



TRAINER'S MANUAL

Psychosocial Care of Babies and Young Children Living with HIV and AIDS



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



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How to use this guide

Icon	Description
	Group activity or discussion
	Small group activity
	Individual activity
	Skills practice
	Definition

Background information

The comprehensive approach to the challenge of HIV and AIDS implies a broad spectrum of appropriate interventions. The HIV and AIDS and STI National Strategic Plan 2007– 2011 Goal No. 7 aims at addressing the special needs of pregnant women and children. The objective is to provide a comprehensive package of services that includes wellness, care and ART to HIV-infected, -affected and -exposed children and adolescents. Providing psychosocial support for children has been identified as one of the interventions towards achieving the objective of providing a comprehensive package.

Based on the preceding information, it is therefore imperative to give attention to the psychosocial care of HIV-positive babies and young children.

This manual aims to equip health and child care practices with information and skills for the psychosocial care and support of babies and young children who are living with HIV and AIDS and who are on treatment in the health system.

The manual begins by outlining background information on HIV and AIDS which is essential embedded knowledge for all practitioners working with children. It touches on issues like communicating with children, their developmental milestones and most importantly, the psychosocial impact of HIV and AIDS on young children.

Always review the latest policies from the Department of Health in preparation for this training.

Welcome and introduction

Aim of this session

The welcome and introduction session aims to introduce trainees and facilitators to one another and to determine the trainees' expectations of the course.

Session plan:

Module	Topic	Time (recommended)
Registration	Welcome and introductions	08:30 – 09:00
Module 1	Background to HIV and AIDS	9:00 – 09:30
Module 2	ART criteria and compliance	09:30 – 10:00
Module 3	Nutrition for children living with HIV and AIDS	10:00 – 10:30
Module 4	Developmental milestones in children from birth, and the neurological impact of HIV and AIDS on development	10:30 – 11:00
Tea		11:00 – 11:30
Module 5	Stimulation and development programmes	11:30 – 12:00
Module 6	Record-keeping assessments	12:00 – 12:30
Module 7	Psychosocial impact of HIV and AIDS on young children	12:30 – 13:00
Lunch		13:00 – 13:30
Module 8	Family and community support systems	13:30 – 14:00
Module 9	Communication with children living with HIV and AIDS	14:00 – 14:30
Module 10	Counselling and children	14:30 – 15:00
Final comments and closing		15:00 – 15:30

Resources

- ✓ Trainer's Manual and Trainee's Handout
- ✓ Whiteboard and markers
- ✓ Flip chart and markers
- ✓ Name labels
- ✓ Pens or pencils

Activity – Introduction



Time: 10 minutes

Method: Group activity

Aim: To allow trainees and trainers to introduce themselves to the rest of the group

Trainer's instructions

- ✓ Hand out the labels and marking pens. Make sure each trainee receives a label.
- ✓ Ask each trainee to think of an adjective to describe him or herself. The first letter of the adjective must be the same letter as his or her name, e.g. Lovely Lucy.
- ✓ Each trainee must write the adjective with his or her name on the label provided.
- ✓ Each member of the group must have a chance to stand up and introduce themselves, to explain why they have chosen their particular adjective.



Module 1: Background to HIV and AIDS

Aims of this module

Module 1 aims to reinforce trainees' prior knowledge of HIV and AIDS transmission before equipping them with the skills to provide the psychosocial care and support required by babies and children living with HIV and AIDS and who receive Antiretroviral Therapy (ART).

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate an understanding of the differences between HIV and AIDS
- ✓ Describe the transmission of HIV
- ✓ Role play how the immune system of an individual living with HIV and AIDS becomes deficient
- ✓ Demonstrate an understanding of how adults and infants progress from HIV to AIDS.

Further reading

- ✓ Van Dyk, A. *HIV/AIDS Care and Counselling. A multidisciplinary approach*. Cape Town, Pearson Education, 1999.

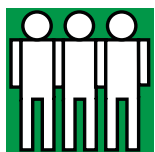
Resources

- ✓ Overhead slides or PowerPoint presentation showing the answers to the questions under "Assessment of essential embedded knowledge"
- ✓ One label per title printed with the names of the most common opportunistic infections:

● human body	● swollen glands
● flu	● fungal infection
● STI	● TB
● shingles	● pneumonia
- ✓ Four labels printed with the term: CD4 cells
- ✓ Two labels printed with the acronym: HIV
- ✓ Flip chart, pens and paper
- ✓ Overhead projector and slides, or a laptop computer and projector
- ✓ Handouts on the phases of infection in adults and children.



1.1 Activity – Assessment of essential embedded knowledge



Time: 10 minutes

Method: Question and answer

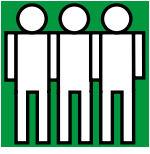
Aim: To determine the trainees' prior knowledge of course content

Trainer's instructions

- ✓ Introduce the module by asking the group the following questions:
 - What does HIV stand for?
 - What is the difference between HIV and AIDS?
 - Explain immune system in simple terms.
 - How does a virus differ from bacteria?
 - Name any kind of germ. How it can be treated?
 - Is AIDS the name of a particular disease? Motivate your answer.
- ✓ Allow the learners to brainstorm answers with their peers/partners before they give you the answer they think is correct. If the answer is incorrect, ask leading questions that will guide trainees to the correct answer.
- ✓ Finally, put up overhead slides or the PowerPoint presentation to show the correct answers to round off the discussion.



1.2 Activity – Progression from HIV to AIDS



Time: 15 minutes

Method: CD4 soldier game in group

Aim: To allow learners to discover how HIV progresses to AIDS

Trainer's instructions

Note: This activity may take longer than the allocated time. To shorten the activity, leave out some of the common opportunistic infections.

CD4 soldier game

- Invite trainees to come forward and represent the titles on your labels.
- Give each trainee their label.
- Tell the CD4 cells their job is to protect the body from germs.
- Now ask the group: "What is the most common sickness that human beings get? Flu – that's right."
- Tell flu to try and attack the human body; get a grip of the person's body anywhere and hold on tight.
- Wait for flu to get hold of the human body and then shout: "Freeze – nobody moves!"
- Ask the group to describe what has happened and then explain that the immune system or CD4 cells are supposed to help the human body fight off flu. Now tell the CD4 cells to get rid of flu by pulling it off the human body.
- Remind the group that when a person gets an STI, it is because he or she has had unprotected sex, allowing the STI to walk right into the body.
- Instruct STI and HIV to attack the human body, to hold on tightly and try to prevent the CD4 cells from pulling them away from the body. STI must allow him- or herself to be pulled off the human body, but HIV must keep hanging on.
- Now ask the group if the CD4 cells would be able to get rid of the STI if this were a bacterial infection. HIV came in with the STI; since antibiotics do not kill viruses, when STI was killed, HIV remained inside the body. HIV does not attack the human body; it attacks the CD4 cells or 'soldier' cells.
- Now tell HIV to grab one of the CD4 cells and prevent it from fighting germs.
- Then call the shingles germ (also a virus) to attack and instruct the CD4 cells to make no move to prevent it.
- Tell HIV to take the infected CD4 cell away from the body. The CD4 cell will die and be replaced by a new HIV cell.
- The new HIV cell must attack the healthy CD4 cells.
- Call on swollen glands and fungal infection to attack. Tell the group to note how tired the CD4 cell soldiers are becoming from fighting off all the germs.
- Ask the group whether it is the body doing the fighting. No, it's the CD4 cells doing the fighting.
- Tell HIV to get rid of one (or more) CD4 cell.
- Invite TB and pneumonia to attack.
- Again HIV must get rid of another CD4 cell.
- Tell the rest of the germs to attack and kill the body.

Conclusion to activity:

- When the body is lying on the floor, tell everyone to freeze.
- Ask the group: "Did HIV kill this body?" The answer is no.

Module 2: ART criteria and compliance

Aims of this module

Module 2 aims to:

- ✓ Provide basic information about ART to community members of similar cultural backgrounds and mother tongue
- ✓ Facilitate treatment compliance for the child who is receiving ART
- ✓ Outline factors that promote the success of ART
- ✓ Explain the psychosocial and cultural factors that have an effect on a child receiving ART.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate a fundamental knowledge of ART and its role in HIV and AIDS
- ✓ Explain the psychosocial and cultural factors that affect the child receiving ART, the family and the community
- ✓ Explain the factors that promote the success of ART.

Further reading

- ✓ Guidelines for management of the HIV-infected child
- ✓ Soul City literature
- ✓ Pamphlets at local clinics
- ✓ Childline literature

Resources

- ✓ Appropriately sized syringes
- ✓ Medicine glasses
- ✓ Water
- ✓ Labels and different coloured stickers
- ✓ Pill boxes
- ✓ Medication diaries and/or ART chart



2.1 Activity – Administering ART



Time: Five minutes

Method: See procedure below

Aim: To educate the family about the correct way of administering ART

Trainer's instructions

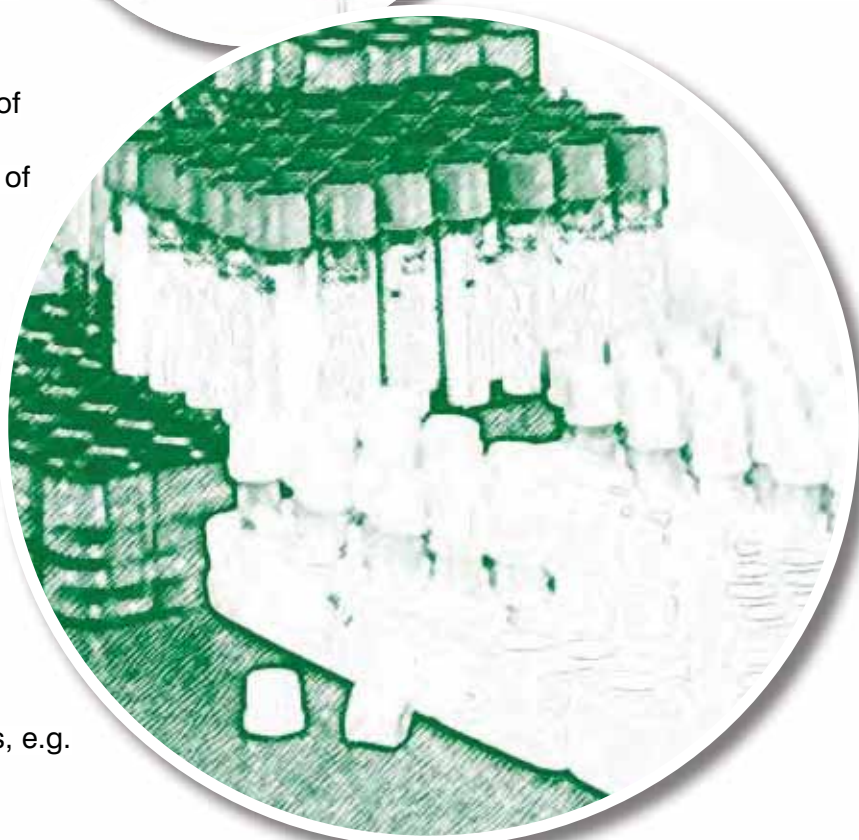
You will need:

- ✓ Antiretrovirals
- ✓ Appropriately sized syringes
- ✓ Medicine glasses
- ✓ Water
- ✓ Different coloured stickers
- ✓ Pill boxes
- ✓ Labels
- ✓ Medicine diary.



Procedure:

- ✓ Wash your hands
- ✓ Measure the prescribed amounts of liquid medication
- ✓ Dispense the prescribed amounts of capsules into a medicine glass
- ✓ Administer the medication with food or after eating
- ✓ Make sure that the medication has been swallowed by politely asking the child to open his or her mouth
- ✓ Give the child yoghurt, sweets or oranges after the medication to alleviate the bitter taste
- ✓ Wash, rinse and store utensils according to policies and procedures
- ✓ Sign or tick the medication chart provided and record any reactions, e.g. vomiting.

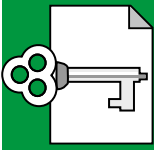


Trainer's notes

This activity may be done as a group demonstration or individually.

2.2 ART criteria and compliance

Every child living with HIV and AIDS has the right to comprehensive therapy which includes ART to reduce morbidity and age-related mortality from HIV infection and to improve the quality of their life.



What is ART?

- ART comprises a regime of medications that suppress or prevent the activity of HIV
- These medications disrupt the HIV enzyme's ability to perform genetic copying and produce a virus that can infect other cells
- Best if used in a combination with three medications
- The Highly Active Antiretroviral Therapy (HAART) is a combination regimen to reduce viral load to undetectable levels
- With ART, the CD4 cell count rises and remains above the baseline count.

Benefits of compliance

- Children experience a type of 'high', or a feeling of extreme emotional well-being when starting ART
- Their appetite improves
- They gain weight
- They experience a reduction in opportunistic infections
- Hope is restored in both parent and caregiver
- Their immune systems are boosted.

Adherence

- The patient must stick to the treatment plan
- The prescribed ART medication must be taken at the right time and in the right dosage daily
- The patient must meet scheduled medical appointments
- The patient must collect medical repeats.

Consequences of non-adherence

- Building up a resistance to the ART medication
- The virus is free to reproduce itself
- The virus mutates, preventing the medication from working when it is taken again
- Doctors will need to do a viral load test to detect whether or not a high resistance has developed.

2.3 How can we improve the efficacy of ART in children?

To answer this question, we need to look at what makes ART adherence in children difficult.

What makes ART adherence in children generally difficult?

- The child may refuse to take their medication
- The child may spit out or vomit up the medication
- The child may develop side-effects
- Timing of the doses may be difficult for caregivers to adhere to
- Mothers/caregivers may want to hide the fact that the child is on treatment
- Medication supply/ordering from pharmacies may be a problem.

In a residential care setting there are different obstacles to be overcome, including:

- A multiple caregiver system, shift changes and new staff
- Hospitalisation of children on ART
- Several children within a family needing ART at the same time
- Timing of dosing may be difficult for caregivers
- Confidentiality/disclosure issues in homes.

How can we improve this?

There are a number of ways to improve adherence. Remember it is vitally important to administer the child's medication with love, care and understanding. If you are calm and have a positive attitude about giving or taking the medication, the child will see this and soon begin to mimic your behaviour. Some ideas on how to improve adherence are:

1 Tools that serve as reminders to take drugs:

- ✓ Setting alarms on watches and cellphones.
- ✓ Having a 'treatment buddy' who phones to remind the patient to take his or her medication.
- ✓ Recording medications that have been administered on a diary card.
- ✓ Packing medication into a weekly pill-box.

2 Ways to ensure that the complete dose of drug is ingested:

- ✓ Pill swallowing should be encouraged from as early as three years of age.
- ✓ When administering syrups, a syringe is preferable to a spoon because spillage from a teaspoon is potentially greater than from a syringe.
- ✓ If a child vomits within 30 minutes of having ingested a medication, it is most likely that the majority of the medication was not absorbed, since gastric emptying is not completed in this short time. In this case, the full dose should be repeated. If vomiting occurs more than an hour after ingestion, it is not necessary to repeat the dose.
- ✓ Poor palatability often affects the completeness of medication ingestion. Infants and young children often spit out a foul tasting medicine. The protease inhibitor Norvir is well known for its poor palatability.
- ✓ If spillage occurs or the medication must be repeated because they were spat out or vomited up, this should be recorded so that extra medication can be acquired before the supply runs out.

- ✓ If a child on ART is hospitalised, his or her treatment must be taken along to hospital. This is especially important for those hospitals that are not roll-out sites or that do not provide ART.

3 Ways to remember appointments and medication collection days:

- ✓ Diaries, wall calendars, etc.
- ✓ Notes stuck to fridges, mirrors, etc.
- ✓ Cellphone reminders.
- ✓ Internal networks, i.e. working teams within the organisation who would ensure specific tasks run according to plan, e.g. transport is arranged to and from doctors' appointments.

4 Ways to overcome obstacles in the residential care setting:

- ✓ One way to maximise ART administration in children's homes is to have written rules and regulations about the treatment. This could be called the home's "ART PLAN" or "ART PROTOCOL". These rules and regulations should include guidelines for volunteers or host families who take children out of the home for weekends or holidays.

2.4 Psychosocial factors and care

Individuals and families could experience these losses:

Financial: Absenteeism as a result of illness eventually leads to dismissal

Physical: Gross loss of weight and physical changes, e.g. ulcers (mouth and face)

Social: The sick person may be abandoned or neglected

Psychological: The sick person may feel lonely and isolated as a result of the disease

These losses may have a direct impact on the child's or individual's motivation and willingness to follow the prescribed treatment.

Major areas of emotional distress:

Discrimination: Against the child as a result of lack of knowledge about HIV and AIDS

Stigmatisation: Diagnosis of HIV infection presents a major crisis and can result in discrimination as there is no cure

Culture: Because HIV and AIDS is spread through sexual intercourse, it is not discussed in some households because sex is a taboo subject

Lifestyle: The sick person may withdraw socially

Losses: Financial, physical and social

Conflicting emotions: Feelings of denial, anger, guilt and fear

Before any intervention, pain should be alleviated by:

- Administering analgesics regularly.
- Treating and managing all symptoms promptly and appropriately.
- Explaining what the intervention will be like prior to the procedure, if the child is old enough.
- Creating an adequate and comfortable child-friendly area where the intervention will take place.
- Offering a variety of toys to distract the child during the intervention.
- Sitting and talking to the child before, during and after the intervention.

Module 3: Nutrition for children living with HIV and AIDS

Aim of this module

Module 3 aims to provide the trainee with knowledge to understand the relationship between HIV and AIDS and malnutrition so that he or she can provide good nutrition to a child who is living with HIV and AIDS in a variety of contexts.

Learning outcomes

By the end of this module, the trainee should be able to:

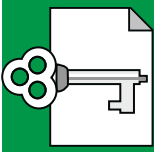
- ✓ Describe the nutritional needs of a child living with HIV and AIDS
- ✓ Describe the contributing factors towards malnutrition in children living with HIV and AIDS
- ✓ Describe the different food groups and their sources
- ✓ Draw up an appropriate nutritional plan for a child living with HIV and AIDS within a family context or an institution.

Resources

- ✓ Flip chart, pens and paper
- ✓ 1 litre of boiled water; allow to cool
- ✓ 8 level teaspoons sugar
- ✓ Half teaspoon salt



3.1 Definition



Nutrition is when the body receives healthy foods in the correct quantity to aid and allow the functioning, repair, growth and maintenance of the body.

The science of nourishing the body properly.

3.2 The nutritional needs of a child living with HIV and AIDS

Children living with HIV and AIDS have increased energy needs compared to uninfected children. Their energy needs increase by 10% in asymptomatic children and between 50% and 100% in symptomatic children. These children also experience a deficiency in micronutrients. Nutrition therefore forms an integral part of any care plan for children living with HIV and AIDS. Nutrition is also important in the provision of ART to achieve the full benefits.

Good nutrition is important because it:

- Strengthens the body's protection and recovery from diseases
- Provides adequate storage of required nutrients
- Helps maintain body weight, muscle thickness and tone
- Assists the body in absorption of medication, thus resulting in positive reactions.

Maintaining good nutrition can be achieved by:

- Eating a balanced diet, containing a variety of foods
- Exercising regularly
- Preventing infections by practising good food hygiene
- Taking ARTs, as this reduces the viral load and boosts the immune system.

To benefit from good nutrition the child should:

- Be weighed regularly to ensure there is no sudden drastic drop in weight
- Eat a balance meal consisting of a variety of foods at least three times a day
- Have new infections or illnesses treated as soon as possible
- Be taught good hygiene practices to prevent the spread of infections.



3.3 Contributing factors towards malnutrition in children living with HIV and AIDS

Malnutrition is a common complication associated with HIV and AIDS. It adds stress to an already weakened immune system and may complicate the treatment of the disease by affecting the intestinal tract's ability to absorb drugs, proteins, carbohydrates and fats.

The following are factors why a child living with HIV and AIDS could become malnourished:

1 Children living with HIV and AIDS have higher nutritional requirements to sustain the different functions and developmental needs of their bodies. Generally, these children have poor food intake due to inadequate food in the home increasing the risk of becoming malnourished.

2 As the disease progresses, opportunistic infections worsen, resulting in different symptoms affecting the body. Some of these symptoms are:

- ✓ Sores in the mouth
- ✓ Thrush which may be present in the mouth and/or oesophagus (throat). It is important to note that thrush may be present in the oesophagus without being present in the mouth
- ✓ Nausea and vomiting
- ✓ Side-effects from medication
- ✓ Diarrhoea, the cause of which may or may not be known
- ✓ Inability to tolerate fats and lactose (milk sugars).

3 Children living with HIV and AIDS and taking ART can experience a decrease in daily nutritional needs. This is because these children often experience side-effects associated with the consumption of ART. Some of these side-effects are:

- ✓ Anaemia
- ✓ Allergic reactions
- ✓ Abdominal pain, loss of appetite, nausea, vomiting and constipation or diarrhoea
- ✓ Elevated blood cholesterol
- ✓ Bone marrow suppression
- ✓ Weakness and dizziness
- ✓ Skin reactions and rashes.

Other contributing factors are:

1 Changes in metabolism

- ✓ Depletion of mineral and vitamin stores
- ✓ Increased use of body stores
- ✓ Changes in the function of the gastrointestinal tract that affect the body's ability to use food in an efficient way
- ✓ Recurrent fevers and infections causing a rise in metabolic rates.

2 Functional impairment

- ✓ Chewing and swallowing may be greatly affected in children where HIV has affected the nervous system.

3.4 Intervention strategies

Sores in the mouth and oral thrush

- Provide small, frequent meals.
- Provide soft, non-irritating foods, e.g. yoghurt, eggs, soups, custard, etc.
- Avoid food that is spicy, sour or sweet.
- Serve food cold or at room temperature.
- Allow the child to use a straw for drinking, so that the fluid does not touch the sore parts of the mouth.

Nausea and vomiting

- Encourage the child to drink lots of water as it contains most nutrients and enzymes needed by the body.
- Eating dry toast and rusks may be helpful.
- Encourage the child to eat when he or she feels hungry and not only at set meal times.
- Avoid foods with a high content of fat and a strong aroma.
- Avoid very sweet food.
- Encourage the child not to lie down flat directly after a meal, as this may cause regurgitation.
- Make meals tasty and enjoyable.
- Good oral hygiene is essential.

Diarrhoea

- Provide lots of fluids to replace the lost fluid; prepare rehydration fluid.

To make rehydration fluid, use the following:

1 litre boiled water, allow the water to cool

8 level teaspoons sugar

Half a teaspoon salt

NB: Prepare fresh rehydration fluid every day



- Provide small, frequent meals.
- Soya milk is the preferred form of milk, if available.
- Offer rice cereals, pasta, soft porridge, mashed fruits (except pears) and vegetables, boiled or steamed meat.
- Avoid fatty foods.

Fever

- Provide plenty of fluids – either cold water, rehydration fluid or any type of clear fluid drink, e.g. rooibos tea with no milk. Rehydration solution is especially important when there is a risk of dehydration.
- The child may not want to eat solid food. However, as soon as the temperature is down, encourage him or her to eat.
- If the child does not want solid food, begin with small quantities of soft foods like porridge and cereal.

Weight loss

- Increase the quantity of food provided, as long as the child is able to eat more. However, this may not be enough, as the child may still lack certain vitamins and minerals. Nutritional supplements which increase the appetite and encourage weight gain can be given (e.g. Progress and Complian). These supplements must be taken under the supervision of a health care provider.
- Encourage the child to eat three regular, well-balanced meals every day, with nutritious snacks between meals
- If the child will not eat, provide regular nutritious liquid meals.
- Try to make sure that all food given to the child has nutritional value.
- You may also try to include the following in the child's diet: butter, eggs, sugar, honey, yoghurt, cheese, dried fruit and peanut butter.
- Make meal times relaxed, ensuring the food is tempting and varied.
- Be patient.

3.5 Nutritional management

Different food groups and their sources

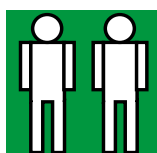
It is important to understand the different food groups and their functions in the body. The body requires different amounts of different foods in order to function properly, although not all nutritional requirements may be met at any particular meal. It is therefore important to formulate and adhere to a well-planned menu.

Food group and quantity	Food sources
Starchy foods	
These foods should be included in every meal.	Bread, pap/phuthu/ting, soft porridge, cereals, rice, potatoes, sweet potatoes, samp, millet, mealies, sorghum, pasta, mavhele, corn, umnqusho, sorghum and amadumbe.
Fruit and vegetables	
Children should eat at least five portions of fruit and vegetables every day.	Vegetables: spinach, morogo/mifuno, delele, mushidzhi, vowa, pumpkin leaves, green peppers, sweet potatoes, unomxoxozi/ibhece, pumpkin, beetroot and beetroot leaves and carrots. Fruit: yellow peaches, apricots, paw-paws and mangoes. Citrus fruits like oranges, naartjies, grapefruit, lemons and guavas. Mangoes, tomatoes, marula fruit and potatoes supply vitamin C. Sweet potato leaves, thanga, dried or fresh pumpkin, unomxoxozi, dandelion, watermelon, idolofiya, uqgumqgumu, umsobo, amarula, semphemphe, mahuhuma, madzidzi and mazwilu.



Food group and quantity	Food sources
Meat and dairy foods	
These may be eaten on a daily basis.	<ul style="list-style-type: none"> • Meat: beef, mutton, goat, pork, chicken and fish may be eaten daily. Organ meats from animals (liver, kidney, heart and brains), trotters, mautuana and tripe (mala mogodu) may be included. • Eggs, milk, yoghurt, buttermilk, sour milk, milk powder and cheese may also be eaten. • Insects: mopani worms, insects, izinhlwabusi, termites (such as izintethe/nzie); grasshoppers should also be included as they provide good protein sources; mbiba, unogwaja, rabbits and mbila.
Dried beans, peas, lentils, peanuts or soya	
To be included regularly.	<ul style="list-style-type: none"> • Dried beans, peas, lentils, peanuts, peanut butter, jugo beans and soy beans, amantonggomane, dhovi, nduhu, izindlubu, dinawa and ditloo.
Sugar	
To be included especially after infections or periods of weight loss.	<ul style="list-style-type: none"> • Vetkoek, cakes, pastries, biscuits, cookies, tarts, puddings, deserts and magwinya.
Fats and oils	
To be included daily in moderation.	<ul style="list-style-type: none"> • Butter, margarine, cooking oils, cream, mayonnaise and salad dressings.

3.6 Activity – Menu preparation



Time: 15 minutes

Method: Group work

Aim: To assist the trainees to develop an ability to plan an appropriate diet in relation to the different circumstances of a child living with HIV and AIDS

Trainer's instructions

- 1 Divide the main group into smaller groups of four learners.
- 2 In their groups, ask the learners to choose one of the following scenarios:
 - A three-year-old child with thrush in the mouth.
 - A five-year-old boy with diarrhoea.
 - A four-year-old boy with a fever (high temperature).
 - A five-year-old girl with nausea and vomiting.
- 3 In their groups, the learners are to design/develop a menu plan for one day. Remind the learners to develop the menu according to the specific needs of the child.
- 4 Let them choose one person who will present their work to the bigger group.

Module 4: Developmental milestones in children from birth, and the neurological impact of HIV and AIDS on development

Aim of this module

Module 4 aims to develop an understanding and awareness of delays in developmental milestones in children living with HIV and AIDS from birth to five years.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate an understanding of the basic developmental milestones of children from birth to five years
- ✓ Reflect on the neurological impact of HIV and AIDS on development.

Further reading

- ✓ *Know the pre-school child:*
Transvaal Education
Department
- ✓ *Is your child school
ready?* by Anna-Marie
Wentzel

Resources

- ✓ Pen
- ✓ Flip chart pens
and paper



4.1 Developmental milestones from birth to three months

Emotional

- Learns to depend on adults if adults respond when he or she cries
- Feels secure when adults hold him or her in their arms.

Physical

- Sucks on fingers or hands because this is soothing
- Moves hands and feet
- Is able to hold their head up for a short period of time.

Social

- Recognises parents' voices.

Language

- Cries to 'call' adults.



4.2 Developmental milestones from three months to six months

Emotional

- Responds positively when adults smile at him or her
- Frowns or cries when adults stop paying attention or playing
- Needs comfort when upset or frightened.

Physical

- Studies hands and fingers
- Discovers that hands and feet are a part of his or her body
- Smiles often
- Puts hands and objects into their mouth
- Is able to roll over
- Has favourite positions but likes change, e.g. to move from being on the back, to the stomach, to sitting up.

Social

- Prefers human contact to toys
- Likes being held
- Likes adults to talk softly and to smile.

Intellect

- Likes to look around and see new things.

Language

- Communicates through facial expressions and gestures
- Has different cries, facial expressions and body movements to communicate sleepiness
- Stretches arms out when wanting to be picked up
- Closes eyes or turns head away when losing interest.

4.3 Developmental milestones from six months to nine months

Emotional

- Learns to wait a few minutes when he or she has a need to be met, if secure in the knowledge that adults will always come and attend to his or her needs
- Laughs aloud sometimes with a belly laugh
- Needs to feel protected when feeling overwhelmed
- Is sometimes fussy.

Physical

- Can shake a rattle and make sounds
- Can kick a mobile and make it move
- Smiles and wiggles when an adult plays with him or her
- Can hold something, let it go and get hold of it again
- Can move an object from one hand to another
- Can sit without help
- Is able to crawl
- May be able to stand with help.

Social

- Afraid of strangers
- Prefers a few special people
- May cry if a stranger gets too close or looks directly at him or her
- Likes to play with adults
- Primary caregiver is the most important person to him or her.

Intellect

- Likes to play games with adults, like peek-a-boo and hide-'n-seek.

Language

- Learns to make many different sounds
- Uses sounds, changes of expression and moves around to get adults' attention
- Begins to imitate sounds



- Likes it when adults imitate his or her sounds
- Enjoys being spoken to, sung to and read to.

4.4 Developmental milestones from nine months to one year

Emotional

- Shows affection
- Grows in confidence when adults allow him or her to try new things.

Physical

- Can pull self up and stand holding onto furniture.

Social

- Has fun making silly faces and noises with other children
- Struggles to share, but learns through supervised play with others.

Intellectual

- May use a stick or another object to reach a toy.

Language

- Knows own name
- Points to an object they want
- Learns to look at the ball when the adult says 'ball' in the child's home language
- Is able to sense whether the adult is happy or upset from the tone of their voice and how much tension is in the adult's body when they hold the child.



4.5 Developmental milestones from 13 months to 18 months

Emotional

- Respects him- or herself when there is a sense that the adult is really listening
- Feels proud of what he or she can do and praise makes him or her feel even better
- Sometimes insists on doing things in his or her own way
- Laughs and may shriek with joy when happy and having fun
- May sometimes hit, push or bite because of anger or frustration
- Feels competent when the adult invites him or her to help
- Can be angry or frustrated and show it by saying "No!" or "Mine!".

Physical

- Can make marks on paper with crayons
- Can stack and line up big blocks
- Can feed self with fingers and later on with a spoon
- Is able to drink from a cup
- Can sit in a chair
- Learns to walk, first with help and then alone
- Learns to walk forward, take a few steps backwards and try to climb stairs
- May begin to dress and undress themselves
- Is able to push their foot into a shoe and their arm into a sleeve.

Social

- Has favourite toys and favourite foods
- Adults can help peaceful play by providing duplicates of favourite toys
- Learns how to relate to other people by watching adults
- Likes to choose what to wear
- May role play simple scenes with others such as, caring for dolls and talking on a cellphone
- Imitates adults' actions like pushing a vacuum cleaner, sweeping and wiping
- Enjoys being given 'adult' tasks to do.

Intellectual

- Is able to solve problems such as going around a chair when chasing a ball, knowing that it will come out on the other side
- Enjoys wind-up toys, e.g. music box
- Is very interested in how the world works.

Language

- Can point to and tell the names of one or more body parts
- Points to pictures of interesting objects, animals and people in books
- May hit, kick or bite when frustrated or angry
- Creates long babbled sentences
- Uses sounds other than crying to get help
- May be able to say between two and ten (or more words) clearly.
- Listens to and watches adults because they understand more than just words
- Begins to use 'I', 'me' and 'mine'
- Needs help to express feelings in an acceptable way.

4.6 Developmental milestones from 18 months to three years

Emotional

- Relies on adult to set clear and consistent limits that will keep him or her safe
- When testing the limits, is learning his or her place in the family unit and how to behave
- Has a sense of belonging when spoken to in his or her home language
- Feels proud when seeing pictures of him- or herself with other friends or family members hanging on the wall

- Feels safe when familiar adults work together to offer care
- Demonstrates self-respect when adults show him or her respect
- Knows when adults feel he or she is good or bad, pretty or ugly and smart or dumb
- Tunes in carefully to adults' tone and words when they talk about him or her (**Note:** Please don't talk about them as if they can't understand)
- Sometimes wants to walk, other times wants a ride in the pram
- Sometimes insists on doing things his or her own way, other times wants an adult to do things for him or her
- Learns to control behaviour best when given only a few simple, clear rules to follow and an adult is there to remind him or her
- Feels proud of things he or she makes or achieves
- Can get very frustrated and angry and may hit, push or bite to express feelings
- May be afraid of the dark, imagined or illustrated monsters, and people in masks or costumes.

Physical

- Turns the pages of a book
- Scribbles with a crayon or marker and may be able to draw shapes, like circles
- Pounds and squeezes clay and makes shapes with a cookie cutter
- Can thread beads with large holes
- Is learning to use scissors
- Can kick and throw a ball
- Stands on one foot
- Is learning to stand and walk on tiptoe
- May be able to walk upstairs putting one foot on each step
- Is learning to eat with a spoon and fork, though sometimes uses fingers
- Can dress self in simple clothes
- Can pour milk on cereal.

Social

- Is aware of other children of the same age and sex
- Is aware of skin colour and may begin to be aware of physical differences
- Can tell who is missing from the group
- Is learning to use words to express feelings
- May pretend to go to work or cook supper
- Explores environment, going over couches or under tables
- Builds block towers
- Sometimes practises how to express feelings when playing
- Learns how to treat others by watching how adults treat others
- Shows care by imitating adults
- Is learning he or she doesn't always get his or her own way
- Sometimes can control self when things don't go his or her way, and sometimes can't
- Is learning to take turns
- Sometimes shares.

Intellectual

- May be able to put toys in groups, e.g. putting all of the toys with wheels together
- Can find a familiar toy in a bag, even when he or she can't see it
- May know up to 200 words in their home language and sometimes in a second language, and can put them together in sentences

- Can talk about things that happened yesterday and about things that will happen tomorrow
- May get frustrated when having trouble expressing self so needs adults to listen patiently; it may help if an adult puts into words what the child is trying to say.

Language

- Enjoys stories that are about something the child knows
- Sometimes may listen for a long time, other times may listen for just a little while before losing interest
- Likes to join in when a story is told
- Sometimes likes to 'read' or tell a story
- Likes songs, finger plays and games with nonsense words
- Talks together with friends as they role play scenes about serving lunch, driving a car or cleaning a house
- Sometimes improvises by using an object as something else, e.g. a block for a telephone.

4.7 Developmental milestones from three to four years

Emotional and social

- Develops friendships
- Plays with other children, instead of just side by side
- Follows simple directions
- Enjoys helping with household tasks
- Begins to recognise own limits, asks for help
- Does not cooperate or share well
- Is able to make choices between two things
- Begins to notice other people's moods and feelings.

Physical

- Walks along a straight line and runs around obstacles
- Balances on one foot for five to ten seconds and is able to hop on one foot
- Pushes, pulls and steers wheeled toys and rides a tricycle
- Uses a slide independently
- Jumps over 10 cm high objects and lands on both feet together
- Throws ball overhead and is able to catch a bouncing ball
- Builds tower of nine small blocks
- Drives nails and pegs
- Able to copy a drawing of circles or a cross
- Manipulates clay material (e.g. rolls balls, snakes, cookies).

Intellectual

- Can describe how two objects are used
- Uses four to five words in a sentence
- Names two actions (e.g. skipping, jumping)
- Can follow a two- or three-component command
- Gets dressed without help
- Understands most of what is said

- Matches pictures to objects
- Learns by doing and through the senses
- Understands concepts of 'now', 'soon' and 'later'
- Recognises cause-and-effect relationships.

Language

- Hears when being called from another room
- Hears television or radio at the same loudness level as other family members
- Understands simple Who, What, Where and Why questions
- Talks about activities at school
- Uses a lot of sentences that have four or more words
- Usually talks easily, without repeating syllables or words
- Uses the pronouns 'I', 'you' and 'me' correctly
- Uses some plurals and past tenses
- Knows at least three prepositions, usually 'in', 'on' and 'under'
- Has a vocabulary of about 900–1000 words
- About 90% of what is said should be intelligible
- Verbs begin to predominate
- Knows chief parts of the body and should be able to indicate these if not name
- Understands most simple questions dealing with the immediate environment and activities
- Relates experiences in a logical way
- Is able to reason out such questions as: "What must you do when you are sleepy, hungry, cold, or thirsty?"
- Should know own sex, name and age.

4.8 Developmental milestones from four to five years

Emotional and social

- Takes turns, shares and cooperates
- Expresses anger verbally rather than physically
- Can feel jealousy
- May sometimes lie to protect him- or herself; understands the concept of lying
- Enjoys pretending and has a vivid imagination.

Physical

- Walks backward toe-heel
- Jumps forward ten times without falling
- Walks up and down stairs independently, alternating feet
- Turns somersaults
- Cuts on a line continuously
- Copies a drawing of a cross
- Copies a drawing of a square
- Prints some capital letters.



Intellectual

- Uses a 1 500 word vocabulary
- Uses relatively complex sentences
- Understands the difference between fantasy and reality
- Understands number and space concepts 'more', 'less' and 'bigger'
- Still thinks literally
- Beginning to grasp that pictures and symbols can represent real objects
- Recognises patterns among objects
- Grasps the concept of past, present and future but still doesn't understand duration of time.

Language

- Pays attention to a short story and answers simple questions about it
- Hears and understands most of what is said at home and at school
- Voice sounds clear like other children's
- Uses sentences that give lots of details (e.g. "I like to read my books")
- Tells stories that stick to a topic
- Communicates easily with other children and adults
- Says most sounds correctly
- Uses the same grammar as the rest of the family
- Knows names of familiar animals
- Can use at least four prepositions or can demonstrate his or her understanding of their meanings when given commands
- Names common objects in picture books or magazines
- Knows one or more colours
- Can repeat four digits when they are given slowly
- Can usually repeat words of four syllables
- Demonstrates understanding of 'over' and 'under'
- Often indulges in make-believe
- Extensive verbalisation as he or she carries out activities
- Understands such concepts as 'longer' and 'larger' when a contrast is presented
- Readily follows simple commands even though the stimulus objects are not in sight
- Much repetition of words, phrases, syllables and sounds.

4.9 The neurological impact of HIV and AIDS on children

When HIV is passed from the mother to a child, the virus has an impact at an early stage when there is no immune system in effect. HIV has been found in the brain as early as two days after initial infection (Bowers). Half of all children living with HIV or AIDS are affected by cognitive problems. This is because HIV can enter the brain and infect parts of the brain that are vital for learning and living. The child's cognitive development is then impaired in all areas – academic, physical and social. Premature birth, low birth weight and mental problems are some of the problems a child will face, and these escalate over time.

Children living with HIV and AIDS are also subject to a depressive disorder during the illness. In addition to having cognitive disabilities leading to a failure to understand simple things, they suffer depression. These children may not understand why they are depressed, resulting in more anguish.

Treatment made available to the children should slow down the infections and eventually prevent the infections from occurring.

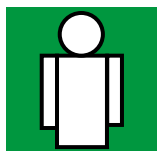
Neuropsychological problems in children living with HIV and AIDS

Developmental delays in infancy

- Declines in intellectual/cognitive functioning
- Language delays
- Gross and fine motor deficits
- Attention Deficit Disorder
- Hyperactivity
- Emotional disorder (withdrawal, depression, apathy)
- Progressive cognitive impairment may be due to Central Nervous System (CNS) effects of HIV
- Loss of paediatric milestones already passed
- Short-term memory loss
- Acquired microcephaly (abnormally small brain)
- Cerebral atrophy (brain tissue wasting), calcifications (calcium deposits) in basal ganglia (nerve structures deep inside the brain) and white matter changes.

4.10 Activity – Understanding basic developmental milestones

It is important to recognise the potential of each child as a unique individual. Interaction with a child in a nurturing environment provides the foundation for developing the child's full potential. Being aware of the child's developmental abilities and the factors affecting his or her development, will allow for maximum developmental interventions.



Time: Five minutes

Method: Individual activity

Aim: Develop an understanding of basic developmental milestones

Trainer's instructions

Select and insert the appropriate age by which a child should have mastered the milestones in the table below.

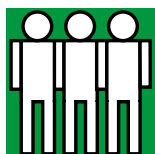
birth – 3 months	3 – 6 months	6 – 9 months
9 – 12 months	13 – 15 months	18 months – 3 years
3 – 4 years	4 – 5 years	5 – 6 years

Developmental milestones table		Appropriate age
1	Learns to walk on their own	
2	Can stand on one foot	
3	Discovers that hand and feet are a part of their body	
4	Prints some letters	
5	Sucks on fingers	
6	Walks up and down stairs alternating feet	
7	May be able to stand if supported	
8	Runs around obstacles	
9	Can move object from one hand to the other	

Trainer's notes

It is important to remember that all children develop at their own pace. Children should reach their developmental milestones at a recommended age, but should they reach these milestones a short while before or after the recommended age, there is no reason for concern.

4.11 Activity – The impact of HIV and AIDS on a child's development



Time: 10 minutes

Method: Discussion

Aim: To reflect on the neurological impact of HIV and AIDS on a child's development

Trainer's instructions

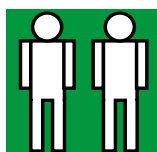
In groups, discuss how the following would affect a child's development:

- 1 Fatigue
- 2 Fits
- 3 Muscle degeneration
- 4 Eye impairments

Trainer's notes

The impact of neurological damage on development varies for each child. We should use the general developmental milestones as a guide, with the aim of providing opportunities for the child to develop at their own pace. When one or more factors contribute to the child being developmentally delayed, it would become necessary to alter the environment or equipment so that the child is still able to develop skills in a way that is not only comfortable, but also beneficial.

4.12 Activity – Accommodating neurological delays



Time: 10 minutes

Method: Case study

Aim: Discuss ways in which resources can be altered to accommodate neurological delays

Trainer's instructions

In small groups, read the scenarios and discuss what advice you would give the parents.

- 1 Mary is four years old and her family feels it is important that she sits at the table and eats the evening meal together with the family. She will often ask to be excused and falls asleep if they do not allow her to leave the table.
- 2 Sue has a 13-month-old son. He is very eager to walk and often stands up, supporting himself against things. Since he has begun throwing fits, Sue does not let him stand on his own anymore.
- 3 Paulina has a six-year-old son who is weak as a result of AIDS. He has watched coverage of the World Cup soccer eagerly and wants to play with a soccer ball himself. However, his legs are weak and he is not able to kick the soccer ball as far as his brother and this is causing him a lot of frustration.
- 4 Anna's three-year-old daughter attends the local nursery school. She enjoys colouring in and doing creative work, but as a result of neurological damage, her eyesight is deteriorating and because of this, she no longer wants to attempt the activities and has even started refusing to go to school.

Trainer's notes

Children are often happier to learn alongside someone else. It is no fun doing things on your own. Rather than excluding children from an activity or game just because they are unable to do it as well as the other children, adjust the apparatus or the environment to accommodate them.

Some suggestions:

- Allow children to rest before they are required to participate in a busy activity.
- Use resources with bold, big print and pictures for children who are struggling to see.
- Provide lighter or softer equipment for children who are struggling with strength or stamina.
- Allow children to complete an activity later if they are tired or uncomfortable.
- Provide easily managed books, toys and games for children confined to bed.
- If they are unable to participate for the entire time, ask the child to indicate to you when he or she would like to join in.

Module 5: Stimulation and development programmes

Aim of this module

Module 5 aims to address the developmental needs of children living with HIV and AIDS.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate an understanding of the concept 'stimulation'
- ✓ Understand the need to stimulate children living with HIV and AIDS
- ✓ Identify and explain what aspects of developmental growth should be stimulated.

Further reading

- ✓ *Daily sensorimotor* by William T Braley; Geraldine Konick; Catherine Leedy (suitable for 3–5 year olds)
- ✓ *Just for Babies* by Theodosia Sideropoulos Spewock

Resources

- ✓ Different coloured pens

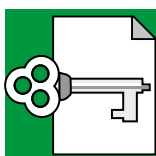


5.1 Introduction

Children should be able to reach and accomplish certain milestones (development challenges, such as walking, talking and socialising) as they develop. Babies and children living with HIV and AIDS generally do not develop and progress at the same rate as children who are not infected. At times, they do not progress at all. The first four to five years of a child's life are very important, since 50% of the child's intellectual development takes place between birth and five years of age.

Children living with HIV and AIDS must be stimulated and allowed to play. They must not be made to feel different from other children. Even though children living with HIV and AIDS develop more slowly than non-infected children, they must be given the opportunity and be encouraged to learn. Accomplishing milestones and being acknowledged for this, will encourage the development of a happy and mentally healthy child.

5.2 What is stimulation?



Stimulation can be defined as provoking interest or increasing alertness of the mind and body in activity through play; also to goad, or prod and incite one into action and stir up what is latent. It is important to stimulate the development of intellectual, social, emotional, spiritual and physical qualities of a child living with HIV and AIDS. Through play, children learn problem solving, interpersonal skills, communication and other skills integral to success in school and life. Playing with your child is not only fun – it is one of the most important ways to nurture development. There are no rules when it comes to play. Play is truly the work of childhood!

5.3 Importance of stimulation

Effective learning can only take place in a relaxed, nurturing atmosphere. There must be a warm, loving relationship between the care worker, the teacher and the child, based on mutual acceptance and respect. This will nurture a positive self-image and the child will begin to feel good about him- or herself.

- When children living with HIV and AIDS play, they learn
- They use their senses
- They begin to understand how their bodies move and function
- When they explore, they discover new things
- They start to use language to express their needs and desires.

5.4 Aspects of stimulation

Decades of research clearly demonstrate that play which is active and full of imagination, is more than just fun and games. It boosts the healthy development of a child living with HIV and AIDS across a broad spectrum of critical areas: intellectual, social, emotional, spiritual and physical. The benefits are so impressive that every day of childhood should be a day for play. To understand the normal development of a child living with HIV and AIDS, one must be aware that there are different aspects of development. Concentrating on only one aspect may benefit the child, but it will not lead to an understanding of the child holistically. Children living with HIV and AIDS need daily stimulation in all aspects of development.

Cognitive/intellectual development

Intellectual development refers to our ability to think, understand and reason.

The child is born with the normal capacity for intelligence, the brain. However, these building blocks of intelligence only begin to develop when the child moves, explores, manipulates, sees, describes and makes use of the elements of his or her world.

A baby's intelligence is influenced by:

- Biological intelligence: the genetic intelligence inherited from his or her parents.
- Cultural intelligence: influenced by the child's culture and the stimulation received from that culture.
- Environmental intelligence: influenced by the different environments the child is exposed to and the stimulation received from these environments.

Language development

Language is unique to man and is the highest human achievement. The child must learn to develop competence in language and speech. The three main purposes of language are:

- To communicate (feelings, information and thoughts)
- To develop our thought processes (learn, remember and understand)
- To assist in the transmission of culture (learn and gain knowledge from past generations)

Emotional expression

Every human experiences many kinds of emotions. These include love, happiness, contentment, excitement, worry, fear, sorrow, anger, pride, jealousy and frustration. The intensity of these emotions will depend on your child's personality and his or her age. Babies have a powerful inborn ability to communicate their emotional needs which they express through their behaviour. In the early stages, their greatest emotional need is for affection.

Emotional development will be influenced by their inborn temperament and their environment. A child may be a natural extrovert with a happy personality, or may be shy and introverted. Early experiences in the home and the type of emotional input they receive from their parents and caregivers, will have a direct influence on how they deal with their emotions and how they express themselves. This in turn affects the way in which they share their feelings and how they deal with worry and frustration.

Motor/muscle development

Movement is a fundamental need for every child living with HIV and AIDS, on the same level as healthy eating and sleeping. A child is born with an inner drive for movement and most children discover this drive spontaneously and use it to move.

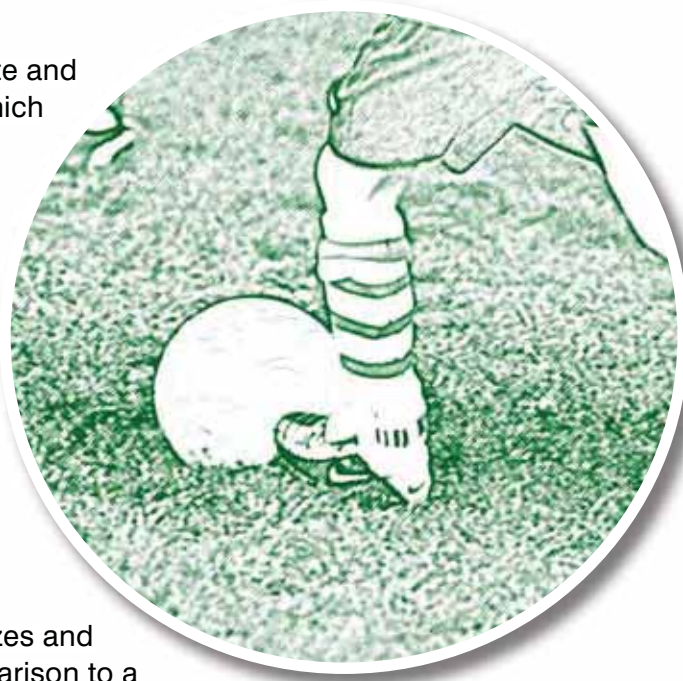
The child plays movement games which involve the whole body, physically and mentally. These movement games give the child's muscles exercise and at the same time, develop many critical physical and perceptual skills needed for learning.

5.5 Ideas on how to stimulate a child living with HIV and AIDS

There are endless activities you can do with a child living with HIV and AIDS.

Gross motor coordination

Gross motor activities are those which help stimulate and develop the large muscles of the body. Activities which use the body's large muscles can be incorporated into most physical games. Look around your environment and use existing apparatus in these activities and games, e.g. tables, chairs and low bricked walls. Gross motor activities are also useful in identifying a child's dominant side (left or right).



Games that require physical exertion

- Leap frog.
- Hop scotch.
- Following obstacle courses.
- Jumping games with ropes and elastics.
- Pushing and pulling objects that are different sizes and weights, e.g. a wagon filled with blocks in comparison to a wagon filled with mud.
- Play games to reinforce the following spatial awareness concepts: under and over, left and right, up and down, in front of, in the middle, next to and behind.

Large movement activities

- Kicking and punching into the air or against a hanging punching bag.
- Climbing onto, up and down apparatus (garden jungle gyms).
- Running races and games include; running while balancing a large stone on a tablespoon, three-legged races and relay-team races.
- Rolling on a carpeted floor or grass patch, either sideways or head first.

Ball skills

Most of the skills practice done with balls can be done with beanbags as well.

Throwing balls:

- Throwing balls of different sizes, shapes and weights.
- The younger child can be encouraged to roll or push a ball away from their body.
- Throwing balls includes throwing overhead, underhand, throwing with both hands (use bigger balls) and throwing with only one hand.
- Throwing balls into buckets or boxes. The distance between the child and the bucket or box can gradually be increased as the child becomes more accurate and older.

Kicking balls:

- Kicking balls of different sizes, shapes and weights.
- Kicking balls ball using both the front of the foot (i.e. toes) and the sides of the foot.
- Kicking a ball which is stationary. Once the child has become accurate in kicking the ball this way, they can then start kicking a ball which is in motion. You can either roll or gently kick a ball in the child's direction. You can also allow the child to stop a moving ball using their feet before they kick the ball away from themselves.
- Children who are able to, should be allowed to run whilst kicking the ball (soccer-type games).

Fine motor coordination

Fine motor refers to the use of the small muscles in the body. Development of these muscles is necessary in order to master the skills required to complete any small movement activities. These activities can include cutting and writing skills, as well as tasks such as manipulating a knife and fork, or doing up the buttons on a jersey.

When children are busy doing fine motor activities, it is important to check the following:

- The child should be sitting with their body placed directly in front of the activity. Make sure they are not at an awkward angle as this will limit their concentration, as well as form a barrier to what they should be doing.
- The child should be seated at a table and chair which is of the correct size and height. Their feet should be placed together and resting on the floor. The table should not be too low, as this will mean the child will have to bend down to work. The child's forearms should rest comfortably on the table-top.
- The child must be encouraged to support their work with their non-dominant hand.
- Encourage a 3-point finger grip when holding writing or colouring-in instruments.

Cutting

Cutting activities will vary according to age as well as existing fine motor development. Ensure that prior to the cutting activity, the child has been pre-assessed and you have the most suitable cutting tools available for the child as well as the activity.

Assess children's cutting with questions such as:

1 Which hand does the child use?

(Left- or right-handed scissors.)

2 Can the child independently open and close the pair of scissors?

(Does the child have sufficient strength in their hand? Test the pair of scissors and check for their tension.)

3 Does the child need assistance to hold the pair of scissors?

(Use dual-control scissors.)

When cutting lines and shapes, encourage the child to:

- Point the tip of the scissors to follow the line they will be cutting. The child is to look at the point of the scissors. If the child struggles to watch the tip, draw attention to the tip by painting it with a bright colour.
- Demonstrate to the child the correct way the scissors should be lined up against the cutting line.
- The child is to hold the paper with their non-dominant hand. They should hold the paper close to the scissors as this will prevent the paper from tearing.
- Encourage the child not to pull the paper through the scissors.

- The older child can cut away the excess paper around a particular shape to make maneuvering the paper easier.

Tearing paper

- The very young child can be encouraged to rip paper; this can then be developed into controlled tearing of paper.
- The young child must be encouraged to tear long strips of paper and then smaller bits which can be collected and used in a collage.

Cutting with scissors

Snipping:

- Allow the child to hold the scissors and snip at the edge of a piece of paper. This activity allows the child to adjust to holding a pair of scissors and practising the cutting movement.

Fringing:

- The adult can draw a horizontal line across the bottom of the page.
- Draw vertical lines from the horizontal line to the bottom of the page. The vertical lines should be about 2 cm apart.
- The child can then cut the vertical lines, stopping at the horizontal line.
- This activity can be extended to include the child cutting a strip of paper.

Shaped and curved lines:

Remember to give children activities which are age-appropriate to their development. Activities which are either too easy or too difficult, will frustrate the child and possibly hinder their learning.

- It is important to encourage the child to use their non-dominant hand to maneuver the paper into the correct directions for the shape.
- The dominant hand is used to maneuver the scissors only.

Auditory discrimination

Auditory discrimination refers to the development of the child's listening skills. Activities can vary according to age and environment.

- Make children aware of the sounds in the environment. Encourage them to identify and mimic these sounds in their home, e.g. a telephone ringing, running water, a teaspoon tapping against a tea mug, etc., and sounds outside of their home, e.g. an aeroplane flying above, motor cycles, birds chirping in the trees, etc.
- Listen to music with the child. Point out the different sounds that different musical instruments make.
- Sing songs with the child. Sing songs which require different tones, pitches and speeds of their voice, e.g. sing slowly but loudly.
- For the older child, allow them to name objects in a picture book. Help the child to identify how many syllables are in each word. Clap these syllables out with the child, e.g. a / pple, ta / ble and a / ni / mal.

Visual discrimination

Visual discrimination is the ability to identify the differences in objects, colours, shapes, etc. using the functions of the eyes only.

- Assist children in learning and identifying different colours and shapes.
- Colour and shape recognition can be linked to objects in and around the child's environment, e.g. the plate is a circle, the grass is green, etc.
- Encourage the child to look at both 1D, 2D and 3D pictures and objects. This will

include being able to identify which objects are in the front and which objects are in the background.

Language

Language development refers to the development of the way the child speaks and is able to understand spoken language.

- Do not use 'baby talk' when speaking to children.
- Use everyday situations to teach new vocabulary.
- The more experiences a child has, the more words he or she will hear and pick up in his or her vocabulary.
- Develop the child's concept of collective nouns, e.g. a chair, a table and a couch are all types of furniture. There are many categories: fruits, vegetables, animals, transport, etc. It is helpful to make posters of collective nouns and to hang these on the wall to be referred to repeatedly.
- Speak to a child about their current themes at school. Ask open-ended questions that will form a discussion about the themes. This will also assist in the development of the child's memory.
- Use descriptive language; encourage the child to name and describe objects.
- Read stories to the child. Alternate reading stories that do and do not have pictures. Let the child visualise the story and then retell it to you.

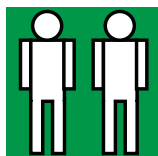
Emotional and social (life skills)

Emotional and social development refers to the development of the child's independence, self-confidence and responsibilities.

- Allow children to dress and undress themselves.
- Teach children to put on their own shoes and tie their laces.
- Let the child make their own beds.
- Encourage children to do chores around the house. This develops a sense of responsibility.
- Older pre-schoolers are expected to look after their clothing and belongings at school, including their stationery and lunchboxes.
 - Develop children's self-confidence by encouraging them to pray (if you are aware of their religious status) and to sing and say rhymes by themselves.



5.6 Activity – Stimulation activities



Time: 10 minutes

Method: Group work according to age groups

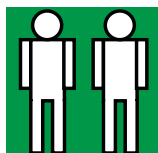
Aim: To provide examples of stimulation activities

Trainer's instructions

Using the information provided in Module 4, these are the activities you must plan for:

- 1 A two-year-old child who is struggling with large muscle activities.
- 2 A baby who has poor grip.
- 3 A four-year-old child who has poor language skills.

5.7 Activity – Stimulation programmes



Time: 15 minutes

Method: Group activity

Aim: To develop stimulation programmes

Trainer's instructions

- 1 Look through the following example of a stimulation programme and then design your own programme, or fill in the information on the template provided.



Stimulation programme from birth to 12 months (example)

Skill	Monday	Tuesday	Wednesday	Thursday	Friday
Language and social development	<ul style="list-style-type: none"> Carried out throughout the day. 	<ul style="list-style-type: none"> Music to be played daily. Singing songs, rhymes, lullabies. 	<ul style="list-style-type: none"> Talking to babies during all activities. Cuddling of babies. 	<ul style="list-style-type: none"> Feeding the babies and maintaining good eye-to-eye contact. 	<ul style="list-style-type: none"> Talking to babies while feeding.
Cognitive (intellectual and mental) development	<ul style="list-style-type: none"> Items of daily use: Manipulation. Reaching out for objects. 	<ul style="list-style-type: none"> Use of sound-producing toys like rattles, bells, drums, etc. 	<ul style="list-style-type: none"> Manipulation of objects that are different shapes and sizes. 	<ul style="list-style-type: none"> Paper play: Crushing of paper. Use of things made out of paper. 	<ul style="list-style-type: none"> Exposure to outside environment: plants flowers birds animals.
Motor development (gross and fine)	<ul style="list-style-type: none"> Massaging. Helping the babies to roll over. 	<ul style="list-style-type: none"> Crawling. Making babies sit with support. 	<ul style="list-style-type: none"> Helping babies stand and walk. Reaching out for shapes. 	<ul style="list-style-type: none"> Manipulation of objects. 	<ul style="list-style-type: none"> Free play.

Indoor and outdoor stimulation programme for 1 – 2½ years (example)

Skill	Monday	Tuesday	Wednesday	Thursday	Friday
Language and social development	<ul style="list-style-type: none"> Carried throughout the day. 	<ul style="list-style-type: none"> Children to be spoken to constantly. Brief and clear instructions for all activities. 	<ul style="list-style-type: none"> Identification of different pictures and objects. Repetition as frequently as possible. 	<ul style="list-style-type: none"> Music to be played daily. Singing songs, rhymes, lullabies. 	<ul style="list-style-type: none"> Talk constantly to children. Always involve them in conversations.
Cognitive (intellectual and mental) development	<ul style="list-style-type: none"> Sand and water play. Use of sand-pit and water pool. 	<ul style="list-style-type: none"> Paper play: Folding of paper. Crushing. Making of paper puppets and balls. 	<ul style="list-style-type: none"> Exposure to outside environment: plants trees flowers birds animals. 	<ul style="list-style-type: none"> Use of clay: Making of different shapes. Manipulation. 	<ul style="list-style-type: none"> Use of colours: Hand printing. Leaf printing. Colouring of paper and different objects.
Motor development (gross and fine)	<ul style="list-style-type: none"> Helping children to stand and walk without support. 	<ul style="list-style-type: none"> Running. Jumping. 	<ul style="list-style-type: none"> Climbing stairs. Activities on swings, slides, seesaws. 	<ul style="list-style-type: none"> Use of pull-along toys. 	<ul style="list-style-type: none"> Free play.

2 When you develop a stimulation programme, look around and try to utilise equipment or apparatus that already exists, e.g. chairs.

Module 6: Record-keeping assessment

Aim of this module

Module 6 aims to provide an understanding of the child's circumstances and needs.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ List information which is necessary to record
- ✓ Complete a general observation record.

Resources

- ✓ Pens and paper
- ✓ Flip chart pens and paper

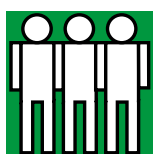


6.1 Introduction

Accurate and up-to-date record keeping is important to compile a history of each child from admission to discharge. It allows the institution to identify and monitor any patterns in behaviour, as well any areas of concern and/or significant changes.

Should it become necessary to refer the child for additional assistance, the person or organisation to which the child is referred to will require detailed information on the child.

6.2 Activity – Implications of an observation record



Time: 10 minutes

Method: Group activity

Aim: Discuss the practical implications of an observation record

Trainer's instructions

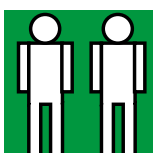
In the group, discuss the following in relation to an observation record:

- ✓ How often should the document be updated?
- ✓ Who will have access to the information recorded?
- ✓ Who will be involved in monitoring and documenting the information?
- ✓ Where and how should the information be stored?

Trainer's notes

Any information recorded should be of value and accurate. Every institution will vary in terms of its information requirements, so the observation record should be a user friendly, working document.

6.3 Activity – Admission forms



Time: 10 minutes

Method: Group activity

Aim: Design an admission form

Trainer's instructions

Using suggestions from ACTIVITY 6.2, design a form for your organisation or department that will be beneficial and relevant.

Observation record (example)

Date:	
Name:	
Surname:	
Date of birth:	Age:
Weight:	Height:
General development:	
Milestones achieved:	
Milestones not achieved:	
Strengths:	
Recommendations:	
Social development:	
Current friends:	
General behaviour:	
Problematic behaviour:	
General health:	
Goals:	
Actions to be taken:	
Referrals:	
Staff member's details:	
Name:	
Surname:	
Staff number:	
Signed by:	

Trainer's notes

It is necessary to observe the child in many different situations and at different times of the day. Record any changes in his or her behaviour, as well as any accomplishments. This allows the institution to offer the most appropriate care to the child and make decisions that will be in the child's best interests. An observation record could be of use to a variety of people who deal with and assist the child in different areas and at different stages. Ensure that the information you record is clear, accurate and honest. Do not allow your personal opinions to affect the way you document the facts.

6.4 Assessment record-keeping

It is important to document a variety of information relating to each child in order to track his or her history and progress from the time of admission. This information includes:

- ✓ Admission form
 - General details, e.g. name, date of birth
 - Physical assessment, e.g. weight, height, scars
 - Immunisations
 - Palliative care
 - History – presenting problem
 - Physical assessment

- ✓ Medication administration schedule
 - Date
 - Time
 - Dose

- ✓ Prescription chart
 - Acute – drug, frequency, duration
 - Chronic – prescribing doctor, change in dosage

- ✓ Assessment form
 - Date
 - Child's details
 - Admission details
 - Birth history
 - Family history
 - Milestones
 - Medical history
 - Clinical examination
 - Special investigations
 - Referrals
 - Prescribed medication
 - Follow-up
 - Recommendations/comments

- ✓ Feeding chart
- ✓ Weight chart
- ✓ Growth chart



Example of progress report

(Insert logo)

Progress report

3 – 6 months old

Name and surname:	
Date of birth:	Group average:
Age:	Group average:
Height:	Group average:
Weight:	Group average:

Language development	Highly competent	Competent	Needs assistance	Not yet competent
Smiles at the sound of your voice				
Babbles				
Imitates some sounds				
Turns head towards direction of sound				
Turns head towards bright colours and lights				
Turns towards the sound of a human voice				
Recognises bottle				
Responds to rattle or bell shaking				
By six months				
Babbles, making almost 'sing-song' sounds				
Recognises familiar faces				
Laughs and squeals with delight				
Screams if annoyed				
Smiles at him- or herself in a mirror				
General:				

Social development	Highly competent	Competent	Needs assistance	Not yet competent
Develops a social smile				
Enjoys playing with other people, and may cry when playing ends				
More communicative and expressive with face and body				
Imitates some movements and facial expressions				
Smiles when smiled at				
Communicates hunger, fear, discomfort (through crying or facial expression)				
Usually quiets down at the sound of a soothing voice or when held				
Anticipates being lifted by reaching out with his or her arms				
Reacts to 'peek-a-boo' games				
Recognises own name				
By six months				
Blows bubbles				
Imitates sounds				
General:				

Motor skills	Highly competent	Competent	Needs assistance	Not yet competent
Raises head and chest when lying on stomach				
Supports upper body with arms when lying on stomach				
Stretches legs out and kicks when lying on stomach or back				
Opens and shuts hands				
Pushes down on legs when feet are placed on a firm surface				
Brings hand to mouth				
Reaches out for dangling objects with hands				
Grasps and shakes hand toys				
Watches faces intently				
Follows moving objects				
Recognises familiar objects and people at a distance				
Starts using hands and eyes in coordination				
Lifts head when held at caregiver's shoulder				
Lifts head and chest when lying on his or her stomach				
Turns head from side to side when lying on stomach				
Grasps rattle when given				
Has started cutting teeth				
By six months:				
Holds head steady when sitting with support				
Reaches for and grasps objects				
Plays with his toes				
Helps hold the bottle during feeding				
Explores by mouthing and banging objects				
Moves toys from one hand to another				
Shakes a rattle				

Motor skills	Highly competent	Competent	Needs assistance	Not yet competent
Pulls up to a sitting position on own if caregiver grasps hands				
Sits with only a little support				
Sits in a high chair				
Rolls over in both directions				
Bounces when held in a standing position				
Opens mouth for spoon				
Imitates familiar actions caregivers perform				
Eats solids				
Starts crawling				
General:				
Observations and general feedback:				

Checked by:

Moderated by:

Date:

Module 7: Psychosocial impact of HIV and AIDS on young children

Aim of this module

Module 7 aims to provide an understanding of the psychosocial impact of HIV and AIDS on young children.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Identify the psychosocial impact of HIV and AIDS on young children.

Resources

- ✓ Paper and pens
- ✓ Flip chat pens and paper



7.1 Case study

This is a story about a family that has been severely impacted by HIV and AIDS. The family comprised a mother, father and three children – a girl, called Zodwa, who was four when we first met her, and twin boys, Themba and Siphso, who were two years old. The father died from an AIDS-related illness a year ago, leaving the mother to care for her three young children alone. The mother did not tell her own family, who lived in the Eastern Cape, that she and the twins were HIV positive, nor the cause of her husband's death, so she received no support from them.

Shortly after the father died, the mother's health also began to deteriorate. This was probably as a result of the loss of the family breadwinner, the grief of losing her husband and the stress of adapting to life without her spouse. More and more responsibility of caring for the family fell on Zodwa, even though she was still very young. It became her duty to care for her younger brothers and to find food for the family. The twins began seeing her as the mother figure in their lives.

These changed circumstances had the following impact on the family:

- The children started showing signs of malnourishment.
- Their hygiene suffered and this, together with poor diet, increased their vulnerability to opportunistic infections.
- Poor living conditions contributed to the family's health problems. They lived in a shack in an informal settlement that had no running water, no bathroom facilities and no electricity. The communal toilet was far from the house and when the mother was too ill to accompany her, Zodwa had to walk on her own to use the toilet. This increased her vulnerability to abuse.
- Although the twins started ART, the family circumstances meant that they did not comply with the regime, so treatment was stopped.
- The mother was afraid to ask for help from the neighbours as she did not want to disclose her family's HIV status, so she started to avoid them.
- The mother and children stopped attending the HIV clinic for fear that someone would find out that they were living with HIV and AIDS.
- All three children lost their trust in adults, perceiving that they had been let down by their parents, firstly by their father dying, followed by their mother's inability to care for them. They were too young to understand the reasons for this.
- At the age of two, neither twin could sit or crawl, their verbal skills were undeveloped and they displayed signs of serious developmental delays.
- Zodwa could not attend pre-school as she had to care for her family and there was no money available to pay the fees anyway.

The circumstances at home deteriorated to the point that the neighbours, who really were concerned for the children, reported the family to the authorities. Unfortunately, by the time this happened, the situation at home was so serious that the children had to be removed as the mother no longer had the emotional, physical or financial resources to provide for them. She was admitted to hospital and later transferred to a TB facility, and the children were placed in the care of Cotlands.

On admission to Cotlands, the following behaviour was noted:

Zodwa (four years old)

- She displayed signs of being a parentified child and had a lot of difficulty relinquishing responsibility for her brothers to the caregivers.
- She couldn't relate to children her own age and did not know how to play or behave like a child.
- She lacked trust in adults as her emotional needs had not been met.
- She displayed signs of anger and depression.
- Although she didn't eat compulsively, she tended to hide food away for later.

- In the classroom setting, she struggled to adapt to the routine, interact with her peers and teacher, follow the developmental programme and had no knowledge of how to function in an educare system. She was often overwhelmed in this setting.
- She was very tearful and even when she wasn't crying, she always seemed close to tears.
- She constantly asked to see her mother.

Themba and Sipho (two years old)

- They showed marked delays in their physical and mental development and were way behind in their developmental milestones, functioning at below a six-month level.
- They were reliant on their sister and emotionally dependent on each other for comfort and could not settle down unless they were all together.
- They ate excessively and never seemed satisfied that they had enough food.
- They were anxious about the activity, noise and equipment in their new environment, which made them fretful.
- When they were made to sit (with support), they cried continuously, most likely because this position was painful and unfamiliar.
- They responded in the same manner towards adults and children and did not clearly differentiate between the different age groups.
- Apart from crying, they made no attempt to communicate.

Six months later, in an environment in which all their physical needs are being met and their emotional, psychological, developmental and medical needs are being addressed, the following is noted:

Zodwa (five years old)

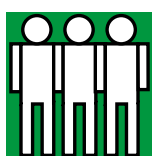
- Zodwa struggles to develop relationships as she still does not trust adults. She hasn't bonded with any staff members or volunteers, despite continual efforts.
- She still seeks solace in her brothers and continues to feel responsible for them. As she is not in the same unit, she frequently feels the need to go in and check on them.
- She remains tearful.
- She does not have the emotional resources to deal with her feelings and acts out these feelings by behaving in a destructive and aggressive manner.
- She often withdraws from a group setting, although she is making some effort to join in activities with her peers.
- She is making some progress with play and is starting to explore, using the play equipment available to her.
- Contact with her mother is extremely traumatic for her. She becomes very anxious before each visit, heightened by the fact that her mother is still seriously ill and as a result of AIDS-related dementia, doesn't always recognise her children.
- Zodwa never asks to see her mother and all contact with her must be initiated by Cotlands.
- Grief is displayed as despair and helplessness.
- She still feels abandoned by her parents and is angry with them.
- She is anxious about learning and fears failure.

Themba and Sipho (two years old)

- They have adapted far more readily to their new environment.
- They have formed attachments with staff and volunteers.
- They are more comfortable with touch and will actively seek out an adult to be held and cuddled.
- They feel safe enough to explore their surroundings.
- They show excitement about their physical progress and have made tremendous progress, although they are still significantly delayed.
- They are still closely bonded to their sister.

- They still continue to eat excessively and never seem satisfied.
- They do not recognise their mother as an important figure in their lives and will cling to the caregiver when visiting her.
- They are playful, laugh a lot and appear relaxed and content.
- They seem to have overcome the early trauma in their lives.

7.2 Activity – Understanding the impact of HIV on a family



Time: 30 minutes

Method: Case study and role play

Aim: To illustrate the impact HIV has on a family

Trainer's instructions

Read the case study and discuss the questions.

Trainer's notes

There are three major psychosocial impacts of HIV and AIDS on young children:

- 1 Loss of social and family support
- 2 Stigma and discrimination
- 3 Decreased access to education, health care and social services

1 Loss of social and family support

The most important direct consequence of AIDS in young children is the loss of their family unit and with it, their economic, social and emotional safety net. This is evident in the case study. Can you identify which of the issues suggests this has happened to these children?

2 Stigma and discrimination

Stigma and discrimination are caused by ignorance and fear of AIDS, and the moralistic and often judgmental views of community members about AIDS. How did stigma, or the fear of stigma, impact on this family?

3 Decreased access to education, health care and social services

The above two factors result in children having less access to education, health care and social services. Without intervention, what do you think the future would have held for Zodwa, Themba and Siphoh?

Role play:

You are Zodwa's child care worker. Please role play how you will interact with Zodwa to help her:

- Prepare for a visit to her mother
- Learn to trust adults
- Express her feelings

Module 8: Family and community support systems

Aim of this module

Module 8 aims to equip the trainee with basic information on the role and importance of family and community support systems.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Assist families in evaluating choices and options
- ✓ Demonstrate the knowledge of available community resources and services.

Further reading

- ✓ *HIV and AIDS Care and Counselling*: Alta Van Dyk
- ✓ *Community Help for Children Living in an HIV+ World*: Noreen Ramsden

Resources

- ✓ Paper and pens for the trainer
- ✓ Flipchart paper and pens
- ✓ List of community resources
- ✓ A copy of child HIV services.
- ✓ A directory of organisations in South Africa (can be obtained from www.childaidsservices.org)



8.1 The circles of help

Families and the community have an indispensable role to play in the care and support of children living with HIV and AIDS, and in ensuring that they are not deprived of their basic rights to shelter, food, health and education. However, the burden of caring for these children falls on families who are already poor and need help from the community.

The circles of help start with neighbours and friends and then widen to include those concerned with children.

They begin in the immediate community and spread beyond.

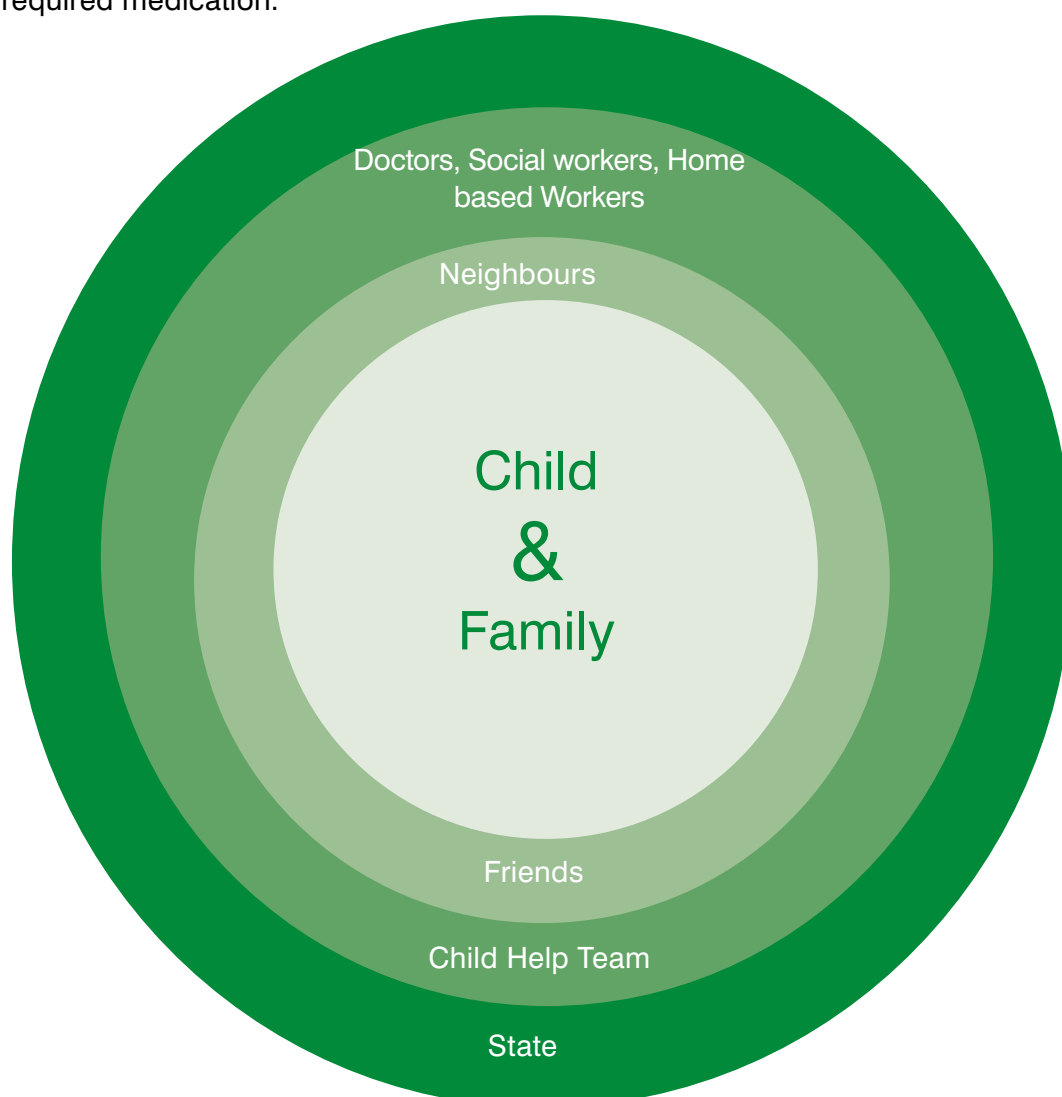
First circle – Neighbours and Friends

Second circle – Community Child Help Team

Third circle – The State

1 First circle – Neighbours and Friends

- They may provide material help in the form of food and clothes.
- They may provide physical help by caring for the child while the mother is running errands or needs to rest.
- They may provide practical help by taking the child to hospital appointments or collecting the required medication.



2 Second circle – Community Child Help Team

- Community caregivers are people in the community trained to help the primary caregivers with direct care and support. Community caregivers may be professionals or volunteers.
- Professional caregivers such as professional nurses, community health or TB workers, medical doctors, psychologists or counsellors, pharmacists, physiotherapists and occupational therapists.
- Trained volunteers and others who offer supportive services such as residential care, respite services, pastoral care, legal aid and advice, transport services and the staff of various NGOs and CBOs (Community Based Organisations).
- Community support from community leaders, traditional leaders, village committees, religious and spiritual leaders, teachers and youth groups.

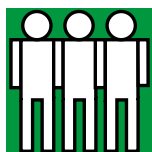
3 Third circle – State support

According to South Africa's Constitution, the State has the responsibility of helping families and communities to meet the needs of children. The Department of Social Development provides four kinds of grants for children:

- The Child Support Grant is given to any person who takes care of a child under the age of 11. To apply for the grant, the total household income should be less than R800 if you live in a town or city. and less than R1 100 if you live in a rural area or informal settlement.
- The Care Dependency Grant is given to parents or foster parents of children who need constant care. HIV-positive children qualify for this grant. Medical reports and the report of a social worker must be handed in with the application to the office of the Department of Social Development. The income of parents is assessed, but not that of foster parents.
- The Foster Care Grant is given to the caregiver of a child who is not their own. This process can only be facilitated by a social worker from a local Child Welfare Society.
- The Social Relief Grant is a temporary grant, given to caregivers who have applied for a permanent grant and are waiting for this application to be processed.

Families and communities can do so much together to help meet the needs of children.

8.2 Activity – Case study



Time: 20 minutes (10 minutes discussion, 10 minutes feedback)

Method: Discussion of a case study

Aim: To demonstrate the ability to identify relevant family and community resources

Thami was orphaned by HIV two years ago. He is 15 years old and lives with his grandmother and two of his four brothers, who are both on ART. His eldest brother (18) has gone to Durban to look for work. None of the children attend school and they survive on their grandmother's pension. Thami has not seen his father for more than five years. The last he heard of his father was that he was employed at a petrol station in Pietermaritzburg as a cashier. The family does not get any support from their extended family members. Thami does not know what he will do if his grandmother dies and the family lose her pension. He is the second eldest in the family and will have to provide for their needs. There is no employment in the area.

- Who should be responsible for Thami and his siblings' support? The father, grandmother, other family members or the State? Motivate and suggest how such support can be obtained.
- If Thami were living in your area, where would you refer him for help?

Trainer's instructions

- ✓ Instruct individuals/groups to discuss the case study and report back on their discussion.
- ✓ Use the circle of support diagram to facilitate a general discussion on the roles of different community support systems.
- ✓ At the end of the session, give the trainees the list of community resources to fill in at home and keep it for reference.

Trainer's notes

- ✓ The primary duty is on Thami's parents to support him and his brothers. The only parent he has is his father, so he could try to apply for maintenance from him if they could get his address. Failing this, the duty falls upon the State to support the children.
- ✓ Home-based care workers, social workers and religious groups can assist in ensuring that Thami's grandmother receives a foster care grant, that the brothers attend school, receive proper nutrition, that the two boys on ART adhere to their treatment and that their adherence is monitored.

8.3 Community resources – role play



Time: 20 minutes

Method: Role play

Aim: To demonstrate the ability to identify relevant community resources

Themba Ndlovu lives in the suburb of Rondebosch in Cape Town. His mother is a domestic worker. Four-year-old Themba is disabled due to HIV and needs constant attention. As a result she has asked her sister to come and stay with them to look after Themba. When the family went to apply for a care dependency grant, they were told that Themba did not qualify but if they paid R300 to the official, his medical records could be reconsidered.

- ✓ Is Themba's mother entitled to a care dependency grant?
- ✓ What should Themba's mother have done regarding the official's request that she bribe him in order to get the grant?
- ✓ What other grants could Themba's mom apply for?

Trainer's instructions

Divide the participants into pairs and ask them to act out the above scenario.

Trainer's notes

- ✓ Themba's mother can't claim a care dependency grant unless she stops work and Themba is found to be severely disabled.
- ✓ She can report the official to the Director of Welfare in her region or to a human rights organisation.
- ✓ Child Support Grant.

8.4 Community resources – template

Community resources

HERE I AM:	
My work place:	
Work address:	
Work telephone: ()	Work fax: ()
Home telephone: ()	My cell number:
CLINIC	
Name:	
Address:	
Clinic telephone: ()	Clinic fax: ()
Community health nurse:	
Home-based care:	
Other:	
HOSPITAL	
Name:	
Address:	
Hospital telephone: ()	Hospital fax: ()
Contact person:	
Other:	
HOSPICE	
Name:	
Address:	
Hospice telephone: ()	Hospice fax: ()
Contact person:	
Other:	
SCHOOLS	
Crèche/nursery school	
Telephone: ()	Fax: ()
Contact person:	
Junior primary school:	
Telephone: ()	Fax: ()
Contact person:	
Senior primary school:	
Telephone: ()	Fax: ()
Contact person:	
High school:	
Telephone: ()	Fax: ()
Contact person:	
Other:	
WELFARE	
Social Welfare office:	
Telephone: ()	Fax: ()
Contact person:	
Child Welfare office:	
Telephone: ()	Fax: ()
Contact person:	

Department of Home Affairs:	
Telephone: ()	Fax: ()
Contact person:	
Other:	
SECURITY AND LEGAL	
Police:	
Telephone: ()	Fax: ()
Contact person:	
Child Protection Unit (CPU):	
Telephone: ()	Fax: ()
Contact person:	
Legal resource:	
Telephone: ()	Fax: ()
Contact person:	
Other:	
RELIGIOUS GROUPS	
Church:	
Telephone: ()	Fax: ()
Contact person:	
Women's group:	
Telephone: ()	Fax: ()
Contact person:	
Youth group:	
Telephone: ()	Fax: ()
Contact person:	
Other:	
SUPPORT GROUPS	
Trauma centre:	
Telephone: ()	Fax: ()
Contact person:	
Community resources centre:	
Telephone: ()	Fax: ()
Contact person:	
Women's group:	
Telephone: ()	Fax: ()
Contact person:	
Men's group:	
Telephone: ()	Fax: ()
Contact person:	
Youth group:	
Telephone: ()	Fax: ()
Contact person:	
Other:	
OTHER	
Traditional healer:	
Telephone: ()	Fax: ()
Contact person:	
Local authority:	
Telephone: ()	Fax: ()
Contact person:	
Other:	

Module 9: Communication with children living with HIV and AIDS

Aims of this module

Module 9 aims to reinforce the trainee's prior knowledge and understanding of how to communicate effectively with children, and provides an overview of how the psychosocial aspect of the child is influenced by the development of their self-esteem and discipline.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate the ability to communicate effectively with babies and young children living with HIV and AIDS
- ✓ Demonstrate knowledge of factors that affect the communication process with babies and young children living with HIV and AIDS.

Further reading

- ✓ *Speech and language: Cause, milestones and suggestions* by Kimberly A. Powel
- ✓ *Positive Discipline* by Jane Nelsen
- ✓ *Bringing Up Kids Without Tearing Them Down* by Dr. Kevin Lemon

Resources

- ✓ Paper and pen for the trainee
- ✓ Flipchart paper and pens
- ✓ Resources for children's activities, i.e. story book, game or creative material



9.1 Activity – Communication and psychosocial development



Time: 30 minutes (10 minutes preparation, 10 minutes presentation, 10 minutes feedback)

Method: Communication activity with the child (observation)

Aim: To demonstrate the ability to communicate effectively with children about HIV issues and to show knowledge of factors that affect the communication process

Trainer's instructions

- ✓ The trainer could give the trainee this activity the day before as homework, to allow time for preparation.
- ✓ Give the trainee ideas on different activities which could be done with children to encourage communication skills, i.e.

1 Stories (flannel board, books, puppets, dramatisation, etc.)

2 Creative activities (movement, art activities, etc.)

- ✓ Ask the trainee to prepare an activity to do with the child which will encourage communication skills.
- ✓ Before the activity, leave the following questions with the trainee:

1 How will the age of the child affect the communication process?

2 How will the child's physical state of health affect the communication process?

3 How will self-esteem and discipline affect the psychosocial aspect of the child?

Trainer's notes and module answers

Question:

How will the age of the child affect the communication process?

Answers:

- ✓ A baby will be limited in verbal communication with the adult but will use body language, crying and smiling to communicate. The adult must be sensitive to these gestures.
- ✓ The health care worker must use age-appropriate language when communicating with the child.
- ✓ Use short, easy sentences with younger children.
- ✓ Use more pictures and objects to communicate with younger children.
- ✓ Use pictures and objects that children can identify with.
- ✓ As the child gets older, use more complex sentences.

Question:

How will the child's physical state of health affect the communication process?

Answers:

- ✓ The language development of a baby or child living with HIV and AIDS could be delayed due to neurological problems, hearing disabilities, a weak immune system causing opportunistic illnesses, etc.

- ✓ Depending of the stage of infection, the child might not have the energy or desire to communicate.
- ✓ Thrush and ear infections also influence the child's communication skills.

Question:

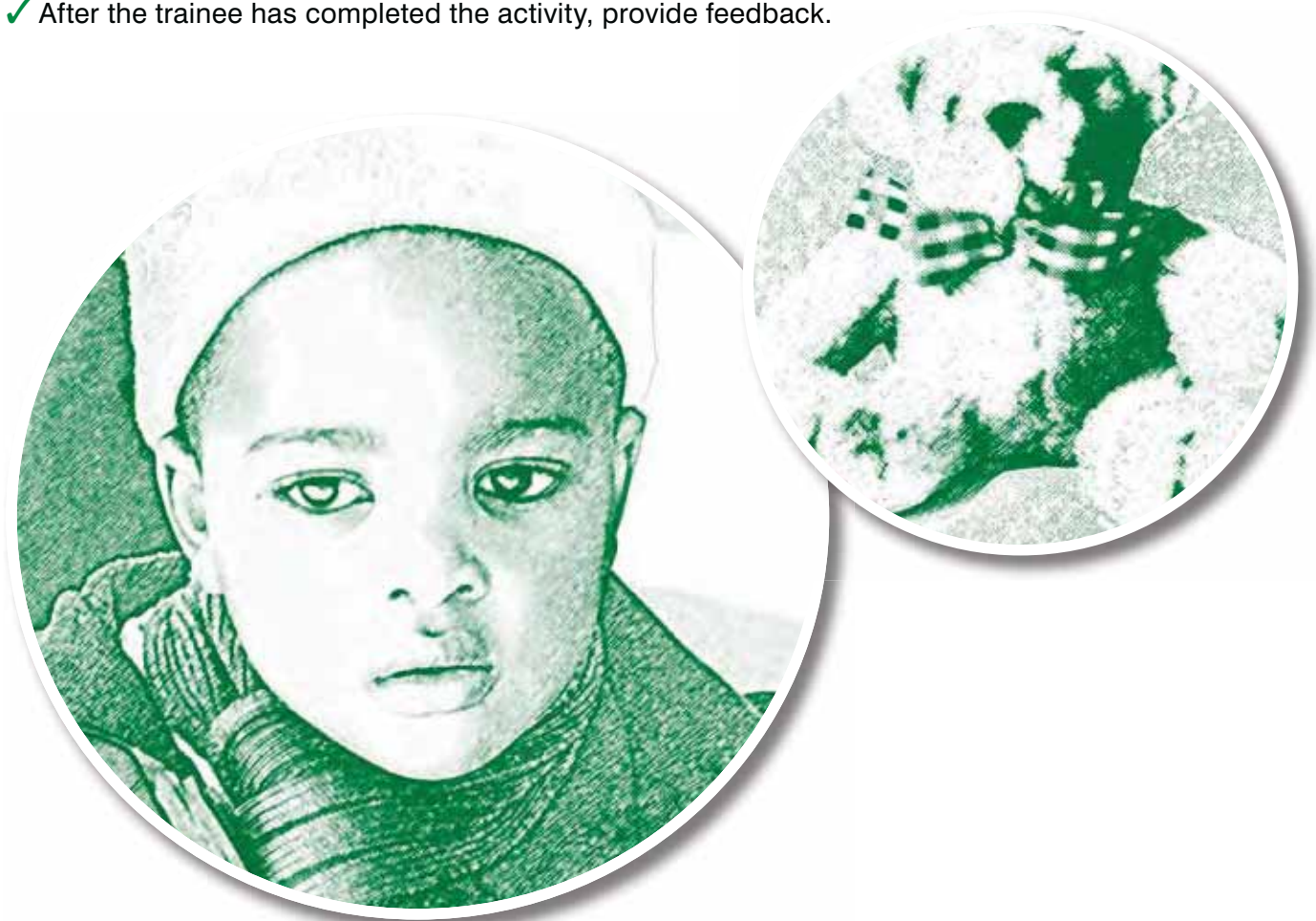
How will self-esteem and discipline affect the psychosocial aspect of the child?

Answers:

- ✓ Cultural belief can also affect the communication process, i.e. not being allowed to talk about death; the old saying: 'children should be seen and not heard' is practised in some cultures, while other cultures don't allow females to express their views verbally.
- ✓ A child that has low self-esteem might avoid trying new things.
- ✓ The child with low self-esteem can be easily influenced and might pick up negative language patterns, i.e. swearing, shouting, mumbling, moaning, etc.
- ✓ Discipline and boundaries must be established and enforced by the adult as this will also effect the child's behaviour.
- ✓ Positive discipline will help the child learn how to communicate effectively and behave in a sociably acceptable manner.
- ✓ A child with positive self-esteem will have the freedom to communicate more and to learn how to express their feelings verbally.

Trainer's instructions (continued)

- ✓ Use the observation sheet provided to observe the trainee during the communication activity with the child.
- ✓ Observe to see the trainee's ability to communicate effectively with the child living with HIV and AIDS.
- ✓ After the trainee has completed the activity, provide feedback.



Observation of communication activity

Name of trainee/learner	
Name of trainer	
Date	
Name of child	
Age of child	
Type of activity observed	

Criteria to observe Comments (and explain your answer)

Did the trainee greet the child and make the child feel at ease?	
Did the trainee maintain eye contact with the child?	
Did the trainee use verbal and non-verbal communication to show understanding of the child's needs? What type of verbal/non-verbal communication was used? Were open-ended questions used? What tone of voice did the trainee use?	
Did the child use verbal communication? If yes, make a note of what type of statements or questions the child asked. What type of non-verbal communication did the child use?	
Was the activity appropriate for the cultural beliefs, age, gender, emotional and physical development of the child?	
Did the trainee make adjustments to meet the child's communication needs? Explain.	
Did the trainee use appropriate listening skills?	
General comments and suggestions:	

Module 10: Counselling and children

Aim of this module

Module 10 aims to guide the trainer on how to talk to children about HIV issues and death.

Learning outcomes

By the end of this module, the trainee should be able to:

- ✓ Demonstrate an understanding of the concepts of grief and loss and the associated feelings
- ✓ Apply the principles and process of talking to children about HIV issues and death.

Further reading

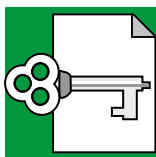
- ✓ *Elements of Counselling* by Joan Schon, Lauren Gower and Victor Kotze

Resources

- ✓ Paper and pen for the trainee
- ✓ Flip chart paper and pens
- ✓ Storybooks on HIV and AIDS
- ✓ Storybook “What is Death” (optional – Cotlands publication)
- ✓ Art material for the child
- ✓ Observation sheet



10.1 What is counselling?



Trainer to explain the following information to the trainee.

- Counselling is a process that happens between a child and caregiver that explores the trauma/incident that the child has experienced, and helps the child make sense of what has happened to them.
- It aims to assist the child to cope with their situation, emotions and feelings, and helps them make positive choices and decisions.
- Counselling offers a safe place for the child to talk about sensitive and difficult issues.
- Counselling involves the helping skills of caring, listening and prompting. It is based on talking, listening and the respectful, trusting relationship that is built up between the caregiver and the child.
- Counselling helps the child to draw on their own resources to enable them to approach their problems and situations in a fresh and more effective way.
- Counselling is a process which assists the child to focus on their particular concerns.
- It supports the child to address and explore specific problems, make choices, manage crises, work through feelings of inner conflict and improve relationships with others.
- Counselling enables children to gain a better understanding of themselves and their situation, as well as help them develop strategies to manage change.
- Counselling must be treated confidentially between the authorised persons.

10.2 Situations in which a child may need counselling

Situations in which a child may need counselling include:

- Direct exposure to disaster
- Suffered personal loss due to divorce/separation of a parent/guardian, the death of a loved one, close friend or pet, or serious injury to a family member or friend
- HIV-related issues and testing
- Bereavement counselling
- Suspected sexual abuse
- Other forms of emotional or physical distress, i.e. anxiety, relationship problems or bullying
- Ongoing stress from their current situation
- Major behavioural changes
- Personal problems
- Developmental changes.

10.3 Principles of counselling

Principles of counselling include:

- Establishing a relationship with the child
- Helping the child tell their story using communication skills, e.g. questioning, probing, summarising skills, etc.
- Listening carefully
- Providing correct information
- Helping the child make informed decisions
- Helping the child recognise and build on their strengths
- Helping the child develop a positive attitude to life.

It does *not* include:

- Making decisions for the child
- Judging the child
- Interrogating, blaming, preaching, lecturing or arguing with the child
- Making promises that you cannot keep
- Imposing beliefs on the child.

10.4 Physical comfort towards the child living with HIV and AIDS

When working with children living with HIV and AIDS, remember to first assess the child's physical state of health before showing physical comfort to the child. You can show physical comfort in the following ways:

- Smile
- Rock the baby or young child in your arms
- Gently stroke or touch the child
- Hug or gently rub the child's back
- Gently hold the child
- Gently brush the child's hair
- Sing to the child and read/tell them stories
- Give them a cuddle when you tuck them into bed.

In order to provide comfort to the child living with HIV and AIDS, it is important to meet their physical needs as well. The change from curing to caring means providing comfort to the child with the least invasive procedures, while maintaining his or her privacy and dignity. A terminally ill child has many of the same needs as any seriously ill child, including the following:

A routine for sleep and rest

Lack of sleep may be caused by discomfort, fear of not waking up, restlessness, or day/night confusion. Keep a night light on or a bell/intercom available so your child will know where he or she is if awakened and confused.

Nutritional considerations

Nausea, vomiting, diarrhoea and reduced eating are often associated with the effects of treatment and the progression of the disease. High-protein shakes may be an option if the child is only able to eat or drink small amounts.

Changes in elimination

Changes in elimination may also occur with a seriously ill or dying child. Diarrhoea, constipation and incontinence are all possible. Care should be given to provide the child with a clean environment. It is also important not to embarrass or humiliate a child that has recently become incontinent (unable to control the bowel or bladder).

Skin care

Skin care may also be a concern for the child living with HIV and AIDS. Nutritional status, elimination problems and immobility can all cause skin breakdown and/or pain. Infection may likely occur in this situation. The decision to use antibiotics can be discussed with the doctor.

Fever

Fever may be a source of discomfort. Medications that reduce fever, such as acetaminophen, may be given for comfort.

Respiratory changes

Respiratory changes may occur from pneumonia, narcotics or the progression of the disease. Often, the child will feel they are unable to catch their breath. Air hunger, as this is often called, can be frightening for the child. Decreased oxygen in the bloodstream may also cause the child to have a seizure. Oxygen supplied through the nose or by a mask may be needed simply for comfort.

Nasal symptoms

Secretions from the nose, mouth and throat may be difficult to manage in children living with HIV and AIDS. Suction devices are available, or simply, repositioning the child may help drain the excess secretions.

Pain management

Pain management is an important concern for the child living with HIV and AIDS. In a child that is dying, one of the greatest fears is pain. Every measure should be taken to eliminate pain.

Pain control options and management plans should be discussed before the child experiences significant pain. Fear of addiction to narcotics is common among families. It is important to understand, however, that the ultimate goal is comfort, which means taking appropriate measures to assure the child is free from pain.

Pain may be acute or chronic. Acute pain is severe and lasts a relatively short time. It is usually a signal that body tissue is being injured in some way, and the pain generally disappears when the injury heals. Chronic pain may range from mild to severe, and is present to some degree for long periods of time. Medicating pain before it becomes too severe is advised. If pain medication is not given for a long period of time, it may not be as helpful. Pain may occur as a result of the illness, or for other reasons. Children normally have headaches, general discomfort, pains and muscle strains as part of being a child. Not every pain a child expresses is a result of the illness.

Treatment for pain

Specific treatment for pain will be determined by your child's physician based on the following:

- The child's age, overall health and medical history
- Type of illness
- Extent of disease
- Discussion of treatment options
- The child's tolerance for specific medications, procedures or therapies
- Your opinion or preference.

10.5 The sexually assaulted child

Although these signs do not necessarily indicate that a child has been abused, they may help adults recognise that something is wrong. The possibility of abuse should be investigated if a child shows a number of these symptoms, or any of them to a marked degree:

Sexual abuse

- Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age
- Medical problems such as chronic itching, pain in the genitals, venereal diseases
- Other extreme reactions such as depression, self-mutilation, suicide attempts, running away, overdoses, anorexia
- Personality changes such as becoming insecure or clingy
- Regressing to younger behaviour patterns such as thumb sucking or bringing out discarded cuddly toys
- Sudden loss of appetite or compulsive eating
- Being isolated or withdrawn
- Inability to concentrate
- Lack of trust or fear of someone they know well, such as not wanting to be alone with a babysitter or child minder
- Starting to wet again (day or night), nightmares
- Become worried about clothing being removed
- Suddenly drawing sexually explicit pictures
- Trying to be 'ultra-good' or perfect; over-reacting to criticism.

Physical abuse

- Unexplained recurrent injuries or burns
- Improbable excuses or refusal to explain injuries
- Wearing clothes to cover injuries, even in hot weather
- Refusal to undress for gym
- Bald patches
- Chronic running away
- Fear of medical help or examination
- Self-destructive tendencies
- Aggression towards others
- Fear of physical contact – shrinking back if touched
- Admitting that they are punished, but the punishment is excessive (such as a child being beaten every night to 'make him study')
- Fear of suspected abuser being contacted.

Emotional abuse

- Physical, mental and emotional development lags
- Sudden speech disorders
- Continual self-depreciation ('I'm stupid, ugly, worthless, etc.')
- Over-reaction to mistakes
- Extreme fear of any new situation
- Inappropriate response to pain ('I deserve this')
- Neurotic behaviour (rocking, hair twisting, self-mutilation)
- Extremes of passivity or aggression.

Note: A child may be subjected to a combination of different kinds of abuse. It is also possible that a child may show no outward signs and hide what is happening from everyone.

Suspected abuse

If you suspect that a child is being abused, seek advice from your supervisor. Knowing how damaging abuse is to a child, it is up to the adults around them to take responsibility for stopping it.

If a child tells you about abuse:

- Stay calm and be reassuring.
- Find a quiet place to talk.
- Believe in what you are being told.
- Listen, but do not press for information.
- Say that you are glad that the child told you.
- If it will help the child to cope, say that the abuser has a problem.
- Say that you will do your best to protect and support the child.
- If necessary, seek medical help and contact the police or social services.
- If your child has told another adult, such as a teacher or school nurse, contact them. Their advice may make it easier to help your child.
- Determine if this incident may affect how your child reacts at school. It may be advisable to liaise with your child's teacher, school nurse or head teacher.
- Acknowledge that your child may have angry, sad or even guilty feelings about what happened, but stress that the abuse was not the child's fault. Acknowledge that you will probably need help dealing with your own feelings.

10.6 Things to consider when counselling the child

If a caregiver wishes to counsel a child, they first need to establish a relationship with the child. A child under five will need different techniques to an older child.

When counselling the child, consider the following:

- Their age
- Their psychosocial maturity
- Their cognitive development (ability to understand)
- The complexity of their family dynamics
- Their physical and emotional state
- Their past experiences
- Their religious and cultural beliefs
- Their readiness for help.

The following techniques can be used when counselling the child:

- Reading or telling stories, i.e. puppet shows, role play, flannel boards, story books, toys, etc.
- Doing creative activities, i.e. painting, drawing, coloring-in activities, modelling with clay, etc.
- Showing flash cards for conveying information.
- Playing board games or other games.
- Completing physical activities and games.

10.7 What caregivers can do to help the child

As a caregiver, there will be times when you will have to conduct planned or unplanned counselling.

Planned counselling can be:

- At a set date, time and place using pre-planned activities and conducted by specific caregivers
- In a structured environment (private with no barriers or interruptions)
- Recorded.

Unplanned counselling can be:

- At any time with no set date, time, place, specific caregivers or activities
- In an unstructured environment (i.e. during play time, bath time, meal time, outings, etc.)
- Not recorded immediately but informal notes could be jotted down afterwards.

Steps to counselling the child

- Smile, be friendly and show love towards the child, i.e. sit close to the child, or you could place the child on your lap and gently hold or touch the child on their arm.
- Let the child feel at ease.
- Encourage the child to talk, draw pictures or tell their story in a manner that is comfortable to them. You can start off with something like: “It seems that you are not your normal cheerful self today, would you like to tell me how you are feeling?” Sometimes the child will tell you how they are feeling or what has made them feel the way that they do without you having to ask them.
- Use age-appropriate language (i.e. language that the child uses and understands for their age).
- Work from their feelings and ask them probing questions. You can also ask questions like: “What makes you feel happy, sad, scared, and angry?” etc.
- Use open-ended questions (i.e. questions that require more than a yes or no answer).
- Be a good listener and use appropriate gestures and eye contact.
- If the child asks questions, answer as best as you can and be honest.
- Be prepared to repeat yourself as children need time to process and understand issues and events.
- Vary the words that you use and check that the child understands what you have said.
- Be supportive and help the child clarify their problems.
- Don't let the counselling sessions carry on too long as the child will get tired. Normally spend 10-20 minutes depending on the age and developmental level of the child. Use the child as a guideline to see when to end the session.
- Wrap up the session by summarising the important issues discussed and reassure the child that you are there for them if they want to talk again.
- You could hug the child and tell them that you care for them.

10.8 Activity – Process of counselling children



Time: 20 minutes (10 minutes counselling, 5 minutes observation feedback and 5 minutes counselling feedback)

Method: Skills practice / role play

Aim: To practise counselling skills

Trainer's instructions

- ✓ Give the trainees a counselling scenario.
- ✓ One trainee must role play being the counsellor, one the child and one the observer.
- ✓ Explain to the trainees that you will also observe the counselling process and use the observation sheet to take notes.
- ✓ Afterwards you will discuss the observations you recorded.
- ✓ The feedback form is included for the caregiver to use after they have counselled the child. The caregiver must complete it and give feedback to the large group.

Scenario

Anna is a four-year-old girl living with HIV and AIDS. She has displayed some changes in behaviour, i.e. refusing to play with her friends. Her mother usually visits her every second week but was unable to visit her last week due to her own illness caused by her HIV status.

You are Anna's caregiver and during her bath routine, you have noticed that she refuses to get into the bath and just sits on the floor crying.

Do a skills practice demonstrating an unplanned counselling session on how you will deal with this situation.



10.9 Observation feedback on role play

Criteria to observe	Yes	No
Was the caregiver calm, confident and in control?		
Did the caregiver make the child feel at ease? Explain your answer:		
Did the caregiver encourage the child to talk and tell their story? Explain your answer:		
Did the caregiver use probing and open-ended questions?		
Did the caregiver use age-appropriate language? If not, give examples:		
Was the caregiver a good listener?		
Did the caregiver use appropriate eye contact and gestures? Explain your answer:		
Was the caregiver supportive?		
Did the caregiver clarify the child's problem? Give examples:		
Did the caregiver wrap up the session by summarising important issues? Explain your answer:		
Did the caregiver reassure the child and order continuous support? Give examples:		
General observations:		

10.10 Counselling session feedback

Sample form for caregiver to use after the counselling session; modify as needed

Name of child:	
Date of birth of child:	
Name of caregiver:	
Date of counselling session:	
Time of counselling session:	
<i>Reasons for counselling the child:</i>	
<i>Behaviour of child:</i>	
<i>Issues that came up during the counselling session:</i>	
<i>Action plan:</i>	
<i>For the next session I will need:</i>	

Bibliography

- 1 Advisor Group Observation. <<http://www.nipissingu.ca/education>>.
- 2 American Academy of Child and Adolescent Psychiatry. *Fast fact #8. Children and grief*. Updated November 1998. <<http://www.aacap.org/publications/factsfam/grief.htm>>.
- 3 American Academy of Child and Adolescent Psychiatry. *Fast fact #36. Helping children after a disaster*. Updated March 2000. <<http://www.aacap.org/publications/factsfam/disaster.htm>>.
- 4 *Basic Aids counseling guidelines*. Canadian International Development Agency.
- 5 *Basic principles of good parent/child communication*. <<http://www.childdevelopmentinfo.com>>.
- 6 Brown, L.K. and Lourie, K.J. *Children and adolescents living with HIV and AIDS: a review*. Brown University School of Medicine. Providence, USA.
- 7 Children's Rights Centre. <<http://www.childrensrightscentre.co.za>>.
- 8 Cotlands and NICDAM. *Prevention and care of HIV and AIDS in childcare institutions*.
- 9 Cotlands existing records (2000–2006).
- 10 Cotlands. *HIV and AIDS prevention and care in childcare institutions*.
- 11 Department of Education. *Development, stimulation, identifying and overcoming delays for teachers and caretakers of children from birth to three years old*.
- 12 Family and Community Support Services Philosophy. <<http://www.newsarepta.com/family.html>>.
- 13 Hanna, Leslie. (BETA) *HIV/AIDS in children: overview and guidelines for disease management*. Bulletin of Experimental Treatments for AIDS, No. 29. June, 1996.
- 14 Helping Your Child Develop Self-esteem. <<http://www.childdevelopmentinfo.com>>.
- 15 HIV/AIDS Directory. <<http://www.gauteng.gov.za>>.
- 16 HIV and AIDS Treatment and Care. *Our children and AIDS*.
- 17 <http://www.nasponline.org/information/pospaper_aids.html>.

- 18 Khomanani. *Guidelines for the management of HIV-infected children*. First edition, 2005.
- 19 Khomanani. *Prevention and management of side-effects and drug interactions (ART)*. First edition, 2006.
- 20 Meetings and Presentations, 2002–2003, Children’s Homes Outreach Medical Programme (CHOMP).
- 21 Michael Mathews. *The impact of HIV/AIDS on children’s cognitive abilities*. <http://www.associatedcontent.com/article/35382/the_impact_of_hivaids_on_childrens.html>.
- 22 National Cancer Institute. *Loss, grief, and bereavement* (PDQ®). Last updated January 2001. <http://www.cancer.gov/cancer_information/coping>.
- 23 National Institute of Mental Health. *Helping children and adolescents cope with violence and disasters*. <<http://www.nimh.nih.gov/publicat/violence.cfm>>.
- 24 *Nutrition in pediatric HIV infection*. <<http://www.hivpositive.com>>.
- 25 Psychology 101. The virtual psychology classroom, AIPsych ON LINE.
- 26 Ramanujapuram, Anand. *HIV/AIDS and child and adolescent psychiatry: a brief review*. The Internet Journal of Paediatrics and Neonatology, Volume 6, Number 1, 2006.
- 27 Reva Goldsmith (Cotlands Baby Sanctuary), Frayne Furniss Mathijis (NICDAM), Christel Kleingeld (Cotlands Baby Sanctuary), Jennifer Rhim (Cotlands Baby Sanctuary), Claudia Da Silva (NICDAM). *HIV and AIDS in Early Childhood Development Centres*, 1999.
- 28 Saloner, K. *The adherence resource pack*, 2005.
- 29 Senior, Liz and Hopkins, Karen. *Growing up with a smile*. Smile Education Systems, 1998.
- 30 *The power of play (zero to three)*. <<http://www.zerotothree.org>>.
- 31 Wijngaarden, J. and Shaeffer, S. (2002). *The impact of HIV/AIDS on children and young people*. <http://www.crin.org/docs/Impact_of_HIV.pdf>. Retrieved 25 July 2006.

Glossary

Acute pain	Acute pain is severe and lasts a relatively short time. It is usually a signal that body tissue is being injured in some way and the pain generally disappears when the injury heals
Adherence	Sticking to treatment plan
AIDS	Acquired Immune Deficiency Syndrome
AIDS-related dementia	Mental confusion because of HI virus attacking the brain cells
ART	Antiretroviral treatment against the HI virus
CBO	Community based organisation
CD4 count	The number of CD4 cells in the blood
Chronic pain	Chronic pain may range from mild to severe and is present to some degree for long periods of time
Confidentiality	Confirming knowledge on a need-to-know basis
Counselling	Counselling involves the helping skills of caring, listening and prompting. It is based on talking and listening, and the respectful, trusting relationship that is built up between the caregiver and the child
Developmental milestones	Progression of development defined in terms of age
Developmental programme	A programme designed to assist children in reaching their developmental milestones
Discrimination	Treating people differently or unfairly
Elimination	Is the process whereby a substance or other material is expelled from the body usually by a process of extrusion or exclusion but sometimes through metabolic transformation. The combination of chemical degradation of a xenobiotic in the body and excretion by the intestine, kidneys, lungs, skin, in sweat, expired air, milk, semen, menstrual fluid or secreted fluids
Enzyme	A substance that assists chemical processes
HIV	Human Immune Virus
NGO	Non-governmental organisation
Parentified child	A child who has assumed the role of the parent in a family. This occurs when the parent is unable to fulfil the role due to illness, prolonged absence or psychological problems
Nutritional status	Is a global term that refers to nutritional screening, nutritional assessment, nutritional care and nutritional support

Pain management	Surgery, procedure or other treatment designed to reduce pain and help the patient achieve a reasonable quality of life and ability to function
PLWA	People living with HIV and AIDS
Sexual abuse	Abuse of a sexual nature such as rape, incest, fondling and indecent exposure. Sexual abuse can cause various physical and emotional problems including lack of self-esteem, self-destructive behaviour, anxiety and depression
STI	Sexually transmitted infections
Stigmatisation	A mark of disgrace
TB	Tuberculosis
Viral load	Amount of virus in the blood

