UNIT 5 NUTRITIONAL MANAGEMENT AND COUNSELLING

Structure

5.0 OBJECTIVES

After going through this unit, you will be able to:

- Recognize common vitamin and mineral deficiency disorders,
- Assess the child's feeding and identify the feeding problem, and
- Counsel the mother about feeding.

5.1 INTRODUCTION

A child whose diet is deficient in protein and energy is also deficient in essential vitamins and minerals. Sometimes the lack of knowledge regarding different food items that are rich in calories and vitamins can result in various nutritional disorders. It is, therefore, important aspect of health care to convince the care provider (mother or other family member) regarding prevention of nutritional deficiency disorders. To be able to convince the mother, the health personnel must have the technical knowledge and the skills to talk to the mother.

You have already learnt theoretical aspect of Malnutrition and Anaemia in Block 4. You have also learnt the practical skills to check for Malnutrition and Anaemia in the previous unit of this block. This section will, therefore, deal with the assessment of Vitamin-A, Vitamin-C and Vitamin-D deficiency and help you in learning how to counsel the mother on feeding recommendations.

5.2 VITAMIN-A DEFICIENCY

Vitamin-A is essential for the integrity of epithelial cells. The deficient diets cause the disease by 2 – 3 years of age. The deficiency of vitamin-A is associated with high morbidity and mortality from infection. The diagnosis of vitamin-A deficiency is made on clinical grounds.

The signs and symptoms of vitamin-A deficiency include:

- Night Blindness (nyctalopia): The parents notice that the child takes considerable time to adjust to dim light or darkness particularly after sunset. There is often a history of staggering and hitting objects at sunset or the light is very dim. This phenomenon is because of diminished visual acuity of the child.

- Dryness of conjunctiva (Xerosis) is the first sign which can be seen on physical examination of the eyes. It leads to formation of Bitot's Spot (Fig. 5.1), which is a silver grey plaque of a triangular area on the temporal aspect of eye.
- In advanced disease, corneal Xerosis, keratomalacia (necrosis and ulceration of cornea) and finally corneal ectasia and phthisis bulbi occur. Once cornea is involved, photophobia becomes th dominant clinical presentation.
- The eye signs of vitamin-A deficiency are exaggerated by measles, which has a high morbidity and mortality.
- In routine paediatric practice, the diagnosis of vitamin-A deficiency is clinical and does not require laboratory support such as serum level or conjunctival impression cytology

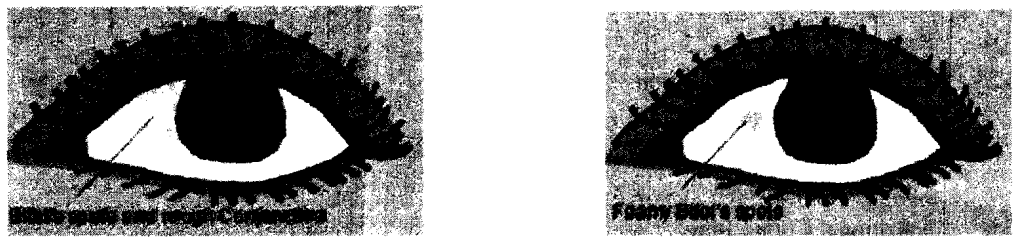

Fig. 5.1: Bitot's Spot

5.3 SCURVY

Ascorbic Acid is essential for the formation of normal collagen. Breast-milk is usually an adequate source of vitamin-C. The majority of vitamin-C deficiency (Scurvy) occurs in infants 6-24 months of age.

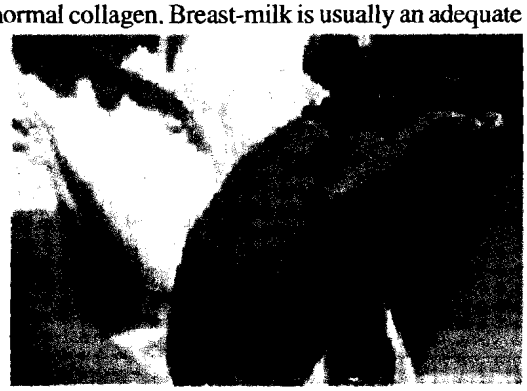

Fig. 5.2: Prominent costochondral juctions

Consider the diagnosis when there is bleeding under the mucous membranes and perifollicular haemorrhage. Costochondral junctions become prominent (scorbutic rosary) (Fig. 5.2), sharp and angular (in Rickets it is globular and round).Child is usually irritable and cries on being handled and is reluctant to move his limbs which are kept in a frog like position (pseudoparalysis).The diagnosis of Scurvy is confirmed by X-Ray of long bones (Figure 5.3).

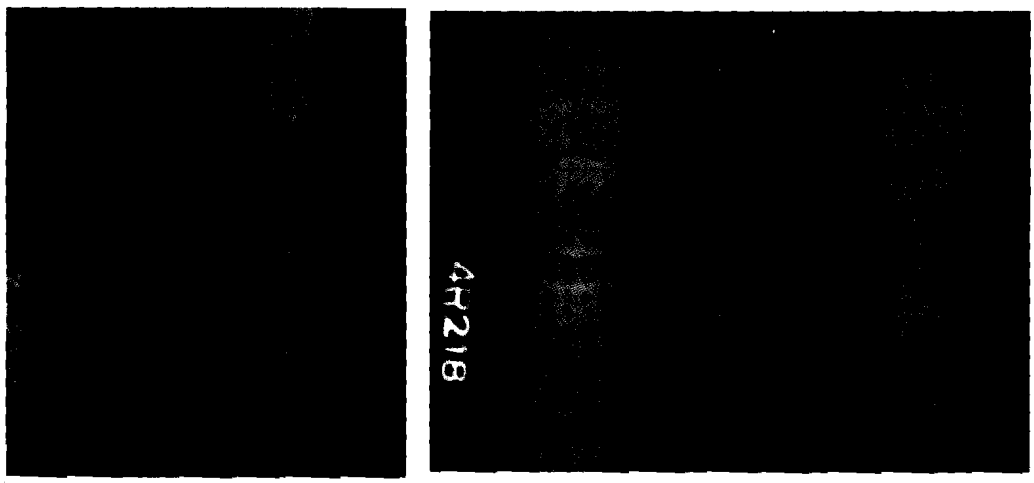

Fig. 5.3: Scurvy X-ray: Both knees showing generalized decreased in bone density, white line of scurvy and pelkan's spur seen (X-ray curtsey – Dr. Shabnam Bhandari)

Other laboratory tests are less satisfactory and are usually not required. A fasting vitamin-C level of blood plasma of over 0.6 mg/dl aids in the exclusion of scurvy, but a lower level of vitamin-C is better furnished to the Ascorbic Acid concentration in the white cell platelet layer (buffy layer) of the centrifuged oxalated blood.

5.3 RICKETS

Vitamin-D deficiency rickets results from a failure to mineralize the bone matrix at the growth plate. It occurs during periods of rapid growth i.e. in children under two years of age and during puberty. Rickets is unusual below 3 months of age. However in the breastfed infants whose mothers have osteomalacia or very low birth infants who did not receive adequate and phosphate supplementation, osteopaenia as precursor of rickets may be appreciated radiologically.

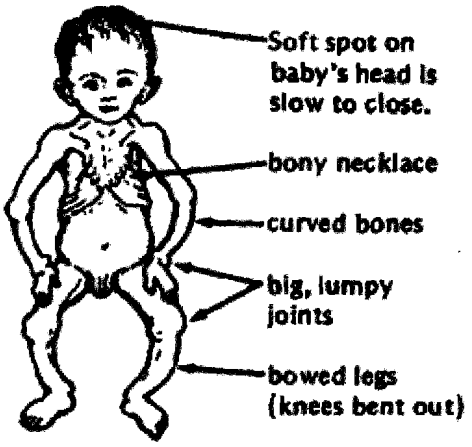

Fig. 5.4: Signs of Rickets

The diagnosis of Rickets depends upon clinical and radiological evidences only. The biochemical parameter confirms it but is not mandatory. Clinically usually the patient is malnourished, has widening of wrists and Costochondral junctions (Rachitic Rosary), frontal bossing, large open fontanel, Harrison's Groove, knocking of knees, bowing of legs, hypotonia and deformity of chest (Fig. 5.4).

For radiological examination, x-ray of both wrists (AP view) including distal end of long bones is taken to look for evidences of rickets. The evidences of rickets are osteopaenia (deficient mineralization of bones), cupping and fraying of distal end of long bones, large gap between epiphysis and metaphysis and wide epiphyseal plate.

Biochemical findings include decreased serum phosphate and highly increased serum alkaline phosphatase. One expects hypocalcaemia but the calcium level is variable.

Fig. 5.5: Rickets X-ray both wrist shows widening, cupping and fraying of metaphysis and widening of growth plates. (X-ray curtsey – Dr. Shabnam Bhandari)

Fig. 5.6: Signs of Rickets : Widened Metaphysis Cupping & Fraying, Wide Metaphysio-Epiphyseal Distance

5.5 PROTEIN ENERGY MALNUTRITION [PEM]

The skills needed for diagnosis of a case of PEM can be discussed under the following headings;

- History Taking
- Physical Examination
- Management

5.5.1 History Taking

The basic approach of history taking remains the same as for other disorders. Particular emphasis needs to be given to:

- Age of the child,

- Underlying cause of PEM (e.g. failure to breastfeed, late introduction of complementary feeds, lack of feeding energy dense foods)
- Socio-economic factors which have contributed to development of PEM and are likely to influence the future outcome if not taken care of (e.g. parental illiteracy, ignorance, girl child or unwanted child, poverty, parental alcoholism/drug addiction).
- Area of residence,
- Detailed feeding history,
- Preceding or associated history of diarrhoea, measles, tuberculosis, HIV or any other infection,
- History regarding appetite, activity and whether the child is vomiting or thirsty,
- Family Income,
- History of contact with tuberculosis,
- Birth History.

5.5.2 Physical Examination

There are many parameters under physical examinations but the IMNCI approach has simplified it very much. According to IMNCI physical examination include;

- Look for Visible Severe Wasting,
- Look for oedema both feet, and
- Record weight of the child and plot it on weight for age curve.

For the 'action' point of view, the above simple examination is accurate. However, besides this IMNCI approach, there are other parameters also for a complete examination.

The essence of diagnosis and assessment of nutritional status is based on detailed clinical examination from head to toe. There is no single sign or signs "diagnostic" for any particular nutritional deficiency. Interpretation of clinical signs is best made by using a "group of signs" the pattern is associated with the deficiency of a particular nutrient. However, it is equally important to know that the clinical patterns on which these 'grouping of signs' are based differ widely according to duration and speed of onset of malnutrition.

Clinical examination for evidence of malnutrition

You must look for the following:

1) General Appearance,
2) Behaviour,
3) Colour, texture, pluckability of hairs,
4) Buccal pad of fat,
5) Loss of subcutaneous fat,
6) Wasting of muscles,
7) Pot belly,
8) Oedema over feet/other parts of body,
9) Any skin changes.

The clinical examination may suggest nutritional marasmus, kwashiorkor or marasmic kwashiorkor.

Record the Weight and Height/Length

You have already gone through the details of assessment of growth and development in the theory units and practical aspects will be dealt after this unit. You will be introduced to various

methods which can be used to record the weight of a child. Children with marasmus have reduction in weight (less than 60% of the expected or standard for age). However, in view of the presence of oedema in kwashiorkor the interpretation from weight alone may be misleading. Therefore, the welcome classification has been recommended which is as follows.

% of expected weight	With Oedema	Without oedema
60 – 80%	Kwashiorkor	Underweight
< 60%	Marasmic Kwashiorkor	Marasmus

The Indian Academy of Paediatrics has also recommended a classification based on weight for age which is as follows (Reference Weight: 50th centile of NCHS Standard).

> 80% of expected	=	Normal
71 – 80% of expected	=	Grade I
61 – 70%	=	Grade II
51 – 60%	=	Grade III
< 50%	=	Grade IV

In the presence of oedema, an affix "K" is added to the grade of malnutrition.

Look for other features like;

- Vitamin A deficiency.
- Deficiency of other vitamins.
- State of hydration.
- Hypothermia, hypoglycaemia, congestive cardiac failure, infections (particularly respiratory, urinary, CNS, septicaemia and electrolyte imbalance).

5.5.3 Management

By this stage, you should be able to:

1) Identify cases of malnutrition who need to be hospitalized (i.e. cases with severe malnutrition, associated infections, dehydration and other problems).
2) Identify cases that do not need to be hospitalized and can be managed at home.

Management at OPD

Basic Points:

- Give small frequent feeds. The diet should be gradually built with small increments as the appetite improves.
- Educate the mother to prepare mixed food (cereal + legume), green vegetables and milk products within the family diet resources. Addition of small amount of vegetable oil will provide extra calories.
- Infection should be treated.
- Dehydration can be treated with ORS.
- Vitamins and iron should be given.
- Immunize the child.

For those who need not be hospitalized, you will make sure that;

1) Relevant information, history and examination are recorded.
2) Anthropometric measurements particularly of weight recorded.
3) Home based management carried out on outpatient basis.

4) Treat anaemia, infection and worm infestation.

5) Complete immunizations.

6) Depending upon the age and feeding pattern, you have to give advice on:

   a) Existing breastfeeding.

   b) Undiluted artificial milk.

   c) Nutritious and easily available food to be given more frequently, addition of oil to be specifically stressed (see annexure-5 for recipes).

      — Mother should be counseled regarding modification of food cooked at home to improve nutritional status of the child.

      — Objective is to provide 120 – 150 kcal/kg/day of the present weight of the child along with proteins 2 – 3 g/kg/day. As the weight of the child improves, recalculate the target calorie and protein intake.

      — Give small frequent meals. Make improvements as the child's appetite improves.

      — Add vitamin and iron supplements.

      — Monitor for loss of oedema if present, and catch up weight gain.

7) Take care of vitamin and zinc deficiencies.

8) Appropriate treatment of associated problems.

9) **Teaching and convincing mothers:** This is the most crucial part of the management. Give advice on cause and nature of illness and explain the mother how to look after the child. The method of feeding advised should be demonstrated to the mother. She should be constantly encouraged to feed her child, she should also be taught about budgeting from her family income.

10) Follow-up: Child must be followed up every week to see the response of treatment and the progress of the patient. Dietary supplements will be gradually stepped up depending on the response of the patient. If the child is improving, there will be a total change in the personality and behaviour of the child. He will start smiling, take interest in surrounding and play. Child with oedema may first lose weight due to disappearance of oedema fluid. Those without oedema may show weight gain but slow and sustained.

11) Prepare a checklist of activities to be performed while evaluating and managing a case from OPD.

Management of the admitted case of Severe Malnutrition in ward

The management of admitted cases of severe malnutrition in ward is done by '10 steps' enlisted below:

10 Steps' of management of Severe Malnutrition

1. Treat/prevent hypoglycaemia.
2. Treat/prevent hypothermia.
3. Treat/prevent dehydration.
4. Correct electrolyte imbalance.
5. Treat/prevent infection.
6. Correct micronutrient deficiencies.
7. Start cautious feeding.
8. Achieve catch up growth.
9. Provide sensory stimulation and emotional support.
10. Prepare for follow up after recovery.

5.6 NUTRITIONAL COUNSELLING

Before starting counseling on nutrition, it is essential to assess the feeding of the young infant or child to identify the exact feeding problem(s). The counseling may be done in a more effective way once the feeding problem(s) has been identified.

You have already learnt in great detail the feeding assessment of young infant age up to 2 months in Unit 4, Block 1. Now you will learn assessing feeding of the sick child age 2 months up to 5 years.

5.6.1 Assessing the Child's Feeding

Whenever a mother visits you for any illness of child or for his/her immunization, you can utilize that opportunity for assessing the child's feeding and advise according to the feeding-problem identified.

However, if the child is very sick requiring urgent medical management, you may delay assessing feeding and counseling until a later visit.

According to the CRF, there are 3 indications for assessing child's feeding.

1) If child is VERY LOW WEIGHT, or

2) has ANAEMIA, or

3) is less than 2 years old.

Any one or more of above indications is an indication for assessment of child's feeding. However, priority is to be given to urgent treatment if any. You have to ask very simple questions to mother in a language she understands well. The questions are given below.

Assess the child's feeding

- Ask quetions about the child's feeding and feeding during illness
- Compare the mother's answers to the feeding recomendations for the child's age.

ASK

- 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 receive any food or fluids? Yes _____ No _____

  If yes, what food or fluid? _____

  _____

  How many times per day? _____ times.

  What do you use to feed the child and how? _____
- How large are servings? _____
- Does the child receive his own serving? Yes _____ No _____

  Who feeds the child and how? _____
- During the illness, has the child's feeding changed? Yes _____ No ____

  If yes, how?

5.6.2 Identifying Feeding Problems

Once you have obtained answer to above questions, please consult the food box applicable to age group of the child concerned and compare with the recommendations and the actual feeding given to the child. Any difference detected is feeding problem. The food boxes can be seen at annexure-2 of this block.

To summarize,

- The difference between what is recommended for age and what the child is fed are the feeding problems.
- You should identify all the feeding problems before advising on feeding.
- Common feeding problems that are observed,
  - Difficulty in breast feeding,
  - Giving sugar water or tea before 6 months of age,
  - Breast-milk is not considered to be enough,
  - Feeding bottle is used for giving milk,
  - The child does not feed well during the illness.

The common feeding problems and their possible solutions are listed in Annexure-1.

5.6.3 Counseling the Mother about Feeding Problems.

The basic principle of counseling is to focus on the problem identified. Once you have identified feeding problems, you may be able to limit your advice to what is most relevant to the mother.

- If attachment is good and the baby is suckling effectively, praise the mother and explain her benefits of exclusive breastfeeding.
- If attachment is not good, teach her correct positioning (see section 4.2.1 & 4.2.2).
- If still not suckling effectively, ask the mother to express breastmilk and feed with cup and spoon in the clinic.
- If able to take with a cup and spoon, advise mother to continue breastfeeding the baby and at the end of each feed express breastmilk and feed with a cup and spoon.
- If not able to feed with a cup and spoon, refer to hospital.

Give Relevant advice:

- If feeding recommendations are being followed, and there are no problems, encourage her to keep feeding the child same way. Praise the mother for her good feeding practice.
- If feeding recommendations not being followed, explain them.
- If child is about to enter a new age group, with different feeding recommendations, explain these to her.
- If you have found any of the feeding problems, counsel the mother accordingly.

If the child is less than 6 months old and taking other milk or food:

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

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

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

If the child is undernourished:

- Increase the food amount by 2 tea spoons at every meal
- Give foods which are thick and have added oils
- Give foods more often

- Include snacks (Procured from Anganwadi Centre) or, Biscuits, Chikki, Channa, Groundnut, Laddoo, Panjiri, Fried Potato, seasonal fruit) in between 3 meals.

Use good communication skills

When we wish to impart useful information to mothers or other family members of the child (such as starting semi solid foods after the age of 6 moths), we need to establish good communication with them. Good communication not only means taliking to the mother, but also listening to what she says. To have the greatest possible influences on the parents of what we wish them to follow, we need to understand and learn some basic skills.

Non-verbal communication

Non-verbal communication means showing your attitutde through posture, expression and gesture; everything in fact, except through speaking;

Tips for helpful non-verbal communication are:

- Sit at the mother's level
- Touch appropriately/play with child
- A friendly smile
- Nod, hmmm..... when mother is saying something (makes her fee understood)
- Pay attention
- Take time

When counselling mothers, it is important to greet the mother appropriately, with warmth and ask her to sit with her child and then:

- **Ask and listen:** Ask questions to assess the child's feeding. Use words the mother understands, use local language. Give the mother time to understand. Listen carefully to find out what the mother is already doing for her child. Then we will know that she is doing well and what practices need to be changed.
- **Praise:** Praise the mother for her actions that are helpful to the child. The Praise should be genuine and should appear in your expression and gesture language.

  Advise

  — Gvie relevant advice and use the language that the mother will understand.

  — use pictures or real objects to help explain, e.g. show amounts of fluid in a cup or container.

  — Don't make her feel guilty or incompetent when correcting a harmful practice.

- **Check understanding:** Ask questions to find out what mother understands and clarify your advice as necessary.

Example of good communication skills

If a mother tells that she is breast-feeding her 3 months old baby only 4 times daily and giving him cow's milk at other times.

— First listen to mother why she is not exclusively breast-feeding her child. She might be having difficulty in breast-feeding.

— Praise her for continuing breast-feeding.

Watch the mother breast-feed the baby. Show the mother correct positioning and attachment. Ask her to breast-feed more often (minimum 8 times) and for longer duration and discontinue cow's milk gradually.

— Check that she has understood your advice correctly by avoiding direct questions with answers yes or no, e.g. ask: How many times would you breast-feed your baby in 24 hrs? Show me the correct position and attachment.

Use mother's card as communication tool

A mother's card can be given to each mother to help her remember appropriate foods and fluids, and when to return to health personnel for further follow-up. The Mother's Card has words and pictures that illustrate the main points of advice (Annexure 3)

- It will remind health personnel of important points to cover when counselling the mothers about foods, fluids and when to return.
- It will remind the mother what to do when she gets home.
- The mother may show the card to other family members or neighbours, so more people will learn the message it contains.
- Multivisit cards can be used as a record of treatments and immunization given.

When reviewing a Mother's Card with a mother, explain each picture. This will help the mother remember what the pictures represent. Circle or record information that is relevant to the mother e.g., circle the feeding advice for the child's age. Also ask the mother to tell you in her own words what she should do at home. Encourage her to use the card to help her remember. If you do not have supply of cards in your health facility, keep few, in the clinic to show to mothers.

5.7 LET US SUM UP

In this unit you learnt the practical tips on diagnosis of Vitamin-A, Vitamin-C and Vitamin-D deficiency in children, art of taking history and physical examination for diagnosis and management of Malnutrition, and skills of nutritional counseling. These skills can be mastered only after continuous practice. Remember to use mother's card as communication tool while practising these skills.

Practical Approach to Feeding problems

Age group up to 6 moths

- ***Mother feels she does not have enough breast milk:***
  - — Breast-feed the baby more often and for longer period at each feed.
  - — Breast-feed during the day and night
  - — Mother should eat more and take more fluids.
- ***Mother goes out to work and is not able to feed the baby:***
  - — Mother shold breast-feed the baby often before going to work, after returning from work, and at night.
  - — She can express milk and baby can be fed the milk, kept at room temperature for 24 hours.
- ***Child is fed by a bottle:***
  - — Advice the mother to stop bottle-feeding. Explain her the dangers of bottle-feeding.
  - — Put the baby to breast every time baby is hungry and feed for as long as the baby sucks.
  - — Since the breast milk may take 3-4 days to improve, feed the formula milk by a cup.

Age group 6 months up to 12 months

- ***Mother has discontinued breast-feeding. She considers child is too old to breast-feed:***
  - — Breast-feeding can be done up to 2 years of age.
  - — Advice mother to resume breast-feding by putting the baby to breast every 2-3 hours.
  - — Breast milk will resume after 3-4 days.
- ***Complementary food is not being given:***
  - — Explain the mother that only breast milk is not sufficient for the child's growth.
  - — Introduce soft mashed but thick foods that have some added oil e.g. dalia, rice, kheer and suji kheer, Given mashed seasoned frits (banana, chikoo, mango, guava, papaya).
- ***Complementary food given is small in amount:***
  - — Increase complementary food by 1 teaspoon per feed unitl the child takes ½-1 cup or katori (50-60 g).
  - — If the child cannot take large amount of food, feed 5 times/day instead of 3 times per day.

Age 12 months up to 5 years

- ***Child is not actively fed:***
  - — Mother or some one in the family should feed the child
  - — The food for the child should be separate from the rest of the family
  - — Some food should be left behind when the child has finished the meal.
- ***Child is undernourished:***
  - — Increase the amount by 2 teaspoon at every meal.
  - — Give foods, which are thick and have oil added
  - — Give food more often
  - — Include snacks (biscuits, chikki, chana, groundnut, laddoo, panjiri, fried potato, seasoned fruit) in between 3 meals.

Feeding Recommendations During Sickness and Health

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 any other foods or fluids not even water

Remember:

- Continue breastfeeding if the child is sick.

6 Months up to 12 Months

- Breastfeed as often as the child wants.
- Give at least one katori serving* at a time of :
  - Mashed roti/ rice /bread/biscuit mixed in sweetened undiluted milk OR
  - Mashed roti/rice/bread mixed in thick dal with added ghee/oil or khichri with added oil/ghee. Add cooked vegetables also in the servings OR
  - Sevian/dalia/halwa/kheer prepared in milk or any cereal porridge cooked in milk OR
  - Mashed boiled/fried potatoes
- Offer banana/biscuit/ cheeko/ mango/ papaya

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

Remember:

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

12 Months up to 2 Years

- Breastfeed as often as the child wants.
- Offer food from the family pot
- Give at least 1½ katori serving* at a time of :
  - Mashed roti/rice/bread mixed in thick dal with added ghee/oil or khichri with added oil/ghee. Add cooked vegetables also in the servings OR
  - Mashed roti/ rice /bread/biscuit mixed in sweetened undiluted milk OR
  - Sevian/dalia/halwa/kheer prepared in milk or any cereal porridge cooked in milk OR
  - Mashed boiled/fried potatoes
  - Offer banana/biscuit/ cheeko/ mango/ papaya

* 5 times per day.

Remember:

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

2 Years and Older

- Give family foods at 3 meals each day.
- Also, twice daily, give nutritious food between meals, such as: banana/ biscuit/ cheeko/ mango/ papaya as snacks

Remember:

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

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.
  - Add cereals to milk (Rice, Wheat, Semolina)
- For other foods, follow feeding recommendations for the child's age.

Name _____ Sex: M/F Date of Birth : _____

Address _____

Always bring this card with you to the clinic

WHEN TO RETURN IMMEDIATELY

BRING ANY SICK CHILD

If not able to drink

If becomes sicker

If develops a fever

BRING CHILD with DIARRHOEA

If blood i stool

If drinking poorly

BRING CHILD with COUGH

If Difficult breathing

If Fast breathing

BRING YOUNG INFANT (<2 months)

Breastfeeding or drinking poorly
Become sicker
Develops a fever or feels cold to touch
Fast breathing
Difficult breathing

Yellow palms and soles (if infant has jaundice)
Diarrhoea with blood in stool.

FLUIDS

FOR ANY SICK CHILD

- Breasfteed frequently.
- Increase fluid. Give soup, rice water, yuoghurt drinks, or clean water.

FOR CHILD WITH DIARRHOEA

Giving more fluid can belifesaving !

- Give these extra fluids, as much as the child will take:
  - ORS Solution
  - Food based fluids, such as : soup, rice water, yougthurt drinks
  - clean water
- Breasfteedmore frequently and longer at each feeding.
- Continue giving extra fluids until diarrhoea stops.

IMMUNIZATIONS VITAMIN A & IFA SUPPLEMENTATION

(Record Date Given)

☐ BCG	☐ DPT 1	☐ DPT 1	☐ DPT 1	☐ DPT (Booster)	☐ DT
☐ OPC 0	☐ OPV 1	☐ OPV 2	☐ OPV 3	☐ OPV	☐ IFA
	☐ HEP B-1	☐ HEP B-2	☐ HEP B-3	☐ MEASLES	☐ VITAMIN A

Return for next immunization or vitamin A or IFA supplementation on:

_____ _____

_____ _____