Use milk within two hours and discard any left over (a fridge can store formula for 24 hours)
Cup feeding is safer than bottle feeding
Clean the cup and utensils with hot soapy water
Give these amounts of formula 6 to 8 times per day

* Exception: heat-treated breast milk can be given

### Up to 6 Months of Age

<table>
<thead>
<tr>
<th>Age up to 6 months of age</th>
<th>Amount and times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 up to 1</td>
<td>60 ml x 8</td>
</tr>
<tr>
<td>1 up to 2</td>
<td>90 ml x 7</td>
</tr>
<tr>
<td>2 up to 3</td>
<td>120 ml x 6</td>
</tr>
<tr>
<td>3 up to 4</td>
<td>120 ml x 6</td>
</tr>
<tr>
<td>4 up to 5</td>
<td>150 ml x 6</td>
</tr>
<tr>
<td>5 up to 6</td>
<td>150 ml x 6</td>
</tr>
</tbody>
</table>

### 6 Months up to 12 Months

If still breast feeding, breastfeed as often as the child wants
Give 3 adequate servings of nutritious complementary foods plus one snack per day (to include protein, mashed fruit and vegetables).
Each meal should be 3/4 cup*. If possible, give an additional animal-source food, such as liver or meat

If an infant is not breastfeeding, give about 1-2 cups (500 ml) of full cream milk or infant formula per day
Give milk with a cup, not a bottle
If no milk is available, give 4-5 feeds per day
* one cup = 250 ml

### 12 Months up to 2 Years

- If still breastfeeding, breastfeed as often as the child wants.
- Give adequate servings of:
  [table...

- or family foods 5 times per day.
  If breastfed, give adequate servings 3 times per day plus snacks

- If an infant is not breastfeeding, give about 1-2 cups* (500 ml) of full cream milk or infant formula per day
Give milk with a cup, not a bottle
If no milk is available, give 4-5 feeds per day
* one cup = 250 ml

### Stopping breastfeeding

#### Stopping breastfeeding
means changing from all breast milk to no breast milk (over a period of 2-3 days to 2-3 weeks). Plan in advance to have a safe transition.
Stop breastfeeding as soon as this is AFASS (see page 27). This would usually be at the age of 6 months but some women may have to continue longer.

Help mother prepare for stopping breastfeeding:
- Mother should discuss and plan in advance stopping breastfeeding with her family if possible
- Express milk and give by cup
- Find a regular supply of formula or other milk, e.g. full cream cows milk
- Learn how to prepare and store milk safely at home

Help mother make the transition:
- Teach mother to cup feed her baby
- Clean all utensils with soap and water
- Start giving only formula or cows milk once the baby takes all feeds by cup

Stop breastfeeding completely:
- Express and discard enough breast milk to keep comfortable until lactation stops
COUNSEL THE MOTHER ABOUT HER OWN HEALTH

- If the mother is sick, provide care for her, or refer her for help.

- If she has a breast problem (such as engorgement, sore nipples, breast infection), provide care for her or refer her for help.

- Advise her to eat well to keep up her own strength and health.

- Check the mother’s immunization status and give her tetanus toxoid if needed.

- Make sure she has access to:
  - Family planning
  - Counselling on STD and AIDS prevention.

- Encourage every mother to be sure to know her own HIV status and to seek HIV testing if she does not know her status or is concerned about the possibility of HIV in herself or her family.
### FLUID

**Advise the Mother to Increase Fluid During Illness**

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

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

### WHEN TO RETURN

**Advise the Mother When to Return to Health Worker**

**FOLLOW-UP VISIT**

<table>
<thead>
<tr>
<th>If the child has:</th>
<th>Return for first follow-up in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PNEUMONIA</td>
<td>2 days</td>
</tr>
<tr>
<td>• DYSENTERY</td>
<td></td>
</tr>
<tr>
<td>• MALARIA, if fever persists</td>
<td></td>
</tr>
<tr>
<td>• FEVER-MALARIA UNLIKELY, if fever persists</td>
<td></td>
</tr>
<tr>
<td>• MEASLES WITH EYE OR MOUTH COMPLICATIONS</td>
<td></td>
</tr>
<tr>
<td>• PERSISTENT DIARRHOEA</td>
<td>5 days</td>
</tr>
<tr>
<td>• ACUTE EAR INFECTION</td>
<td></td>
</tr>
<tr>
<td>• CHRONIC EAR INFECTION</td>
<td></td>
</tr>
<tr>
<td>• FEEDING PROBLEM</td>
<td></td>
</tr>
<tr>
<td>• COUGH OR COLD, if not improving</td>
<td></td>
</tr>
<tr>
<td>• SEVERE UNCOMPlicated MALNUTRITION</td>
<td>7 days</td>
</tr>
<tr>
<td>• ANAEMIA</td>
<td></td>
</tr>
<tr>
<td>• CONFIRMED HIV INFECTION</td>
<td></td>
</tr>
<tr>
<td>• SUSPECTED SYMPTOMATIC HIV INFECTION</td>
<td></td>
</tr>
<tr>
<td>• HIV EXPOSED/ POSSIBLE HIV</td>
<td></td>
</tr>
<tr>
<td>• VERY LOW WEIGHT FOR AGE</td>
<td>30 days</td>
</tr>
</tbody>
</table>

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

**WHEN TO RETURN IMMEDIATELY**

<table>
<thead>
<tr>
<th>Advise mother to return immediately if the child has any of these signs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any sick child</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>If child has NO PNEUMONIA: COUGH OR COLD, also return if:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>If child has Diarrhoea, also return if:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- Any sick child
- Not able to drink or breastfeed
- Becomes sicker
- Develops a fever
- Fast breathing
- Difficult breathing
- Blood in stool
- Drinking poorly
ASSESS, CLASSIFY AND TREAT THE SICK YOUNG INFANT AGE UP TO 2 MONTHS

DO A RAPID APPRAISAL OF ALL WAITING INFANTS

ASK THE MOTHER WHAT THE YOUNG INFANT’S PROBLEMS ARE

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

CHECK FOR VERY SEVERE DISEASE AND LOCAL INFECTION

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

LOOK, LISTEN, FEEL:
- Count the breaths in one minute. Repeat the count if more than 60 breaths per minute.
- Look for severe chest indrawing.
- Look and listen for grunting.
- Look at the young infant’s movements.
  - Does the infant move only when stimulated?
  - Does the infant not move even when stimulated?
- Measure axillary temperature.
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules.

Classify ALL YOUNG INFANTS

Any one of the following signs:
- Not feeding well or
- Convulsions or
- Fast breathing (60 breaths per minute or more) or
- Severe chest indrawing or
- Grunting or
- Movement only when stimulated or no movement even when stimulated or
- Fever (37.5°C* or above)* or
- Low body temperature (less than 35.5°C*)

Classify as VERY SEVERE DISEASE

- Umbilicus red or draining pus
- Skin pustules

Classify the illness.

LOCAL BACTERIAL INFECTION

None of the signs of very severe disease or local bacterial infection

SEVERE DISEASE OR LOCAL INFECTION UNLIKELY

Give an appropriate oral antibiotic.

TREATMENT

(Urgent pre-referral treatments are in bold print)

Local Referral**

- Give first dose of intramuscular antibiotics.
- Treat to prevent low blood sugar (see page 16)
- Advise mother how to keep the infant warm on the way to the hospital.
- Refer URGENTLY to hospital.

Key:
- YOUNG INFANT MUST BE CALM

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

** If referral is not possible, see Integrated Management of Childhood Illness, Treat the Child, Annex: when referral is not possible.
## CHECK FOR JAUNDICE *

**ASK:** Look, Listen, Feel:
- Look for jaundice (yellow eyes or skin)
- Look at the young infant’s palms and soles. Are they yellow?

### Classify Jaundice

<table>
<thead>
<tr>
<th>Jaundice appearing after 24 hours of age and</th>
<th>SEVERE JAUNDICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palms and soles not yellow</td>
<td></td>
</tr>
</tbody>
</table>

- Any jaundice if age less than 24 hours or
- Yellow palms and soles at any age

- Treat to prevent low blood sugar.
- Refer URGENTLY to hospital.**
- Advise mother how to keep the infant warm on the way to the hospital.

<table>
<thead>
<tr>
<th>No jaundice</th>
<th>NO JAUNDICE</th>
</tr>
</thead>
</table>

- Advise the mother to give home care for the young infant.
- Advise mother to return immediately if palms and soles appear yellow.
- Follow-up in 1 day.

* Jaundice is optional; national guidelines may include it based on the epidemiology of these conditions in the country.
Does the young infant have diarrhoea*?

**IF YES, LOOK AND FEEL:**
- Look at the young infant’s general condition:
  - Does the infant move only when stimulated?
  - Does the infant not move even when stimulated?
  - Is the infant restless and irritable?
- Look for sunken eyes.
- Pinch the skin of the abdomen. Does it go back:
  - Very slowly (longer than 2 seconds)?
  - Or slowly?

### Classify DIARRHOEA FOR DEHYDRATION

#### SIGNS
- Two of the following signs:
  - Movement only when stimulated or no movement even when stimulated
  - Sunken eyes
  - Skin pinch goes back very slowly.

#### CLASSIFY AS
- **SEVERE DEHYDRATION**
  - If the infant does not have VERY SEVERE DISEASE:
    - Give fluid for severe dehydration (Plan C).
  - If the infant also has VERY SEVERE DISEASE:
    - Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way,
    - Advise mother to continue breastfeeding

- **SOME DEHYDRATION**
  - Give fluid and breast milk for some dehydration (Plan B)
  - If the infant also has VERY SEVERE DISEASE:
    - Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way,
    - Advise mother to continue breastfeeding
  - Advise mother when to return immediately
  - Follow up in 2 days if not improving

- **NO DEHYDRATION**
  - Give fluids and breast milk to treat for diarrhoea at home (Plan A)
  - Advise mother when to return immediately
  - Follow up in 2 days if not improving

* What is diarrhoea in a young infant?

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

The normally frequent or semi-solid stools of a breastfed baby are not diarrhoea.
CHECK THE YOUNG INFANT FOR HIV INFECTION

| SIGNS | CLASSIFY AS | TREATMENT | (Urgent pre-referral treatments are in **)
|-------|-------------|-----------|-----------------------------------------------
| • Child has positive virological test | CONFIRMED HIV INFECTION | ➢ Give cotrimoxazole prophylaxis from age 4-6 weeks  
➢ Assess the child’s feeding and counsel as necessary  
➢ Refer for staging and assessment for ART  
➢ Advise the mother on home care  
➢ Follow-up in 14 days |  
| One or both of the following conditions:  
• Mother HIV positive  
• Child has positive HIV antibody test (sero-positive) | POSSIBLE HIV INFECTION/ HIV EXPOSED | ➢ Give co-trimoxazole prophylaxis from age 4-6 weeks  
➢ Assess the child’s feeding and give appropriate feeding advice  
➢ Refer/ do virological test to confirm infant’s HIV status at least 6 weeks after breastfeeding has stopped  
➢ Consider presumptive severe HIV disease (p 9) |  
| Negative HIV test for mother or child | HIV INFECTION UNLIKELY | ➢ Treat, counsel and follow-up existing infections  
➢ Advise the mother about feeding and about her own health |  

ASK:  
Has the mother or the infant had an HIV test?  
What was the result?

** If referral is not possible, see Integrated Management of Childhood Illness, Treat the Child, Annex: when referral is not possible.
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN BREASTFED INFANTS*

ASK:
- Is the infant breastfed? If yes, how many times in 24 hours?
- Does the infant usually receive any other foods or drinks?
  If yes, how often?

LOOK, LISTEN, FEEL:
- Determine weight for age.

Classify FEEDING

FEEDING PROBLEM OR LOW WEIGHT

SIGNS

CLASSIFY AS

TREATMENT
(Urgent pre-referral treatments are in bold)

- Not well attached to breast or not suckling effectively
  OR
  - Less than 8 breastfeeds in 24 hours
    OR
    - Receives other foods or drinks
    OR
    - Low weight for age
  OR
  - Thrush (ulcers or white patches in mouth)

- Not low weight for age and no other signs of inadequate feeding.
  NO FEEDING PROBLEM
  ➢ Advise mother to give home care for the young infant.
  ➢ Praise the mother for feeding the infant well.

- If not well attached or not suckling effectively, teach correct positioning and attachment.
  ➢ If low weight and still not able to attach well, teach the mother to express breast milk and feed by a cup.

- If breastfeeding less than 8 times in 24 hours, advise to increase frequency of feeding. Advise her to breastfeed as often and for as long as the infant wants, day and night.

- If receiving other foods or drinks, counsel mother about breastfeeding more, reducing other foods or drinks, and using a cup.
  ➢ If not breastfeeding at all:
    - Refer for breastfeeding counselling and possible relactation.
    - Advise about correctly preparing breastmilk substitutes and using a cup.

- Advise the mother how to keep the low weight infant warm at home.

- If thrush, teach the mother to treat thrush at home (page 13).

- Advise mother to give home care for the young infant.

- Follow-up any feeding problem or thrush in 2 days.

- Follow-up low weight for age in 14 days.

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

IF AN INFANT: Is less than 7 days old, is breastfeeding less than 8 times in 24 hours, is taking any other foods or drinks, or is low weight for age, AND Has no indications to refer urgently to hospital:

ASSESS BREASTFEEDING:
- Has the infant breastfed in the previous hour?
  If the infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeeding for 4 minutes.
  (If the infant was fed during the last hour, ask the mother if she can wait and tell you when the infant is willing to feed again.)
  - Is the infant able to attach well?

TO CHECK ATTACHMENT, LOOK FOR:
- 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).

- Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
  not suckling effectively      suckling effectively
  Clear a blocked nose if it interferes with breastfeeding.
  • Look for ulcers or white patches in the mouth (thrush).
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT FOR AGE IN INFANTS RECEIVING NO BREAST MILK

(Use this chart when an HIV positive mother has chosen not to breastfeed)

**ASK:**
- What milk are you giving?
- How many times during the day and night?
- How much is given at each feed?
- How are you preparing the milk?
  - Let mother demonstrate or explain how a feed is prepared, and how it is given to the infant.
- Are you giving any breast milk at all?
- What foods and fluids in addition to replacement feeds is given?
- How is the milk being given? Cup or bottle?
- How are you cleaning the feeding utensils?

**LOOK, LISTEN, FEEL:**
- Determine the weight for age.
- Look for ulcers or white patches in the mouth (thrush).

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY AS</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk incorrectly or unhygienically prepared Or Giving inappropriate replacement feeds Giving insufficient replacement feeds Or An HIV positive mother mixing breast and other feeds before 6 months Or Using a feeding bottle Or Thrush Or Low weight for age</td>
<td>FEEDING PROBLEM OR LOW WEIGHT FOR AGE</td>
<td>☑ Counsel about feeding ☑ Explain the guidelines for safe replacement feeding ☑ Identify concerns of mother and family about feeding. ☑ If mother is using a bottle, teach cup feeding ☑ If thrush, teach the mother to treat it at home (page 37) ☑ Follow-up FEEDING PROBLEM or THRUSH in 2 days ☑ Follow up LOW WEIGHT FOR AGE in 7 days ☑ Vitamin A</td>
</tr>
<tr>
<td>Not low weight for age and no other signs of inadequate feeding</td>
<td>NO FEEDING PROBLEM</td>
<td>☑ Advise mother to continue feeding, and ensure good hygiene ☑ Praise the mother for feeding the infant well</td>
</tr>
</tbody>
</table>
THEN CHECK THE YOUNG INFANT’S IMMUNIZATION AND VITAMIN A STATUS:

<table>
<thead>
<tr>
<th>IMMUNIZATION SCHEDULE:</th>
<th>AGE</th>
<th>VACCINE</th>
<th>VITAMIN A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth</td>
<td>BCG</td>
<td>200 000 IU to the mother at delivery</td>
</tr>
<tr>
<td></td>
<td>6 weeks</td>
<td>OPV-0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 weeks</td>
<td>OPV-1</td>
<td>50 000 IU for infants at 6 weeks if not breastfed</td>
</tr>
<tr>
<td></td>
<td>DPT+HIB-1</td>
<td>Hep B 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DPT+HIB-2</td>
<td>OPV-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hep B 2</td>
<td></td>
</tr>
</tbody>
</table>

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

ASSESS OTHER PROBLEMS

ASSESS THE MOTHER’S HEALTH NEEDS
Nutritional status and anaemia, contraception. Check hygienic practices.
Give an Appropriate Oral Antibiotic

For local bacterial infection:

First-line antibiotic: ______________________________________________________________________________________
Second-line antibiotic: ______________________________________________________________________________________

Give two times daily for 5 days

CO-TRIMOXAZOLE
(trimethoprim + sulphamethoxazole)

For local bacterial infection:

Give three times daily for 5 days

AMOXICILLIN

Give First Dose of Intramuscular Antibiotics

- Give first dose of ampicillin or benzylpenicillin intramuscularly.
- Give first dose of Gentamicin intramuscularly

<table>
<thead>
<tr>
<th>AGE or WEIGHT</th>
<th>Adult Tablet</th>
<th>Paediatric Tablet</th>
<th>Syrup</th>
<th>Tablet</th>
<th>Syrup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth up to 1 month (&lt; 3 kg)</td>
<td>1/2*</td>
<td>1</td>
<td>2.5 ml</td>
<td>1/4</td>
<td>2.5 ml</td>
</tr>
<tr>
<td>1 month up to 2 months (3-4 kg)</td>
<td>1/4</td>
<td>1</td>
<td>2.5 ml</td>
<td>1/4</td>
<td>2.5 ml</td>
</tr>
</tbody>
</table>

* Avoid co-trimoxazole in infants less than 1 month of age who are premature or jaundiced. See page 11 for prophylaxis dose.

Give First Dose of Intramuscular Antibiotics

- AMPICILLIN
  - Dose: 50 mg per kg
  - Undiluted 2 ml vial containing 20 mg = 2 ml
  - To a vial of 600 mg
  - To a vial of 1 000 000 units:
  - Add 1.6 ml sterile water = 500 000 units/ml

<table>
<thead>
<tr>
<th>AGE &lt;7 days</th>
<th>Dose: 5 mg per kg</th>
<th>AGE&gt;7 days</th>
<th>Dose: 7.5 mg per kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - &lt;1.5 kg</td>
<td>0.4 ml</td>
<td>0.6 ml*</td>
<td>0.9 ml*</td>
</tr>
<tr>
<td>1.5 - &lt;2 kg</td>
<td>0.5 ml</td>
<td>0.6 ml*</td>
<td>1.3 ml*</td>
</tr>
<tr>
<td>2 - &lt;2.5 kg</td>
<td>0.7 ml</td>
<td>1.1 ml*</td>
<td>1.7 ml*</td>
</tr>
<tr>
<td>2.5 - &lt;3 kg</td>
<td>0.8 ml</td>
<td>1.4 ml*</td>
<td>2.0 ml*</td>
</tr>
<tr>
<td>3 - &lt;3.5 kg</td>
<td>1.0 ml</td>
<td>1.6 ml*</td>
<td>2.4 ml*</td>
</tr>
<tr>
<td>3.5 - &lt;4 kg</td>
<td>1.1 ml</td>
<td>1.9 ml*</td>
<td>2.8 ml*</td>
</tr>
<tr>
<td>4 - &lt;4.5 kg</td>
<td>1.3 ml</td>
<td>2.1 ml*</td>
<td>3.2 ml*</td>
</tr>
</tbody>
</table>

* Avoid using undiluted 40 mg/ml gentamicin.

GENTAMICIN

Treat the Young Infant to Prevent Low Blood Sugar

- If the young infant is able to be breastfeed:
  - Ask the mother to breastfeed the young infant.
  - If the young infant is not able to breastfeed but is able to swallow:
    - Give 20-50 ml (10 ml/kg) expressed breast milk before departure. If not possible to give expressed breast milk, give 20-50 ml (10 ml/kg) sugar water (To make sugar water: Dissolve 4 level teaspoons of sugar (20 grams) in a 200-ml cup of clean water).
    - If the young infant is not able to swallow:
      - Give 20-50 ml (10 ml/kg) of expressed breast milk or sugar water by nasogastric tube.
TREAT THE YOUNG INFANT

➢ To Treat for Diarrhoea, See TREAT THE CHILD chart

➢ Teach the Mother How to Keep the Young Infant Warm on the way to the Hospital
  ➢ Provide skin to skin contact or
  ➢ Keep the young infant clothed or covered as much as possible all the time. Dress the young infant with extra clothing including hat, gloves, socks and wrap the infant in a soft dry cloth and cover with a blanket.

➢ Teach the Mother to Treat Local Infections at Home
  ➢ Explain how the treatment is given.
  ➢ Watch her as she does the first treatment in the clinic.
  ➢ Tell her to do the treatment twice daily. She should return to the clinic if the infection worsens.

➢ To Treat for Skin Pustules or Umbilical Infection
  The mother should do the treatment twice daily for 5 days:
  • Wash hands
  • Gently wash off pus and crusts with soap and water
  • Dry the area
  • Paint with full strength gentian violet (0.5%) 
  • Wash hands

➢ Treat for Thrush with Nystatin or Gentian Violet
  The mother should do the treatment four times daily for 7 days:
  • Wash hands
  • Wash mouth with clean soft cloth wrapped around the finger and wet with salt water
  • Give nystatin 1 ml 4 times a day or paint with diluted 0.5% gentian violet
  • Wash hands
TREAT THE YOUNG INFANT AND COUNSEL THE MOTHER

➢ Advise the Mother How to Keep the Low Weight Infant Warm at Home

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

➢ Teach the Mother How to Express Breast Milk

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

➢ Teach Correct Positioning and Attachment FOR BREASTFEEDING

➢ Show the mother how to hold her infant:
  - with the infant’s head and body 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 her how to help the infant to attach. She should:
  - touch her infant’s lips with her nipple
  - wait until her infant’s mouth is opening wide
  - move her infant quickly onto her breast, aiming the infant’s lower lip well below the nipple

➢ Look for signs of good attachment and effective suckling. If the attachment or suckling is not good, try again.

➢ Counsel the HIV-positive mother who has chosen not to breastfeed
  (or the caretaker of a child who cannot be breastfed)
  The mother or caretaker should have received full counselling before making this decision

➢ Ensure that the mother or caretaker has an adequate supply of appropriate breast milk substitute replacement feed.
➢ Ensure that the mother or caretaker knows how to prepare milk correctly and hygienically and has the facilities and resources to do so.
➢ Demonstrate how to feed with a cup and spoon rather than a bottle.
➢ Make sure that the mother or caretaker understands that prepared feed must be finished within an hour after preparation.
➢ Make sure that the mother or caretaker understands that mixing breastfeeding with replacement feeding may increase the risk of HIV infection and should not be done.

➢ Teach the Mother How to Feed by Cup

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

- Wash your hands before preparing the formula.
- Make ____ ml for each feed. Feed the baby ____ times every 24 hours.
- Always use the marked cup or glass to measure water and the scoop to measure the formula powder. Your baby needs _____ scoops.
- Measure the exact amount of powder that you will need for one feed.
- Boil enough water vigorously for 1 or 2 seconds.
- Add the hot water to the powdered formula. The water should be added while it is still hot and not after it has cooled down. Stir well.
- Only make enough formula for one feed at a time. Do not keep milk in a thermos flask because it will become contaminated quickly.
- Feed the baby using a cup. Discard any unused formula, give it to an older child or drink it yourself.
- Wash the utensils.
- Come back to see me on ____.

GIVE FOLLOW-UP CARE FOR THE SICK YOUNG INFANT

➤ JAUNDICE

After 1 day:
Look for jaundice. Are palms and soles yellow?

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

1. **FLUIDS:**
   Breastfeed frequently, as often and for as long as the infant wants, day or night, during sickness and health.

2. **WHEN TO RETURN:**

<table>
<thead>
<tr>
<th>Follow up visit</th>
<th>Return for first follow-up in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the infant has:</td>
<td></td>
</tr>
<tr>
<td>JAUNDICE</td>
<td>1 day</td>
</tr>
<tr>
<td>LOCAL BACTERIAL INFECTION</td>
<td>2 days</td>
</tr>
<tr>
<td>ANY FEEDING PROBLEM</td>
<td></td>
</tr>
<tr>
<td>THRUSH</td>
<td></td>
</tr>
<tr>
<td>SOME DEHYDRATION / NO DEHYDRATION</td>
<td></td>
</tr>
<tr>
<td>LOW WEIGHT FOR AGE</td>
<td>14 days</td>
</tr>
<tr>
<td>CONFIRMED HIV INFECTION or POSSIBLE HIV INFECTION/ HIV EXPOSED</td>
<td>14 days</td>
</tr>
</tbody>
</table>

3. **MAKE SURE THAT THE YOUNG INFANT IS KEPT WARM AT ALL TIMES.**
   In cool weather cover the infant's head and feet and dress the infant with extra clothing.

WHEN TO RETURN IMMEDIATELY:

- Advise the caretaker to return immediately if the young infant has any of these signs:
  - Difficulty feeding
  - Becomes sicker
  - Develops a fever
  - Fast breathing
  - Difficult breathing
  - Vomits everything
  - Less than normal movement
  - Convulsions
GIVE FOLLOW-UP CARE FOR THE SICK YOUNG INFANT

➤ LOCAL BACTERIAL INFECTION

After 2 days:
- Look at the umbilicus. Is it red or draining pus? Does redness extend to the skin?
- Look at the skin pustules. Are there many or severe pustules?

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

➤ THRUSH

After 2 days:
- Look for white patches in the mouth (thrush).
- Reassess feeding > See "Then Check for Feeding Problem or Low Weight for age " above (p. 33).
- If thrush is worse check that treatment is being given correctly, consider HIV (p.32).
- If the infant has problems with attachment or suckling, refer to hospital.
- If thrush is the same or better, and the baby is feeding well, continue with nystatin (or gentian violet) for a total of 5 days.

➤ FEEDING PROBLEM

After 2 days:
- Reassess feeding > See ‘Check For Feeding Problem or Low Weight ‘ above.
- Ask about any feeding problems found on the initial visit.
- Counsel the mother about any new or continuing feeding problems. If you counsel the mother to make significant changes in feeding, ask her to bring the young infant back again.
- If the young infant is low weight for age, ask the mother to return after 14 days of this follow up visit. Continue follow-up until the infant is gaining weight well.

Exception:
If you do not think that feeding will improve, refer the child.
GIVE FOLLOW-UP CARE FOR THE YOUNG INFANT

POSSIBLE HIV/HIV EXPOSED

- Follow-up after 14 days and then monthly or according to immunization programme.
- Counsel about feeding practices. Avoid giving both breast milk and formula milk (mixed feeding).
- Start co-trimoxazole prophylaxis at 4-6 weeks, if not started already and check compliance.
- Test for HIV infection as early as possible, if not already done so.
- Refer for ART if presumptive severe HIV infection as per definition above.
- Counsel the mother about her HIV status and arrange counselling and testing for her if required.

LOW WEIGHT FOR AGE

After 14 days:

- Weigh the young infant and determine if the infant is still low weight for age.
- Reassess feeding > See “Then Check for Feeding Problem or Low Weight” above.
- If the infant is no longer low weight for age, praise the mother and encourage her to continue.
- If the infant is still low weight for age, but is feeding well, praise the mother. Ask her to have her infant weighed again within 14 days or when she returns for immunization, whichever is the earlier.
- If the infant is still low weight for age and still has a feeding problem, counsel the mother about the feeding problem. Ask the mother to return again in 14 days (or when she returns for immunization if this is within 2 weeks). Continue to see the young infant every few weeks until the infant is feeding well and gaining weight regularly and is no longer low weight for age.

**Exception:**
If you do not think that feeding will improve, or if the young infant has lost weight, refer to hospital.
ANNEX A: SKIN AND MOUTH CONDITIONS*

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY AS</th>
<th>TREATMENT</th>
<th>UNIQUE FEATURES IN HIV</th>
</tr>
</thead>
</table>
| Itching rash with small papules and scratch marks. Dark spots with pale centres. | **PAPULAR ITCHING RASH (PRURIGO)** | Treat itching:  
- Calamine lotion  
- Antihistamine by mouth  
- If not improved, 1% hydrocortisone  
Can be an early sign of HIV and needs assessment for HIV | Is a Clinical stage 2 defining disease |
| An itchy circular lesion with a raised edge and fine scaly area in centre with loss of hair. May also be found on body or web of feet. | **RINGWORM (TINEA)** | Whitfield’s ointment or other anti-fungal cream if few patches  
If extensive refer, if not give:  
ketoconazole for 2 up to 12 months (6-10 kg) 40 mg per day. For 12 up to 5 years give 60 mg per day. Or give griseofulvin 10 mg/kg/day.  
If in hairline, shave hair, treat itching as above. | Extensive: There is a high incidence of coexisting nail infection which has to be treated adequately, to prevent recurrences of tinea infection of skin  
Fungal nail infection is a Clinical stage 2 defining disease |
| Rash and excoriations on torso; burrows in web space and wrist. Face spared. | **SCABIES** | Treat itching as above.  
Manage with anti-scabies medication:  
25% topical benzyl benzoate at night, repeat for 3 days after washing.  
1% topical lindane cream or lotion once – wash off after 12 hours. | In HIV positive individuals scabies may manifest as crusted scabies.  
Crusted scabies presents as extensive areas of crusting mainly on the scalp face, back, and feet. Patients may not complain of itch but the scales will be teeming with mites. |

* IMAI acute care module gives more information
<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY AS</th>
<th>TREATMENT</th>
<th>UNIQUE FEATURES IN HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vesicles over body. Vesicles appear progressively over days and form scabs after they rupture.</td>
<td>CHICKEN POX</td>
<td>Treat itching as previous page. Refer URGENTLY if pneumonia or jaundice appear.</td>
<td>Presentation atypical only if child is immuno-compromised. Duration of disease longer, complications more frequent, chronic infection with continued appearance of new lesions for &gt;1 month: typical vesicles evolve into nonhealing ulcers that become necrotic, crusted, and hyperkeratotic.</td>
</tr>
<tr>
<td>Vesicles in one area on one side of body with intense pain or scars plus shooting pain. Herpes zoster is uncommon in children except where they are immuno-compromised, for example if infected with HIV.</td>
<td>HERPES ZOSTER</td>
<td>Keep lesions clean and dry. Use local antiseptic. If eye involved give acyclovir – 20 mg/kg (max 800 mg) 4 times daily for 5 days. Give pain relief. Follow-up in 7 days.</td>
<td>Duration of disease longer Hemorrhagic vesicles, necrotic ulceration. Rarely recurrent, disseminated or multidermatomal. <strong>Is a Clinical stage 2 defining disease</strong></td>
</tr>
<tr>
<td>Vesicular lesion or sores, also involving lips and/or mouth.</td>
<td>HERPES SIMPLEX</td>
<td>If child unable to feed, refer. If first episode or severe ulceration, give acyclovir as above.</td>
<td>Extensive area of involvement. Large ulcers. Delayed healing (often greater than a month). Resistance to Acyclovir common. Therefore continue treatment till complete healing of ulcer. <strong>Chronic HSV infection (&gt;1 month) is a Clinical stage 4 defining disease</strong></td>
</tr>
<tr>
<td>Red, tender, warm crusts or small lesions.</td>
<td>IMPETIGO OR FOLLICULITIS</td>
<td>Clean sores with antiseptic. Drain pus if fluctuant. Start cloxacillin if size &gt;4cm or red streaks or tender nodes or multiple abscesses for 5 days (25-50 mg/kg every 6 hours). Refer URGENTLY if child has fever and/or if infection extends to the muscle.</td>
<td></td>
</tr>
<tr>
<td>SIGNS</td>
<td>CLASSIFY AS</td>
<td>TREATMENT</td>
<td>UNIQUE FEATURES IN HIV</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Skin colored pearly white papules with a central umblication. It is most commonly seen on the face and trunk in children.</td>
<td><strong>MOLLUSCUM CONTAGIOSUM</strong></td>
<td>Can be treated by various modalities: Leave them alone unless superinfected. Use of phenol: Pricking each lesion with a needle or sharpened orange stick and dabbing the lesion with phenol. Electrodesiccation. Liquid nitrogen application (using orange stick). Curettage.</td>
<td>Incidence is higher. Giant molluscum (&gt;1cm in size), or coalescent double or triple lesions may be seen. More than 100 lesions may be seen. Lesions often chronic and difficult to eradicate. <strong>Extensive molluscum contagiosum is a Clinical stage 2 defining disease</strong></td>
</tr>
<tr>
<td>The common wart appears as papules or nodules with a rough ( verrucous ) surface.</td>
<td><strong>WARTS</strong></td>
<td>Treatment: Topical salicylic acid preparations (e.g. Duofilm). Liquid nitrogen cryotherapy. Electrocautery.</td>
<td>Lesions more numerous and recalcitrant to therapy. <strong>Extensive viral warts is a Clinical stage 2 defining disease</strong></td>
</tr>
<tr>
<td>Greasy scales and redness on central face, body folds</td>
<td><strong>SEBBHORREA</strong></td>
<td>Ketoconazole shampoo. If severe, refer or provide topical steroids. For seborrheic dermatitis: 1% hydrocortison cream X2 daily. If severe, refer.</td>
<td>Seborrheic dermatitis may be severe in HIV infection. Secondary infection may be common</td>
</tr>
</tbody>
</table>
## ANNEX A: ASSESS, CLASSIFY AND TREAT SKIN AND MOUTH CONDITIONS

### Mouth problems: Thrush

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY AS</th>
<th>TREATMENTS</th>
</tr>
</thead>
</table>
| Not able to swallow | SEVERE OESOPHAGEAL THRUSH | Refer URGENTLY to hospital. If not able to refer, give fluconazole. If mother is breastfeeding check and treat the mother for breast thrush.  
(Stage 4 disease) |
| Pain or difficulty swallowing | OESOPHAGEAL THRUSH | Give fluconazole.  
Give oral care to young infant or child.  
If mother is breastfeeding check and treat the mother for breast thrush.  
Follow up in 2 days.  
Tell the mother when to come back immediately.  
Once stabilized, refer for ART initiation  
(Stage 4 disease) |
| White patches in mouth which can be scraped off. | ORAL THRUSH | Counsel the mother on home care for oral thrush. The mother should:  
- Wash her hands  
- Wash the young infant / child’s mouth with a soft clean cloth wrapped around her finger and wet with salt water  
- Instill 1ml nystatin four times per day or paint the mouth with half strength gentian violet for 7 days  
- Wash her hands after providing treatment for the young infant or child  
- Avoid feeding for 20 minutes after medication  
If breastfed, check mother’s breasts for thrush. If present (dry, shiny scales on nipple and areola), treat with nystatin or GV.  
Advise the mother to wash breasts after feeds. If bottle fed, advise to change to cup and spoon.  
If severe, recurrent or pharyngeal thrush, consider symptomatic HIV.  
Give paracetamol if needed for pain.  
(Stage 3 disease) |
| Most frequently seen on the sides of the tongue, a white plaque with a corrugated appearance. | ORAL HAIRY LEUCOPLAKIA | Does not independently require treatment, but resolves with ART and Acyclovir  
(Stage 2 disease) |
# ANNEX A: ASSESS, CLASSIFY AND TREAT SKIN AND MOUTH CONDITIONS

## Mouth ulcer or gum problems

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>CLASSIFY AS:</th>
<th>TREATMENTS</th>
</tr>
</thead>
</table>
| Deep or extensive ulcers of mouth or gums or Not able to eat | **SEVERE GUM OR MOUTH INFECTION** | ➢ Refer URGENTLY to hospital.  
➢ If possible, give first dose acyclovir pre-referral.  
➢ Start metronidazole if referral not possible.  
➢ If child is on antiretroviral therapy this may be a drug reaction so refer to second level for assessment. |
| Ulcers of mouth or gums | **GUM / MOUTH ULCERS** | ➢ Show mother how to clean the ulcers with saline or peroxide or sodium bicarbonate.  
➢ If lips or anterior gums involved, give acyclovir, if possible. If not possible, refer.  
➢ If child receiving co-trimoxazole or antiretroviral drugs or isoniazid (INH) prophylaxis (for TB) within the last month, this may be a drug rash, especially if the child also has a skin rash, so refer.  
➢ Provide pain relief.  
➢ Follow up in 7 days. |
### ANNEX A: ASSESS, CLASSIFY AND TREAT SKIN AND MOUTH CONDITIONS

#### Drug-related skin rashes

<table>
<thead>
<tr>
<th></th>
<th>SIGNS</th>
<th>CLASSIFY</th>
<th>TREATMENT</th>
<th>UNIQUE FEATURES IN HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIXED DRUG REACTIONS</strong></td>
<td>Generalized red, widespread with small bumps or blisters; or one or more dark skin areas (fixed drug reactions).</td>
<td>Stop medications. Give oral antihistamines. If peeling rash refer.</td>
<td>Could be a sign of reaction to ARV's.</td>
<td></td>
</tr>
<tr>
<td><strong>eczema</strong></td>
<td>Wet, oozing sores or excoriated, thick patches.</td>
<td>Soak sores with clean water to remove crusts (no soap). Dry skin gently. Short-term use of topical steroid cream not on face. Treat itching</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEVEN-JOHNSON SYNDROME</strong></td>
<td>Severe reaction involving the skin as well as the eyes and/or mouth. Might cause difficulty breathing.</td>
<td>Stop medication. Refer Urgently.</td>
<td>May be seen with use of co-trimoxazole or nevirapine.</td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX B: ARV THERAPY - DOSAGES

#### efavirenz (EFV)
**TREATMENT DOSE:**
15 mg/kg/day (capsule or tablet) for age 3 years or more
Once daily

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Combinations of 200, 100 and 50 mg capsules</th>
<th>600 mg tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 13.9</td>
<td>One 200 mg</td>
<td></td>
</tr>
<tr>
<td>14 - 19.9</td>
<td>One 200 mg + one 50 mg</td>
<td></td>
</tr>
<tr>
<td>20 - 24.9</td>
<td>One 200 mg + one 100 mg</td>
<td></td>
</tr>
<tr>
<td>25 - 29.9</td>
<td>One 200 mg + one 100 mg + one 50 mg</td>
<td></td>
</tr>
<tr>
<td>30 - 39.9</td>
<td>Two 200 mg</td>
<td></td>
</tr>
<tr>
<td>40 and over</td>
<td>Three 200 mg or one</td>
<td></td>
</tr>
</tbody>
</table>

#### stavudine (d4T)
**TREATMENT DOSE:**
1 mg/kg/dose (to maximum 30 mg dose)
Give dose twice daily

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Solution 1</th>
<th>15 mg, 20 mg, 30 mg capsules</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>AM</td>
</tr>
<tr>
<td>PM</td>
<td>AM</td>
<td>PM</td>
</tr>
<tr>
<td>5 - 5.9</td>
<td>6 ml</td>
<td>0.5 20 mg capsule</td>
</tr>
<tr>
<td>6 - 9.9</td>
<td>0.5 tablet</td>
<td>0.5 20 mg capsule</td>
</tr>
<tr>
<td>10 - 13.9</td>
<td>One 15 mg capsule</td>
<td>One 15 mg capsule</td>
</tr>
<tr>
<td>14 - 24.9</td>
<td>One 20 mg capsule</td>
<td>One 20 mg capsule</td>
</tr>
<tr>
<td>25 and above</td>
<td>One 30 mg capsule</td>
<td>One 30 mg capsule</td>
</tr>
</tbody>
</table>

#### abacavir (ABC)
**TREATMENT DOSE:**
8 mg/kg/dose (to maximum dose of 300 mg/dose)
Give dose twice daily

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Syrup 20 mg/ml</th>
<th>300 mg capsules</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>AM</td>
</tr>
<tr>
<td>PM</td>
<td>AM</td>
<td>PM</td>
</tr>
<tr>
<td>5 - 5.9</td>
<td>2 ml</td>
<td>2 ml</td>
</tr>
<tr>
<td>6 - 6.9</td>
<td>3 ml</td>
<td>3 ml</td>
</tr>
<tr>
<td>7 - 9.9</td>
<td>4 ml</td>
<td>4 ml</td>
</tr>
<tr>
<td>10 - 10.9</td>
<td>5 ml</td>
<td>5 ml</td>
</tr>
<tr>
<td>11 - 11.9</td>
<td>5 ml</td>
<td>5 ml or 0.5 tablet</td>
</tr>
<tr>
<td>12 - 13.9</td>
<td>6 ml</td>
<td>6 ml or 0.5 tablet</td>
</tr>
<tr>
<td>14 - 19.9</td>
<td>0.5 tablet</td>
<td>0.5 tablet</td>
</tr>
<tr>
<td>20 - 24.9</td>
<td>1 tablet</td>
<td>0.5 tablet</td>
</tr>
<tr>
<td>25 and above</td>
<td>1 tablet</td>
<td>1 tablet</td>
</tr>
</tbody>
</table>

#### lamivudine (3TC)
**TREATMENT DOSE:**
4 mg/kg/dose (to maximum 150 mg dose)
Give dose twice daily

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Syrup 10 mg/ml</th>
<th>150 mg tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>AM</td>
</tr>
<tr>
<td>PM</td>
<td>AM</td>
<td>PM</td>
</tr>
<tr>
<td>30 days or older</td>
<td>5 - 6.9</td>
<td>3 ml</td>
</tr>
<tr>
<td>7 - 9.9</td>
<td>4 ml</td>
<td>4 ml</td>
</tr>
<tr>
<td>10 - 11.9</td>
<td>5 ml</td>
<td>5 ml</td>
</tr>
<tr>
<td>12 - 13.9</td>
<td>6 ml</td>
<td>6 ml or 0.5 tablet</td>
</tr>
<tr>
<td>14 - 19.9</td>
<td>0.5 tablet</td>
<td>0.5 tablet</td>
</tr>
<tr>
<td>20 - 24.9</td>
<td>1 tablet</td>
<td>0.5 tablet</td>
</tr>
<tr>
<td>25 kg and over</td>
<td></td>
<td>1 tablet</td>
</tr>
</tbody>
</table>
## ANNEX B: ARV THERAPY - DOSAGES

### zidovudine (AZT or ZDV)
**TREATMENT DOSE:** 180-240 mg/kg/dose
Give dose twice daily

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Syrup 10 mg/ml</th>
<th>100 mg (capsule), 300 mg (tablet)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM</td>
<td>PM</td>
</tr>
<tr>
<td>5 - 5.9</td>
<td>6 ml</td>
<td>6 ml</td>
</tr>
<tr>
<td>6 - 6.9</td>
<td>7 ml</td>
<td>7 ml</td>
</tr>
<tr>
<td>7 - 7.9</td>
<td>8 ml</td>
<td>8 ml</td>
</tr>
<tr>
<td>8 - 8.9</td>
<td>9 ml</td>
<td>9 ml</td>
</tr>
<tr>
<td>9 - 11.9</td>
<td>10 ml</td>
<td>10 ml</td>
</tr>
<tr>
<td>12 - 13.9</td>
<td>11 ml</td>
<td>11 ml</td>
</tr>
<tr>
<td>14 - 19.9</td>
<td>two 100 mg capsules or 0.5 300 mg</td>
<td>one 100 mg capsule or 0.5 300 mg</td>
</tr>
<tr>
<td>20 - 24.9</td>
<td>two 100 mg capsules or 0.5 300 mg</td>
<td>two 100 mg capsule or 0.5 300 mg</td>
</tr>
<tr>
<td>25 - 29.9</td>
<td>two 100 mg capsules or one 300 mg</td>
<td>two 100 mg capsules or 0.5 300 mg</td>
</tr>
</tbody>
</table>

**zidovudine 10mg/ml syrup for PMTCT prophylaxis in newborns.**
Give 4 mg/kg/dose twice daily

<table>
<thead>
<tr>
<th>Weight in kg</th>
<th>1 - 1.9</th>
<th>2 - 2.9</th>
<th>3 - 3.9</th>
<th>4 - 4.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>0.4 ml</td>
<td>0.8 ml</td>
<td>1.2 ml</td>
<td>1.6 ml</td>
</tr>
<tr>
<td>PM</td>
<td>0.4 ml</td>
<td>0.8 ml</td>
<td>1.2 ml</td>
<td>1.6 ml</td>
</tr>
</tbody>
</table>

### nevirapine (NVP)
**TREATMENT: MAINTENANCE DOSE:** 160-200 mg/kg/dose
(to max 200 mg twice daily dose)

**Maintenance dose - give dose twice daily**
**Lead-in dose during weeks 1 and 2 = only give a.m. dose**

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Syrup 10 mg/ml</th>
<th>200 mg tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM</td>
<td>PM</td>
</tr>
<tr>
<td>5 - 5.9</td>
<td>6 ml</td>
<td>6 ml</td>
</tr>
<tr>
<td>6 - 6.9</td>
<td>7 ml</td>
<td>7 ml</td>
</tr>
<tr>
<td>7 - 7.9</td>
<td>8 ml</td>
<td>8 ml</td>
</tr>
<tr>
<td>8 - 8.9</td>
<td>9 ml</td>
<td>9 ml</td>
</tr>
<tr>
<td>9 - 9.9</td>
<td>9 ml</td>
<td>9 ml</td>
</tr>
<tr>
<td>10 - 11.9</td>
<td>10 ml</td>
<td>10 ml</td>
</tr>
<tr>
<td>12 - 13.9</td>
<td>11 ml</td>
<td>11 ml</td>
</tr>
<tr>
<td>14 - 24.9</td>
<td>one tablet</td>
<td>0.5 tablet</td>
</tr>
<tr>
<td>25 and above</td>
<td>one tablet</td>
<td>one tablet</td>
</tr>
</tbody>
</table>

**nevirapine for PMTCT prophylaxis in newborns**
2 mg/kg/dose within 72 hours of birth—once only

<table>
<thead>
<tr>
<th>Unknown weight</th>
<th>0.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 1.9</td>
<td>0.2</td>
</tr>
<tr>
<td>2 - 2.9</td>
<td>0.4</td>
</tr>
<tr>
<td>3 - 3.9</td>
<td>0.6</td>
</tr>
<tr>
<td>4 - 4.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>
### ANNEX B: COMBINATION ARV DOSAGES

**DUAL Fixed-dose combinations (FDCs)**

<table>
<thead>
<tr>
<th></th>
<th>Weight (kg)</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>stavudine + lamivudine</td>
<td>10 - 13.9</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>(d4T-3TC)</td>
<td>14 - 24.9</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>30 mg d4T / 150 mg 3TC</td>
<td>25 - 34.9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Weight (kg)</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>zidovudine + lamivudine</td>
<td>14 - 19.9</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>(ZDV-3TC = AZT-3TC)</td>
<td>20 - 29.9</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>300 mg ZDV / 150 mg 3TC</td>
<td>30 or above</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**TRIPLE FDCs**

<table>
<thead>
<tr>
<th></th>
<th>Weight (kg)</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>stavudine + lamivudine</td>
<td>10 - 13.9</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>+ nevirapine (d4T-3TC-NVP)</td>
<td>14 - 24.9</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>30 mg d4T / 150 mg 3TC / 200 mg NVP</td>
<td>25 or above</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Weight (kg)</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>zidovudine + lamivudine</td>
<td>14 - 19.9</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>+ abacavir (ZDV-3TC-ABC = AZT-3TC-ABC)</td>
<td>20 - 29.9</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>300 mg ZDV / 150 mg 3TC / 300 mg ABC</td>
<td>30 or above</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
## ANNEX C: ARV THERAPY - SIDE EFFECTS*

<table>
<thead>
<tr>
<th></th>
<th>Very common side-effects:</th>
<th>Potentially serious side effects:</th>
<th>Side effects occurring later during treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>d4T stavudine</strong></td>
<td>Nausea, Diarrhoea</td>
<td>Seek care urgently:</td>
<td>Changes in fat distribution:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe abdominal pain</td>
<td>Arms, legs, buttocks, cheeks become THIN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue AND shortness of breath</td>
<td>Breasts, belly, back of neck become FAT</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Seek advice soon:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tingling, numb or painful feet or legs or hands</td>
<td></td>
</tr>
<tr>
<td><strong>3TC lamivudine</strong></td>
<td>Nausea, Diarrhoea</td>
<td>Seek care urgently:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe skin rash</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue AND shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td><strong>NVP nevirapine</strong></td>
<td>Nausea, Diarrhoea</td>
<td>Seek care urgently:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yellow eyes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe skin rash</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue AND shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td><strong>ZDV zidovudine</strong> (also known as AZT)</td>
<td>Nausea, Diarrhoea, Headache, Fatigue, Muscle pain</td>
<td>Seek care urgently:</td>
<td>Pallor (anaemia)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Seek care urgently:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yellow eyes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe skin rash</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue AND shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td><strong>EFV efavirenz</strong></td>
<td>Nausea, Diarrhoea, Strange dreams, Difficulty sleeping, Memory problems, Headache, Dizziness</td>
<td>Seek care urgently:</td>
<td>Yellow eyes, Psychosis or confusion, Severe skin rash</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Seek advice soon:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tingling, numb or painful feet or legs or hands</td>
<td></td>
</tr>
</tbody>
</table>

* for more guidance, refer to IMAI chronic care guideline module
## ANNEX D: DRUG DOSAGES FOR OPPORTUNISTIC INFECTIONS

### Recommended dosages for ketoconazole:

<table>
<thead>
<tr>
<th>Age of child</th>
<th>Weight</th>
<th>Dose, frequency and duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months up to 12 months</td>
<td>3-&lt;6kg</td>
<td>20 mg once daily</td>
</tr>
<tr>
<td></td>
<td>6-&lt;10kg</td>
<td>40 mg once daily</td>
</tr>
<tr>
<td>12 months up to 5 years</td>
<td>10-19 kg</td>
<td>60 mg once daily</td>
</tr>
</tbody>
</table>

### Recommended dosages for fluconazole:

<table>
<thead>
<tr>
<th>Weight of child</th>
<th>50mg/5ml oral suspension</th>
<th>50 mg capsule</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 -&lt;6kg</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 -&lt;10kg</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10 -&lt;15kg</td>
<td>5 ml once a day</td>
<td>1</td>
</tr>
<tr>
<td>15 -&lt;20kg</td>
<td>7.5 ml once a day</td>
<td>1-2</td>
</tr>
<tr>
<td>20 -&lt;29kg</td>
<td>12.5 ml once a day</td>
<td>2-3</td>
</tr>
</tbody>
</table>

### Recommended dosages for Nystatin:

**Oral suspension 100,000 units/ml**

1-2ml four times per day for all age groups

### Recommended dosages for acyclovir:

<table>
<thead>
<tr>
<th>Age of child</th>
<th>Dose, frequency and duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2 years</td>
<td>200mg 8 hourly for 5 days</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>400mg 8 hourly for 5 days</td>
</tr>
</tbody>
</table>

### Recommended dosages for cloxacillin / flucloxacillin:

<table>
<thead>
<tr>
<th>Weight of child</th>
<th>Form</th>
<th>Dose, every 6 hours for 5 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6kg</td>
<td>250mg capsule</td>
<td>1/2 tablet</td>
</tr>
<tr>
<td>6-&lt;10kg</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>10-&lt;15kg</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>15-&lt;20kg</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
MANAGEMENT OF THE SICK CHILD AGED 2 MONTHS UP TO 5 YEARS

Name: ___________________________________________      Age: _____________   Weight: __________ kg    Temperature: ________°C

ASK: What are the child's problems? ___________________________________________________

Initial visit? ___  Follow-up Visit? ___

ASSESS

(Circle all signs present)

CLASSIFY

CHECK FOR GENERAL DANGER SIGNS

General danger signs present?

NOT ABLE TO DRINK OR BREASTFEED

VOMITS EVERYTHING

CONVULSIONS

LETHARGIC OR UNCONSCIOUS

CONVULSING NOW

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.

• Look for chest indrawing.

• Look and listen for stridor/wheeze.

DOES THE CHILD HAVE DIARRHOEA?

Yes ___ No __

• For how long? _____ Days

• Is there blood in the stools?

• Look at the child's general condition. Is the child:

  Lethargic or unconscious?

  Restless or irritable?

• Look for sunken eyes.

• Offer the child fluid. Is the child:

  Not able to drink or drinking poorly?

  Drinking eagerly, thirsty?

• Pinch the skin of the abdomen. Does it go back:

  Very slowly (longer than 2 seconds)?

  Slowly?

DOES THE CHILD HAVE FEVER?

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

Decide Malaria Risk: High    Low

• For how long? _____ Days

• If more than 7 days, has fever been present every day?

• Has child had measles within the last three months?

  Yes___ No___

• Look or feel for stiff neck.

• Look for runny nose.

Look for signs of MEASLES:

• Generalized rash and

• One of these: cough, runny nose, or red eyes.

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

• Look for mouth ulcers.

  • If Yes, are they deep and extensive?

• Look for pus draining from the eye.

• Look for clouding of the cornea.

DOES THE CHILD HAVE AN EAR PROBLEM?

Yes___  No___

• Is there ear pain?

• Is there ear discharge?

If Yes, for how long? ___ Days

• Look for pus draining from the ear.

• Feel for tender swelling behind the ear.

THEN CHECK FOR MALNUTRITION AND ANAEMIA

• For children < 6 months, Look for visible severe wasting.

• Look for palmar pallor.

  Severe palmar pallor? Some palmar pallor?

• Look for oedema of both feet.

• Determine weight for age. Very Low ___   Not Very Low ___

CHECK FOR HIV INFECTION

HIV tested before (confidential):  Mother  o  positive   o negative   o unknown   Child  o   positive  o  negative  o unknown

/Box3

Pneumonia

/Box3

Parotid enlargement

/Box3

Very Low weight for age

/Box3

Oral thrush

/Box3

Ear discharge

/Box3

Generalized persistent lymphadenopathy

/Box3

Persistent diarrhoea

If mother is HIV infected, and child less than 24 months old, decide on infant feeding counselling needs

CHECK THE CHILD'S IMMUNIZATION STATUS

Circle immunizations needed today.

______ ______ ______ ______

BCG DPT1 DPT2 DPT3

______ ______ ______ ______ _______

OPV 0              OPV 1              OPV 2        OPV 3       Measles

Return for next immunization on:

________________

(Date)

ASSESS OTHER PROBLEMS

Ask about mother's own health

Time taken:

Feeding problems

ASSESS CHILD'S FEEDING if child has ANAEMIA OR VERY LOW WEIGHT or is less than 2 years old.

• 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 food or fluids? _______________________________________________________________

  _______________________________________________________________________________________

  How many times per day? ___ times. What do you use to feed the child? __________________________

• During the illness, has the child's feeding changed? Yes ____  No ____     If Yes, how?

CHECK FOR MALNUTRITION AND ANAEMIA

1. YES

2. NO

For children > 6 months old,

• check if MUAC < 110 mm

• Assess appetite

DOES THE CHILD HAVE AN EAR PROBLEM?

Yes___  No___

• Look for drainage of the ear.

• Look for redness from the ear.

• Look for swelling behind the ear.

• Look for tenderness in the ear.

• Check for perforation. Noise or redness?

• Generalized and tuned up.

• Look for signs of otitis.

• Look for discharge.

• Look for auricular eruptions.

• Look for eardrum.

• Look for perforation.

• Look for external ear deformity.

• Do the following. Ear cleaning.

• Do the following. Antibiotics.

• Check for redness or swelling.

• Check for tenderness.

• Check for discharge.

• Check for signs of inflammation.

DOES THE CHILD HAVE DIARRHOEA?

Yes ___ No __

• Check for frequency.

• Check for consistency.

• Check for offensive odour.

• Check for complaints.

• Check for history.

• Check for appetite.

• Check for fever.

• Check for signs of dehydration.

DOES THE CHILD HAVE FEVER?

Yes ___ No ___

• Check for temperature.

• Check for signs of infection.

• Check for history.

• Check for complaints.

• Check for signs of dehydration.

DOES THE CHILD HAVE ANAEMIA OR DIFFICULT BREATHING?

Yes ___ No ___

• Check for pallor.

• Check for tachypnoea.

• Check for signs of distress.

• Check for history.

• Check for complaints.

• Check for signs of dehydration.

DOES THE CHILD HAVE AN EAR PROBLEM?

Yes___  No___

• Check for drainage of the ear.

• Check for redness from the ear.

• Check for swelling behind the ear.

• Check for tenderness in the ear.

• Check for perforation. Noise or redness?

• Generalized and tuned up.

• Check for signs of otitis.

• Check for discharge.

• Check for auricular eruptions.

• Check for eardrum.

• Check for perforation.

• Check for external ear deformity.

• Do the following. Ear cleaning.

• Do the following. Antibiotics.

• Check for redness or swelling.

• Check for tenderness.

• Check for discharge.

• Check for signs of inflammation.

GOVERNMENT TO PAY UP TO 3 TIMES THE COST OF CARE
MANAGEMENT OF THE SICK YOUNG INFANT AGED UP TO 2 MONTHS

Name_______________________________________   Age: _________      Weight:  ________          Temperature: ______

ASK: What are the baby's problems?_____________________________      Initial visit? ________       Follow-up visit?_____

ASSSESS

CHECK FOR VERY SEVERE DISEASE AND LOCAL INFECTION

 Is the infant having difficulty feeding?
 had convulsions
 fast breathing : breaths per minute: ______ Repeat if required:____
 grunting
 severe chest indrawing
 umbilical draining pus or redness
 Fever (38 or above) or low temperature (below 35.5 or feels cold)
 skin pustules
 Does the infant move only when stimulated?
 Does the infant not move even when stimulated?

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT

in breastfed infants (infants receiving breast milk)

Breastfeeding
 no
 yes   ______   times in 24 hours

Receiving other food or drinks
 no
 yes    ______  times in 24 hours

If yes what do you use to feed the baby?__________________________________

Plot weight for age
 low weight
 not low weight
 Poor weight gain

If any difficulty feeding, feeding less than 8 times in 24 hours, taking any other food or drinks, or is low weight
for age AND has no indication to refer urgently to hospital

Assess breastfeeding
Breastfed in previous hour?
 yes
 no

If the infant has not fed in the previous hour, ask the mother to put the child to the breast
Observe the breastfeed for four minutes, check attachment:
Chin touching breast
 yes
 no

Mouth wide open
 yes
 no

Lower lip turned out
 yes
 no

More areola above than below the mouth
 yes
 no

 not attached
 not well attached
 Good attachment

Is the young infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
 Not sucking at all
 not suckling effectively
 suckling effectively

Is thrush present?

CHECK FOR HIV INFECTION

 Has  the mother or infant had an HIV test?
 What was the result ?

THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT
in infants receiving no breast milk

Difficulty feeding?
 yes
 no

What made you decide not to breastfeed*? ____________________________

Which breast-milk substitute?______________________

Is enough milk being given in 24 hrs?
 yes
 no

Correct feed preparation?
 yes
 no

Any food or fluids other than milk?
 yes
 no

Feeding utensils:
 cup
 bottle

Utensils cleaned adequately?
 yes
 no

Thrush present?
 yes
 no

Plot weight for age:
 low weight
 not low weight
 Poor weight gain

ARE THERE ANY SPECIAL RISK FACTORS PRESENT?
 yes
 no

 Premature or low birthweight
 Young adolescent mother
 Birth asphyxia
 Not breast fed
 Severe socioeconomic deprivation
 Young disabled mother
 Previous or present mother

CHECK THE YOUNG INFANTS IMMUNIZATION STATUS

mark immunizations needed today

Birth
 BCG
 OPV-0

6weeks
 OPV-1
 DPT+HIB-1
 HepB 1

10weeks
 OPV-2
 DPT+HIB-2
 HepB 2

Return for next
immunization on:
___________________ (Date)
Integrated Management of Childhood Illness Complementary Course on HIV/AIDS.

8 v.

1. HIV infections - diagnosis. 2. HIV infections - therapy. 3. Acquired immunodeficiency syndrome - diagnosis. 4. Acquired immunodeficiency syndrome - therapy. 5. Infant. 6. Child. 7. Disease management. 8. Teaching materials. I. World Health Organization. II. Title: IMCI complementary course on HIV/AIDS. III. Title: Complementary course on HIV/AIDS.

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For further information please contact:
Department of Child and Adolescent Health and Development (CAH)
World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland
Tel: +41-22 791 3281 email: cah@who.int
Fax: +41-22 791 4853 http://www.who.int/child-adolescent-health
IMCI - Weight-for-age (combined sexes)