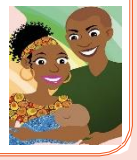
MINISTRY OF HEALTH
NATIONAL HEALTH

Write down the phone numbers that can help you during pregnancy and childbirth:

Nearest Health Centre:



Always carry this Maternal and Child Health Handbook with you
when attending your consultations.
Do not dispose of this handbook even after the child is 5 years old,
so that you can present it to him (her) when he (she) reaches adulthood
then he (she) knows how much love he (she) received in childhood.

The sale of this booklet is prohibited.

Thanks

3rd Edition – 2017

Ministry of Health

National Directorate of Public Health

# Maternal and Child Health Handbook

Mother's name:_____

Child's name_____

Emergency contact phone no.: _____

# Index


| | |
|---|---|
| Mother and father's message of love for the baby | 3 |
| For you, beloved child | 4 |
| Basic information of the Pregnant Woman | 5 |
| Personal history | 6 |
| Pre-natal consultation | 7 |
| Tetanus vaccine | 8 |
| Criteria for special attention and/or reference Pregnancy | 9 |
| Pregnancy | 10 |
| Care and Hygiene | 12 |
| Birth Plan | 13 |
| Breastfeeding | 14 |
| Summary of the Delivery and Evaluation of the newborn | 15 |
| Baby's Birth Registration | 16 |
| Postpartum consultation around six days after delivery | 17 |
| Consultations | 18 |
| Child care | 26 |
| Child diet | 27 |
| Expected child behavior | 28 |
| Growth Curves for girl and boy | 30 |
| Immunization/Vaccination | 34 |
| Registry of other medical consultations | 35 |


## Presentation

The present MATERNAL INFANTEL HEALTH REPORT (CSMI), prepared in partnership with the Maternal and Child Health Handbook Commission, responsible for the elaboration of a new instrument for monitoring maternal and child health in Angola. It is an important instrument that will guide health care providers who provide care for the mother and the newborn, and raise questions about testing and care, including new guidelines and guidelines.

## Datasheet

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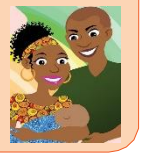
## Mother and father's message of love for the baby

Family Photo

Message



Dear Father:
You should support your wife for her pregnancy to go smoothly. Thus, the delivery will be easier and the child will have a healthier life. Actively participate in the whole process!

## For you, beloved child

For you, beloved and desired child:

With this Maternal and Child Health Handbook,
we want to welcome you to this world!
We can see a life of happiness and joy
that you will have ahead, if it depends on us
daddy, mommy and health professionals, it will
be a perfect life, we want you to know how important you are.

Everyone, mommy, daddy, and health
professionals, wish that you grow up with
health, happiness, development of our country,
Angola.

*Dr. Miguel dos Santos de Oliveira*
*Director of the National Directorate of Public Health*
*Minister of Health*



## Basic Information of the Pregnant Woman

| | | | | | | |
|---|---|---|---|---|---|---|
| Health Facility | | | | | | |
| Mother's name | | | | | | Registry No. |
| Age | Marital Status | | | | | Acad. Background |
| Name of the Child's Father | | | | | | Father's Age: |
| Person responsible for the child | | | | | | |
| Address | | | | | | |
| Reference point | | | | | | |
| In case of emergency, contact | | | | | | |
| Mother's blood type: | A ☐ | B ☐ | AB ☐ | O ☐ | RH + ☐ | RH - ☐ |
| Father's blood type: | A ☐ | B ☐ | AB ☐ | O ☐ | RH + ☐ | RH - ☐ |

### Every pregnancy can be dangerous

For the Health Professional:

Help the pregnant woman recognize the warning signs, and tell her where she can find the appropriate medical assistance, whenever necessary.

### Registry of the first consultation

Last menstrual period _____/_____/20_____

Probable Date of Delivery (PDD)_____/_____/20_____

Prenatal Care is the best way to promote the health of the pregnant woman, the father, and their baby. This handbook is important for all mothers. Because it will guide you through your pregnancy, childbirth, postpartum, and the development of your child. Go with your husband or partner to the next prenatal appointment for him to watch, help, and support your pregnancy.

## Personal History

Hypertension: ☐ Renal disease: ☐ Diabetes: ☐ Hepatitis: ☐
Malformation: ☐ Heart problems: ☐ Urinary Infection: ☐ Infertility: ☐
Uter. pelvic surg.: ☐ Thyroid diseases: ☐ Breast Cancer: ☐ Sickle Cell: ☐
Uterine cancer: ☐ Others:_____

Have you suffered some type of violence? (Sexual, beatings, psychological, etc.)

_____

Have you ever had surgery: No ☐ Yes ☐ (name of the disease:_____)
Physical Disabilities: No ☐ Yes ☐ (_____)
Medicines you are taking (That you usually take:_____)
Do you drink alcohol? No ☐ Yes ☐ (_____ glasses per day)
Do you smoke? No ☐ Yes ☐ (_____ cigarettes per day)
Does your husband have any health problems? No☐ Yes ☐
If "Yes", what problem?_____ Sickle Cell: ☐
Does the husband drink alcohol? No ☐ Yes ☐ (_____ glasses per day)
Does the husband smoke? No ☐ Yes ☐ (_____ cigarettes per day)
Have you ever had any of the following transmissible diseases:

HIV/AIDS: Yes☐ ____ years of age No☐
Tuberculosis Yes☐ ____ years of age No☐
Rubella: Yes☐____ years of age No☐ Vaccinated☐
Measles: Yes☐____ years of age No☐ Vaccinated☐
Chicken Pox: Yes☐____ years of age No☐ Vaccinated☐

### Gynecologic Problems:

Vaginal discharge: ☐ Itching: ☐ Wounds: ☐ Myoma: ☐ Others : ☐ What?: _____

### Gynecologic History:

1st menstrual period:_____ Duration of menstrual cycle:_____days
Contraceptive use: Yes ☐ No ☐ Which method: _____
Usage time: _____

### Obstetric History: (fill out with numbers)

Gestations _____ Normal births _____ Caesarean Sections _____
Ectopic gestations _____ Spontaneous abortions _____ Live Births _____
Stillbirths _____ Current living children _____ Deaths in 1st week _____
Deaths after 1st week _____ Cause of death _____

### Questions about the last delivery:

Last delivery date: ____/____/____
Was the child born dead? Yes ☐ No☐ Do you know why? _____
Were forceps or suction cups used? Yes☐ No☐ If yes, do you know why?_____
Did you have any other problem during your last pregnancy or delivery?
(Such as convulsions, loss of consciousness) Yes ☐ No ☐

**The presence of a yellow signal ☑ is an alert.**



## Pre-natal consultation

| | 1st visit | 2nd visit | 3rd visit | 4th visit | 5th visit | 6th visit | 7th visit | Others |
|---|---|---|---|---|---|---|---|---|
| Date | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 |
| Gestational age weeks/months | | | | | | | | |
| Fundal height | cm | cm | cm | cm | cm | cm | cm | cm |
| Fetal movements | | | | | | | | |
| Weight, (Kg) | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg |
| Blood Pressure | | | | | | | | |
| Edemas | | | | | | | | |
| Anemia | | | | | | | | |
| Presentation | | | | | | | | |
| Fetal Heart Rate (FHR) | | | | | | | | |
| Ultrasound | | | | | | | | |
| HIV counseling and testing | | | | | | | | |
| ART | | | | | | | | |
| Tuberculosis | | | | | | | | |
| Fansidar (SP) | | | | | | | | |
| Treated mosquito net | | | | | | | | |
| Folic Acid and Ferrous Sulfate | | | | | | | | |
| De-wormer (Albendazole) | | | | | | | | |
| Data of next consultation | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 | / /20 |
| Legible name of professional | | | | | | | | |

**Recommendations: Guide Family Planning and encourage the father's presence in consultation.**

## Tetanus vaccine

When to start the vaccine schedule in pregnant women:
Every mother should consider the vaccines administered before the current pregnancy.
Every mother should receive at least 2 doses of vaccines, the first dose should be taken at the first consultation and the last dose should be given 20 days before the expected delivery date.

| Doses | 1st | 2nd | 3rd | 4th | 5th |
|---|---|---|---|---|---|
| Date | / /20 | / /20 | / /20 | / /20 | / /20 |
| Date of next dose | / /20 | / /20 | / /20 | / /20 | / /20 |

## Malaria prevention with Fansidar

The pregnant woman should take 4 doses of Fansidar during pregnancy to prevent malaria.
Starting in the 13th week of gestation, there should be a 1-month interval between each dose, and it can be taken up until the delivery. The doses should always be taken under the Health professional's direct observation and in the ANC room.

| Doses | 1st | 2nd | 3rd | 4th | Others |
|---|---|---|---|---|---|
| Date | / /20 | / /20 | / /20 | / /20 | / /20 |

## Complementary diagnostic test results

| | 1st Exam | 2nd Exam |
|---|---|---|
| Date | / /20 | / /20 |
| Blood Type | | |
| Plasmodium Survey | | |
| VDRL | | |
| Sickle Cell | | |
| CBC | | |
| Urine Type II | | |
| Glycemia VN: 60/90mg/dl | | |
| Proteinuria | | |
| Hepatitis B (HBs Ag) | | |
| Toxoplasmosis | | |
| Rubella | | |
| Cytomegalovirus | | |
| Coombs test | | |
| Vaginal discharge | | |
| Other tests | | |



## Criteria for special attention and/or reference

(Health facility with greater technical capacity)

| | Yes | No |
|---|---|---|
| Neonatal death or stillbirth? | | |
| History of 3 or more spontaneous abortions? | | |
| Last birth weight < 2500g? | | |
| Last birth weight > 4500g? | | |
| Last pregnancy: Hospitalized of hypertension? Preeclampsia, Eclampsia | | |
| Caesarean section or other gynecological surgeries? | | |
| Known or suspected twin pregnancy? | | |
| Under 18 years old? | | |
| Over 35 years old? | | |
| Vaginal bleeding? | | |
| Pelvic tumor? | | |
| Cancer? | | |
| Arterial hypertension? | | |
| Diabetes? | | |
| HIV? | | |
| VDRL + and no doctor in the Health Facility? | | |
| Malaria? | | |
| Severe anemia/Sickle Cell Anemia? | | |
| Epilepsy? | | |
| Heart problems? | | |
| Kidney problems? | | |
| Respiratory problems? | | |
| Collagen disease (Systemic Lupus Erythematosus, Rheumatoid Arthritis, etc.)? | | |
| Other severe diseases? If so, what disease(s)? | | |

Can the pregnant woman maintain standard ANC follow up? Yes ☐ No ☐

She will be transferred to

Advisable place for Childbirth: _____

If you have one of the abovementioned conditions mark with X in the Yes column box, meaning that the pregnant woman should not continue the normal prenatal consultation.
Important notes (take note of treatments you are undergoing)

_____

_____

# Pregnancy

## Pregnancy care

In order to maintain your health and your baby's health during pregnancy, the mother should rest and avoid powerful endeavors like cutting firewood, fetching water with large containers in remote locations or washing clothes in a tank/basin

## What should be avoided in pregnancy:

- Heavy labor, extensive hours
- Drinking alcoholic beverages
- Smoking tobacco
- Using drugs
- Self-medication (taking medications without consulting a health professional)
- Stress

## Danger Signs

In the following cases, immediately go to the health center/hospital.

- Loss of blood or water from the vagina
- Stomach ache
- Fever
- Headache or dizziness
- Vaginal discharge with bad odor
- Swelling of the face, hands, and legs
- Difficulties breathing or seeing
- Seizures
- Lack of baby movement



## Safe pregnancy and childbirth

## Diet during pregnancy

- A pregnant woman must have a variety of foods based on local productions.
- Eat 4 or 5 times a day
- Avoid eating too much fat, salt, sugar and spicy things.

## Good nutrition:

- **Foods giving energy / strength:** funge, potatoes, cassava, pasta, rice, bread, etc;
- **Food making growth:** meats, chicken, fish, seafood, catatus, eggs, milk, yogurt, beans, peas, etc.
- **Foods protecting against diseases:** vegetables and greens (kale, kizaka, lombi, gimboa, okra, carrot, pumpkin, tomato, etc.) and fruits (banana, papaya, mango, orange, etc);
- **Foods giving more energy**: soybean oil, palm oil, butter, peanut

## HIV testing serves to protect mother, father, and children

The mother and father's HIV test let them know if they have HIV and protects their child.

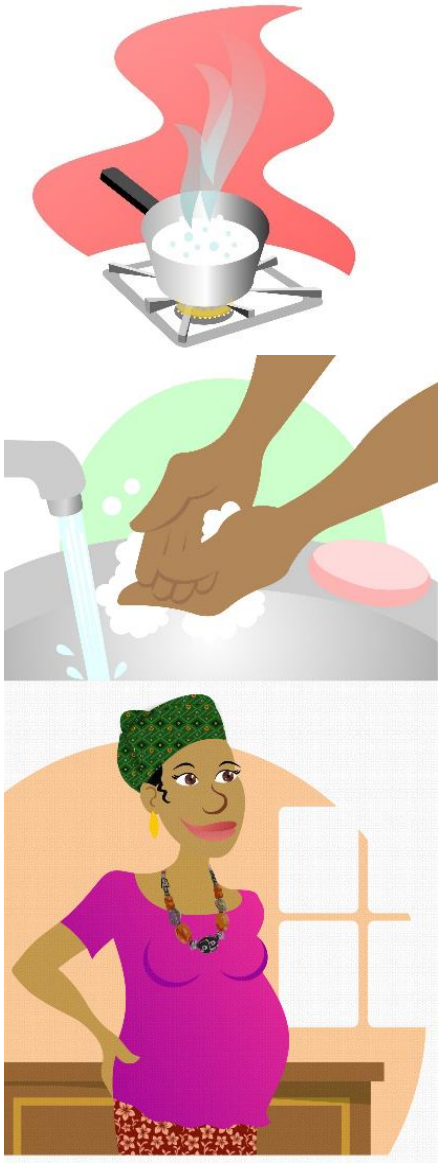
Knowing your HIV status is important to prevent the transmission of HIV to the child during pregnancy, childbirth, lactation and growth.

## Malaria Prevention

In order to prevent malaria, the pregnant mother and her small children should always sleep under a mosquito net treated with a long-lasting insecticide.

## Care and Hygiene

- Drink filtered or boiled water, or water treated with bleach (4 drops / liter)
- Wash the utensils (pots, pans, plates, glasses, etc) and food
- Brush your teeth after every meal
- Bathe every day
- Wash hands before meals and after using the bathroom
- Keep the latrines clean and with a lid
- Wear comfortable clothes without tightness around the belly
- If the mother or the father is HIV positive, take medications every day and at the correct time and day



## Birth Plan

The family should prepare for the childbirth situation, a case with clean cloths and clothes to cover and dress the baby and the mother.

The mother and father should be certain of which health facility will deliver the baby, what kind of transportation to use, and the person who will take them.

# Breastfeeding

Breast milk is the best milk you can give and it's free

## Preparing for Breastfeeding

All pregnant women who have small, flat or inverted nipples (tip of nipples) can gently massage each time she bathes so that when the child is born, the child can suckle without difficulty.

## Immediate Breastfeeding

Shortly after birth, the baby should be put into direct skin contact with the mother and then the mother should breastfeed the baby. The first milk(colostrum) looks a little different and there are people who say, "You cannot give the first milk because it is spoiled." This is not true.

The first milk has very important things to create immunity for baby body.

## Exclusive Breastfeeding

Up to 6 months old the baby ***does not need*** water nor kissangua, but only the mother's milk. The breast milk already has water and all the nutrients that the baby needs.

## Feeding of the breastfeeding mother

- Drink plenty of water, especially treated water, to increase milk production
- Have a varied food, the basis of local products;
- Eat 4-5 times a day;
- Avoid eating too much fat, salt and sugar.
- Breastfeed frequently, the more the mother breastfeeds the more milk she produces;
- Sleep well to avoid tiredness and stress



# Summary of the Delivery

Health facility: _____

Date_____/_____/20_____ Time:_____

Gestational Age:_____ weeks

Monitoring by Professional: Yes: ☐ No: ☐

At home: Yes: ☐ No: ☐

Fetus (s): Single: ☐ Multiple fetus: ☐ Multiple fetus Case, how many? _____

*In case of multiple, deliver Maternal and Child Health Handbook*

Primparent or Multivalent: Primipara: ☐ Multipara: ☐

Delivery Duration: <6 h: ☐ 6 ~12 h: ☐ 12~24 h: ☐ >24 h: ☐

Type of delivery: Normal delivery: ☐ Hard delivery: ☐

Presentation: Cephalic: ☐ Breech: ☐ Other: _____

Afterbirth: Normal: ☐ Bleeding: ☐ Retained placenta: ☐

Intervention: Caesarean Section: ☐ Forceps: ☐ Suction cup: ☐ None: ☐

Was there been transferred any secondary/tertiary facility unit during delivery or post-partum? Yes: ☐ No: ☐

Vitamin A administration: Yes: ☐ No: ☐

HIV +: Yes: ☐ No: ☐ If "Yes", PMTCT: Yes: ☐ No: ☐

If "Yes", ARV: Yes: ☐ No: ☐ Which one?_____

Maternal death: Yes: ☐ No: ☐ Cause?_____

Observation: _____

# Evaluation of the newborn

Time:_____ Sex: Male ☐ Female ☐ Birthweight: _____kg

Birth length:_____cm. Cephalic circumference:_____cm

Live birth: ☐ Stillbirth: ☐ Resuscitation: Yes: ☐ No: ☐

APGAR: 1st min: _____ 5th min:_____

Apparent malformation: Yes: ☐ No: ☐ If yes, what? _____

Ointment/ophthalmic drops?: Yes: ☐ No: ☐

BCG Vaccine?: Yes: ☐ No: ☐

Polio vaccine?: Yes: ☐ No: ☐

Hepatitis B: Yes: ☐ No: ☐

Exposed child? Yes: ☐ No: ☐

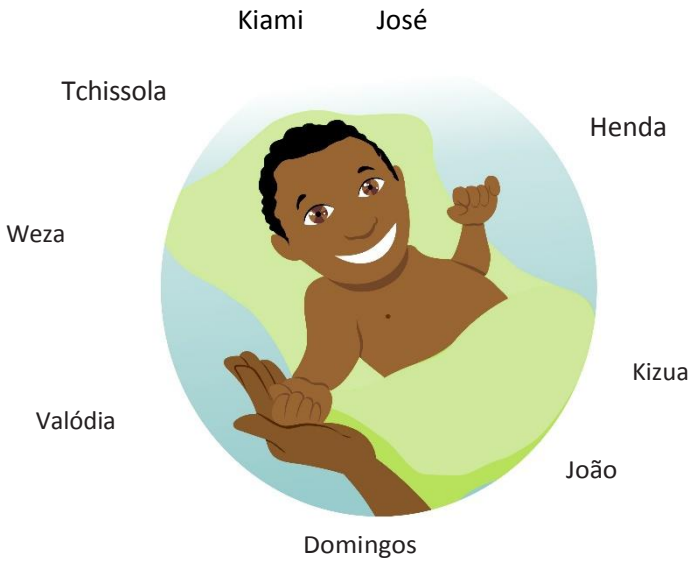
If "exposed", was the child treated? Yes: ☐ How?_____ No: ☐

Neonatal heel prick: Done: ☐ (If not done, please forward immediately)

Legible signature of the professional: _____

## Birth Registry

**No registration no identity!**
**Register now!**




| Birth Data | |
|---|---|
| Name of the Child: | Sex: ☐male ☐female |
| Place of birth: City/Town/District | |
| Date of birth Year: Month: Day: | |
| Live birth: ☐ | Stillbirth: ☐ |
| Hospital, Maternity Hospital, Clinic, or Health Centr: Province/City/Town/District: | |

## Postpartum consultation around 6 days after delivery

### ● Postpartum consultation of the mother 6 days after

Date_/_____/20____Healthcare Facility:_____

Person Responsible:_____

Disease after the delivery? Yes: ☐ No: ☐

If yes, which one?_____

Check uterine involution:_____

Lochia characteristics: Normal: ☐ Abundant: ☐ Fetid: ☐
Tetanus vaccination? Yes: ☐ No: ☐ No. of doses: _____
Vital signs: Temperature:_____ $^{O}$C BP_____/_____mmHg
Contraceptive information: Yes: ☐ No: ☐
In case of transfer change, location:_____

Inform the mother and father about: Family planning consultation,
Breastfeeding and vaccination

### ● Baby consultation 6 days after delivery

Is the child breastfeeding? Yes: ☐ No: ☐

Child's weight:_____ kg Cephalic circumference:_____ cm

BCG vaccine: Yes: ☐ No: ☐ If not, vaccinate today
Polio vaccine: Yes: ☐ No: ☐ If not, vaccinate today
Dry navel? Yes: ☐ No: ☐
Exposed child? Yes: ☐ No: ☐
If "Exposed", HIV prophylaxis:_____ Dose:_____
Appearance of congenital malformation? Yes: ☐ No: ☐ If yes, refer
Have you been informed about exclusive breastfeeding and child vaccination:
Yes: ☐ No: ☐
Neonatal heel prick: Yes: ☐ No: ☐

Date:_____/_____/20_____

# Consultations

## Child's 1st month Consultation

| Date _____/_____/20_____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |
| Exclusive Breastfeeding: ☐Y ☐ N | Different feeding: ☐ Y ☐ N Which?_____ | |
| Neonatal heel prick: ☐Y ☐ N Result: ☐ + ☐ – | Jaundice: ☐ Y ☐N | Eye colour: ☐Normal ☐ Altered |
| Sickle cell test: ☐ Y ☐ N Result: ☐ + ☐ - | | |
| Exposed child: ☐ Y ☐ N If "Yes", do prophylaxis What prophylaxis is being done?_____ | | |
| Does your baby move both his (her) feet and hands? ☐Y ☐ N | | |
| Does your baby suckle vigorously? ☐Y ☐ N | | |
| When hearing loud noises, does the baby cry and move his (her) limbs? ☐Y ☐ N | | |
| Is the navel dry? ☐Y ☐ N | | |
| What is the color of the baby's stool? | | |
| Write freely about your concerns with your baby  | | |
| Recommendations: | | |



## Child's 2nd month Consultation

| Date _____/_____/20_____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____ cm |
| Exclusive Breastfeeding: ☐ Y ☐ N | Different feeding: ☐ Y ☐ N Which?_____ | |
| Neonatal heel prick: ☐Y ☐ N Result: ☐ + ☐- | Jaundice: ☐ Y ☐ N | Eye colour: ☐ Normal ☐ Altered |
| Exposed child: ☐ Y ☐ N If "Yes", do prophylaxis What prophylaxis is being done?_____ | | |
| Does your baby move both his (her) feet and hands? ☐Y ☐ N | | |
| Does your baby suckle vigorously? ☐Y ☐ N | | |
| Does the baby turn his (her) head on both sides? ☐Y ☐ N | | |
| Does the baby holds his (her) head and tries to raise his (her) head when pulled to sit? ☐Y ☐ N | | |
| When hearing loud noises, does the baby cry or move his (her) limbs? ☐Y ☐ N | | |
| When face down, does the baby try to lift his (her) head? ☐Y ☐ N | | |
| Does your baby follow the movements around with his (her) eyes? ☐Y ☐ N | | |
| Write freely about your concerns with your baby  | | |
| Recommendations: Only brestfeed until 6 months old 2nd month vaccines | | |

**Children up to 1 year of age should be vaccinated 5 times**

## Child's 3rd and 4th month Consultation

| Date _____/_____/20_____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____ cm |
| Exclusive Breastfeeding: ☐ Y ☐ N | Different feeding: ☐ Y ☐ N Which?_____ | |
| Thigh joint: ☐ Normal ☐ Signs of dislocation | Jaundice: ☐ Y ☐ N | Eye colour: ☐ Normal ☐ Altered |

Exposed child: ☐ Y ☐ N If "Yes", do prophylaxis
What prophylaxis is being done?_____

| | |
|---|---|
| Does the child hold up his (her) head? | ☐ Y ☐ N |
| Are there any irregular eye movements or expressions? | ☐ Y ☐ N |
| When calling the child, does the child look or search? | ☐ Y ☐ N |
| Does the child smile when touched? | ☐ Y ☐ N |
| Plays with his (her) fingers of both hands and puts objects in mouth? | ☐ Y ☐ N |

Write freely about your concerns with your baby

Recommendations:

**Children under 1 year of age should be taken to receive vaccinations 5 times**



## Child's 6th and 7th month Consultation

| Date _____/_____/20_____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | Brachial circumference: _____cm |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |

Breastfeeding: ☐ Y ☐ N Is fed_____per day
Feeding difficulty ☐ Y ☐ N If "Yes" What Kind?_____

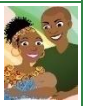
| | |
|---|---|
| Sickle cell test: ☐ Y ☐ N Result: ☐ + ☐ - | Vision problem: ☐ Y ☐ N |

Exposed child: ☐ Y ☐ N If "Yes", do prophylaxis
What prophylaxis is being done?_____

Do parents do tooth hygiene? ☐ Y ☐ N
Are there problems with the gums? ☐ Y ☐ N
Mark the child's teeth with an X

| | |
|---|---|
| Can the baby turn by him(her)self? | ☐ Y ☐ N |
| Can your baby sit by him(her)self? | ☐ Y ☐ N |
| Does the child pick up nearby toys? | ☐ Y ☐ N |
| Does the baby make sounds when playing? | ☐ Y ☐ N |
| Does the baby look in the direction of the radio or TV when it's on? | ☐ Y ☐ N |
| Does your baby already eat solid food? | ☐ Y ☐ N |
| Does the child grab his (her) feet when playing? | ☐ Y ☐ N |

Write freely about your concerns with your baby



Recommendations:
6th months vaccines
Only in the case of an exposed child with the definitive result, prepare the mother and the father to stop breastfeeding when the exposed child reaches 1 year.

**Children up to 1 year of age should be vaccinated 5 times**

## Child's 9th and 10th month Consultation

| Date _____/_____/20____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | Brachial circumference: _____cm |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |

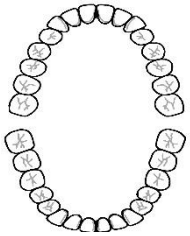
Breastfeeding: ☐ Y ☐ N Is fed_____per day

Feeding difficulty ☐ Y ☐ N If "Yes" What Kind?_____

Vision Problem: ☐ Y ☐ N

Exposed child: ☐ Y ☐ N If "Yes", do prophylaxis

What prophylaxis is being done?_____



Does the baby have teeth? ☐ Y ☐ N

Do parents do tooth hygiene? ☐ Y ☐ N

Are there cavities? ☐ Y ☐ N

Are there problems with the gums? ☐ Y ☐ N

Mark the child's teeth with an X

| | |
|---|---|
| Can the baby sit by him(her)self? | ☐ Y ☐ N |
| Can your baby crawl? | ☐ Y ☐ N |
| Can the baby manipulate the toys beside him (her)? | ☐ Y ☐ N |
| Can the baby play alone? | ☐ Y ☐ N |
| Can the child eat solid food without difficulty? | ☐ Y ☐ N |
| Does the baby react to your voice? | ☐ Y ☐ N |
| Does the baby babble words? | ☐ Y ☐ N |

Write freely about your concerns with your baby

Recommendations:
9th month vaccines

**Children under 1 year of age should be taken to receive vaccinations 5 times**



## Child's 1st year Consultation

| Date _____/_____/20____ | Health facility: | Province/City: |
|---|---|---|
| Legible name of the professional: | | Brachial circumference: _____cm |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |

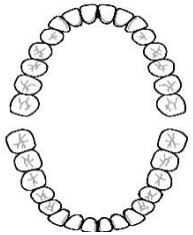
Breastfeeding: ☐ Y ☐ N

Exposed child? ☐ Y ☐ N
If "Yes", stop breastfeeding

Is fed _____ per day

Feeding difficulty: ☐ Y ☐ N
What Kind? :_____

Vision Problem: ☐ Y ☐ N



Do parents do tooth hygiene? ☐ Y ☐ N

Are there cavities? ☐ Y ☐ N

Are there problems with the gums? ☐ Y ☐ N

Mark the child's teeth with an X

| | |
|---|---|
| Can the child walk by him(her)self or holding on to an object? | ☐ Y ☐ N |
| Can the child say hello through hand gestures? | ☐ Y ☐ N |
| Does the child dance listening to music? | ☐ Y ☐ N |
| Can the child understand words like: come here, give me? | ☐ Y ☐ N |
| Does the child interact with other children and family members? | ☐ Y ☐ N |

What is the child's favourite game?

Write freely about your concerns with your baby

Recommendations:

**Do not forget to vaccinate (Measles and Rubella) at 15 months**

## Child's 15th month Consultation

| Date | Health facility: | Province/City: |
|---|---|---|
| _____/_____/20____ | | |
| Legible name of the professional: | | Brachial circumference: _____cm |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |

Breastfeeding: ☐ Y ☐ N

Exposed child? ☐ Y ☐ N If yes, the child must not be breastfed after 12 months

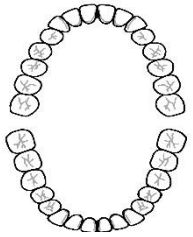
If yes, was the first test conducted? ☐ Y ☐ N When?_____/_____/20_____

Feeding difficulty ☐ Y ☐ N

What Kind?_____

Is fed _____per day

Vision Problem: ☐ Y ☐ N



Does the baby have teeth? ☐ Y ☐ N

Do parents do tooth hygiene? ☐ Y ☐ N

Are there cavities? ☐ Y ☐ N

Are there problems with the gums? ☐ Y ☐ N

Mark the child's teeth with an X

| | |
|---|---|
| Can the child walk by him(her)self? | ☐ Y ☐ N |
| Does the baby go up and down stairs? | ☐ Y ☐ N |
| Can the child eat solid food without difficulty? | ☐ Y ☐ N |
| Can the baby speak? | ☐ Y ☐ N |
| Does the child understand simple commands? | ☐ Y ☐ N |
| Does the child play alone? | ☐ Y ☐ N |
| Does the child play with other children? | ☐ Y ☐ N |

Write freely about your concerns with your baby

Recommendations:

Booster vaccine



## Child's 18th month Consultation

| Date | Health facility: | Province/City: |
|---|---|---|
| _____/_____/20____ | | |
| Legible name of the professional: | | Brachial circumference: _____cm |
| Weight: _____Kg | Length / Height: _____cm | Cephalic circumference: _____cm |

Breastfeeding: ☐ Y ☐ N

Final result of the exposed child test? ☐ Pos. ☐ Neg.

If "Positive", refer to specialized service

What type of feeding does the baby have?

Is fed_____per day

Feeding difficulty ☐ Y ☐ N

What Kind?_____

Vision Problem: ☐ Y ☐ N

Do parents do tooth hygiene? ☐ Y ☐ N

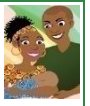
Are there cavities? ☐ Y ☐ N

Are there problems with the gums? ☐ Y ☐ N

Mark the child's teeth with an X

| | |
|---|---|
| Can the child walk without support? | ☐ Y ☐ N |
| Does the child speak simple words like "mama or "bye"? | ☐ Y ☐ N |
| Can the child drink water by holding a cup with his(her) own hands? | ☐ Y ☐ N |
| Is the timing of meals and snacks more or less pre-established? | ☐ Y ☐ N |
| Does the child feed him(her)self? | ☐ Y ☐ N |
| Do you feel that the child is very sensitive to light or that his (her) eyes make strange movements? | ☐ Y ☐ N |
| When called from behind, does the child turn around? | ☐ Y ☐ N |
| Does the child play with other children? | ☐ Y ☐ N |

Write freely about your concerns with your baby



Recommendations:

Booster vaccine

# Child care

To safeguard the child's health, the mother and the father must take the following precautions:

Maintain the child's personal hygiene

Water treatment

Only drink water that was treated with bleach (4 drops/1liter) or boiled.

When the child has diarrhea, give him (her) ORS to prevent dehydration.

**Preparation of homemade serum**

1 - Prepare 1 liter of boiled or treated water;
2- Add 1 small spoon of salt, 2 large spoons of sugar. When the taste is similar to tears, it is a sign that it's ready;
3 – If you have any, add half a lemon.


De-worm the child

The child should be de-wormed at his(her) 1st birthday and afterwards, every 6 months



# Child diet

## 0 -6 MONTHS:

EXCLUSIVE BREASTFEEDING
(GIVE ONLY MOTHER'S BREAST MILK)

- Mother's breast milk has everything the child needs to grow healthy and avoid illness.
- Do not give baby food, juice, water, tea and kissangua as they can cause diarrhea.

## FROM THE 6 MONTHS:

CONTINUE WITH MOTHER'S BREAST MILK AND VARIETY OF FOOD

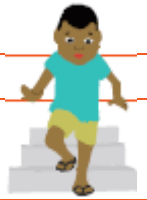
### From 6 months old:

- Give well-crushed potatoes or food.
- Food should be semi-liquid, soft and enriched with vegetables, fruits, a little fat.
- Give more breast milk and more daily meals (2-3 times).

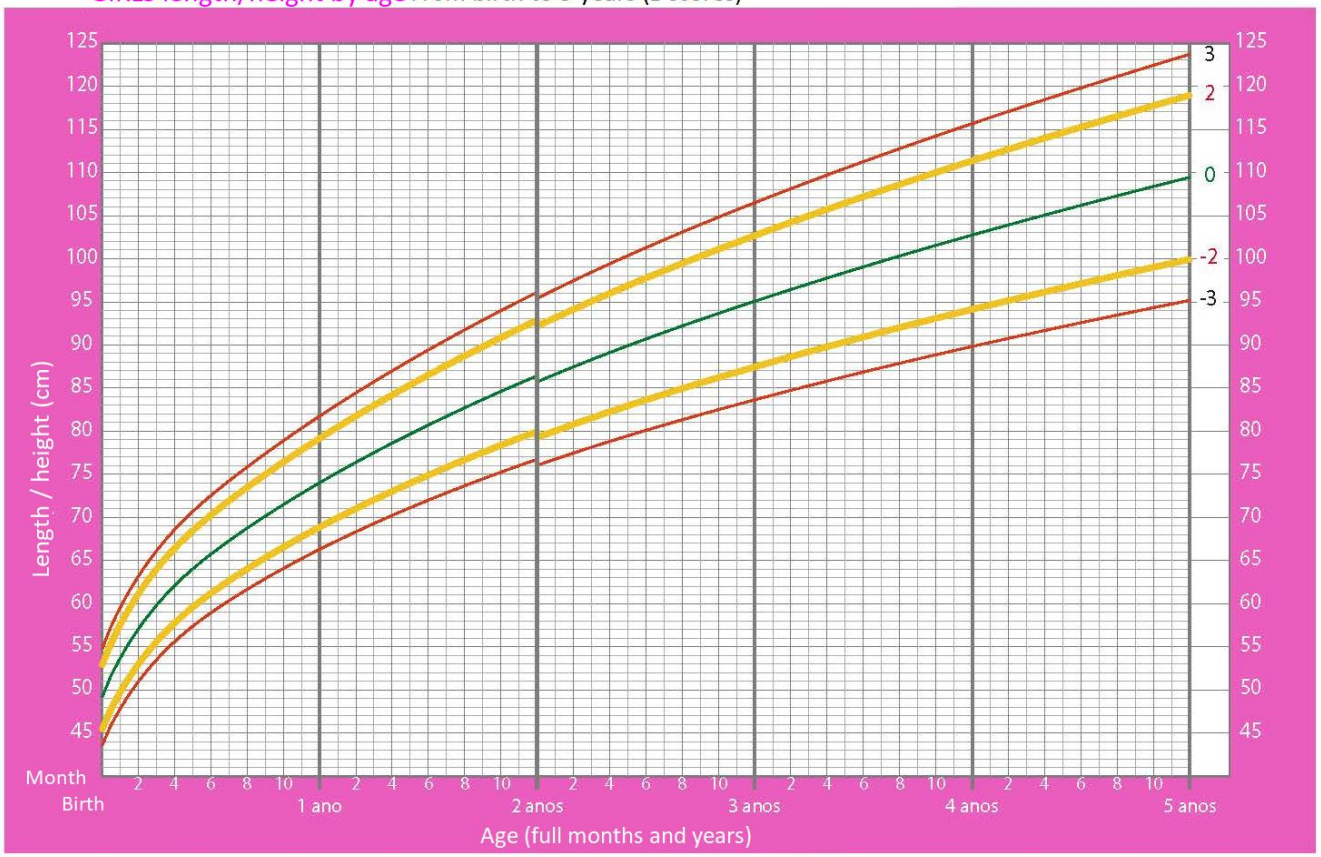
### From 9 months old:

- Increase the consistency of food gradually.
- At around 12 months old, the child can eat the same food as the family - easy to chew.
- Avoid fried foods and lots of salt.
- Give breast milk and more daily meals (4-6 times).
- A healthy diet should use locally sourced foods.
- Always use IODIZED SALT, in small amounts.

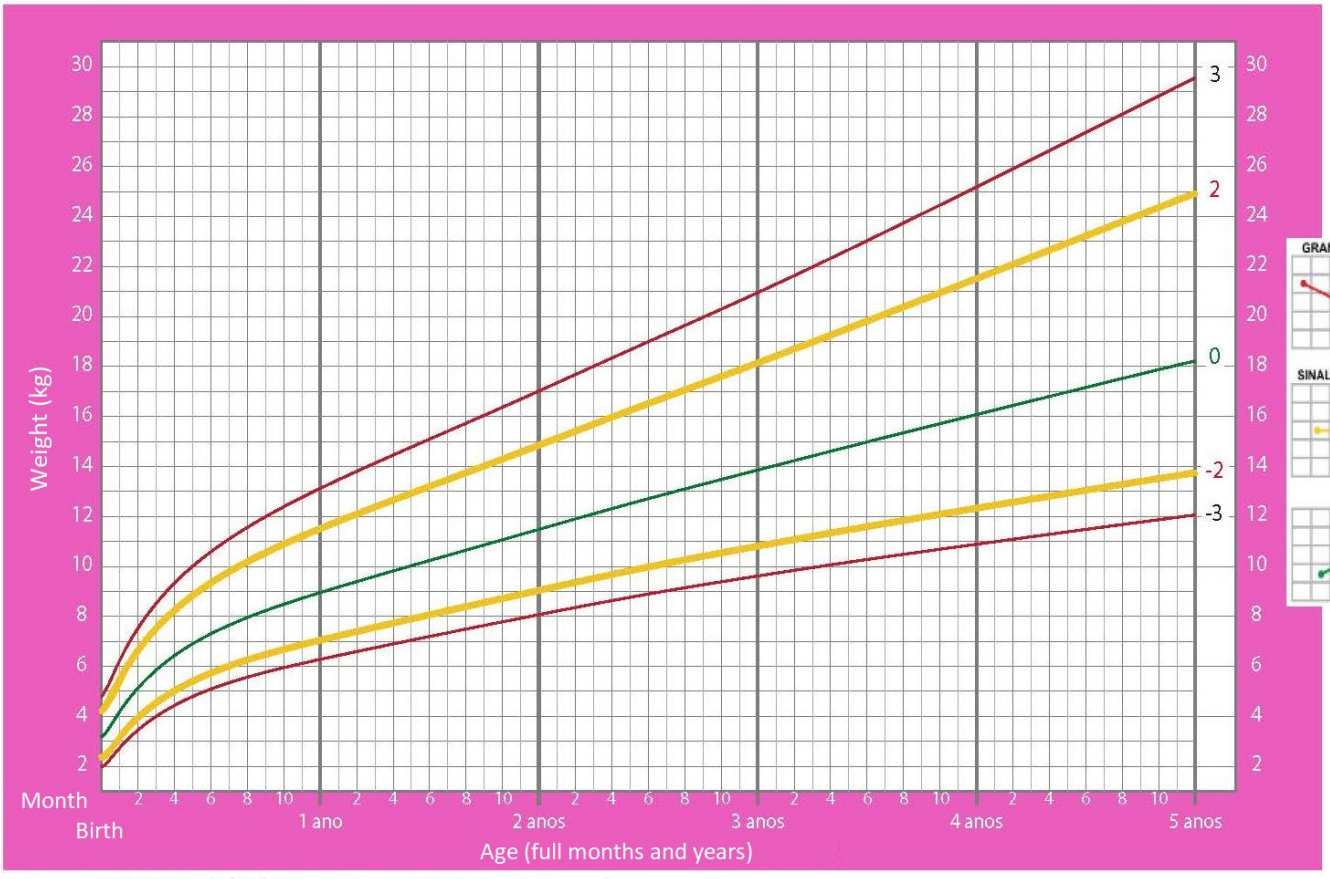
## Expected child behavior at each stage

| | 2nd year | 3rd year | 4th year | 5th year |
|---|---|---|---|---|
| Date of Consultation | _____/_____/20 _____  | _____/_____/20 _____  | _____/_____/20 _____  | ____/_____/20 _____  |
| Weight | Kg | Kg | Kg | Kg |
| Length / Height | Cm | Cm | Cm | Cm |
| Brachial Circumference | Cm | Cm | Cm | Cm |
| Motor Development | Walk alone ☐Y ☐N<br>Manipulate objects with both hands ☐Y ☐N | Run, jump, go up and down stairs ☐Y ☐N | Try brushing the teeth, removing and getting clothes ☐Y ☐N | Dress and take off alone ☐Y ☐N |
| Speech development | Produce a sentence with 3 or 4 words ☐Y ☐N | Produces understandable phrases ☐Y ☐N | Speak fluently and ask for help ☐Y ☐N | Speak fluently and ask for help ☐Y ☐N |
| Psychic Development | Recognize and remembers places ☐Y ☐N<br>Identify at least 1 image ☐Y ☐N<br>Imitate and participate in activities of adults ☐Y ☐N<br>Accept and refuse decisions ☐Y ☐N<br>Recognize as "I" ☐Y ☐N | Very curious and questioning ☐Y ☐N<br>Imitate and participate in adult activities ☐Y ☐N<br>Play alone and with other children ☐Y ☐N<br>Distinguish what is right or wrong ☐Y ☐N<br>Ask to urinate and defecate ☐Y ☐N | Share with others ☐Y ☐N<br>Challenging and opposing behavior ☐Y ☐N<br>Like to play with others ☐Y ☐N | Describe an image ☐Y ☐N<br>Great concern to please adults ☐Y ☐N<br>Recognize the gender difference ☐Y ☐N |
| Vision Problem | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ |
| Tooth Problem | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ |
| Hearing Problem | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ | ☐Y ☐N<br>If yes, what problem?_____ |
| Physical Exam | | | | |
| Name of professional | | | | |
| Date of next consultation | ____/_____/20 _____ | ____/____/20 _____ | ____/_____/20 _____ | ____/_____/20 _____ |

GIRLS length/height by age From birth to 5 years (z-scores)



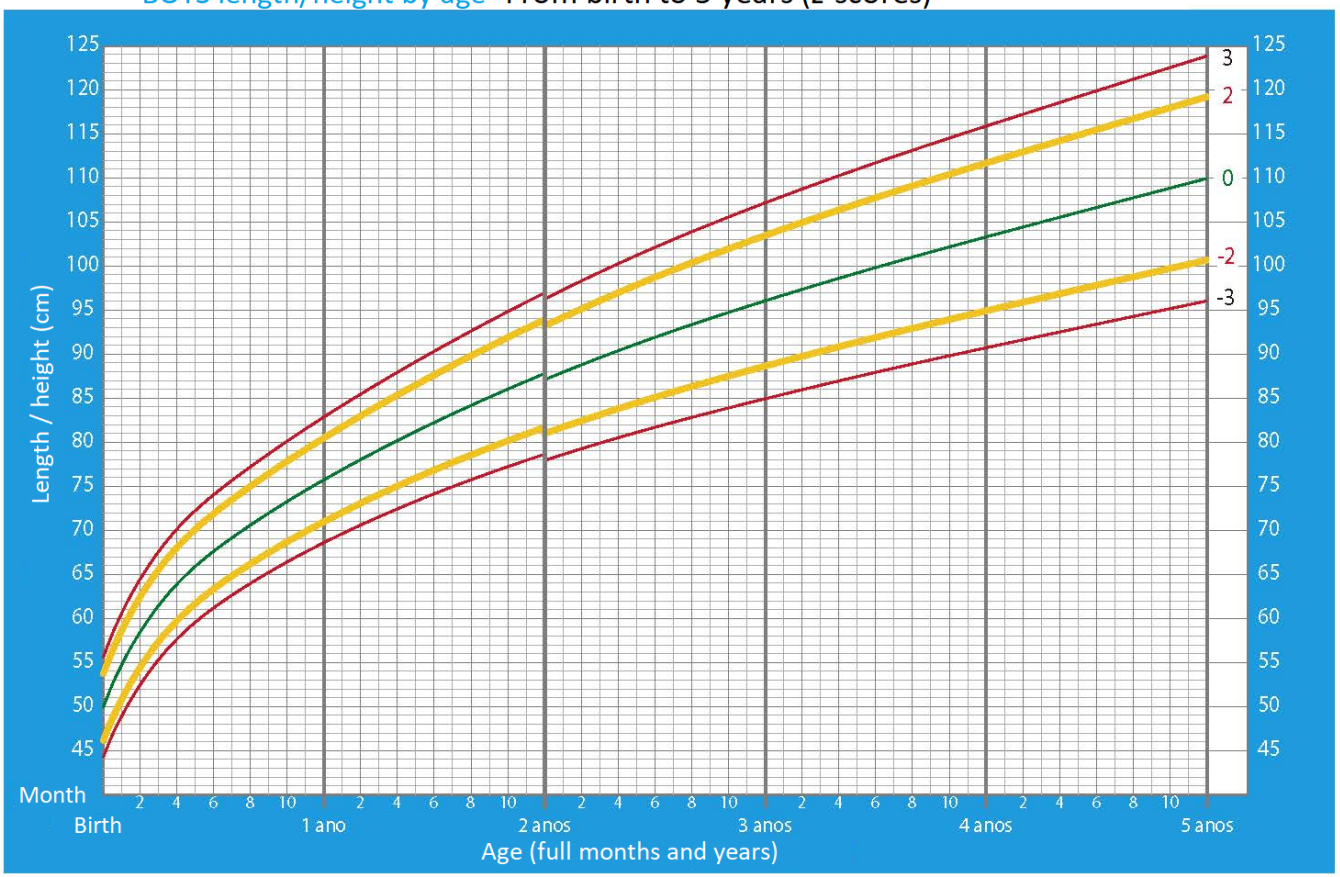

| Age | Nasci-mento | 1 mês | 2 meses | 3-4 meses | 6-7 meses | 9-10 meses | 1 ano | 1 ano e 3 meses | 1 ano e 6 meses | 2 anos | 3 anos | 4 anos | 5 anos |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Length | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm |
| Weight | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg |
| Data | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / |



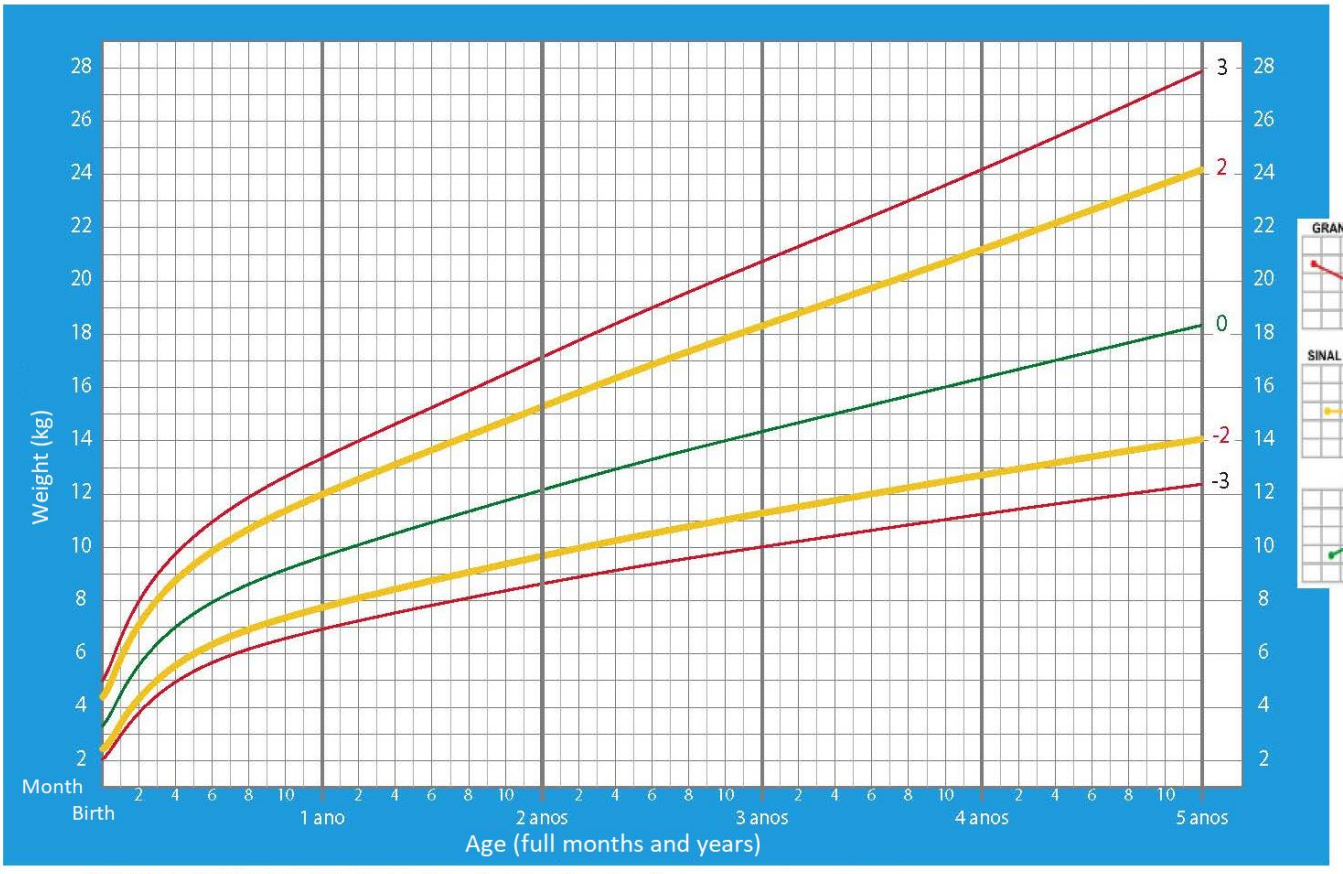


GIRLS weight by age From birth to 5 years (z-scores)

## BOYS length/height by age From birth to 5 years (z-scores)




| Age | Nasci-mento | 1 mês | 2 meses | 3-4 meses | 6-7 meses | 9-10 meses | 1 ano | 1 ano e 3 meses | 1 ano e 6 meses | 2 anos | 3 anos | 4 anos | 5 anos |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Length | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm | cm |
| Weight | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg | Kg |
| Date | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / | / / |



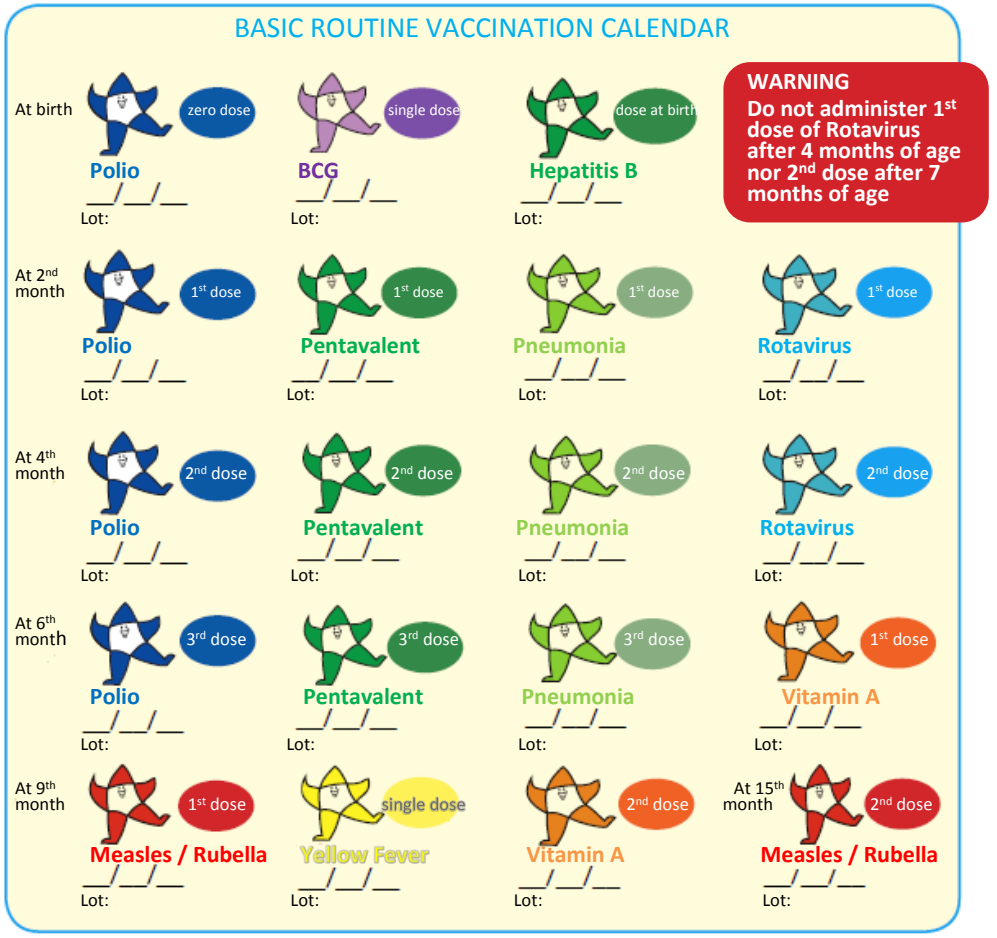


## BOYS weight by age From birth to 5 years (z-scores)

## Immunization / Vaccination

A vaccinated person is like a house with its doors and windows closed and an unvaccinated person is like a house with its doors and windows open. The wind, mosquitoes, and diseases can enter.

### BASIC ROUTINE VACCINATION CALENDAR




VACCINATION / BOOSTER

| VACCINE | Lot | DATE |
|---|---|---|
| Polio (Injection) at 4 months | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

VITAMIN A (1-4 years)

| DATE |
|---|
| |
| |
| |
| |
| |
| |
| |

ALBENDAZOLE (1-4 years)

| DATE |
|---|
| |
| |
| |
| |
| |
| |
| |

MOSQUITO NET DELIVERY

| DATE |
|---|
| |
| |
| |
| |
| |
| |
| |



## Record of other medical consultations

| Date | Complication | Treatment | Pers. Respons. |
|---|---|---|---|
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |
| ____/____/___ | | | |