



**Operational Guidelines
for
Facility Based IMNCI (F-IMNCI)**



सत्यमेव जयते

**Ministry of Health and Family Welfare
Government of India**

Foreword

The National Population Policy Goals aims at achieving an Infant Mortality Rate of 30/100,000 live births by the year 2010. The National Rural Health Mission launched in April 2005 reiterates this commitment.

The Ministry of Health and Family Welfare is implementing the Integrated Management of Neonatal and Childhood Illness (IMNCI) as a key child health strategy within the National Reproductive Child Health Programme II and the National Rural Health Mission. The aim of the strategy is to implement a comprehensive newborn and child health package at the household and the community level through medical officers, nurse and LHVs. However this excludes the skills required at facilities to manage new born and childhood illness. The long term program needs therefore can only be met if the health personnel and workers possess optimum skills for managing newborn and children both at the community level as well as the facility level. The F-IMNCI training manual would be able to provide the optimum skills needed at the facilities by the Medical officers and Staff Nurses.

According to the Bulletin on Rural Health Statistics 2007, there is an acute shortage of Pediatricians in the country; as against the required number of 4045 there are only 898 pediatricians in position. The introduction of F-IMNCI will help build capacities of the health personnel at facilities to address new born and child hood illness and thus help bridge this acute shortage of specialists.

The Child Health Division, Department of Health and Family Welfare have prepared these operational guidelines to enable States to roll out F-IMNCI in their States. I congratulate the Division and the other Professional Bodies, Development Partners and Field Experts who have given their whole hearted assistance for the development of this Operational Manual.

I am sure that this manual, when implemented in word and spirit, will go a long way in reducing the enormous burden of newborn and child mortality in our country.

Secretary (Health & Family Welfare)

Preface

The Government of India is committed to achieve a reduction in infant and child mortality to achieve the National Population Policy and National Rural Health Mission Goal of Infant mortality of 30 per thousand live births. The Integrated Management of Neonatal and Childhood Illness (IMNCI) is the Indian adaptation of the WHO-UNICEF generic Integrated Management of Childhood Illness (IMCI) strategy and is the centrepiece of newborn and child health strategy under Reproductive Child Health II and National Rural health Mission.

F-IMNCI is the integration of the Facility based Care package with the IMNCI package, to empower the Health personnel with the skills to manage new born and childhood illness at the community level as well as the facility. It helps to build capacities to handle referrals taking place from the community. Referrals include the most common childhood conditions responsible for over 70 per cent of all deaths in children under the age of 5 years in resource poor setting.

The implementation of F-IMCI strategy will help improve the performance and quality of health workers. The critical element of this strategy is the evidence-based integrated approach with a focus on new born and child hood illness. This package will also help address the acute shortage of pediatricians at facilities.

An operational manual for implementation of F- IMNCI in States has been developed with inputs form various professional bodies such as Indian Academy of Pediatrics, NNF, WHO and UNICEF and Field level experts. It would not have been possible to bring out these guidelines without their active interest and support. I thank them all.

I would also like to place on record my appreciation for the hard work and untiring efforts put in by the the Child Health Division in developing these operational manual.

Joint Secretary (RCH)

Operational Guidelines for Facility Based IMNCI (F-IMNCI)

SECTION A: The package

1. Introduction

Bringing down Infant and Child Mortality Rates and improving Child Survival has been an important goal of the National Programmes of India. Since 1977 to 1992, programmes like Universal Immunization; Oral Rehydration Therapy (ORT) and Management of Acute Respiratory Infections (ARI) were implemented to address child mortality as vertical programmes. These programmes were integrated for the first time under the Child Survival and Safe Motherhood Programme in 1992 and made a part of the Reproductive & Child Health Programme in 1997.

As a result of these programmes, the Infant Mortality Rate (IMR) has come down significantly over the years from 114 in 1980 to 55 in 2007. It has, however, been seen that the IMR decline during the period 1980 to 1990 was 34 points (114 to 80), whereas the decline was only 12 points (80 to 68) during the period 1990 to 2000. The major was the very slow decline in the neonatal mortality rate. However in the subsequent years i.e. in 7 years (2001-2007) the decline in IMR has been 13 points (68 – 55).

However, a large number of children continue to die during the first month of life (neonatal period) and efforts are required to tackle this situation of high Neonatal mortality in a much focused manner. At the same time efforts have to be continued to bring down child deaths due to diarrhea and acute respiratory infections as these continue to major causes of child mortality.

The Reproductive and Child Health programme (RCH) II under the National Rural Health Mission (NRHM) comprehensively integrates interventions that improve child health and addresses factors contributing to Infant and under-five mortality. The National Population Policy (NPP) 2000, the National Health Policy 2002 and the Tenth Five Year Plan (2002-07) and National Rural Health Mission (NRHM - 2005 – 2012) have laid down the goals for child health.

Under the RCH II National Programme – Implementation Plan, IMNCI approach has been mentioned as the centerpiece of newborn and child health strategy. As more and more physicians and health workers are being trained in IMNCI young infants and sick children are being referred to first referral facilities. Medical officers and Staff Nurses working in these facilities would be responsible for providing optimum care to the referred sick young infants and children. Hence building the capacity of the Health workers in these facilities to manage sick neonates and children acquires greater importance.

Facility Based Care for severely ill children is complementary to primary care for providing a continuum of care for severely ill children. Good quality inpatient care for children is required at these facilities to increase the impact of appropriate primary care interventions on child survival and to contribute to achieving the National Population Policy Goals, which aims to reduce child mortality to below 30 per 1000 live births.

Strengthening the health facilities is one of the main objectives of RCH-II under NRHM. Capacity building of medical officers and staff nurses also needs to be addressed simultaneously to provide quality care to sick children and newborns at facilities. It was therefore very essential to prepare standard guidelines for managing these cases in a first referral facility keeping in view available resources. Keeping in view the acute shortage of specialists (pediatricians) at facilities, it becomes important to build skills of the health staff at these facilities to manage referred sick newborn and children. F-IMNCI is such a package which enhances the skills of the health staff.

2. What is Facility Based IMNCI (F-IMNCI)

F- IMNCI is an integration of the existing IMNCI package and the Facility Based Care package in to one package. The integrated approach of IMNCI and Facility based care; (F-IMNCI) therefore provides a continuum of quality care for severely ill newborns and children from the community and to the facility.

Majority of the health facilities (24x7 PHCs, FRUs, CHCs and District hospitals) do not have trained pediatricians to provide specialized care to the referred sick newborns and children, the F-IMNCI training will therefore help in skill building of the medical officers and staff nurses posted in these health facilities to provide this care.

3. The F-IMNCI Package

The F-IMNCI package has been developed by a committee of experts constituted by the Ministry of Health and Family welfare, Government of India. The committee members included members from professional bodies like the Indian Academy of Pediatrics (IAP) and the National Neonatology Forum (NNF), Development Partners, Heads of the Department of Pediatrics' from Medical colleges and field level experts.

This package includes the following:-

A) IMNCI training package:

- Set of 9 IMNCI modules for physicians
- IMNCI Physician chart book
- IMNCI photo book for Physicians
- IMNCI facilitator guide
- IMNCI indoor and out-patient guide

- IMNCI video CDs

B) Facility based care of sick newborns and children:

- Module1-Emergency Triage Assessment and Treatment (ETAT)
- Module2-Care of sick young infant
- Module3-Care of sick child
- Chart book
- Facility care video CD

IMNCI package (OUTPATIENT)	FACILITY BASED CARE
<ul style="list-style-type: none"> • Module1- Introduction • Module2-Assess & Classify the sick young infant age upto 2 months • Module3-Identify treatment for the sick young infant • Module4-Treat the young infant and Counsel the mother • Module5-Assess & Classify the sick child age 2 months up to 5 years • Module6-Identify treatment for the sick child • Module7-Treat the child • Module8-Counsel the mother • Module9-Follow- up 	<p>Module1- ETAT (Emergency Triage Assessment and Treatment)</p> <ul style="list-style-type: none"> • Triage • Maintain Temperature • Check & Treat hypoglycaemia • Airway & Breathing • Give oxygen • Circulation • Coma and Convulsions • Dehydration
	<p>Module2- Facility based care of sick young infant</p> <ul style="list-style-type: none"> • Care at birth including neonatal resuscitation • Care of newborn in postnatal ward • Management of sick newborn • Management of low birth weight babies • Neonatal transport
	<p>Module3- Facility based care of sick child</p> <ul style="list-style-type: none"> • Case Management of Children Presenting with Cough or Difficult Breathing • Case Management of Children Presenting with Diarrhoea • Case Management of Children Presenting with Fever • Management of Children with Severe Anaemia • Case Management of Children with Severe Malnutrition

4. Components of F-IMNCI

□ Training

F-IMNCI is skill based training. The training is based on a participatory approach combining classroom sessions with hands-on clinical sessions.

Broadly, two categories of training are included:

1. Medical officers and nurses not trained in IMNCI and working at health facilities would get the full package of training with duration of training being 11 days (see agenda in annex1).
2. Medical officers and nurses already trained in IMNCI will receive a training of facility based care portion (FBC) of 5 days duration only. There is no need for the whole package as these persons are already trained in IMNCI.

PRE-TRAINING STATUS	PACKAGE TO BE USED	DURATION
IMNCI not trained	F-IMNCI complete package	11 days
IMNCI trained	Facility based care package of F-IMNCI	5 days

While training is an important input for implementation of F-IMNCI, this is not the only one. Effective implementation of F-IMNCI in a district also involves the following components.

- **Improvements to the health system.** The essential elements should include:
 - ❖ Ensuring availability of the essential drugs and functional equipments with workers and at facilities covered under F-IMNCI.
 - ❖ Referral mechanisms should be put in place to ensure that an identified sick infant or child can be swiftly transferred to a higher level of care whenever needed. Every health worker must be aware of where to refer a sick child and the staff at appropriate health facilities must be in position to identify and acknowledge the referral slips promptly and give priority care to the sick children.
 - ❖ Functioning referral centres should be identified, especially where healthcare systems are weak, referral institutions identified could be developed as a private/public partnership for F-IMNCI. Referral mechanism like 108/ EMRI could be made a part of the F-IMNCI referrals.
 - Availability of F-IMNCI trained health manpower at CHCs/FRUS and 24 x 7 PHCs should be ensured throughout the day so that all cases are attended. The trained staff (in F-IMNCI) should not be transferred from the health facility for minimum period of 2-3 years.
 - ❖ Supervision and monitoring through follow up visits by trained supervisors as well as on-the-job supportive supervision

- **Improvement of Family and Community Practices** Counseling of families and creating awareness among communities on their role is an important component of F-IMNCI this includes
- Promoting healthy behaviors such as good care practices – (early initiation and exclusive breastfeeding), recognition of danger signs in a new born and child, early care seeking etc.
 - BCC/IEC campaigns for awareness generation.
 - Counseling of care givers and families on management of the sick new born and child should be ensured by staff at these facilities.

Implementation of F-IMNCI in the districts has to be seen as part of the overall Child Health Strategy under Child Health Programme- Phase II and the National rural health mission/Reproductive. ***“While training of the staff will need special efforts, the Coordination mechanisms, improvement in the health systems and improvement in family and community practices should be a part of the ongoing activities under the RCH Programme-Phase-II and National Rural Health Mission”.***

SECTION B: Institutional Arrangements

F-IMNCI is an important Child Health Intervention to be implemented as part of NRHM/RCH-II. Training for F-IMNCI will therefore be part of the overall training plan under RCH-Phase II/NRHM.

1. State Level

- **Appoint a nodal officer for F-IMNCI.** Implementation of F-IMNCI would require coordination at all levels. It is therefore suggested that at the State level, the existing IMNCI nodal officer be designated as nodal officer for F-IMNCI and the State RCH Programme Director as the overall in charge for the implementation of F-IMNCI in the State.
- **Set up a co-ordination Group.** F-IMNCI is a major intervention for bringing down IMR. It is therefore necessary that a proper coordination mechanism is put in place at the State level. The coordination mechanism should include members from the Departments of medical education and Health; Development partners, Professional Bodies, and Senior Faculty members of Medical Colleges. The Faculty members of the Medical Colleges will not only be involved in F-IMNCI implementation but also in pre- service training of medical and nursing students. The coordination group should be part of the State Health Mission of the NRHM.
The activities of the coordination group would include the following:-
(i) Provide technical support for implementation of F-IMNCI, (ii) monitor financial expenditures, (iii) review logistics of drugs supply and equipment (iv) review progress of the implementation of F-IMNCI every quarter.
- **Arrange printing and supply of training material.** F-IMNCI Training materials developed at the central level will be shared with the States. The soft copies of modules, charts, booklets, videos and facilitators guides will be made available to States for facilitating the training under F-IMNCI. Requirement of funding for printing the training material may be reflected as part of State PIPs.
- **Create pool of State level trainers.** Depending on the number of districts selected and the availability of medical colleges, States are to work out their requirement for State level trainers. These trainers are required for training and also to monitor quality of training in the districts. These trainers will be trained at State Nodal training institution (Medical College). Existing IMNCI trainers would be developed into F-IMNCI trainers and utilized to implement F-IMNCI.

- **Select priority districts for F- IMNCI implementation.** F-IMNCI will have to be implemented in a well planned manner as it requires a great deal of time and resources. It is therefore suggested that initially only CHCs/FRUs and 24 x7 PHCs having adequate deliveries (a minimum of 3-4 deliveries every day) in a month. The initial trainings may be restricted to high mortality districts.

Each state should strive to complete implementation of F-IMNCI in all the districts by 2012.

The states which have not included F-IMNCI in their earlier PIPs may do so from the next year.

There will be 2 kinds of situations in each state i.e. one in which medical officers and nurses are trained in IMNCI. In such situations train the medical officers and nurses in the facility based care package of F-IMNCI.

In the second situation where medical officers and nurses are not trained in IMNCI, train them for 11 days using the complete package of F-IMNCI package.

- **Monitoring, follow-up and review of implementation of IMNCI**

States will need to carefully monitor the health facilities of the trained medical officers and nurses under the NRHM. The monitoring tools for a health facility should include:

1. Percentage of medical officers and nurses trained in F-IMNCI
2. Availability of essential drugs and functional equipment (see annexure)
3. Number of sick young infants admitted and managed (Sepsis, Asphyxia and Low birth weight)
4. Number of sick children admitted and managed (Severe pneumonia, Severe dehydration, Fever, Severe acute malnutrition)
5. Severely malnourished children detected should be linked with the NRC being developed in the States.

- **Identify the state nodal institute for F-IMNCI training.** The institute must have adequate case load of new born and under five children (both sick and normal) and good facilities for training and should be designated as the state nodal institute. The institute must have a dedicated trained staff. Medical colleges may be used for this purpose as they would generally have all the prerequisites.

- **IEC activities**

Improving community behaviors for newborn and child care is an important objective of F-IMNCI. This should be achieved through IEC/BCC activities as a part of RCH/NRHM BCC strategy. The messages should be consistent with

F-IMNCI protocols/guidelines. Major emphasis should be laid on early care seeking by the families for sick newborn (through recognition of danger signs) and children and ensuring quality care in the health facilities by trained and skilled staff. F-IMNCI wall charts for assessment and management of sick babies should be displayed in the OPD, Indoor and emergency room for regular use of health providers.

F-IMNCI Training is part of RCH- II Training. The funding will be based on the norms as applicable under the RCH Programme. The requirement of funds on the basis of the RCH norms will have to be projected by States as part of the overall budget under the RCH Programme.

2. District Level

- **Appoint District Coordinator for IMNCI.** The district IMNCI nodal officer should be designated as district coordinator for F-IMNCI. District Coordinators will attend the 'F-IMNCI orientation workshop organised by the State.
- **Set up an IMNCI Coordination Group.**
- The purpose of the coordination group is to (i) coordinate and plan F-IMNCI training and implementation (ii) recommend district F-IMNCI monitoring on a regular basis, (iii) organize and schedule F-IMNCI trainings, (iv) review progress of F-IMNCI training on a quarterly basis. The F-IMNCI coordination group should be part of the District Health Mission.
- **Develop a detailed plan for IMNCI Implementation in the District.**
- Each district will need to formulate a detailed training plan/ training calendar and budget funds accordingly. The plan will reflect in detail overall training workload and gradual coverage of all the Medical Officers and nurses in 24x7 PHCs, FRUs, CHCs and district hospital. In addition, selection of training sites, number of trainers and training materials, training calendar, referral, and monitoring and review arrangements should be addressed well in advance.

F-IMNCI Training is part of RCH-Phase II Training. The funding will be based on the norms of TA/DA and other expenses as applicable under the RCH Programme. The requirement of funds on the basis of the norms will have to be projected as part of budget under the flexi-pool funding for RCH Programme.

As with the State F-IMNCI plan, the District F-IMNCI plan should be planned and presented together with the District NRHM / RCH II plan, not in isolation. Before advancing, this plan will need to be approved by the state F-IMNCI coordination group for F-IMNCI and will form the basis of implementation as also for monitoring and the periodic reviews to be undertaken at the district level.

- **Ensure timely supplies & logistics, supervision and follow-up**

Uninterrupted timely supply of drugs and equipments and maintenance of equipments as listed out at annexure A, B, C; an issue which needs to be addressed by all States if implementation of F-IMNCI is to be ensured. Since the workers acquire new skills in the F-IMNCI training, it is imperative to provide on-the-job guidance to them. Regular supportive supervision in the form of skill reinforcement, facility support and record review has to be ensured. Rogi Kalyan Samitis (RKS) can ensure the drugs and equipment need of the health facilities.

□ **IEC activities**

This has been detailed earlier.

SECTION C: Training in F-IMNCI

1. Focus on Skill Development

The training under F-IMNCI is focused on applied skill development. Around 50% of training time is spent building skills by “*hands-on training*” involving actual case management and counselling, the remaining 50% is spent in classroom sessions, building theoretical understanding of essential health interventions. The hands-on training is undertaken through clinical training sessions in hospitals.

Skill development is critical to the implementation of F-IMNCI.

2. Training at two levels

- **Inservice training for the existing staff** – The existing staff in the 24x7 PHCs, FRUs, CHCs and District hospitals will have to be provided in-service training in a phased manner. The objective of the training effort would be to ensure that all medical officers and nurses are trained in F-IMNCI.
- **Pre-Service Training** –**For including F-IMNCI in the pre-service teaching of doctors and nurses. *The State Governments will need to issue instructions in this regard.***

3. Personnel to be Trained

There are 2 types of trainings under F-IMNCI

Type of Training	Personnel to be trained	Duration	Package to be used	Place of Training
The entire package of F-IMNCI training for personnel not trained in IMNCI	Medical Officer and Nurses	11 days	F-IMNCI package	Medical college /District* Hospital
Facility based care package of F-IMNCI for personnel already trained in IMNCI	Medical Officers and Nurses	5 days	Facility based care package of F-IMNCI	Medical college /District* Hospital

* While medical college will be an ideal place for training, a big district hospital or a private health facility with adequate deliveries and admitted cases of sick newborns and children under 5 years of age (at least 5 each) can be used as a site for training.

** An orientation meeting of 1 to 2 days may be organized for planners and key personnel such as senior health functionaries and other stake holders to orient them about F-IMNCI and its implementation plan.

4. **Training of Trainers**

For training of the medical officers and nurses it would be essential to have adequate number of trainers within the state and districts. **The trainers at state level include faculty from the departments of pediatrics and community medicine of the medical colleges. The trainers at district level include all the pediatricians in the district. All F-IMNCI facilitators undergo 11 days F-IMNCI training or 5 days Facility based care training if already trained in IMNCI.** The TOT for State and District facilitators will be facilitated by National F-IMNCI facilitators. Districts with limited manpower might also consider including freelance facilitators (private paediatricians or retired teachers from the medical colleges but adequately trained in F-IMNCI).

5. **Number to be trained**

Keeping in mind the participant to facilitator ratio of 1:4-6 (one trainer to 4 – 6 participants) and availability of adequate number of facilitators at all times, it is felt that a total of 16-18 participants should be included for each training.

6. **Training Institutions**

Each state will need to train adequate number of trainers for training the medical officers and nurses. Therefore the state will have to identify a Regional Training Centre. Since training is mainly skill based, choice of the regional or local medical college is obvious. The Departments of Pediatrics and Preventive & Social Medicine in each college will have to take up this responsibility. Another benefit of selecting the medical colleges as regional training centre would be in the pre-service training of undergraduate students. The staff of these medical colleges will be trained by National F-IMNCI facilitators.

In addition the state has to identify training institutions for medical officers and nurses. As F-IMNCI training focuses on building skills by hands on training on cases, the selected institution for training should have sufficient load of inpatient newborns and sick children to provide case material for hands on training. Do not select facilities that are not busy because it will not be possible to show enough number of sick children. In addition to medical colleges other centres including district hospitals and private centres can also be used for training provided they have the requisite clinical material and facilities for training available.

7. Pre-service Training

Pre-service training in medical colleges will need to include training on F-IMNCI in the training schedules of undergraduate students and interns, during their postings in the Departments of Paediatrics and Preventive & Social Medicine. Staff Nurse's training schools will need to include training on F-IMNCI in their training schedules. The State Governments will need to issue instructions in this regard to be implemented by teaching institutions by respective directorates.

SECTION D: Funding arrangements for F-IMNCI Trainings

1. State Level training:

- ❖ **TRAINING OF TRAINERS:** The state needs to develop a pool of Trainers who have undergone the training of the Trainers course. (Faculty of Medical Colleges of departments of Pediatrics and Community medicine and District Pediatricians could be trainers). The States needs to provide adequate budget in their NRHM/RCH-II-Programme and Implementation Plans (PIPs). This will include all costs such as TA/DA, stay and other training expenses of participants and National facilitators from the centre as per RCH norms. Adequate pool of trainers for each State would be around of 32- 48.
- ❖ **TRAINING OF MEDICAL OFFICERS AND NURSES:** Following training of trainer's course all the doctors and nurses working in the inpatient departments dealing with sick newborns and children of 24x7 PHCs, FRUs, CHCs and District hospitals need to be trained. **These training would be completed by 2012.**

Venue: Venue of training shall be a medical college hospital or a district hospital with at least 10 children and 5 newborns admitted at any time.

Duration of training: 11 days for Medical Officers and Staff Nurses who have not been trained in IMNCI and 5 days for those already trained in IMNCI.

Trainers: Senior Pediatricians of Medical Colleges and district hospitals and faculty members of Social and Preventive Medicine of Medical Colleges having undergone trainers training in F-IMNCI.

Participant facilitator ratio should be 6:1

Number of Participants –For any workshop the participants should not be more than 16 per workshop.

The States also need to project their funding requirements for the following in their NRHM/RCH-II-PIPs:

- TA/DA and honorarium to the trainees and trainers as per RCH norms for the training of medical officers and nurses by the state trainers in the medical colleges or district hospitals
- Equipments for imparting training such as:
 - Two mannequin (Basic Model for bag and mask ventilation, chest compression and umbilical cord pulsation)
 - Two television (which is VCD player compatible)
 - Two VCD player
 - Other miscellaneous training/ teaching accessories.

2. Translation, printing and supply of training material:

The soft copies of the modules, charts, booklets, videos and facilitators guides will be made available to the States for facilitating training under IMNCI. These will need to be and printed by the States depending on their needs. The funding requirements for the same may be projected in the State NRHM/RCH-II-PIPs under the NHM/RCH Programme. (Part A)

3. Field-level Monitoring Support, Follow up and Coordination:

States may indicate under the NRHM/RCH-II PIPs funds for monitoring and follow up visits/meetings, coordination and other related activities for successful implementation of F-IMNCI trainings.

Annexure-A

LIST OF EQUIPMENTS

- Plastic / disposable syringes
- IV canulas (22G and 24G)
- Scalp vein set No. 22 and 24
- IV infusion sets (adult and pediatric)
- Face masks (all sizes)
- Self-inflating ventilation bag (all sizes)
- Nasogastric tube (8,10,12FG)
- Suction catheter (6,8,10 FG)
- Laryngoscope
- Uncuffed tracheal tube (all sizes)
- Oropharyngeal airway (000-4 Guedel size)
- Oxygen Cylinders/Oxygen Concentrator
- Nasal prongs
- Suction machines
- Radiant Warmers
- Phototherapy unit
- Weighing machine(infant & adult)
- Stadiometer for height
- Infantometer for length
- Nebulisers/ MDI with spacer
- Glucometer with dextrostix
- Thermometers
- Gloves
- Torch
- Adhesive tape
- Cotton / gauze

Annexure - B

LIST OF DRUGS

Injections

- Adrenaline
- Dextrose (10%) and (25%)
- Diazepam
- Phenobarbitone
- Phenytoin sodium
- Pheniramine (Avil)
- Hydrocortisone
- Calcium gluconate
- Sodium bicarbonate
- Dopamine
- Antibiotics (Ampicillin, Gentamicin, Chloramphenicol, Cefotaxime, Ceftriaxone)
- Quinine
- Mannitol
- Potassium chloride (KCL)
- Vitamin K
- Nebuliser solution of salbutamol
- Water for injection

IV fluids

- Ringer's lactate
- Normal saline
- N/5 in 5% dextrose
- 5% and 10% dextrose

Oral drugs

- ORS
- Cotrimoxazole pediatric tablets & Syrup
- Amoxicillin tablets & Syrup
- Zinc tablets
- Chloroquine tablets
- Paracetamol
- Vitamin A
- IFA tablets
- Doxycycline
- Salbutamol
- Anti-Tubercular drugs (INH, Rifampicin, Ethambutol, Pyrazinamide)
- Prednisolone tablets
- Frusemide tablets

Topical preparations

- Gentian violet
- Tetracycline/Ciprofloxacin eye ointment
- Zinc ointment
- Spirit
- Glutaldehyde

ANNEXURE - C

EMERGENCY KIT

<p><u>INJECTIONS</u></p> <ul style="list-style-type: none">• Adrenaline• Dextrose (10%)• Diazepam• Phenobarbitone• Pheniramine (Avil)• Hydrocortisone• Calcium gluconate• Sodium bicarbonate• Dopamine <p><u>IV fluids</u></p> <ul style="list-style-type: none">• Ringer's lactate• Normal saline• N/5 in 5% Dextrose	<ul style="list-style-type: none">• Plastic / disposable syringes• IV canulas (22G and 24G)• Scalp vein set No. 22 and 24• IV infusion sets (adult and pediatric)• Face masks (all sizes)• Self-inflating ventilation bag (all sizes)• Nasogastric tube (8,10,12FG)• Suction catheter (6,8,10 FG)• Laryngoscope• Uncuffed tracheal tube (all sizes)• Oropharyngeal airway (000-4 Guedel size)• Torch• Adhesive tape• Cotton / gauze• Gloves
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ANNEXURE-D

MONITORING TOOL:

Form-1 – BASIC INFORMATION

Name of the Health Facility _____

Address of the Health Facility _____

Type of Health facility: PHC/ CHC/ District Hospital

Name of Doctor _____ Designation _____

Name of Supervisor _____

Date of follow-up _____ Date on which Doctor has received training _____

A) Staff available:	Total	Exclusive for children
Specialists		
Medical Officers		
Nurses		
Others		

B) Beds

C) Laboratory Facilities available:	Round the clock	Limited time
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D) Blood Bank Facilities	Yes/ No
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E) Is Emergency care available	Yes/No
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F) Transport facilities available	Yes/No
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G) Kitchen facility for children	Yes/No
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H) Source of drinking water

I) Toilet facilities

Form-2 - Record Review Form

Name of Doctor _____ Designation _____

Date of follow-up _____ Date on which Doctor has received training _____

Period of record review: Starting Date: _____ last Date: _____

Births:

1 month prior to training	1 month after training
Number of deliveries	
Preterm	
Term	
No. of newborns requiring resuscitation	

Young infants admitted:

Diagnosis	Before training	After training
Septicaemia		
Diarrhoea		
Pneumonia		
Meningitis		
Jaundice		
Low birth weight		

Children admitted(2 months up to 60 months):

Diagnosis	Before training	After training
Severe Pneumonia		
Diarrhoea		
Meningitis		
Severe Malaria		
Severe mainutrition		

Referrals:

Young infants	Indication	Referral facility	Transport provided

Referrals:

Children	Indication	Referral facility	Transport provided

Case fatality rate:

	No. of cases	No. of deaths	Case fatality rate
Young infants: Up to 1 month			
1 month up to 2 months			
Children with severe pneumonia			
Children with diarrhoea			
Children with meningitis			
Children with severe malaria			
Children with severe malnutrition			

Chart review:

Age(up to 1 month)	Indication for admission	Correct management

Age(1 month up to 2 months)	Indication for admission	Correct management

Sick Children:

Diagnosis	No. of cases	No. of cases with correct management	Proportionate of cases correctly managed
Severe pneumonia			
Diarrhoea with dehydration			
Meningitis			
Severe malaria			
Severe malnutrition			

Name of Supervisor_____

Form 3: Facility Support

Name of Doctor and Designation: _____

Date: _____ Type of Facility: _____

<u>Infrastructure</u>	<u>Observation</u>
1. Is emergency care available If yes : Is oxygen available Is emergency kit available	
2. Are deliveries conducted If yes : 2a. Is hand washing facility available 2b. Does newborn corner exist	
3. Is blood bank available	
4. Is transport available for referral	
5. Is the referral centre within 2 hours travelling time	
6. Number of pediatric beds at the centre	
7. Is oxygen available in ward 8. Is a source of potable drinking water available in ward 9. Toilet facilities with running water available. 10. General cleanliness of the ward 11. Biomedical waste segregation practiced 12. Is kitchen available for preparing diet for children	
<u>Equipment</u>	
1. Is functional weighing scale available	
2. Is functional phototherapy available	
3. Is functional radiant warmer available	
4. Are bag & mask of different sizes available 5. Is functional suction machine available 6. Is functional nebuliser available	
<u>Supplies</u>	<u>No. of weeks available</u> <u>Stock in hand</u>
1. ORS packets	
2. Cotrimoxazole tab.	
3. Paracetamol tab.	
4. Inj. Diazepam	
5. Inj. Ampicillin	
6. Inj. Gentamicin 7. Ringer's lactate 8. Isolyte-P 9. Salbutamol respiratory solution 10. 10% Dextrose 11. Dextrostix 12. IV canulas 13. Nasal prongs/Catheter 14. Infant feeding tube	

Observation if any:

Name of Supervisor: _____,

Form No. 4: REPORT OF FOLLOW-UP VISIT

Name of doctor & Designation: _____ Date: _____

Type of Facility: _____

After review, leave one copy with Doctor and keep one with you

Results of visit	Strengths	Problems	Actions required
Case management			
Facility support			
1. Infrastructure			
2. Staff			
3. Lab. services			

4.Functional Equipments			
Quality of records			
Drugs and supplies			

Name of Supervisor: _____