UNIT 3 MANAGEMENT OF A SICK CHILD

Structure

3.1 OBJECTIVES

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

- use IMNCI Chartbook
- fill up a case recording form for a child age 2 months upto 5 years
- assess breathing, dehydration, neck stiffness and malnutrition
- learn to clear the nostrils and to apply eye ointment;
- administer drugs and prioritise treatment and
- assess the child's feeding and advice according to feeding problem.

3.2 INTRODUCTION

Clinical practice is an essential component of the integrated management process. You have already learnt about the case management process of sick child age 2 months up to 5 years in your block 2 of course MME-203. This unit describes the skills you need to practise so that you can perform them proficiently when you use them in your own clinic.

3.3 HOW TO USE I.M.N.C.I. CHART BOOK

You have already learnt the details of chart book and how to use it in the unit 2 of this block and now you know that the chart book is divided into 2 sections.

1) Sick Young infant age up to 2 months, and

2) Sick child age 2 months up to 5 years.

You have learnt use of chart book for sick young infant age up to 2 months. Now you will learn the skill used for sick child age 2 months up to 5 years. Please keep the chart book in your hand when you read the description of its contents.

The section sick child age 2 months up to 5 years of the chart book is further divided into following sub-sections.

1) Assess and Classify (including Identify Treatment) the sick child age 2 months up to 5 years,

2) Treat the Child,

3) Counsel the mother, and

4) Give Follow Up Care.

These sections are followed by recording forms for two different age groups and, lastly, by weight for age chart on the back cover.

You already know about columns, colour coded rows and different boxes of the chart book.

'Assess, Classify and Identify Treatment' has three main columns. The 'Assess' column is on the left side. You will find boxes under this column. These boxes suggest what is to be done and how it is to be done. You should start from the top and go down following the directions, and then follow the arrows. At places there are texts below the boxes or small boxes in the column. These text or small boxes help you in taking decisions. The arrows in the column 'Assess' lead to the next column of 'Classify' and 'Identify Treatment. Here, the boxes are divided into three columns. The most left one is the column for 'SIGNS', the middle one is 'CLASSIFY AS' and the most right one shows 'TREATMENT'. The rows are coloured in pink, yellow and green. The pink colour denotes the most severe situation whereas the green denotes the mild form. You will find the urgent pre-referral treatment in bold print.

After asking about the child's problem, determine if it is an initial or follow up visit. In case of follow up, go to the next section 'TREAT THE CHILD' in the chart. If it is an initial visit, check for the 'GENERAL DANGER SIGNS' and then ask about main symptoms in the given order of COUGH OR DIFFICULT BREATHING, DIARRHOEA, FEVER and EAR PROBLEM and then CHECK FOR MALNUTRITION, ANAEMIA AND CHILD'S IMMUNIZATION STATUS. Lastly, ASSESS OTHER PROBLEMS. If the child does not have symptom of 'COUGH OR DIFFICULT BREATHING', move to second symptom of 'DIARRHOEA' and so on. Assess, Classify and Identify Treatment for each symptom separately. There is no need of doing so for a symptom, which is not present.

'TREAT THE CHILD' includes:

1) Treatment of different classifications.

2) Teaching the mother to give oral drug and to treat local infection at home.

3) Pre-referral treatment with Antibiotics and Quinine in clinic.

4) To prevent Low Blood Sugar.

5) Fluid Therapy, including Plan-A, B & C, for correction of dehydration and continue feeding in diarrhoea.

6) Follow Up Care.

3.4 HOW TO FILL CASE RECORDING FORM.

In the previous unit, you have learnt the art of filling up a case recording form (CRF) for sick young infant age up to 2 months in details. The same skill is required to fill up the CRF for the sick child age 2 months up to 5 years. While selecting the CRF, please check carefully that you have the CRF for correct age. You will find that the number of boxes are more and their titles are different.

The introductory data of the CRF is similar to young infant. However, the subsequent boxes are different and these are:

1) Check for General Danger Signs,
2) Assess & Classify for major symptoms:
   a) Cough or Difficult Breathing,
   b) Diarrhoea,
   c) Fever, and
   d) Ear Problem.
3) Check for Malnutrition,
4) Check for Anaemia,
5) Check for child's immunization, prophylactic Vitamin-A and Iron Folic Acid Status.
6) Assess the child's feeding, and
7) Assess other problems.

The box of fever has a supplementary box of 'measles' under the dotted line.

The filling of CRF for sick child age 2 months up to 5 years is explained below in detail.

You will notice that the CRF starts with filling up the child's name followed by his/her age, weight in kg and temperature in degree Celsius. Then ask the mother about child's problem, fill up in the appropriate space and put a tick mark (Ö) if it is an initial visit or follow-up visit. After this, you will find two main columns divided into several boxes. The first column is the ASSESS column and the second one is the CLASSIFY column. You have to circle the signs present. It starts with checking for general danger signs and follows the four main symptoms mentioned above. At the bottom, there is space for 'assess other problems'.

Here is the first box. It tells you how to check for general danger signs.

CHECK FOR GENERAL DANGER SIGNS	General danger sign present?
NOT ABLE TO DRINK OR BREASTFEED (LETHARGIC OR UNCONSCIOUS)	Yes ____ No ____
VOMITS EVERRYTHING	Remember to use danger sign when selecting classification.
CONVULSIONS	

Please ask the mother if the child is not able to drink or breastfeed, or vomits everything or had convulsion. Then look if the child is lethargic or unconscious. Circle the finding that is present and put a tick mark (Ö) at 'Yes' in the next box under the column CLASSIFY.

If the child does not have any sign or symptom of GENERAL DANGER SIGNS, put a tick mark at 'No' and move to the next box below. There are suggested question and physical examination in each box under the column ASSESS and there are blanks provided. You have to fill up these blanks on the basis of the answers obtained and on the basis of findings on physical examination. Circle the positive finding and write your classification under the column CLASSIFY. Then move to the box below. If the child does not have that particular symptom, put a tick mark against 'No' and move to the box below.

ASSESS (Circle all signs present)		CLASSIFY
DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? Yes √ No__		
* For how long? 4 Days	· Count the breaths in one minute. 61 breaths per minute. (Fast breathing?) · Look for chest indrawing. · Look and listen for stridor.	PNEUMONIA

When you check the CHILD'S IMMUNIZATION STATUS, put a tick mark for the immunization the child has already received and circle the immunization that is needed today.

When you have finished with the front and recorded the classification in the right column, fold the form at the junction of 'symptoms' and 'classify' so that you can write treatment at the back facing the line of classification.

3.5 IDENTIFY LETHARGY/UNCONSCIOUNESS

See if the child is lethargic or unconscious.

A lethargic child is not awake and alert when he should be. He is drowsy and does not show interest in what is happening around him. Often the lethargic child does not look at his mother or watch your face when you talk. The child may stare blankly and appear not to notice what is going on around him.

An unconscious child cannot be wakened. He does not respond when he is touched, shaken or spoken to.

Ask the mother if the child seems unusually sleepy or if she cannot wake the child. Look to see if the child wakens when the mother talks or shakes the child or when you clap your hands.

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

3.6 ASSESSING BREATHING

3.6.1 Counting of Breathing Rate

COUNT the breaths in one minute.

You must count the breaths the child takes in one minute to decide if the child has fast breathing. The child must be quiet and calm when you look and listen to his breathing. If the child is frightened, crying or angry, you will not be able to obtain an accurate count of the child's breaths.

Tell the mother you are going to count her child's breathing. Remind her to keep her child calm. If the child is sleeping, do not wake the child.

The cut-off for fast breathing depends on the child's age. Normal breathing rate are higher in children age 2 months up to 12 months than in children age 12 months up to 5 years. For this reason, the cut-off for identifying fast breathing is higher in children 2 months up to 12 months than in children age 12 months up to 5 years.

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

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

3.6.2 Identification of Chest Indrawing

If you did not lift the child's shirt when you counted the child's breaths, ask the mother to lift it now and look for chest indrawing.

For chest indrawing to be present, it must be clearly visible and present and present all the time. If you only see chest indrawing when the child is crying or feeding, the child does not have chest indrawing.

3.6.3 Identification of Stridor

Stridor is a harsh noise made when the child breathes IN. Stridor happens when there is a swelling (oedema) of the larynx, trachea or epiglottis. This swelling interferes with air entering the lungs. It can be life threatening when the swelling causes the child's airway to be blocked. A child who has stridor when calm has a dangerous condition.

To look and listen for stridor, look to see when the child breathes IN. Then listen for stridor. Put your ear near the child's mouth because stridor can be difficult to hear.

Sometimes you will hear a wet noise if the nose is blocked. Clear the nose, and listen again. A child who is not very ill may have stridor only when he is crying or upset. Be sure to look and listen for stridor when the child is calm.

You may hear a wheezing noise when the child breathes OUT. This is not stridor

3.7 CLEARING OF NOSTRILS

A nose blocked with secretions is irritating to patients as well to care takers. Younger the child more is the irritability and restlessness, and this may interfere with breastfeeding also. It may interfere with sleep and ingestion of food and fluid. Attempts should be made to relieve this condition.

Clearing the nostrils of secretions may particularly be required before feeding. Placing the infant in prone position can relive of nasal obstruction. If it does not, take a piece of clean-soft cloth, twist it to form a pointed wick, soak it in water and clear the secretions as show in photograph below (Fig.3.1).

Fig. 3.1: Clearing the child's blocked nose

Suction with a soft bulb syringe may occasionally be required to clear the nasal passage sufficiently to permit the young infant to breastfeed comfortably. Alternatively, use a plastic (without needle) to gently suck any secretion from the nose. Instillation of sterile saline may assist with physical removal of excessive mucus. This is best administered 15-20 minutes before feeding and at bedtime. While the child is supine with the neck extended, 1-2 drops are instilled in each nostril.

3.8 ASSESSING DEHYDRATION

Dehydration can be assessed by looking for lethargy/unconsciousness, irritability, sunken eyes, thirsts and skin pinch. You have already learnt looking for lethargy or unconsciousness in the preceding sections. Now you will learn skill to identify remaining signs of dehydration.

Identification of Irritability

A child has the sign restless and irritable if the child is restless and irritable all the time or every time he is touched and handled. If an infant or child is calm when breastfeeding but again restless and irritable when he stops breastfeeding, he has the sign "restless and irritable". Many children are upset just because they are in clinic. Usually these children can be consoled and calmed. They do not have the sign "restless and irritable".

Assessment of Thirst (Drinking eagerly and poorly)

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

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

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

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

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

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

Assessment of Skin Pinch

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

Ask the mother to place the child on the examining table so that the child is flat on his back with his arms at his sides (not over his head) and his legs straight. Or, ask the mother to hold the child so he is lying flat in her lap.

Locate the area on the child's abdomen halfway between the umbilicus and the side of the abdomen. To do the skin pinch, use your thumb and first finger. Do not use your fingertips because this will cause pain. Place your hand so that when you pinch the skin, the fold of skin will be in a line up and down the child's body and not across the child's body. Firmly pick up all of the layers of skin and tissue under them. Pinch the skin for one second and then release it. When you release the skin, look to see if the skin pinch goes back:

— Very slowly (longer than 2 seconds)

— Slowly

— Immediately

If the skin stays up for even a brief time after you release it, decide that the skin pinch goes back slowly.

Note: In a child with marasmus (severe malnutrition), the skin may go back slowly even if the child is not dehydrated. In an overweight child, or a child with oedema, the skin may go back immediately even if the child is dehydrated. Even though skin pinch is less reliable in these children, still use it to classify the child's dehydration.

Assessment of Sunken Eyes

The eyes of a child who is dehydrated may look sunken (Fig. 3.2). Decide if you think the eyes are sunken. Then ask the mother if she thinks her child's eyes look unusual. Her opinion helps you confirm that the child's eyes are sunken.

Note: In a severely malnourished child who is visibly wasted (that is, who has marasmus), the eyes may always look sunken, even if the child is not dehydrated. Even though sunken eyes are less reliable in a visibly wasted child, still use the sign to classify the child's dehydration.

Fig. 3.2: An example of Sunken Eyes

3.9 IDENTIFICATION OF NECK STIFFNESS

A child with fever and stiff neck may have meningitis. A child with meningitis needs urgent hospitalisation and treatment with injectable antibiotics.

Fig. 3.3: Showing a flashlight beam if the child can look down

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

If you did not see any movement, or if you are not sure, draw the child's attention to his umbilicus or toes. For example, you can shine a flashlight on his toes (Fig. 3.3) or umbilicus or tickle his toes to encourage the child to look down. Look to see if the child can bend his neck when he looks down at his umbilicus or toes.

If you still have not seen the child bend his neck himself, ask the mother to help you lay the child on his back. Lean over the child; gently support his back and shoulders with one hand (Fig. 3.3). With the other hand, hold his head. Then carefully bend the head forward towards his chest. If the neck bends easily, the child does not have stiff neck. Often a child with a stiff neck will cry when you try to bend the neck.

Fig. 3.4: Looking and feeling for stiff neck in a child

3.10 ASSESSING FOR MEALSES

Assess a child with fever to see if there are signs suggesting measles. Look for generalized rash and for one of the following: cough, runny nose, or red eyes (conjunctivitis).

Generalized rash

In measles, a red rash begins behind the ears and on the neck. It spreads to the face. During the next days, the rash spreads to the rest of the body, arms and legs. After 4 to 5 days, the rash starts to fade and the skin may peel. Some children with severe infection may have more rash spread over more of the body. The rash becomes more discoloured (dark brown or blackish), and there is more peeling of skin.

A measles rash (Fig. 3.5) does not have vesicles (blisters) or pustules. The rash does not itch. Do not confuse measles with other common childhood rashes such as chicken pox, scabies or heat rash. (The chicken pox rash is a generalized rash with vesicles. Scabies occurs on the hands, feet, ankles, elbows, buttocks and axilla. It also itches. Heat rash can be a generalized rash with small bumps and vesicle, which itch. A child with heat rash is not sick.) You can recognize measles more easily during times when other cases of measles are occurring in your community.

To classify a child as having measles, the child with fever must have a generalized rash AND one of the following signs: cough, runny nose, or red eyes. The child has "red eyes" if there is redness in the white part of the eye. In healthy eye, the white part of the eye is clearly white and not discoloured.

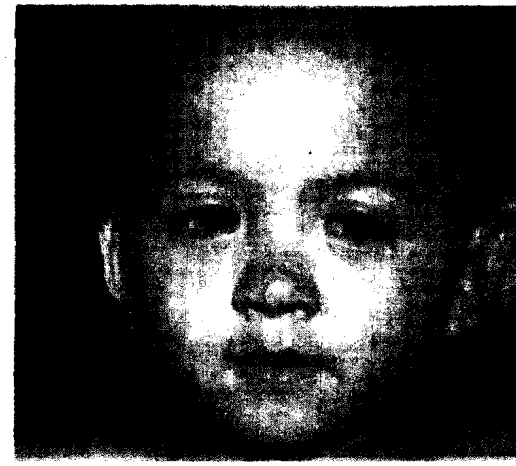

Fig. 3.5: Generalised rashes with red eyes

Mouth ulcers.

Look inside the child's mouth for mouth ulcers (Fig. 3.6) . Ulcers are painful open sores on the inside of the mouth and lips or the tongue. They may be red or have white coating on them. In severe cases, they are deep and extensive. When present, mouth ulcers make it difficult for the child with measles to drink or eat.

Mouth ulcers are different than the small spots called Koplik spots. Koplik spots (Fig. 3.7) occur in the mouth inside the cheek during early stages of the measles infection. Koplik spots are small, irregular, bright red spots with a white spot in the centre. They do not interfere with drinking or eating. They do not need treatment

Fig. 3.6: Mouth Ulcers in two different sick children

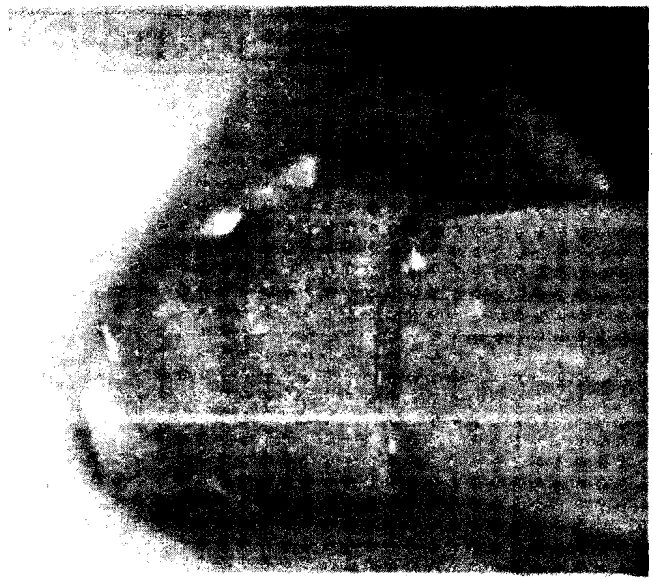

Fig. 3.7: Koplik's Spots

Clouding of the cornea

The cornea is usually clear. When clouding of the cornea is present, there is a hazy area in the cornea.

Look carefully at the cornea for clouding. The cornea may appear clouded or hazy, such as how a glass of water looks when you add a small amount of milk. The clouding may occur in one or both eyes.

Fig. 3.8: Clouding of Cornea

Corneal clouding is a dangerous condition. The corneal clouding (Fig. 3.8) may be due to vitamin A deficiency, which has been made worse by measles. If the corneal clouding is not treated, the cornea can ulcerate and cause blindness. A child with clouding of the cornea needs urgent treatment with vitamin A.

A child with corneal clouding may keep his eyes tightly shut when exposed to light. The light may cause irritation and pain to the child's eyes. To check the child's eye, wait for the child to open his eye. Or, gently pull down the lower eyelid to look for clouding.

If there is clouding of the cornea, ask the mother how long the clouding has been present. If the mother is certain that clouding has been there for some time, ask if the clouding has already been assessed and treated at the hospital. If it has, you do not need to refer this child for corneal clouding.

3.11 EYE OINTMENT APPLICATION

- Clean both eyes 3 times daily
  - — Wash hands,
  - — Ask child to close the eye,
  - — Use clean cloth and water to gently wipe away pus.
- Then apply tetracycline eye ointment in both eyes 3 times daily.
  - — Ask the child to look up,
  - — Squirt a small amount of ointment in the inside of the lower lid,
  - — Wash hands again.
- Treat until redness is gone.
- Do not use other eye ointments or drops, or put anything else in the eye.

3.12 WICKING THE EAR

To teach a mother how to dry the ear by wicking, first tell her it is important to keep an infected ear dry to allow it to heal. Then show her how to wick her child's ear.

As you wick the child's ear, tell the mother to:

1) Use clean, absorbent cotton cloth or soft strong tissue paper for making a wick. Do not use cotton tipped applicator, a stick or flimsy paper that will fall apart in the ear.
2) Place the wick in the child's ear until the wick is wet.
3) Replace the wet wick with a clean one.
4) Repeat these steps until the wick stays dry. Then the ear is dry.

3.13 ASSESSING FOR MALNUTRITION

Malnutrition can be assessed by looking for the presence of visible severe wasting, oedema feet and weight of the child.

3.13.1 Visible Severe Wasting.

A child with visible severe wasting has marasmus, a form of severe malnutrition. A child has this sign if he is very thin, has no fat, and looks like skin and bones. Some children are thin but do not have visible severe wasting. This assessment step helps you identify children with visible severe wasting who need urgent hospitalisation and treatment.

To look for visible severe wasting, remove the child's clothes. Look for severe wasting of the muscles of the shoulders, arms, buttocks and legs. Look to see if the outline of the child's ribs is easily seen. Look at the child's hips. They may look small when you compare them with the chest and abdomen. Look at the child from the side to see if the fat of the buttocks is missing. When wasting is extreme, there are many folds of skin on the buttocks and thigh. It looks as if the child is wearing baggy pants.

The face of a child with visible severe wasting may still look normal. The child's abdomen may be large or distended.

Fig. 3.9: A child with visible severe wasting

3.13.2 Assessment of Oedema Feet

A child with oedema of both feet may have kwashiorkor, another form of severe malnutrition. Oedema is when an unusually large amount of fluid gathers in the child's tissues. The tissues become fluid filled with the fluid and look swollen or puffed up.

Other common signs of kwashiorkor include thin, sparse and pale hair which easily falls out; dry, scaly skin especially on the arms and legs; and a puffy or "moon" face.

Look and feel to determine if child has oedema of both feet. Use your thumb to press gently for a few seconds on the topside of each foot. The child has oedema if a dent remains in the child's foot when you lift your thumb.

Fig. 3.10: Pitting oedema on dorsum of foot.

3.13.3 Assessment of Pallor

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

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

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

Fig. 3.11: An example of some pallor

3.13.4 How to Record Weight

For babies below 10 Kg, any of the following weighing scale is used to measure the weight:

- Beam Balance Scale.
- Portable Spring Balance.
- Dial Type Weighing Scale.
- Electronic Weighing Scale

For children more than 10 Kg, platform type of Weighing Scale is used.

The child can stand on it the weight can be recorded by either a dial type scale or by sliding guide on the beam. Detailed discussion is made in unit 8 of this block.

Whatever type of scale is used.

- Ensure that the weighing scale is accurate and the zero error corrected.
- Fix the weight scale at eye level for correct reading.
- Weigh the child without shoes or sandals and permit only minimal clothing.
- If the child is crying, look at the reading when it becomes steady between the attacks of crying.
- Do not weigh the mother with infant and then mother alone. This causes error.

Determine weight for age.

To determine weight for age:

— Calculate the child's age in months.

— Weigh the child as described above.

— Use the WHO weight for age chart (given at the back of the chart book) to determine weight for age. (Annexure-1)

  - Look at the left-hand axis to locate the line that shows the child's weight.
  - Look at the bottom axis of the chart to locate the line that shows the child's age in months.
  - Find the point on the chart where the line for the child's weight meets the line for the child's age.

— Decide if the point is above, on, or below the bottom curve.

  - If the point is below the bottom curve, the child is very low weight for age.
  - If the point is above or on the bottom curve, the child is not very low weight for age.

3.14 READING DRUG TABLE

How to Read Drug Table

In the chart book, you will find drug table at different places. These are easy to understand and follow. For different clinical conditions, 1st and 2nd Line Drugs are given in a table form according to age and weight of the child. You know the age of the child you are managing. The age is given in the most left column. Find out the row corresponding to the age of the child and follow it horizontally. You will find the dosage of different preparations in the subsequent column. It is easy to decide the dosage in tablets, syrups and injections.

3.15 ADMINISTRATION OF DRUGS (ORAL AND INJECTABLE)

The health care provider gives the drug at clinic and mother gives it at home. Therefore, you have to teach mother how to give oral drug at home appropriately. The injections (I.M./I.V.) are to be given by you (health care provider) only. Whenever you are teaching mother how to do, first do it yourself and demonstrate to mother the exact procedure. She can learn better in this way. Don't forget to check mother's understanding before she leaves. If a mother learns how to give a drug correctly, then the child will be treated properly. Follow the instructions below for every oral drug you give to the mother.

- **Determine the appropriate drugs and dosage for the child's age or weight.** Use the TREAT THE CHILD chart to determine the appropriate drug and dosage to give the child.
- **Tell the mother the reason for giving oral drug to the child, including:**
  — Why you are giving the oral drug to her child, and
  — What problem it is treating.
- **Demonstrate how to measure a dose.**

Collect a container of the drug and check its expiry date. Do not use expired drugs. Count out the amount needed for the child. Close the container.

If you are giving the mother tablets:

Show the mother the amount to give per dose. If needed, show her how to divide a tablet.

If a tablet has to be crushed before it is given to a child, add a few drops of clean water and wait a minute or so. The water will soon soften the tablet and make it easier to crush.

If you are giving the mother syrup:

Show the mother how to measure the correct number of millilitres (ml) for one dose at home. Use the bottle cap or a common spoon, such as a spoon used to stir sugar into tea or coffee. Show her how to measure the correct dose with the spoon.

One teaspoon (tsp) equals approximately 5.0 ml (see below).

Milli Litres (ml)	Teaspoons (tsp)
1.25 ml	¼ tsp
2.5 ml	½ tsp
5.0 ml	1 tsp
7.5 ml	1 ½ tsp
10 ml	2 tsp
15 ml	3 tsp

Adjust the above amounts based on the common spoons in your area.

- **Watch the mother practice measuring a dose by herself.**

Ask the mother to measure a dose by herself. If the dose is in tablet form and the child cannot swallow a tablet, tell the mother to crush the tablet. Watch her as she practices. Tell her what she has done correctly. If she measured the dose incorrectly, show her how to measure it.

- **Ask the mother to give the first dose to her child.**

Explain that if a child is vomiting, give the drug even though the child may vomit it up. Tell the mother to watch the child for 30 minutes. If the child vomits within the 30 minutes (the tablet or syrup may be seen in the vomit), give another dose. If the child is dehydrated and vomiting, wait until the child is rehydrated before giving the dose again.

- **Explain carefully how to give the drug, then label and package the drug.**

Tell the mother how much of the drug to give her child. Tell her how many times per day to give the dose. Tell her when to give it (such as early morning, lunch, dinner, before going to bed) and for how many days.

Write the information on a drug label. This is an example:

Name: Amar		**Date: 10/04/08**	
Drug: Pediatric		**Quantity: 20**	
DOSE			

To write information on a drug label:

a) Write the full name of the drug and the total amount of tablets, capsules or syrup to complete the course of treatment.

b) Write the correct dose for the patient to take (number of tablets, capsules, squirts or spoonful, that is, ½, 1, 1 ½ ….). Write when to give the dose (early morning, lunch, dinner, before going to bed).

c) Write the daily dose and schedule, such as **½ tablets twice daily for 5 days**

Write the instructions clearly so that a literate person is able to read and understand them.

Put the total amount of each drug into its own labelled drug container (an envelope, paper, tube or bottle). Keep drugs clean. Use clean containers.

After you have labelled and packaged the drug, give it to mother. Ask checking questions to make sure she understands how to treat her child.

- If more than one drug will be given, collect, count and package each drug separately.

Collect one drug at a time. Write the instructions on the label. Count out the amount needed. Put enough of the drug into its own labelled package. Finish packaging the drug before you open another drug container.

Explain to the mother that her child is getting more than one drug because he has more than one illness. Show the mother the different drugs. Explain how to give each drug. If necessary, draw a summary of the drugs and times to give each drug during the day.

Show the mother the amount to give per dose. If a child needs a half vitamin A capsule (or cannot swallow a whole capsule), show the mother how to open the capsule and squirt a half or all the liquid into the child's mouth.

Explain that all the oral drug tablets or syrups must be used to finish the course of treatment, even if the child gets better.

Explain to the mother that if the child seems better, continues to treat the child. This is important because the bacteria or the malaria parasite may still be present even though the signs of disease are gone.

Advise the mother to keep all medicines out of reach of children. Also tell her to store drugs in a dry and dark place that is free of mice and insects.

Check the mother's understanding before she leaves the clinic.

Ask the mother checking questions, such as:

"How much will you give each time?"

"When will you give it?"

"For how many days?"

"How will you prepare this tablet?"

"Which drug will you give 3 times per day?"

If you feel that the mother is likely to have problems when she gives her child the drug(s) at home, offer more information, examples and practice.

A child needs to be treated correctly to get better.

3.16 PRIORITAZATION OF TREATMENT.

When a child has several problems, the instructions to mother could be quite complex. In this case, you will have to limit the instructions to what is most important. You will have to determine:

- How much can this mother understand and remember?
- Is she likely to come back for follow-up treatment? If so, some advice can wait until then.
- What advice is most important to get the child well?

If a mother seems confused or you think that she will not be able to learn or remember all the treatment instructions, select only those instructions that are most essential for the child's survival. Essential treatments include giving antibiotic or antimalarial drug and giving fluid to a child with diarrhoea. Teach few treatments well and check that the mother remembers them.

If necessary, omit or delay the following:

- Feeding assessment and feeding counselling.
- Soothing remedy for cough or cold.
- Paracetamol*.
- Second dose of vitamin A*.
- Iron treatment.
- Wicking the ear.

You can give the other treatment instructions when the mother returns for the follow-up visit.

* Give the first dose of Paracetamol or vitamin A. Do not dispense the other doses. Do not overwhelm the mother with instruction for the later doses.

3.17 LET US SUM UP

This unit has described the important practical skills you need to perform to gain proficiency in the management process of a child 2 months up to 5 years of age. Now you know the skill of assessing breathing, dehydration, fever, measles, malnutrition, anaemia and reading of drug table correctly. You now know the use of chart book and art of filling case recording form (CRF) correctly. When practising, you should always remember to use your chart book and be systmatic. Otherwise you are likly to miss some important steps.