

The Integrated Management of Paediatric AIDS/HIV Care and Treatment and PMTCT (IMPACT)

A Bantwana Model Facilitators Manual



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**This toolkit was developed by World Education Inc. and partners
under the auspices of the USAID funded Children First Project.**

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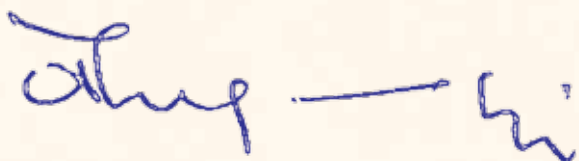
FOREWORD

In sub-Saharan Africa, significant successes have been made in HIV prevention, care and treatment, specifically in relation to promoting HIV prevention among adults and infants, through prevention of mother-to-child-transmission (PMTCT). However, children and young people have often been left out in the HIV testing and treatment response. Zimbabwe bears a high burden of HIV with a national prevalence of 16% among antenatal care attendees. The national antiretroviral therapy (ART) coverage for children aged 0-15 years remains unacceptably low, at 42%, as at the end of December 2012.

World Education/Bantwana aims to improve community level knowledge on paediatric HIV with the hope of improving and scaling up the uptake of paediatric ART and PMTCT services through the implementation of the IMPACT programme. In collaboration with the Ministry of Health and Child Welfare, and through a process of extensive consultation, World Education/Bantwana developed a model called Integrated Management of Paediatric AIDS/HIV Care and treatment (IMPACT, which seeks to improve access to HIV care and treatment services for children and young people.

This programme is implemented through use of a toolkit which offers a step-by-step guide to support planning and implementation of the IMPACT programme. The toolkit can be used as a resource for sensitising and training programme staff (managers and programme officers) who are planning to implement the model, or as a tool to guide training for community health workers (CHWs). Most importantly, the toolkit was fashioned to support community-based organisations operating in under-served areas, to advocate for and support the implementation of paediatric ART, as well as to identify previously undiagnosed children and young people living with HIV. The toolkit consists of a Guidebook, which seeks to introduce potential implementing organisations to the model, a poster for community sensitisation and awareness to support the programme, and a Facilitators Manual which guides implementing organisations on how to work with communities. An accompanying set of Reference Cards provides a ready reference tool for community health workers in the field. A series of information booklets in local languages is also provided for distribution to affected families.

The Ministry of Health and Child Welfare and its partners recognise the need to significantly strengthen paediatric HIV prevention, care, treatment and support services. This will contribute to achieving the millennium development goal number four of reducing child deaths by two-thirds, from 85 deaths per 1,000 live births, to 27 deaths by 2015. I therefore encourage you to make use of this toolkit in the planning, capacity building and implementing of these vital services.



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September, 2013

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Glossary of Terms¹

Acquired Immune Deficiency Syndrome (AIDS): the name given to a group of illnesses in HIV positive people.

Adherence: means sticking to or being devoted to something. In ART, adherence involves taking medications in the correct amount, at the correct time and in the way they were prescribed.

Antiretrovirals (ARVs): medicines used to treat HIV.

Antiretroviral Therapy (ART): a term used to describe giving ARVs in the correct way, with adherence support.

CD4: a common name for a type of white blood cell that fights infection and is destroyed by HIV. In general, the more CD4 cells a person has, the healthier he or she is.

Co-infected: a term used to describe being infected with two things at once. In terms of HIV, the most common co-infection is with Tuberculosis (TB).

Community Health Worker (CHW): a community health worker may or may not have previous experience in community-based HIV care, or home-based care.

Community mobilisation: activities and approaches initiated to spark community engagement, participation and empowerment, for the creation of a supportive environment for PLHIV.

Confidentiality: the obligation owed by one person to another not to disclose information given by or about another, or the obligation to disclose it only in limited circumstances. Confidentiality means any information shared between two people is not revealed to anyone else without consent.

Cotrimoxazole (CTX): a commonly prescribed preventive treatment to improve health in PLHIV.

Counselling: a confidential dialogue that involves an interpersonal relationship between a person or group of people seeking help on a problem(s) and someone who can assist in solving the problem.

Disclosure: the process a person living with HIV goes through in telling others about their HIV status.

Food Safety: a term used to describe keeping food safe from contamination or spoiling, so that it is healthy to eat rather than a source of infection.

Human Immunodeficiency Virus (HIV): the virus that leads to AIDS by weakening the body's immune system.

HIV Related Illnesses: illnesses that PLHIV contract as a result of lowered immunity

HIV testing and Counselling: a broad umbrella term that indicates the different ways of being tested for HIV.

Informed Consent: means that an individual has been given important information, has fully understood what has been discussed and on this basis agrees to undergo a medical procedure.

1 Definitions adapted from IFRC, SAfAIDS, WHO (2004), HIV Prevention Treatment, Care and Support- A Training Package for Community health workers, Geneva.

Integrated: Made complete or more comprehensive by the addition or combining of another component.

Immune System: the body's defense against disease.

Malnutrition: a term used to describe a condition where the body either does not get enough of the right foods, or is unable to process food properly to remain healthy.

Micronutrients: vitamins and minerals in food that play a special role in keeping people healthy.

Non-adherence: not taking ARV medications as they are prescribed.

Nutritional Goals: specific ways in which PLHIV can prevent malnutrition and promote a healthy and active lifestyle regarding food.

Opportunistic Infections (OIs): diseases that attack the body when the immunity is low or weak.

Peer Support: support for people by people in the same situation.

Pill Count: counting the number of pills remaining in a prescription during a scheduled visit. If the number of pills remaining is greater or less than it should be, problems with adherence are revealed.

Positive Living: a term used to describe steps taken by people living with HIV that enhance their lives and improves their health.

Positive prevention: a term used to describe activities aimed at increasing the self-esteem and confidence of HIV positive people to protect their own health and avoid passing on the infection to others.

Prevention of Mother-to-Child Transmission (PMTCT): methods that help prevent an HIV positive mother from passing HIV on to her baby during pregnancy, child birth or breastfeeding.

Prophylaxis: a therapy or treatment taken to prevent infections developing.

Provider Initiated HIV testing: when health professionals routinely offer an HIV test to all clients seeking health care services. The aim is to increase the numbers of people who are aware of their HIV status.

Psychosocial Support: a term used to describe caring for the emotional, psychological, social and spiritual well-being of others.

Resistance: the ability of HIV to change its structure in ways that make medicines such as ARVs less effective.

Second-line Regimen: a combination of medicines prescribed to individuals on first-line ART regimens when treatment failure occurs, or if the side-effects of first-line medicines are too severe. A second-line regimen is therefore a new or changed prescription of ARV medications.

Stigma: negative attitudes towards people who belong to a particular group or who have different characteristics than others.

Supplement: something you eat, often as a pill or tablet, in addition to food to improve diet and health.

Support Network: a term used to describe people in your life with whom you can talk openly and honestly about things that trouble you. A support network often includes people whom you feel understand you and what you are going through.

Treatment Failure: a condition in which medicines (such as ARVs) stop being effective.

Treatment Preparedness: the process of preparing PLHIV and their surrounding community to initiate or start ARVs.

Treatment Supporter: a person, usually a family member or friend - and preferably someone who lives with the client and can help with the 'day-to-day' adherence to ART.

Tuberculosis (TB): an illness caused by a germ (bacteria) that is breathed into the lungs. There are two types of TB, pulmonary (affecting the lungs) and extra-pulmonary (affecting organs of the body other than the lungs).

Universal Precautions: simple infection control procedures that reduce the risk of transmitting agents through exposure to blood, body fluids, or contaminated medical or other types of equipment among clients, family members and health care workers.

Viral Load: a term used to describe the amount of HIV in a person's body. The more HIV, the higher a person's viral load will be.

Acronyms

AIDS	Acquired immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral medicines
BMI	Body Mass Index
CBO	Community-Based Organisation
CHW	Community Health Worker
CPC	Child Protection Committee
DBS	Dried Blood Spot
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IPT	Isoniazid Preventive Therapy
OI	Opportunistic Infection
MUAC	Mid Upper Arm Circumference
PCP	Pneumocystis Carinii Pneumonia (PCP)
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Counselling and Testing
PLHIV	Person/people Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
PSS	Psychosocial Support
SFP	Special Feeding Programme
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

Introduction

Throughout southern Africa, significant successes have been made in HIV prevention, care and treatment, specifically in relation to promoting HIV prevention among adults and infants through **prevention of mother-to-child-transmission (PMTCT)**. However children and young people (aged from six weeks to 18) years have often been left out in the HIV testing and treatment response. Barriers to testing, treatment, and adherence include transport to service sites, lack of cash to pay for services and medicines, and lack of counsellors or clinicians within communities. Through the Integrated Model for Pediatric AIDS Care and Treatment (IMPACT) programme, the Children First Initiative, implemented by World Education/ Bantwana Zimbabwe has developed a model programme for improving access to HIV care and treatment services for children and young people. This user-friendly toolkit has been designed to introduce the model and guide potential implementing organisations through the steps to introducing it into their work with communities.

IMPACT- A Bantwana Model

The IMPACT model has been implemented by World Education Inc./ Bantwana Zimbabwe, in partnership with local non-governmental organisations. The programme targets children and young people in Zimbabwe, aged from six weeks to 18 years. The IMPACT programme aims to:

- ✘ Identify HIV positive children and address barriers preventing them from accessing antiretroviral (**ART**) services
- ✘ Connect HIV positive children with **ART** services such as counselling, **CD4** monitoring, treatment adherence and support services
- ✘ Build the capacity of existing Community health workers from community-based organisations to identify, mobilise on behalf of, and follow-up HIV-positive children and young people
- ✘ Create a safe space for children and young people to share their experiences and gain knowledge on how to manage the disease and live positively with it.

The key programme activities are to:

- ✘ Build capacity and support a network of Community health workers to:
 - identify children and young people with symptoms suggestive of HIV infection and negotiate with primary caregivers to take them for HIV testing
 - provide basic counselling and **psychosocial support** for children, young people and their caregivers
 - offer education on HIV testing, **CD4** count monitoring and treatment of **opportunistic infections (OIs)**
 - follow-up and support children and young people on antiretroviral therapy (**ART**) with adherence issues.
- ✘ Reduce barriers to access, including transport costs
- ✘ Start HIV infected children and young people on treatment and support regular **CD4** monitoring

- ✖ Support the formation of **psychosocial support** groups for HIV positive children and young people and their guardians, to ensure adherence and prevent loss to follow-up.

Routine monitoring of the programme has highlighted the following results:

- ✖ Increased identification of children living with HIV and their initiation on treatment
- ✖ Significant reduction in the time from diagnosis to initiation of treatment for children and young people living with HIV
- ✖ Reported reduction in the number of school days missed by children and young people due to ill health
- ✖ Reported improvement in the health and confidence of young people living with HIV.

Through its implementation in rural, peri-urban and urban areas, the IMPACT model was shown to be a model that could be reproduced in a number of settings.

Goal of the Toolkit

The Toolkit has been designed to support community-based organisations operating in under-served areas to advocate for and support the implementation of paediatric **ART**, as well as the identification of previously undiagnosed children and young people living with HIV, using the IMPACT model. The toolkit includes:

- ✖ A Guidebook describing the IMPACT model and outlining in a step-by-step approach how organisations can implement it
- ✖ Reference materials to guide Community health workers in their discussions with children and young people and their families
- ✖ A series of information booklets for distribution to families
- ✖ Posters for community sensitisation and awareness to support programmes.

Who is the toolkit for?

The Toolkit is intended for programme managers/implementers and their Community health workers, working in community-based organisations that operate in under-served areas.

How can the toolkit be used?

The Toolkit has been designed as a reference tool to support planning and implementation of programmes using the IMPACT model. It can be used as resource for sensitising and training programme staff (managers, and programme officers) who are planning to implement the model, or as a tool to guide training for community health workers (CHWs), among others. The factsheets and posters included in the toolkit can be copied and used to complement other IEC materials for community education initiatives.

What does the toolkit contain?

The Toolkit includes:

- ✖ Facilitators Manual (this document)
- ✖ IMPACT Programme Implementation Guidebook
- ✖ IMPACT Reference Materials

- ✘ Community booklets on:
 - Prevention of mother-to child transmission
 - Treatment and Adherence to **ART** for children and young people
 - Paediatric Nutrition.
- ✘ Awareness raising Poster on PMTCT: Give your child the best possible start

Description of key terms - Throughout the toolkit, key concepts and terms are highlighted in **blue**. The definitions of these terms are presented in the Description of Key Terms at the end of the Facilitators Manual.

Training Methodology

Facilitators introducing the IMPACT model may plan a sensitisation training for programme staff, or training for Community health workers. In both cases, it is wise to adopt a participatory approach to training, grounded in the principles of adult learning. It is important to recognise that participants have life experience and knowledge which will be valuable to the programme. The participatory approach allows facilitators to reinforce the concepts of the model and motivate participants to roll it out.

The toolkit is useful for two different trainings:

1. sensitisation of programme staff in implementing organisations;
2. training of community-based volunteers as Community health workers (CHWs).

Each group will use the toolkit materials (handbook, factsheets and posters), but for slightly different purposes. The section below outlines the training methodology for the two different target groups.

A. Sensitisation training for Programme Managers and Officers of Implementing Organisations (2 days)

Objectives:

By the end of the training, Programme Managers and Officers of implementing organisations should be able to:

1. Understand and integrate the IMPACT model into their existing programmes
2. Understand and use phase-by phase readiness scorecard for assessing the capacity of their organisation to successfully implement the IMPACT model.

Materials:

1. Copies of the toolkit for each participant
2. Copies of Phase-readiness scorecard
3. IMPACT model poster
4. Flipchart, markers, pens.

Recommended Preparation:

1. Collect national policies and recent reports on HIV prevention, care, treatment and support
2. Research reflecting factors contributing to the transmission of HIV among children in the specific area or community
3. Annual report and audit statements or similar information, on the implementing organisation
4. Strategic plan and annual work-plan for implementing organisation
5. Policy documents of implementing organisation
6. Research on reasons why families in the community have not been accessing testing and treatment
7. Identify where pregnant mothers and postnatal mothers access care before and after delivery.

Suggested Training Programme Programme

Content	Time	Activity
1. Introducing IMPACT model	1 hour	Mini Lecture. Reference Card 1. Resource: Poster – Awareness poster.
2. Session 1 - Review of pre-assessment of adult focused home-based care network	2 hours	Group Discussion on HIV prevalence and available services in programme area. Review of definition of confidentiality and organisational policy on confidentiality.
3. Session 2 - Community awareness and mobilisations	1 hour	Mini Lecture on strategies to gain buy-in of stakeholders and community members on benefits of early diagnosis. Review IMPACT Guidebook Phase 2.
4. Session 3 - Training home-based caregivers in paediatric HIV care	2 hours	Mini Lecture. Review IMPACT Guidebook Phase 3. Reference Cards 2-9. Action Planning - Developing a training agenda.
5. Session 4 - Connecting children living with HIV to ART services	1 hour	Group Discussion on barriers solutions for improving ART access for children. Review IMPACT Guidebook Phase 4. Reference Cards 8 – 10, 14 & 15. Handout: PMTCT; Adherence.
6. Session 5 - Follow-Up treatment for children living with HIV	1 hours	Mini-Lecture. Review IMPACT Guidebook Phase 5. Reference Cards 16-22. Handout: Nutrition.
7. Session 6 - Referrals and record Keeping	1 hour	Review IMPACT Guidebook Phase 6.
8. Phase-readiness assessment	4 hours	Score Card. Action planning Group work using Phase Readiness.

B. Community Action Training for Community health workers /Home based Caregivers (5 days)

The course can be given as a 5-day training course, or as a series of 1-day sessions, depending on availability of time and venues. This will also depend on the existing knowledge base of the volunteers. Facilitators should bear in mind that Community health workers are not used to long training sessions and may have to absorb a lot of new information, it is recommended that each day of training should not be too long.

Objectives:

To equip Community health workers with the necessary skills and knowledge to successfully implement the IMPACT model in their communities.

Required Materials:

1. 5-6 copies of the toolkit (depending on the number of trainees)
2. Copies of Factsheets (PMTCT, adherence, nutrition)
3. Large poster of IMPACT model
4. Flipchart, markers, pens.

Recommended Preparation:

1. Collect national policies and recent reports on HIV prevention, care, treatment and support
2. Research reflecting factors contributing to the transmission of HIV among children in the specific area or community.

Training Content

This course consists of five modules.

Module 1: The purpose of the IMPACT Programme. The role of the CHWs: This module covers the purpose of the training, the role of the CHWCHWs, skills development and how the CHW should record, report and follow up.

Module 2: The Basics of HIV: This module covers all the basic information on HIV infection, prevention and treatment. It particularly focuses on children, and PMTCT.

Module 3: Identifying HIV in children: This module covers everything to do with the symptoms and assessment of children as they pertain to HIV.

Module 4: The Comprehensive Care of Children living with HIV and AIDS. This module covers treatment, care, nutrition, psychosocial support and integration of support groups with ISAL groups etc.

Module 5: Community care and support: This module explains how to access services such as support groups, nutrition gardens and how to care for those living with sickness and disability.

3.1.2 Supporting Resources

The detailed Reference Cards included in this manual provide the Training Facilitator all the information they may need to carry out the training. A set of Reference Cards is provided as a reference instrument for use by CHWs. This book includes a recording tool for home visits, that will assist CHWs perform their assigned tasks at both a household and community level. CHWs are also provided with Community booklets in local languages on key areas; Antiretroviral Treatment; Nutrition and Adherence.

CHWs need to be made aware that they may be required to employ more than one tool per visit, if their organization requires different tools for different family circumstances.

It is important that the need to make use of these tools is emphasised during the training.

Suggested Training Programme for Community health workers

DAY 1. Module 1: Welcome and Introductions; the Role of the CHW

Agenda Item	Instructions/proposed Activities
Welcome and introductions (40 minutes)	<ul style="list-style-type: none">The organisers first introduce themselves.Pair up participants and ask them to share two things about themselves with the other person. Once everyone is done – get them to feedback on behalf of their partner.
Housekeeping issues (10 minutes)	<ul style="list-style-type: none">Go through all key information participants need to know about logistics, meals, transport, reimbursement etc.
Expectations (20 minutes)	<ul style="list-style-type: none">Ask participants in the plenary to share any particular expectations they have of the programme, any fears, and hopes.
Ground rules (10 minutes)	<ul style="list-style-type: none">Highlight to participants that it is important to create a conducive environment. Get them to identify key elements that will create an environment that is safe for learning and sharing. Some elements could include confidentiality, asking questions, no matter how basic they may seem, listening and communicating, full participation.
Overview of the IMPACT programme (10 minutes)	<ul style="list-style-type: none">Run through the different elements of the IMPACT programme and ask if any of the participants have any questions.

The Role of the CHW (1.5 hours)

Agenda Item	Instructions/proposed Activities
Brainstorm	<ul style="list-style-type: none">Ask participants to identify anything that is associated with community care.
Role-plays	<ul style="list-style-type: none">Divide participants into three groups. Each group has to role-play a potential scenario where referral for PMTCT or paediatric HIV testing may be needed.Debrief as to the key issues that emerged.
The role of the CHW	<ul style="list-style-type: none">Referring to Reference Cards 2, 4 and 5, run through the critical role of the CHW and the importance of that role.

3. Skills needed by the CHW (3 hours)

Agenda Item	Instructions/proposed Activities
Brainstorm	<ul style="list-style-type: none"> Ask participants what they think are the critical skills needed to effectively fulfill the role of CHW.
Outline the skills needed	<ul style="list-style-type: none"> Run through the skills as per Reference Card 3
Knowledge needed (30 minutes)	<ul style="list-style-type: none"> Ask participants, in pairs, to identify what knowledge they would need to fulfill their roles effectively. Run through the key issues they would need to have knowledge on and indicate to them that this knowledge will be built through the training. Highlight to participants that a critical role for the CHW is having the knowledge to assess and check for the symptoms of HIV, to be able to educate mothers about PMTCT and also to identify when to refer and where to refer to, so they need to have enough knowledge to be able to do that successfully.
Communication skills (1 hour)	<ul style="list-style-type: none"> Do a role-play listening exercise. Place participants in two sets of pairs; Set A. will practice a listening exercise, where the CHW reflects back what the client is saying. Set B will practice drawing out information from a child. The person playing the CHW must encourage the child to talk about their situation. Run through the listening techniques (as per Reference Cards) – reflecting back, repeating and clarifying and creating space for someone to share openly, and the techniques for communicating with children.
Educating/advocating (30 minutes)	<ul style="list-style-type: none"> Note to participants that one of the key things they will need to do in the programme is to communicate and empower households with relevant information. Get participants, in groups of four, to choose a topic they are familiar with and educate the rest of the class. After each group has presented, give them feedback on clarity and effective message transfer. Also ask questions. Provide them with tips on how to do it better.
Recording and Follow up (1 hour)	<ul style="list-style-type: none"> Do an exercise where participants do visits without records and follow-up. Run through the lessons from doing this and thus identify why record keeping is important. Go through the different forms needed to do the recording and reporting.

DAY 2. Module 2: BASICS OF HIV AND AIDS

Agenda Item	Instructions/proposed Activities
Checking In	<ul style="list-style-type: none"> Ask participants to do a drawing about how they feel and to share that with the group. Highlight the focus of the day, being to gain concrete and accurate information about HIV and PMTCT.
Defining HIV and AIDS (20 minutes)	<ul style="list-style-type: none"> Write HIV and AIDS on two separate flipcharts. Ask the group to go around and write on them anything they know or want to know and also to define what the term means. Using Reference Card 7, provide the correct definitions. Also respond to any issues or questions people may have.
Transmission (40 minutes)	<ul style="list-style-type: none"> Ask participants in small groups to prepare role-plays on how HIV is transmitted. Run through the notes in Reference Cards 7, 11 and 12 to correct anything that may come out of the group.
Prevention (20 minutes)	<ul style="list-style-type: none"> Create an interactive exercise where participants get to choose ways they can prevent HIV transmission. Prepare some ways that one can and cannot prevent it. Participants then choose the ones that are correct. Use this as the opportunity to educate them on the ways that one can prevent HIV infection. Refer to Reference Cards 7, 11 and 12
HIV in children (2 hours)	<ul style="list-style-type: none"> Ask participants to identify in small groups: <ul style="list-style-type: none"> How children become infected? Why is HIV infection in children such a big concern? How can we prevent HIV infection in children. Highlight the points from Reference Cards 7, 11 and 12
PMTCT (1 hour)	<ul style="list-style-type: none"> Write PMTCT on a flipchart sheet. Explain what PMTCT means and then ask participants to write up anything they know about mother-to child-transmission and how it can be prevented. Using reference cards 11 and 12, provide the correct definitions. Also respond to any issues or questions people may have and allow for questions and discussion among the group.

DAY 3. Module 3: CONFIRM DIAGNOSIS AND DISCLOSURE IN CHILDREN

Agenda Item	Instructions/proposed Activities
Checking In	<ul style="list-style-type: none"> Ask participants to do a mime activity about how they feel. Highlight the focus of the day, being to gain concrete and accurate information about how to check children for symptoms of HIV.
Symptoms of HIV infection (1 hour)	<ul style="list-style-type: none"> Ask participants if they know what are the symptoms to look out for in terms of HIV infection in children. If possible, using pictures, show some of the symptoms and discuss.
Diagnosing infection in children (30 minutes)	<ul style="list-style-type: none"> Run through the different ways to diagnose infection in children – using Reference Cards 8 and 15.
Disclosure of children's HIV status (30 minutes)	<ul style="list-style-type: none"> Divide participants into three groups. Tell each group to role play a process whereby they have taken a child for testing and have confirmed a positive diagnosis. Ask them to role play how they would disclose. Refer to Reference Card 18 highlighting some of the key issues in relation to diagnosis to take into account where children are concerned.

Agenda Item	Instructions/proposed Activities
HIV in children (2 hours)	<ul style="list-style-type: none"> Ask participants to identify in small groups: <ul style="list-style-type: none"> How children become infected? Why is HIV infection in children such a big concern? How can we prevent HIV infection in children. Highlight the points from Reference Cards 9 11, 12 and 13
Test your knowledge game show (45 minutes)	<ul style="list-style-type: none"> Put all the knowledge about diagnosing, symptoms and also disclosure into a game show format and test participants. (Suggest game show) This is a fun way to ensure that the learning is enforced. Also provide some incentives like chocolate or some reward for the winners.
Review instruments and tools for this part of the CHWs work (30 minutes)	<ul style="list-style-type: none"> Run through any forms that the CHWS will use in screening and assessing.

DAY 4. Module 4: TREATMENT AND CHILDREN

Agenda Item	Instructions/proposed Activities
Checking In	<ul style="list-style-type: none"> Ask participants to write a statement of no more than two paragraphs of how they feel in the training at the moment. Highlight the focus of the day, being to gain concrete and accurate information about treatment as it pertains to children.
What does treatment mean? (20 minutes)	<ul style="list-style-type: none"> Ask participants what they know about treatment, what it means and whether they have any questions. Run through the meaning of treatment as it refers to children, PMTCT and HIV - refer to Reference Cards 16 and 17.
Opportunistic Infections (1 hour)	<ul style="list-style-type: none"> Check that everyone knows what opportunistic infections are. Then ask them to identify what are the key opportunistic infections that need to be addressed for children. Go through Reference Card 8 to correct anything that may come out of the group.
Starting treatment in children (40 minutes)	<ul style="list-style-type: none"> Ask participants when they think children are ready? What are some of the key things to bear in mind? Refer to Reference Card 16.
Key considerations for treatment: adherence, side effects (40 minutes)	<ul style="list-style-type: none"> Ask participants why adherence is important. Also if they know of side effects of treatment? Highlight the points from Reference Cards 16 and 17.
Review of knowledge (1 hour)	<ul style="list-style-type: none"> Use the Case Studies at the end of this manual to assess comprehension.
Test your knowledge (30 minutes)	<ul style="list-style-type: none"> Provide participants with the opportunity to reinforce their knowledge by providing them with the True or False questionnaire on the content covered.
Review of instruments or material to use in the field (1 hour)	<ul style="list-style-type: none"> Run through any material to be used by the CHW in the field.

DAY 5. Module 5: NUTRITION AND PSYCHOSOCIAL SUPPORT

Agenda Item	Instructions/proposed Activities
Checking In	<ul style="list-style-type: none">• Ask participants to share something about how they feel in the group.• Highlight the focus of the day, being to review issues such as nutrition and psychosocial support.
Comprehensive care for children living with HIV (1 hour)	<ul style="list-style-type: none">• Ask participants, in pairs, to highlight what they think a comprehensive package of care for children with HIV would look like.• Then highlight information in Reference Cards 10, 14, 15, 18,19, and 22 to add to what they have shared.
Nutrition (45 minutes)	<ul style="list-style-type: none">• Ask participants to develop a plan of a good and healthy lifestyle. What would be included in it? Ask five people to share.• Run through the notes in Reference Card 21 to correct anything that may come out of the group.
Psychosocial support (1 hour)	<ul style="list-style-type: none">• Ask participants what effective psychosocial support would look like for children, adolescents and for adults. Ask groups to role play scenarios for you of each.• Refer to the Reference Card 20.
Support in community (40 minutes)	<ul style="list-style-type: none">• Ask the group to identify any organisation or groups that could be of assistance to households when it comes to HIV, children and disclosure and psychosocial support. Ask them to highlight what each group would be able to provide.
Course wrap up (30 minutes)	<ul style="list-style-type: none">• Recap information covered in the course.
Evaluation (1 hour)	<ul style="list-style-type: none">• Evaluation of training.• Evaluation of CHWs.• Outlining next steps (fieldwork).

Issues of Adaptation

The IMPACT model was designed and implemented with organisations in Zimbabwe. These included organisations working in both urban and rural areas. The model can easily be adapted to support organisations working in communities to address the needs of children living with HIV, in particular those in underserved areas. The contents of the toolkit have been designed to provide training facilitators and programme managers with information on the key components of the model, as well as resource tools to guide organisations in its implementation.

Facilitator Reference Cards to Support the Training

1. What is the IMPACT Model?

The Integrated Management for Paediatric AIDS/HIV Care and Treatment (IMPACT) model is an intervention that responds to the special need to address the special vulnerabilities and impact of HIV and AIDS, on children, especially those who have not yet been diagnosed.

The programme aims to:

- ✖ make paediatric HIV prevention, care and treatment accessible to communities
- ✖ ensure that the barriers to provision of PMTCT are addressed by:
 - working together with committed leadership and involving communities, to ensure the provision of integrated services that promote health and well-being for all, especially children.

Through this model, government services and the community come together to understand what is needed, and to provide services to the community to reduce the impact and vulnerability of children and their families to HIV and AIDS.

Who is involved in the IMPACT Model?

- ✖ The Ministry of Health
- ✖ Community health workers and volunteers
- ✖ NGOs, Community-based organisations (CBOs), faith based organisations
- ✖ Youth groups
- ✖ PLHIV support groups
- ✖ Families.

Through a process of community mobilisation, the IMPACT model will engage the community and appoint a local committee to support the roll-out and implementation of the model in the community.

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The toolkit contents have been designed to provide training facilitators and programme managers with information on the key elements of the IMPACT model. The kit also includes resource tools for use by community health workers.

IMPACT MODEL

Integrated Management of PMTCT and Paediatric AIDS/HIV Care and Treatment (IMPACT) – uses a four tiered approach to improve children's access to HIV care and treatment.

Community Health Workers

Identifies and follows up HIV positive infants and children to ensure they have regular access to treatment

- ✱ Undertakes a comprehensive assessment of a child's needs and ensures referrals to appropriate services to address them using a case management approach and co-ordinates services to meet each child's needs
- ✱ Provides counselling, treatment and adherence support, and other forms of practical support to children and their caregivers
- ✱ Develops support networks for children and their caregivers within the wider community
- ✱ Identifies and follows up post PMTCT mother-baby pairs and those who delivered at home.

Local Clinic

- ✱ Provides improved access for mothers, infants and children to prevention of mother-to-child (PMTCT), HIV testing and treatment services from trained health workers, at local clinics and outreach services
- ✱ Offers assistance with transport for those who live far from local clinics and lack the resources to get there
- ✱ Delivers HIV testing services at reduced cost
- ✱ Integrates with PMTCT programmes to provide follow up of pregnant and post-natal women to ensure that HIV exposed babies receive care and treatment from infancy to adulthood
- ✱ Identify and support post-PMTCT mothers and babies as well as those who delivered at home
- ✱ Brings the laboratory to the community, reducing the time from diagnosis to treatment to two weeks, enabling earlier treatment for those who require it.

Community

- ✱ Promotes the benefits of getting tested for caregivers and their children
- ✱ Encourages all pregnant women to visit health clinics, keep appointments, and to use health facilities with trained health care workers, when giving birth
- ✱ Encourages men to play an active role in supporting their families, including their attendance at health clinics
- ✱ Provides practical support to families with help with young children and information on local services
- ✱ Encourages community and religious leaders, to support families in protecting babies and children from HIV.

Parents, guardians and caregivers

- ✱ Are provided with a key contact, the community volunteer, who co-ordinates all the service support appropriate for their children
- ✱ Are able to access services and trained health workers locally, at reduced cost and assistance with transport
- ✱ Receive practical support, awareness on symptoms, treatment, and adherence and counselling from the home based caregiver
- ✱ Has the support of the local community on practical matters, in challenging stigma, and in encouraging all families to protect babies and children from HIV infection.

2. The Role and Tasks of Community Health Workers

The Community Health workers (CHWs) (and other volunteers such as home-based caregivers, community-based volunteers, village health workers, child case workers, child protection committee members, among others) are the main champions in the community.

They are responsible for gathering important information about households to help solve challenges related to paediatric AIDS and HIV care, treatment and prevention of mother-to-child transmission (PMTCT).

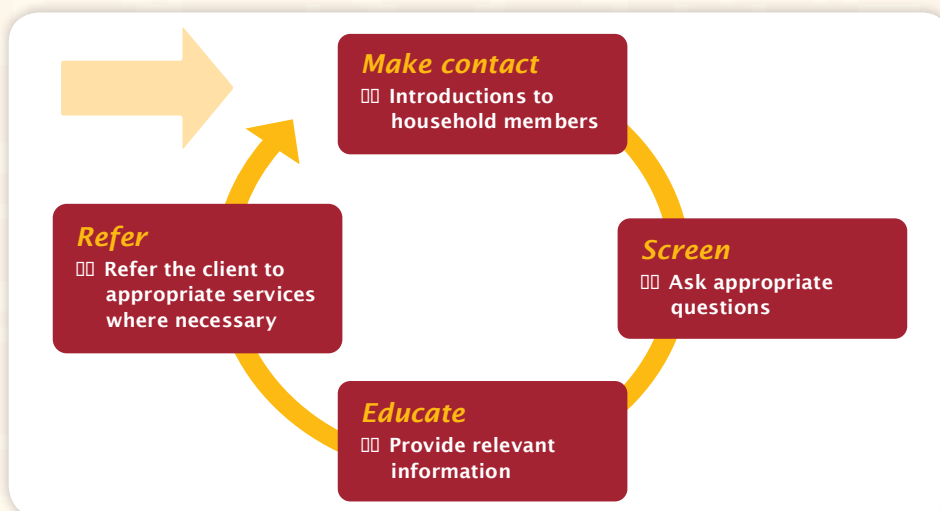
CHWs must ask relevant questions to see what the needs of a household are (screen) and also to identify what information the household needs, (educate) and where to send clients for important services (refer).

CHWs are important because:

- ✖ They are the bridge between communities, their health and health services
- ✖ They may pick up problems or difficulties and refer clients to the relevant service
- ✖ They can help and advise families
- ✖ They understand the community, including cultural influences
- ✖ They can advocate for services that do not exist locally, but which are needed
- ✖ They can also link clinics with communities and individuals who need services
- ✖ CHWs are also facilitators who educate households about HIV and AIDS, symptoms, treatment and prevention, as well as stigma and discrimination
- ✖ Where necessary, the CHWs can accompany children and their guardian to the local clinic for examination and treatment, providing necessary support

CHWs need to (see diagram):

- ✖ Understand family needs
- ✖ Help people to get the necessary care where relevant
- ✖ Educate
- ✖ Identify and refer
- ✖ Follow up.



What should CHWs do in the Household?

- ✖ Provide basic community care in the home
- ✖ Check the health status of children and mothers and provide care for the sick
- ✖ Look for possible symptoms of HIV infection and refer clients to health clinics
- ✖ Provide health awareness and education at household and community levels
- ✖ Make sure that household members stay on and follow treatment exactly as prescribed by clinic staff (adhere to treatment)
- ✖ Identify those who do not adhere to treatment and refer them to the clinic.

Ethics and Confidentiality for Community Health Workers

- ✖ Ethics are the rules that must be followed when dealing with clients – ‘proper’ behaviour
- ✖ Confidentiality means keeping a client’s information secret
- ✖ Shared confidentiality means sharing necessary information about a client, only with the team of professionals with whom you are working to help the client, ideally with the client’s agreement
- ✖ Client’s identifying details should not be revealed when discussing cases.

CHWs as community champions need to:

- ✖ Be respectful
- ✖ Be honest
- ✖ Keep things confidential
- ✖ Be good listeners
- ✖ Build good relationships
- ✖ Show acceptance
- ✖ Be a role model
- ✖ Dress suitably
- ✖ Report concerns.



3. Skills needed by CHWs

CHWs play an important role in education community members about issues around HIV, PMTCT and treatment and care available in the community. In order to perform this role effectively CHWs need to have or to learn certain personal skills. See the diagram below.

Communication skills

To make the IMPACT programme effective and useful, CHWs need to communicate directly with people, whether individually or in groups. Communication means the day-to-day sharing of ideas, feelings and information with other people.

Important skills for communication include:

- ✖ The words you use
- ✖ The tone of your voice
- ✖ Your body language
- ✖ Using good listening skills
- ✖ Observing the reactions and responses of the person you are talking to.
- ✖ Encourage clients to repeat in their own words what you have told them to see whether they have understood correctly.

Things that can harm communication:

- ✖ Not giving the client a chance to talk, or cutting them off in the middle of what they are saying
- ✖ Seeming rude or judgmental, either in the tone of your voice or by your body language
- ✖ Not really hearing what the client is saying (see listening skills below)
- ✖ Pointing fingers at the client while telling them something.

Listening is important because:

- ✖ Your client may stop talking to you if they think you are not listening to them when they have something important to say
- ✖ You need to know what is important to your client
- ✖ By listening well, you are able to ask follow-up questions that help you and your client find a solution
- ✖ You need as much information as possible about your client so that you can offer them the services they need.

To improve listening skills:

- ✖ Listen carefully to what your client says; know when to stay quiet
- ✖ Be respectful and encourage them to speak freely.

Check that what you heard is correct by: asking questions to clarify what was said; and

- ✖ by repeating what was said and asking if you have understood correctly
- ✖ Be respectful
- ✖ Stay focused on the issues at hand and do not be distracted into other things.

Communicating with children

Supporting parents to communicate with children about their health

0-2 years: Reassure the child. While you don't know how many of your words they understand, it's important to talk anyway. You might say, "The medicine will make you feel better," or "mummy is here to help you get well". This kind of talking helps relax the child and calm the parent. Babies have no understanding or perception of death – their greatest concern is fear of separation from loving, comforting and supportive caregivers

3-5 years: Encourage the child to describe or play-act what's bothering them. Ask simple questions to draw out how they are feeling, physically and emotionally. Children at this age don't have a big vocabulary for describing illness. You might ask a child having difficulty describing aches and pains to point to what hurts. At this age, the understanding of death is very limited - it is something that happens to others, and is seen as something similar to sleep –temporary and reversible. Children think they have the power to make anything happen and they may suffer from guilt – believing their thoughts, words or actions may have caused a death. They need reassurance that this is not so.

6-9 years: Talk together about why the child is sick in concrete, simple ways and engage their growing intelligence with open-ended questions. You might ask if they've heard or learned about HIV at school. Be prepared to discuss anything that is worrying the child, even if it is not directly related to the illness or condition. Reassure them. From about six to seven years old, children understand the finality of death better. Feelings of sadness, anger, confusion and even horror may be experienced when they encounter their first death. Questions about death and dying, funerals, burials and so forth need to be answered openly and honestly.

Most teenagers (and many preteens) can understand and discuss the medical details of their illness at an adult level. Talk to them using honest, simple terms and treat their ideas with respect. Plot out a health care programme for the child together with them. Make sure the child agrees to follow it. You should also talk about how he or she plans to get well. While teenagers - especially from the middle teen years (15 years upwards) - are better equipped to understand death and dying, they are emotionally very vulnerable. A well-trusted adult who is a good role-model can be a tremendous support to a bereaved adolescent.

When a CHW communicates with a child, this can give them the chance to share issues that are troubling them and that they don't feel able to talk to their parent or caregiver about. It is also a chance to learn how to find out what the child needs so you can support them better – only the child can tell us this.

This is a very important skill to allow you to help children who do not have a supportive family environment. If parents are absent, sick, or abusive the parent's role in nurturing the child is neglected. It needs to be filled so the child can develop properly.

Talking to children about their thoughts and feelings about living with HIV, is an important part of supporting them. Children need adults to help them process the feelings they may experience, such as sadness, frustration, worry or anger.

There are some creative ways of communicating with children that can encourage them to share their feelings, ideas, thoughts and emotions, if they cannot express them with words. Find ways to make this communication fun, by:

- ✖ **Using toys** - Give the child toys (e.g. a doll) to play with. Watch and listen to the story that he or she makes up. The child may play 'hospitals', or 'funerals.' The toy may have feelings like anger or sadness or act naughty. Ask the child if they sometimes feel like the doll. If the child agrees, this may show that the child is experiencing fear of illness or death. In this case, it may be useful to engage the child in a discussion about illness and/or death as a natural part of living. This information can also tell you if the child should be referred for specialist services such as counselling.
- ✖ **Drawing** - If you do not have paper and pencils, the child can draw in the sand with a stick. A picture of a sick person can show what the child understands about the illness. Ask the child to tell you about the picture - do not guess what she or he has drawn.
- ✖ **Story telling** - Story telling is a good way to help children. You can use traditional stories or make up a story with the child, to help them understand their situation better.

Developmental needs of children and young people:

0-2 years: Child needs protection and love. Begins to express basic needs and attachments

3-5 years: Child needs reassurance and praise and begins to develop imagination.

6-9 years: Child begins to test parents/caregivers, gain insights and starts to develop a conscience.

10-12 years: (Early adolescence) child seeks peer acceptance and begins to challenge the rules with adults.

13-15 years: Child is often insecure, critical of family and friends, focusing on self and need for care and support. Hormone changes may cause mood swings

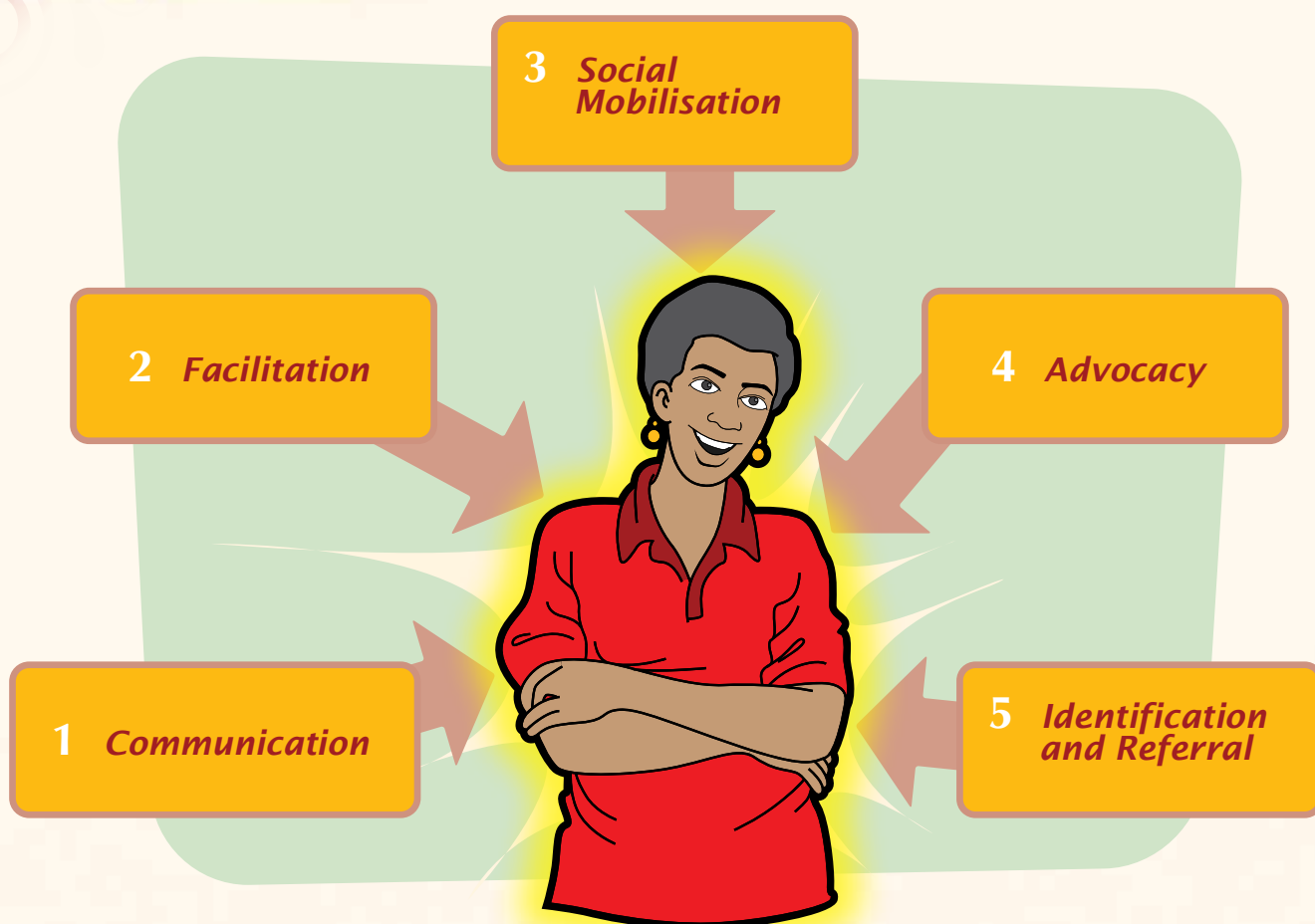
16-18 years: Able to face issues, make decisions and begin to take responsibility. Also prone to risk-taking behaviours.

Facilitation Skills

Facilitation means helping a person or a group of people to change something for the better in their lives. This means helping a client look at all aspects of their lives and sharing information with them to help them reach the best decision for their situation.

What characteristics do CHWs need to be good facilitators?

- ✖ Be strong and confident (assertiveness)
- ✖ Have insight into how others feel (intuition)
- ✖ Be resourceful in solving problems (creativity)
- ✖ Not be rigid about things (flexibility)
- ✖ Be interested and involved (enthusiastic)
- ✖ Be good at working with other people in a team (team player)
- ✖ Be open about their feelings (sincerity)
- ✖ Be dependable (trustworthiness)
- ✖ Be able to put themselves in someone else's shoes (empathy)
- ✖ Be kind (compassionate).



Social Mobilisation Skills

This means helping your community to understand the issues, especially around services needed, and to take action to ensure these services are provided locally if they are not available. For example, making sure your local clinic offers a youth friendly service so that young people are free to seek contraceptive and STI services. To achieve this, you might engage with local teachers and health workers to get them on board, and then help them as a group to approach local councilors and others to ensure that service is provided.

Advocacy Skills

Advocacy is when a person (CHW) tries to gain the support of people in power to change their environment or community. You might advocate against stigma and discrimination around HIV and AIDS, or for HIV testing services to be provided locally, or for youth friendly hours at your local clinic.

Assessing (screening) and Referral Skills

- ✖ Screening means to identify or rule out something, by asking mothers and their children questions, to find out if there are any problems related to a child's health or development, even if they seem healthy and without difficulties
- ✖ Screening must be done for everyone in the client group, e.g. women, children, young people etc
- ✖ When screening, we are gathering important information to help understand the issues so that everyone can work together to help solve the challenges.

What is referral?

After screening, you now have a good understanding of whether and where a client needs to go to receive the services they need, or whether you are able to provide it.

- ✖ Referral means sending the client to the right place where they can be helped
- ✖ Later, you will need to follow up with the household to see what has happened.

Tips for assessing (screening) and referral

- ✖ Ask questions - talk to everyone in the household
- ✖ Listen and observe. Write down all the information/actions
- ✖ Keep all information confidential - store information somewhere safe
- ✖ Make sure you refer clients to the right service
- ✖ Keep a directory of where the different services are e.g. testing, treatment, psychosocial support. Write down addresses, names and phone numbers of people, NGOs, clinics or other service providers
- ✖ Follow up with clients or referrals you have made.

4. Community Health Worker Wellbeing

Being a CHW is a huge responsibility. This should make you feel proud but it can also cause a lot of stress. To make a difference in your community, you need to be.

- ✖ Healthy
- ✖ Have a positive attitude
- ✖ Set a good example

It is good to keep checking on yourself to see how you are feeling.

CHWs often report the following symptoms:

- ✖ Not getting enough sleep
- ✖ Not eating properly
- ✖ Feeling very stressed – tearful, and upset, or very tired
- ✖ Abuse of alcohol and other medicines.

You must look after yourself if you are to be able to help others!

The strain on a caregiver's time and energy in households stressed by the presence of HIV in the family can be enormous. You may feel that the help you give is too small and that most of the things you can suggest to help just mean more work for the home's caregivers.

It may help to remember these points:

- ✖ You cannot solve all problems - but you can link caregivers with other resources in the community and the district
- ✖ You are there to help the children - your focus on the children can help to save children's lives, minds, and hearts
- ✖ Communicating with the caregiver is an important part of providing care and support to the child. When supporting parents or caregivers, ensure they have enough time to ask questions so that they can fully understand the implications of HIV and HIV testing, for themselves and for their child.

Learn to recognise the signs of feeling stressed and what causes them so that you can take action before they cause problems for you. Stress is like tiny rocks falling from a hill, as stress builds more rocks fall (larger boulders) until there is nothing left to support the hill and an avalanche occurs (burnout).

Stress is something that everyone feels almost every day for different reasons. Because care giving involves addressing the emotional and physical needs of people who can be very sick, caregivers can experience a great deal of stress.

Burnout is the result of stress that is not dealt with and builds up over a long period of time, affecting the way caregivers may feel emotionally or physically. Burnout will ultimately affect your ability to care effectively.

Like most problems, coping with stress is best done by addressing it in the open and seeking out methods of helping you cope with stress.

Tips for CHWs well-being

- ✖ Get help. Talking to someone else plays a big role in reducing stress – but remember not to reveal any personal details about clients

- ✘ Learn to recognise the things that cause you the greatest stress or anxiety (your 'triggers')
- ✘ Develop relationships with other caregivers. Caregivers with strong emotional support from other caregivers are less likely to report stress or to fear that they will become abusive
- ✘ Get healthy. Take regular exercise, eat well and get enough rest
- ✘ Do things you enjoy; socialising, playing with your children, going to church, listening to music, reading, going for walks, singing, taking up a new form of exercise, talking with others (without revealing names or recognisable details about your clients), keep a journal, practice a body relaxation technique.

Remember the positive benefits you are bringing the family.

Your communicating with the caregiver has direct benefits for the family, including:

- ✘ Helping the mother keep a positive attitude
- ✘ Offering opportunities for the mother/family to access other support services (e.g. peer support groups and post-test clubs), nutritional support, and **ART**
- ✘ Providing counselling to the mother on infant feeding options, and on nutrition for herself and other family members
- ✘ Providing support for parents to change their behaviour to reduce HIV transmission
- ✘ Parents and/or caregivers need to participate in making decisions and planning appropriate care for their child. This includes making decisions about **ART** and where the child should receive care. The CHW can help ensure that the family considers the social needs of both HIV-infected and -affected children
- ✘ In addition to providing practical and emotional support to caregivers, CHWs can also try to deal with other issues, such as the importance of positive living and ensuring that the educational and recreational needs of children with HIV are met.

Use the checklist below to make sure your stress levels are not reaching burnout stage. If you are experiencing two or more of the signs below, then you need to find ways of relieving your stress levels before they get worse.

Check list for signs of stress.

- ✘ Loss of interest in and commitment to work
- ✘ Loss of punctuality and neglect of duties
- ✘ Feelings of inadequacy, helplessness and guilt
- ✘ Loss of confidence and self-esteem
- ✘ Tendency to withdraw from clients and colleagues
- ✘ Loss of sensitivity in dealing with clients
- ✘ Loss in quality of performance in work
- ✘ Irritability
- ✘ Difficulty getting along with people
- ✘ Tearfulness
- ✘ Loss of concentration
- ✘ Sleeplessness
- ✘ Excessive fatigue
- ✘ Depression
- ✘ Bowel disturbance.

5. Household Screening and Record Keeping

In order for CHWs to implement the IMPACT programme in households and the community, they need to:

- ✖ Know the area they are responsible for
- ✖ Be prepared - are there any problems that may make it difficult for you to help a particular household? Find a solution, or consider asking someone else to take on that household
- ✖ Take precautions and stay safe
- ✖ Dress and speak in the correct way
- ✖ Get involved in the community by attending the community mobilisation meeting.

An HIV diagnosis in a child also has implication for the other family members. Likewise, maternal HIV infection has direct implications on a child's well-being, even if the child is not HIV-positive.

When HIV is suspected in a child, the mother and family should be counselled and offered testing.

Care of the HIV-infected child should be child-focused, family-centred and community-based.

Entering the household

- ✖ Introduce yourself
- ✖ Explain your role as a community volunteer and which organisation (if any) you represent
- ✖ Explain the reason for your visit and how often you will visit
- ✖ Explain confidentiality rules
- ✖ Thank the client.

To support you in your household visits, use the reference cards for information on how to deal with the various issues, such as how to screen the household and identify what help they may need; what information to share and what referrals to make.

As a CHW, you cannot do everything. You need to refer clients to the relevant organisations that provide specific services. This means advising the client to contact one of these organisations for help once you have heard the answers to the questions that have been asked.

Tips for referring

Before referring clients, visit the service organisation to find out what services they offer and any documents or other requirements that your clients will need.

Write this information in your organisation directory, along with what services they provide.

- ✖ Make sure clients understand why they are being referred, where they are being referred to and how they can get there
- ✖ If the client is not comfortable about going to a clinic or organisation, try to understand why and assist where possible. If necessary, go with the client to the organisation, especially if the client is a child or young person
- ✖ Make sure the client knows which documents they may need to take with them

- ✘ Follow up. If the client was not assisted, discuss the matter at the community reference group meeting.

What is Confidentiality of Recording and Record Keeping?

- ✘ Always make sure that you keep your clients' personal information confidential. Confidentiality is knowing private details about a person and not revealing these to other people
- ✘ Clients will only trust CHWs if they believe their personal information will be kept private
- ✘ Diaries and data collection tools should not be left where others may read them (even the CHW's family members).

Recording and Reporting

Recording means that you write down everything you see or hear during a visit to the household that is relevant to the issue you are helping with. This is important to help you remember the client's problems, what advice you have given them and what you have done to help the client solve their problems.

Also observe the household members inside and look outside the household. This will give you a lot of information. You will be able to see things such as if they have good personal hygiene and keep their environment clean, as well as how they relate to each other.

Use this information by sharing with other CHWs and learning their best practices for what has worked in a particular situation. They can also learn from your experiences and best practices.

- ✘ Recording also helps with monitoring. This means checking progress made
- ✘ Every follow-up visit to a household is part of monitoring and evaluation (seeing if you are making a difference)
- ✘ You should know and have blank copies of all the forms that need to be filled in every day, week, and month, as needed
- ✘ Record all activities, challenges or ideas in your diary or exercise book so you can report back at the CHW meetings.

What Needs to be Recorded?

Use forms for record keeping that are given out by the organisation you are supporting. As well as the information mentioned above, you should record:

- ✘ The date of your visit; the name and address of the household
- ✘ The name of the family member you are referring and for what service
- ✘ The date you will next visit to follow up
- ✘ Any activities undertaken during follow-up visits
- ✘ When filling in forms, make sure you complete all the information. Do not leave blanks. If the information does not apply to the client, write 'N/A' (not applicable).
- ✘ Fill out forms neatly. Do not scratch out untidily as it will be difficult to read and may cause the wrong information to be captured
- ✘ Make sure the information you write on the form is correct
- ✘ Arrange with your supervisor to check your forms regularly
- ✘ Record very sensitive information, such as HIV status, in a coded manner.

What is Reporting?

Reporting means giving feedback regularly, either verbally - at the community reference group meetings or CHW meetings - or in writing, by handing in completed record forms.

It includes:

- ✘ Reporting what cases have been found, how clients are improving in other cases you are following up on, how cases were dealt with - usually verbal. Make sure you do not share names and other details that may identify the person or family
- ✘ Any problems identified, e.g. services that are not available in the area, or that are not being provided correctly
- ✘ Provide a written summary report to the community reference group



6. Home Visits and Referrals

Community Health Workers play a key role in supporting children and their families affected by HIV. CHWs can help link vulnerable children and their households to services, help them identify and meet immediate needs and generally check in on the status of vulnerable households.

During home visits CHWs should:

- ✖ Check on the overall status of all children and adults living in the household
- ✖ Examine all areas of need, such as food security, health and psychosocial, well being of the household
- ✖ Use a checklist, or tool from your CBO outlining the key areas of follow up to guide the home visit exercise.

CHWs should include these items in their checklist.

Address the most urgent needs first.

- ✖ Is there anyone in need of immediate medical attention?
- ✖ Is everyone in the family safe?
- ✖ Did everyone in the household eat today? Is there food in the house?
- ✖ Are there children who seem to be suffering abuse or neglect?
- ✖ Does each child have clothing and bedding?

CHWs can then ask about the issues below depending on the nature/purpose of the visit:

Socio-economic Security

- ✖ Follow up in income generating activities in the household. What improvements can be made?
- ✖ Can family be linked to income generating activities through a local CBO or NGO?

Food Security and Nutrition

- ✖ How many meals a day do children in this household eat?
- ✖ Do children in this household regularly eat a variety of foods (balanced diet)?
- ✖ Does the household have any food stored?
- ✖ What does the household do when there is not enough food?

Psychosocial Support (PSS)

- ✖ Do any members of the household have difficulty in sleeping, eating or cry frequently?
- ✖ If there are emotional and social issues the CHW cannot help with, do household members make use of counseling services from religious institutions, local leaders, health workers, or trained counselors?
- ✖ Talk, play, and interact with all household members present on each visit.

Health Status

- ✖ Have the mother & children taken their medication? Checking of ARV pill box
- ✖ Were any children in the household sick in the last month?
- ✖ From what did they suffer? What steps were taken? (type of sickness, referral, treatment)
- ✖ Does the household have a clean water source? Is there a latrine? Overall hygiene?

Access to Education

- ✖ Are all children in the household enrolled in school? Why or why not?
- ✖ How many days in the last month did each child attend school?
- ✖ Are any household members attending non formal education or vocational training?

Child Protection

- ✖ Legal Services
- ✖ Key Documents such as birth registration
- ✖ Does each child have a birth certificate? If not they need to be assisted in obtaining one by referring them to the Department of Social Services.


Making Referrals

Sometimes members of a household may need urgent help you cannot provide. In that case, make referrals to other service providers. Follow up on these referrals to make sure the household has accessed needed services. On your next visit ask what happened with the referral and share with your CBO any challenges that happened in the family accessing the referred services.

Possible referrals you will make include:

- ✖ Medical services (for malaria, TB, malnutrition, immunisation)
- ✖ HIV counseling and testing (all household members should be tested)
- ✖ Prevention of Mother to Child Transmission of HIV (all pregnant mothers should attend ante-natal clinics)
- ✖ Treatment for people living with HIV (especially children)
- ✖ Support for education (through CBOs, for example)
- ✖ Support groups and clubs (including youth clubs)
- ✖ Training institutes
- ✖ Micro-credit and micro-finance groups
- ✖ Police and probation office
- ✖ Birth registration
- ✖ Legal advice (for land and property issues, rights violations, etc).

Work with your CBO and other volunteers to identify service providers in your area. Find out more about the services so you can explain to families what to expect. Where can families go to access the service? Is the service free? If not, what is the cost? What are the conditions for receiving the service? When are the services available? Carry around this information with you.



Once you are ready to make referrals, here are the steps to follow:

1. Discuss with the beneficiary what services are available to them
2. Explain the benefits of accessing the service you have agreed together is needed
3. Fill out the referral forms
4. Discuss with the beneficiary how he or she plans to access the service
5. Offer your support! For example, going to the place together the first time often helps
6. Inform your CBO you have made a referral and hand in the referral form
7. Follow up to make sure the beneficiary has accessed the service
8. Work with your CBO to find out the results of the referral and any additional follow up needed
9. Conduct any additional follow up with the family or service provider that is required.

7. The Basics of HIV and AIDS

Definitions: HIV and AIDS

HIV stands for **Human Immunodeficiency Virus** - the virus that leads to AIDS.

HIV attacks the body's immune system – the body's defence against disease. It is found in blood, breast milk, semen and vaginal fluids.

Once a person is infected with HIV, the virus remains in the body for life. Without treatment it usually leads to serious illness and death between two and 10 or more years after infection.

The **immune system** helps keep the body strong and fights diseases and infections. It is made up of cells in your blood that act like soldiers to attack germs. When the body has been exposed to a germ, the body develops soldier cells that only fight that germ, called antibodies.

Special white blood cells, called **CD4 cells**, tell the body to make the antibody to a germ and are very important in keeping the body strong.

When someone is infected with HIV, the virus starts destroying the **CD4 cells** and eventually there are no soldier cells left to fight infections. This is why people infected with HIV become sick.

AIDS stands for **Acquired Immune Deficiency Syndrome** and is when the immune system is made very weak by HIV. The person gets many different illnesses that someone with a healthy immune system would not get.

- ✖ **Acquired** means a disease you get during life rather than one you are born with
- ✖ **Immune Deficiency** means a weakness in the body's immune system
- ✖ **Syndrome** means a group of health problems that make up a disease.

The 'progression' of HIV to AIDS refers to the time from HIV infection to the time when a person living with HIV develops AIDS. This is different in every person and can be from two years to more than ten years from infection.

There are six major phases in the progression of HIV to AIDS:

1. HIV infection
2. The window period. This is immediately after infection. At this stage the virus cannot be picked up by an HIV test. This period may last up to three months after infection)
3. Seroconversion is when antibodies to the virus can be detected in the blood
4. Asymptomatic stage. The person is HIV positive (and it can be picked up by an HIV test), but they continue to feel and look healthy
5. HIV-related illness begins when many of the person's immune cells have been destroyed by the virus and they begin to experience various illnesses
6. AIDS is when the immune system is very weak. The person may suffer from many different illnesses at once and the body is unable to recover.

There is no cure for HIV yet, but thanks to antiretroviral medicines (**ARVs**), it can now be treated as a chronic condition like diabetes or high blood pressure.

How is HIV Transmitted?

The most common ways that HIV is transmitted are through unprotected sexual contact, and from mother-to-child, during pregnancy, delivery or breastfeeding.

Unprotected sexual contact

HIV can be transmitted during unprotected sexual intercourse (vaginal, oral, or anal) through contact with the blood, semen or vaginal fluids of a person who is infected with HIV.

Blood transmission

- ✖ Receiving a transfusion of blood that is contaminated with HIV. (All blood in Zimbabwe is screened for HIV, so blood transfusions in Zimbabwe are usually safe)
- ✖ Sharing contaminated needles, syringes, razor blades (e.g. in traditional circumcision rites, or traditional healing practices) or other contaminated sharp objects
- ✖ Infected blood entering the body through open wounds.

Parent-to-child transmission

HIV positive mothers can pass HIV to their babies during pregnancy, delivery, or through breastfeeding. However, this can now be prevented through **prevention of mother-to-child transmission (PMTCT)** services.

Without treatment, if a pregnant mother is HIV-positive, there is about a one in three chance that her baby will become infected. However, with **prevention of mother-to-child transmission (PMTCT)** services, this can be reduced to about 6%. Mothers can take **ARVs** and practice exclusive breastfeeding to help reduce the chances of them passing HIV to their baby.

During pregnancy or breastfeeding, the infection may pass from the father to the mother and then to the child; this is known as parent-to-child transmission. It is the responsibility of both parents to prevent transmission of HIV to the baby.

It is important to use condoms during pregnancy and breastfeeding to reduce the likelihood of transmitting HIV to the baby.

HIV is NOT transmitted through:

- ✖ Hugging, kissing, shaking hands
- ✖ Breathing the same air
- ✖ Sweat, contact through sport
- ✖ Tears, consoling someone who is crying
- ✖ Toilet seats, food utensils or drinking cups
- ✖ Clothes
- ✖ Public baths or swimming pools
- ✖ Mosquito bites or any biting insect or animal

How can HIV Transmission be prevented?

a) Practicing safer sex

- ✖ Sex where the penis does not enter the vagina, anus or mouth (non-penetrative sex) - with no exchange of bodily fluids. This includes mutual masturbation, thigh or armpit sex, kissing and cuddling
- ✖ Correct and consistent use of male or female condoms

- ✘ Abstinence (not having sex at all)
- ✘ Having sex in a faithful monogamous (one sex partner only for both parties) or faithful polygamous relationship, where the HIV status of all parties is known
- ✘ Avoiding multiple sexual partners and/or casual sex
- ✘ Being aware of your partner's HIV status and taking the necessary precautions
- ✘ In **discordant couples** (where one person is HIV positive and the other is HIV negative) ensuring the HIV positive partner takes **ARVs** correctly and consistently and using male or female condoms, especially when the HIV positive partner is in ill health.

b) Prevention of mother-to-child transmission (PMTCT)

- ✘ Educate parents (both mothers and fathers) about PMTCT services, how HIV transmission can be prevented and the implications for the health of mother and baby.
- ✘ Encourage couples who are planning to have a baby to go together for HIV testing before getting pregnant
- ✘ Where the female partner is already pregnant, both parents should go together for HIV testing as soon as possible, ideally before 14 weeks of pregnancy
- ✘ Educate couples on the importance of using condoms during pregnancy and breastfeeding to prevent the possibility of passing HIV infection to the mother
- ✘ Encourage all pregnant mothers to deliver in a health facility
- ✘ Encourage all mothers who delivered at home to visit a health facility within 48 -72 hours to assess the baby and get HIV counselling and testing
- ✘ In discordant couples where the woman is HIV negative, educate on the importance of using condoms during pregnancy and breastfeeding
- ✘ Educate on the importance of preventing unintended pregnancies in HIV- infected women by accessing family planning services.

8. Opportunistic infections

People living with HIV may get sick from infections that a person with a normal immune system would be able to fight off. These are called opportunistic infections (OIs) because they take advantage of the weakened immune system. Children living with HIV are more likely to get OIs than older people with HIV because their immune systems are still developing and can't protect them well. HIV may also change the way an infection affects the body and how the body responds to the normal treatment for the infection. Sometimes, more aggressive, longer treatment courses may be necessary, as treatment failures are more common. More frequent contact with the health care system is indicated for HIV infected children.

TB - Tuberculosis (TB) is the most common OI in people living with HIV. See Reference card 10. All children are prone to TB infection when they are in close contact with someone with active TB disease, but in children living with HIV, TB is likely to be more serious and progress more quickly.

Other common OIs in children living with HIV are:

Lung infections such as a special type of pneumonia (mabayo) are common in PLHIV, and the leading cause of death in HIV-infected children.

What are the symptoms? Fever, non-productive cough, shortness of breath (especially on exercise), weight loss, and night sweats.

How is it diagnosed? PCP can be difficult to diagnose in very young children and can be difficult to treat. Diagnosis is confirmed by chest x-ray.

How is it treated? Treatment is a course of appropriate antibiotics for a period of 21 days.

Can it be prevented? Yes. Cotrimoxazole can prevent the development of PCP in children.

A lung disease called lymphocytic interstitial pneumonia (LIP), rarely seen in adults, occurs more frequently in HIV-infected children. It is a secondary infection following infection with a virus.

What are the symptoms? Like PCP, can make breathing progressively more difficult and often results in admission to hospital. Symptoms include fever, cough, shortness of breath, wheezing, enlarged lymph nodes, enlarged liver, spleen and salivary glands.

How is it diagnosed? It may be diagnosed through blood tests. In severe cases a lung biopsy may be required.

How is it treated? Antibiotics may be needed if there is an additional bacterial infection. Bronchodilators are used to ease breathing. Starting **ART** may cause symptoms to resolve.

Can it be prevented? Adhering to **ART** and having regular follow up care are the best prevention.

Diseases caused by parasites are also more common in PLHIV. Serious bacterial infections due to parasites occur more commonly in children than in adults. In those with weakened immune systems the disease can cause serious illness or even be fatal.

What are the symptoms? In the first few weeks after exposure, it may cause a mild, flu-like illness or no illness. The parasite can cause inflammation of the brain and other neurologic diseases, and can affect the heart, liver, inner ears, and eyes. The disease is treated with a variety of antibiotics.

How is it diagnosed? Diagnosis is difficult and is usually done by trials of anti-toxoplasmosis treatment.

How is it treated? Treatment is with antibiotics and sometimes anti-malarial medicines.

Can it be prevented? The parasite is found in infected raw meat so good hygiene and thorough washing of hands and utensils should be practiced when handling it.

Severe candidiasis (thrush), a yeast (fungal) infection that can cause severe nappy rash and infections in the mouth and throat that make eating difficult. Left untreated, thrush can affect the whole body and may even be life threatening.

How is it diagnosed? Thrush is identified by the appearance of white, fuzzy, painful skin sores along the throat, tongue or gums, and around the vagina and anus in HIV infected babies. Other symptoms can include a sore throat, oral itching or swelling, coughing or diarrhoea.

How is it treated? Treatment with antifungal medicines is usually straightforward when caught early, though resistance to medicines can develop.

Can it be prevented? Adhering to ART and having regular follow up care are the best prevention.

WHO Recommended Follow-ups for HIV infected children.

- At birth (for infants delivered at home)
- At age 1 to 2 weeks (mainly for infant feeding counselling)
- At age 6, 10, and 14 weeks (for immunisation and infant feeding counselling)
- After age 14 weeks - monthly through age 12 months
- After age 12 months - every 3 months
- All HIV infected children should be on **ART** so regular clinic visits will be maintained throughout life, as the child receives the necessary medicines.

Chronic diarrhoea: As children with HIV become sicker, they may suffer from chronic diarrhoea due to various opportunistic viruses and bacteria. Since diarrhoea may be caused by a number of factors (including those which have nothing to do with HIV, such as cholera and typhoid) it is important to visit the health centre for assistance. Dehydration from severe diarrhoea can be life threatening, while the failure to absorb nutrients properly can affect the child's growth and development. Seeking treatment early is important.

Regular follow-up care and referrals are critical in dealing with OIs and are the backbone of caring for HIV-exposed children. They also ensure optimal healthcare and psychosocial support for the family. CHWs can ensure that families and caregivers are aware of the importance of follow up visits.

Many PMTCT programmes do not have systems for follow up of HIV-exposed infants. This is where the role of the CHW is very important. A well-informed mother (or CHW) who knows that PCP prophylaxis should be started at six weeks is the best way to ensure adequate follow up care.

Referrals

Referrals are an important part of managing HIV positive children. These include referrals to:

- ✕ Higher levels of specialised care for further investigations and treatment
- ✕ Social support programmes and community-based care programmes
- ✕ Psychosocial support for children, caregivers and other family members.

9. Children and HIV

Children are more vulnerable than adults to many common illnesses, because their immune systems are still developing. As a result, children with HIV will get ill more often and medicines may be less effective. It is now known that the earlier a child starts HIV treatment, the better it is for their overall health and development. All children below 2 years of age who are confirmed HIV positive must start treatment.

About 20% of children with HIV develop serious illness in the first year of life. Without treatment, many of these children will die by the age of four. However, some infected children have a slower rate of disease progression and do not develop serious symptoms of AIDS until starting school or even into adolescence.

Numbers of young people who have been born with HIV are now reaching their teens in Zimbabwe. The IMPACT programme seeks to identify previously undiagnosed children so that they can begin ART.

The key factors responsible for the wide variation in HIV progression in children seem to be the mother's health and the child's health at birth. In particular:

- ✘ The mother's level of vitamin A, and her CD4 and T-cell counts during
- ✘ the pregnancy seem to influence whether a child will experience rapid or slow disease progression
- ✘ Equally, the child's viral load, CD4 and T-cell counts in the first months of life are indicative.

How do children get infected?

Children may be infected:

- ✘ from their father or mother during pregnancy
- ✘ from the mother, during childbirth and breastfeeding. This is how the majority of children are infected
- ✘ A small number of children may also be infected through child sexual abuse or rape
- ✘ Children may also be infected through unsafe blood transfusions, or
- ✘ Through having sexual relations with an infected person (e.g. older children), or through contact with infected blood through non-sterile needles or razor blades).

Ten-Point Package for Comprehensive Paediatric AIDS Care

CHWs should:

1. Help mothers confirm the HIV status of HIV exposed children as early as possible
2. Once HIV infection is confirmed, the child should begin ART as soon as possible
3. Help monitor the child's growth and development
4. Ensure that immunisations are completed according to the recommended schedule
5. Refer both mother and child for relevant prophylaxis (preventive treatment) for opportunistic infections such as pneumocystis carinii pneumonia (PCP) and tuberculosis (TB)
6. Assist mothers in identifying and treating infections early
7. Counsel the mother and family on:
 - a. Practicing exclusive breastfeeding and ART to minimise paediatric transmission, prevent malnutrition and promote growth and development
 - b. Good personal and food hygiene to prevent common infections. Encourage the mother to seek prompt treatment for any infections or other health related problems in herself or her child
 - c. Ensure all follow up visits are attended and that repeat ARV scripts are filled on time.
8. Be aware of the infected child's stage of disease (WHO staging – Reference Card 16)
9. Provide psychosocial support to the infected child, mother and family
10. Refer the infected child to higher levels of specialist care, or to other social or community-based support programme, if necessary.

Caring for children who are HIV positive

Even in the earliest stages of infection, HIV can severely affect a child's development including their physical growth, psychological development and emotional well-being.

Early diagnosis ensures timely treatment and entry into ARV programmes.

Access to follow-up services, and appropriate referral systems for HIV-exposed children and their families are critical components of their care.

Extending HIV care to mothers and other family members provides a support network for the affected child and improves the child's chances of survival. Care providers can do a lot to improve the quality of lives of HIV- infected children.

This means:

- ✖ providing comprehensive care for HIV-exposed children, including PMTCT
- ✖ starting ARV therapy (**ART**) as soon as possible
- ✖ nutrition counselling
- ✖ prevention of infections and growth monitoring.

Access to these services can significantly improve the survival of these children.

Helping adolescents who are HIV Positive

It is important to be aware that adolescents have special considerations and may suffer from a range of difficulties that they may initially be reluctant to talk about.

Reassure them that everything they say will be kept confidential and that you are there to help them.

Their difficulties may include;

- ✖ Denial, which can lead to **adherence** problems
- ✖ Be worried about their developing sexuality and their futures, having boy/girlfriends, getting married...
- ✖ They may be experiencing peer pressure about sex
- ✖ They may be facing stigma at school, or be struggling to keep up with school work
- ✖ Other young people may have additional responsibilities, such as sick parents or be in a child-headed family.



10. HIV and TB Co-infection in Children

TB is one of the most important opportunistic infections to watch out for, in both adults and children. TB can be a serious and life-threatening illness for people living with HIV and can be difficult to diagnose in children.

TB can be in one of two forms:

1. **Pulmonary:** TB affecting the lungs. This is the infectious kind
2. **Extra-pulmonary:** TB affecting organs of the body other than the lungs.

TB can only be diagnosed at a health facility. People with any of the following symptoms should visit a health facility as soon as possible:

- ✖ Productive cough (which may be blood stained) for more than two weeks
- ✖ Night sweats
- ✖ Fever
- ✖ Loss of weight
- ✖ Chest pain
- ✖ A general feeling of being unwell.

CHWs have an important role in being able to recognise these symptoms and in advising parents and caregivers to take children and other family members to a health facility to be checked when these symptoms are present.

All family members should be encouraged to go for testing when a member is confirmed as having pulmonary TB. Contact tracing should also be encouraged (this means following up everyone who has been in close contact with someone with active pulmonary TB).

Children under five years of age living with HIV should have preventive therapy for TB - Isoniazid preventive therapy (IPT).

For HIV-positive children who are not yet on **ART** and who are diagnosed with TB, treatment for both TB and HIV should be started as soon as possible.

For children who are diagnosed with TB while already receiving **ART**, ARV medicines may need to be reviewed and adjusted as there may be drug interactions between some **ARVs** and some of the medicines used to treat TB. These interactions can result in increased risk of, or more severe, side-effects.

To assist in early identification of HIV infection, all TB-infected children should have an HIV test.

What are the most important messages about TB to give to parents and caregivers?

What is TB and what causes it: TB is an illness caused by a germ that is breathed into the lungs. When the lungs are damaged by TB, a person coughs up sputum (mucus from the lungs) and cannot breathe easily. Without correct treatment, a person can die from TB.

Can TB be cured? TB can be cured with the correct drug treatment, even in patients with HIV. The patient must take all of the recommended medicines for the entire treatment time in order to be cured. Medicines for treatment of TB are free and treatment can be done without interrupting normal life and work.

What are the symptoms of TB? If any family member experiences any of the following symptoms they may have TB disease: Productive cough (which may be blood stained) for more than two weeks; night sweats and fever; loss of weight; chest pain; a general feeling of being unwell.

How does TB spread? TB spreads when an infected person coughs, speaks, sings or sneezes, spraying TB germs into the air. Others may breathe in these germs and become infected. It is easy to pass these germs to family members when many people live close together.

How can we stop other members of the family from being infected?

- ✘ Make sure treatment courses are completed as instructed by your health service provider
- ✘ Cover the mouth and nose when coughing or sneezing, by using your elbow or clothes, or a handkerchief
- ✘ Open windows and doors to allow fresh air through the home; use a fan to keep air circulating if possible
- ✘ Air bedding in the sun regularly and open curtains to let in the sun. The TB bacteria is destroyed by the ultraviolet light in sunlight
- ✘ Avoid being confined in overcrowded places where there is little fresh air.

11. Preventing Mother-to-child Transmission of HIV (PMTCT): Primary Prevention and Family Planning

The national strategy for PMTCT has four prongs aimed at stopping new HIV infections in women and children and keeping mothers alive and families healthy. These are:

1. Reducing new infections in women by half
2. Reducing the numbers of people who want to use family planning but are unable to access it (unmet need)
3. Providing ARV prophylaxis (prevention) to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding
4. Providing care, treatment and support for mothers and their families.

This Reference Card covers aspects 1 and 2. Aspects 3 and 4 are covered in Reference Card 12.

IMPACT supports this national strategy by ensuring that all communities are actively involved in PMTCT. Thus, CHWs should educate women of reproductive age about the reproductive health services available to them. Refer them to your nearest health facility for your local community-based distributor so they can get family planning products.

These include: family planning services; antenatal care; postpartum and postnatal care; and other health and HIV service delivery points that include CSOs and CHWs.

Primary prevention

To reach zero new infections in babies, CHWs need to help women and girls to prevent HIV infection (primary prevention) by providing information about available HIV and sexual and reproductive health services:

- ✖ testing and counselling before, during and after pregnancy
- ✖ importance of testing for other sexually transmitted infections (STIs)
- ✖ consistent and correct use of male and female condoms
- ✖ dealing with cases of gender-based violence
- ✖ ensuring men are involved at community level
- ✖ Effective PMTCT depends on pregnant women and girls accessing antenatal counselling and HIV testing.

Helping young women and girls access their sexual and reproductive health and rights

Building the self-esteem and communication skills of young women and girls is an important part of empowering them to reduce risky sexual behaviour and preventing gender-based violence. CHWs should help educate young people – both boys and girls - about their sexual and reproductive health and encourage them to access services, including contraceptives and HIV testing if needed.

CHWs should also advocate for the availability of youth-friendly sexual and reproductive health services and information on HIV testing in their area.

Family planning services

CHWs should provide women and girls, men and boys with knowledge on family planning services, to prevent unplanned pregnancies, and know where to refer them for these services. Fewer unintended pregnancies means fewer infants potentially exposed to HIV.

CHWs can encourage women and girls to obtain contraceptives to ensure spacing of births and promote healthier lives for themselves and their children.

- ✖ CHWs need to explain the importance of dual protection. **Dual protection** protects against both pregnancy and STIs and HIV. It means using male or female condoms together with another contraceptive method, or using male or female condoms alone
- ✖ Counselling young HIV positive women on the importance of avoiding unintended pregnancy is an important role for CHWs.

Young women and girls who have had unsafe sex (or who have been raped) and are worried about pregnancy or HIV and STI infection should be advised to visit their nearest health centre as soon as possible, for **emergency contraception** and **post-exposure prophylaxis (PEP)** for HIV within 72 hours, or they may not be effective.



12. PMTCT: ARVs prophylaxis, care, treatment and support

What is prevention of mother-to-child transmission of HIV?

PMTCT is a comprehensive range of services to reduce HIV transmission from mother to their babies. It involves HIV testing for couples who are planning to have a baby or who are already pregnant and provision of ARVs for women who are HIV positive. Newborns will also be given ARVs to reduce the chances of transmission. Mothers should also practice exclusive breastfeeding. Talk to your local clinics and hospitals to find out about mothers who have undergone PMTCT, and follow up those who had home deliveries so that their infants can be tested and if positive, immediately commenced on treatment.¹

ARVs for HIV positive pregnant women and babies

CHWs should encourage all pregnant women and their partners go for HIV testing. If they are found to be HIV positive, help them access PMTCT services to prevent them passing HIV infection on to their babies during pregnancy, delivery and breastfeeding. Provide counselling if needed.

- ✖ **Antiretroviral therapy (ART)** in pregnancy and during breastfeeding significantly reduces the risk of mother-to-child transmission of HIV. Pregnant HIV positive women should begin **ART** immediately, whether or not they need it for their own health
- ✖ All pregnant HIV positive women with a **CD4 count** of 350 or below, or with serious HIV-related symptoms, should start lifelong ART immediately, regardless of their stage of pregnancy
- ✖ HIV positive pregnant women with a **CD4 count** above 350 will be given **ARV** prophylaxis from 14 weeks into their pregnancy (or as soon as possible after that), until they stop breastfeeding.

CHWs should ensure that all HIV positive women and girls seek HIV care, treatment and support for themselves, their children and other family members, when needed, by directing them to their nearest facility.

Reducing other complications in pregnancy

Vitamin supplementation

Pregnant women should have access to nutritional education and support. Multivitamin supplementation reduces the likelihood of the baby having a low birth weight and is important in ensuring the healthy development of the unborn baby. It can also reduce the chances of the baby being born with physical defects. Supplements can also reduce pregnancy complications in HIV-infected women.

Other infections

CHWs should advise pregnant women to avoid exposing themselves to other infections, including malaria and other STIs.

- ✖ Malaria during pregnancy causes low-birth-weight in infants; dual infection with HIV and malaria is associated with an increased risk of maternal and early infant death, as well as miscarriages

1 The greatest number of infant deaths from HIV occurs after delivery, when the mother and babies are discharged from post natal care at six weeks

- ✘ Insecticide treated bed nets are an effective way of reducing the risk of malaria infection. Women in high malarial areas can take intermittent preventive treatment (IPTp) which consists of taking a single curative dose of an efficacious anti-malarial drug at least twice during pregnancy – regardless of whether the woman is infected or not
- ✘ Sexually transmitted infections (STIs) and urinary tract infections in pregnancy may cause the baby to be born early and increase the baby's risk of HIV infection
- ✘ Condoms should be used during pregnancy to prevent infection from STIs.

Involving men in PMTCT

During pregnancy or breastfeeding, HIV may pass from the father to the mother and then to the child; this is known as parent-to-child transmission. Both parents must take responsibility to prevent transmission of HIV to the baby by using condoms during pregnancy and breastfeeding.

Male involvement in PMTCT is also very important in ensuring that women and girls get access to PMTCT and reproductive health services, and live healthier lives.

Tips for involving men in PMTCT

CHWs have an important role to play in promoting male involvement. They can:

- ✘ Involve local and traditional leaders as advocates and opinion leaders
- ✘ Involve community health workers to mobilise men to support and accompany their pregnant partners for HIV testing and PMTCT services
- ✘ Encourage men, as peers, to speak to other men about PMTCT
- ✘ Highlight to men that they are husbands, partners and protectors and need to ensure the health of their families.

Infant feeding and counselling

The World Health Organization recommends exclusive breastfeeding for all babies for the first six months of life, regardless of their mother's HIV status. This is because the risks of other fatal infections - such as diarrhoeal diseases - as a result of not breastfeeding outweigh the risk of HIV infection. CHWs should promote exclusive breastfeeding in their communities. When a mother is taking **ARVs**, the risk of her infecting her baby through breastfeeding is significantly reduced.

Mothers should be encouraged to breastfeed as soon as their baby is born – the yellow liquid that comes before the breast milk contains antibodies against disease as well as being low fat and high in protein. It also encourages the baby to pass stool.

Some facts about exclusive breastfeeding:

- ✘ Exclusive breastfeeding means the baby receives no other foods (including water) for the first six months of life
- ✘ Breast milk is designed to provide ALL the baby's nutritional requirements right up to the age of six months. Additional feeding may affect the baby's digestive system and cause him or her pain
- ✘ HIV positive women with babies who are confirmed HIV positive should:
 - Breastfeed until the baby is two years of age, including after introducing additional foods at six months

- Stopping breastfeeding should be done gradually over one month to allow the baby's body time to adjust and ensure the baby gets adequate nutrition whilst adjusting to other foods
 - For babies older than six months, breastfeeding should only be stopped if a sufficient supply of infant formula milk - prepared with safe water and in clean conditions, - or a constant supply of animal milk (boiled, for infants younger than one year of age), is assured, as part of a diet including healthy, cooked foods such as mashed vegetables, grains and meat.
- ✘ CHWs should explain that cultural practices that involve giving newborns (or any baby below the age of six months) solid foods, such as sadza, can be harmful and should be avoided. The digestive system of a baby is not yet properly developed and cannot cope with adult foods – these may damage the delicate lining of the stomach. These practices are now known to be harmful, especially in the era of HIV. Mothers-in-law are important allies in preventing transmission of HIV to newborns through breastfeeding.

A new mother may be unsure about breastfeeding. CHWs can help.

- Establishing a comfortable breast feeding routine takes time. Don't give up!.
- The position of the baby on the breast is important so that both mother and baby are comfortable
- The mother should place her nipple between the baby's upper lip and nose and encourage her to open her mouth by brushing her lip with the nipple, or brush the baby's cheek with the nipple, so the baby turns toward it with her mouth open
- When the baby latches on to the breast, her mouth should be wide open and should cover the dark part of the breast with her lips, more on the bottom side than on top. This should be a comfortable position for both mother and baby. If the latch on is painful, the mother can gently put her (clean) little finger between the baby's gums and the breast and try again
- Listen for sounds of the baby swallowing so you know she is getting milk. The more the baby sucks, the more milk will come,
- About half way through a feed, stop feeding and hold the baby up against your shoulder gently patting her back if needed to help her burp (bring up air). After a good burp, switch breasts
- Remember which breast you stopped with last time, so you can start with the other next time
- To remove the baby from the breast without bruising the nipple, the mother can gently put her (clean) little finger between the baby's gums and the breast
- At the beginning the nipples may feel a bit tender – this will soon pass. Try hot or cold compresses. If the pain continues, look out for inflammation, cracked or bleeding nipples, as these make it more likely that HIV will be passed on. If this happens or there are any other problems, consult a health services provider.

Safer delivery practices

All pregnant women should seek antenatal services as soon as possible, and book with their local clinic for delivery, as soon as they know they are pregnant. Many babies are infected with HIV during labour and delivery so it is important that women deliver in facilities under skilled personnel.

- ✘ CHWs should support mothers to book early and to keep all antenatal appointments, and encourage them to take any action advised by the antenatal clinic
- ✘ CHWs should explain the importance of giving birth in a proper health facility with skilled attendants, and encourage mothers to make plans so they can be sure they are able to get to the health facility when the time comes.

The risk of HIV infection during delivery increases if:

- ✘ the baby is born early
- ✘ the waters break long before the baby is born
- ✘ if invasive procedures - like breaking the waters manually - are used. This should be avoided in HIV positive women.

Supporting mothers after delivery (postpartum)

- ✘ CHWs can counsel mothers and help them to practice exclusive breastfeeding. If a mother has cracked or bloody nipples, or breast infections the risk of HIV transmission is increased. Advise them to seek treatment immediately
- ✘ The risk of HIV transmission can also be reduced if the mother keeps herself in good health, maintains good nutrition and hygiene and always practices safer sex during breastfeeding
- ✘ CHWs can provide counselling on food and personal hygiene.

Confirming HIV Infection

- ✘ All women who deliver with unknown HIV status should be tested before delivery, if possible, or as soon as possible after delivery
- ✘ Post-exposure prophylaxis should be given to the baby of an HIV positive woman
- ✘ If the mother is known to be HIV-positive and the child has signs and symptoms that indicate HIV infection, the child should be presumed infected and treated accordingly, while test results are awaited
- ✘ CHWs should encourage routine testing for HIV for all sick children in high HIV prevalence areas.

Checklist for CHWs on information and services for PMTCT:

- ✘ Ensure mothers practice prevention and treatment of opportunistic Infections (OI)
- ✘ Provide psychosocial support and nutritional advice
- ✘ Advise on reproductive healthcare, booking early and the importance of delivering in a health facility
- ✘ Advise on use of condoms during pregnancy and breastfeeding
- ✘ Ensure STIs are treated early and prevented
- ✘ Advise on family planning services
- ✘ Advise on seeking **ART** for HIV positive mothers
- ✘ Advise on exclusive breastfeeding and baby care
- ✘ Encourage **HIV testing** of both partners
- ✘ Encourage baby immunisations
- ✘ Advise on infant growth and development monitoring
- ✘ Ensure acute infections are treated promptly
- ✘ Encourage routine de-worming as worms can have a serious impact on the mother's

- nutritional status, which may affect the development of the baby
- ✘ Encourage multivitamin supplementation during pregnancy
- ✘ Encourage financial independence of women (poverty alleviation).

Non Mother-to-Child HIV Transmission

Babies and young people may also contract HIV in other ways, although this is much less common. Transmission may occur through:

Sexual Abuse - this accounts for a relatively small proportion of infection in children, but child sexual abuse is becoming increasingly common in Zimbabwe. It is often difficult to tell if an older child was infected during pregnancy or through abuse.

Orphans and children living in households where the parents are ill are especially vulnerable to sexual abuse. Where sexual abuse is suspected, refer the matter to the relevant organisations or groups.

Advise mothers how to talk to their children about the dangers of sexual abuse; they should explain to them that no-one (even other family members, or people in authority) should touch a child's their private parts. If anyone tries to do so, they must tell their mother, caregiver, or another person whom they trust, immediately, even if the person tells them not to.

Post-exposure Prophylaxis (treatment which may prevent an infection) - If someone has been sexually abused, it is important that they get post-exposure prophylaxis (PEP) as soon as possible. If someone has been sexually abused, they should get PEP as soon as possible, ideally within 72 hours. It is most effective within 24 hours of the exposure. Prophylaxis may also be needed in other situations, such as exposure to contaminated needles, blood, or other bodily fluids, or after human bites, where the skin is broken.

Points to keep in mind for post-exposure prophylaxis include:

- ✘ **ARVs** need to be given for 28 days. Therefore, on discharge from the health facility, the child should be given enough medication to complete a 28-day course
- ✘ An HIV test will be done at the clinic (after obtaining informed consent) to make sure the person is not already HIV positive. Most HIV infections occur within six to eight weeks of exposure, but repeat HIV testing should be done at six to eight weeks, three months and six months, after the assault.

In children who have been sexually assaulted, CHWs should consider the need to prevent pregnancy and STIs, as well as the collection of forensic evidence, including appropriate perianal and vaginal swabs, and any torn or stained clothing.

Transfusion of blood products

Blood donors in Zimbabwe are routinely screened for HIV, and this has made blood transfusions relatively safe. However, a small number of infections may still be caused this way where HIV-infected donors were not detected during the window period.

Adolescents

Adolescents are vulnerable and may acquire HIV through risky sexual practices and transactional sex.

However, they may also be infected through being sexually abused, or sharing contaminated needles when experimenting with injecting illegal drugs. CHWs can help identify adolescents involved in risky practices and counsel them accordingly.

14. Assessing (screening): for Symptoms of HIV in Children

Accurately diagnosing HIV in infants and children is challenging. Some children who are infected with the virus may not show signs of HIV infection for many years.

Many babies and children living with HIV are known or suspected to be infected because their mothers are known to be infected. However, sometimes infection is not suspected until a child develops symptoms.

Without treatment, children with HIV fall into one of three categories:

- ✖ **Rapid progressors:** children who progress to AIDS very quickly and may die before the age of two unless they receive treatment. Almost 40% of HIV positive children fall in this category; half of infected children never reach their second birthday
- ✖ **Medium progressors:** About 50-60% of children fall in this category, where the disease progresses more slowly and death occurs within three to five years without treatment
- ✖ **Slow progressors:** These children live beyond eight years without treatment. About 5- 25% of children fall in this category.

If a child displays any or a combination of the symptoms below, CHWs should encourage parents/guardians to have the child tested for HIV as soon as possible. Both pre and post-test counselling should be made available for children and their parents.

Symptoms of HIV infection vary by age and individual child, but below are some of the more common ones.

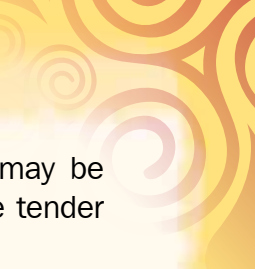
- ✖ Failure to thrive - failure to gain weight or to grow according to standard growth charts used by paediatricians
- ✖ Failure to reach developmental milestones at the normal age
- ✖ The child has frequent childhood illnesses such as ear infections, colds, upset stomach and diarrhoea
- ✖ Severe nappy rash
- ✖ Brain or nervous system problems, which may include seizures, difficulty with walking, or poor performance in school
- ✖ Tuberculosis. However, note that all children are more prone to TB infection if they are in close contact with an adult with TB.

Other early symptoms may be:

Oral yeast infection - Recurrent oral or digestive tract yeast infections. These can be identified by the appearance of white, fuzzy, painful skin sores along the throat, tongue or gums. Other symptoms can include a sore throat, oral itching or swelling, coughing or diarrhoea.

Recurrent ear, sinus or lung infections - These may occur along with fever, body aches, headaches, stomach upsets or extreme tiredness. These infections should be treated early.

Skin rash - Children may develop a severe skin rash (dermatitis), characterised by red, dry itchy patches of skin across the body. This can be uncomfortable and cause the child to scratch the affected skin to the point of causing bleeding. Children with HIV may also develop abnormal reactions to mosquito and other insect bites.



Abdominal swelling - Some children develop significant abdominal swelling. This may be due to inflammation of the liver or spleen, caused by the virus. The abdomen may be tender to the touch and it may be difficult for the child to move about normally.

15. Diagnosis of HIV in children

It is very important that HIV-positive children are identified early so that they can begin **ART** to protect them from the virus and allow them to grow and develop normally. Every HIV positive woman or is pregnant or who has given birth should be counselled on the need to confirm her child's HIV status. The risk of HIV infection from breast milk continues throughout the breastfeeding period.

Ensure that pre and post-test counselling for children and their parents is available in your area. Messages for parents are:

- ✘ Get your child tested for HIV – it can save their life
- ✘ Get your child tested for HIV – so you get the emotional, social and spiritual support you need
- ✘ Mothers – get tested - so you can get treated and be well enough to care for your child and see them grow.

Explain when and where to take the child for HIV testing. This will depend on the availability of HIV testing in your area. If the mother is known to be HIV positive, her baby should be treated as HIV positive until test results prove otherwise.

HIV infection in adults is easily diagnosed by testing the blood for antibodies to HIV. In children, however, an antibody test is not effective, because the mother's antibodies are passed on to the child to protect it from infections while its immune system develops.

- ✘ Antibody tests in infants may give false positive results for up to 18 months, unless the child has never been breastfed, or was completely weaned at least three months before the test
- ✘ A negative antibody test below 18 months of age in an HIV-exposed infant – especially one who has never breastfed, or who was completely weaned at least three months before – does indicate the absence of HIV infection. Nonetheless, it is wise to retest such infants after three months.

PCR testing

- ✘ A test called a PCR test (polymerase chain reaction, also called a viral load test) can be done at or after six weeks of age. The test checks for virus in the baby's blood cells and can be done on whole blood, or on dried blood spots (DBS) from infants. DBS is simple and inexpensive. A small prick is made on the child's foot and the blood is dripped onto filter paper, which is then sent for analysis. The DBS does not need refrigeration.

PCR testing is more readily available in Zimbabwe now. Find out if your local clinic can take the DBS and how long it takes for the results to come back. If not, know where your nearest testing point is.

- ✘ If the test is positive, it should be confirmed by a second DBS. However, for clinical purposes, the child is treated as HIV positive after the initial test
- ✘ Below 18 months of age, if a child has a negative PCR result but is still breastfeeding, or has stopped breastfeeding within three months of the test, the test should be repeated three months after breastfeeding has stopped
- ✘ If your client's baby is having a PCR test, follow up with the clinic to check if the results have come through.

16. Starting Treatment in Children

All HIV positive children should be started on **ART** and Cotrimoxazole prophylaxis immediately on diagnosis.

If the mother is on **ART** or on **ARV** prophylaxis, the child should be given Nevirapine prophylaxis until one week after breastfeeding ceases. If PCR after six weeks shows the child is HIV infected, the child should be started on ART and Cotrimoxazole prophylaxis as soon as possible.

If the child is suspected to have been HIV exposed, **the child should be treated as HIV infected until infection is either confirmed or not by PCR** (see Diagnosis of HIV in Children – Reference Card 15).

Once a child is suspected of being HIV positive, both caregiver and the child (if old enough) should be counselled on ART and the importance of adherence.

ART in HIV positive children below two years of age should begin whether or not there are signs of illness.

A **CD4 count** is used in people living with HIV (PLHIV) to:

- ✖ Check how weak or strong the immune system is (a high **CD4 count** means the immune system is strong)
- ✖ Decide whether the person needs to start antiretroviral therapy. It is now recommended that all PLHIV with a **CD4 count** of 350 or below should start ART
- ✖ Decide whether to change ART medicines. If a person is on ART and their **CD4 count** begins to fall or they begin to get sick, the ARVs he or she is taking may have stopped working.

Because **CD4 counts** in children are higher than in adults, children under 12 years old with HIV are monitored by CD4% rather than absolute CD4 count.

Table: CD4% and CD4 counts for babies and children

HIV disease category	CD4%	CD4 0-12 months old	CD4 1-5 years old	CD4 6-12 years old
1 – no damage	25%	over 1,500	over 1,000	over 500
2 – moderate	15-24%	750-1,500	500-1,000	200-500
3 – severe	under 15%	under 750	under 500	under 200

A Viral Load test shows the amount of HIV in a person's blood and the extent of HIV infection. It also indicates how well ART is working.

Babies known to be infected with HIV should begin ART as soon as possible regardless of disease staging.

Understanding the WHO Clinical Staging for HIV and AIDS in Adolescents and Adults

Stage 1	No symptoms	No need to begin ARVs, although this guideline may change in future, as research into early HIV infection suggests improvements in treatment.
Stage 2	Some weight loss, fungal infections of nails; frequent respiratory infections	Health professional will monitor CD4 blood test to determine the need to start ART.
Stage 3	Severe weight loss; unexplained chronic diarrhoea for more than a month; unexplained persistent fever over a period of one month; TB; Thrush	ART should begin at this stage
Stage 4	Severe weight loss, severe respiratory disease; severe thrush; other serious infections	Needs to be on ART immediately and should receive immediate treatment for any illness.

17. ART, Side-effects and Adherence

About ART

- ✖ **ART** involves a combination of ARVs
- ✖ **ART** is NOT a cure for HIV and AIDS
- ✖ While on **ART**, people living with HIV can still be re-infected with HIV
- ✖ People on **ART** are less likely to pass on the infection to others, but this depends on how well their viral load is controlled and how consistently they take their medication
- ✖ **ARVs** are taken for life
- ✖ Not everyone with HIV needs to begin **ART** immediately, though it is now believed that it is better to start treatment early
- ✖ The goal of **ART** is to reduce the amount of HIV in the blood and increase the number of CD4 cells. ART improves health and quality of life by stopping HIV from making copies of itself (replicating) in the body, reducing the damage HIV causes to the immune system and preventing progression to AIDS
- ✖ Children respond differently to **ARVs** from adults. They have larger increases in CD4 cell counts and more diverse CD4 cells. They seem to recover more of their immune response than adults
- ✖ Bones develop quickly during the early years of life. ARVs can weaken bones in both adults and children. Children are more likely to experience bone disorders as a side-effect of treatment.

Side-effects of treatment

All medicines may have side-effects (unwanted effects on the body). Parents and children should be made aware of possible side-effects so that medical attention can be sought where necessary. It is important that the child continues to take the medicine as instructed, even when having side-effects.

Many side-effects are worse during the first few weeks of treatment and lessen as the body gets used to the medicine. However, some are more serious and need to be attended to by a medical service provider as soon as possible.

Some minor side-effects a child might experience include:

- ✖ **Nausea:** This may be eased by giving the medication either with or without food, depending on which makes the nausea worse. Treat by giving the child bland, plain food and give small amounts of food at a time. Give the child ginger tea or fresh ginger. It is best to consult your health service provider
- ✖ **Vomiting and diarrhoea.** Give oral rehydration solution if severe: 6 level teaspoons sugar with half teaspoon salt in 750 mls of boiled water. Give the child frequent sips when cool. Fruit juice or rooibos tea may also help.
- ✖ **Abdominal pain**
- ✖ **Headache**
- ✖ **Fatigue** – make sure fluid intake is correct; bed rest

- ✖ **Skin rash** – Note: Skin rash may be a serious side effect, especially if it is severe and affects the whole body. This should be checked by a health service provider. Infected mild skin rashes may be eased by adding garlic to skin care ointment and spreading on the rash
- ✖ **Loss of appetite.**

Side-effects that you should check with your health service provider are:

- ✖ Severe headaches
- ✖ Severe abdominal pain
- ✖ Tingling of the hands and feet
- ✖ Yellowing of the skin and pain of internal organs (liver toxicity or jaundice)
- ✖ Severe rash
- ✖ Severe fatigue or shortness of breath
- ✖ Fever
- ✖ Severe mental disturbance
- ✖ Severe muscle pain or cramping
- ✖ Anaemia.

Adherence

CHWs have a vital role in supporting caregivers to ensure that children take their medication as prescribed and should encourage caregivers to observe their children taking their medication where possible.

Children adhering to ART

Many children do not understand why they should have to take medicines that may taste bad or make them feel sick. This is one reason why it is important to disclose to children early. Until recently, paediatric versions of **ARVs** were not available, and many taste bad or have a strange texture.

Counselling and Preparation

Caregivers and children (if they are old enough) should be given pre-ART counselling before ART is started. This should include details on how the medicines should be taken; i.e. with or without food, and how often, as well as any known side-effects and how serious they may be.

Starting ART

When a child starts on treatment, the caregiver and child may need support to deal with the challenges (e.g. side-effects). CHWs can give encouragement and support, reinforcing the importance of taking treatment correctly.

Re-motivation and/or treatment change

Over time, adherence can wane, on the part of either the caregiver or the child, especially when they are feeling well. Experiencing, or being afraid of, stigma can also prevent a child adhering to medicines.

If a particular treatment combination fails, the health service provider will need to change the medication. This can cause additional stress and anxiety, and new side-effects. In this case,

- ✖ CHWs need to intensify their support of the family, reinforcing adherence during visits and giving encouragement
- ✖ CHWs should also offer assistance with practical, emotional and social issues.

How can CHWs help a child on ART?


- ✖ Make sure that the child and caregiver understand the health issues, especially the progression of HIV
- ✖ Reinforce the benefits and address any challenges to **ART**
- ✖ Make sure they remember that **ART** does not cure HIV and that treatment is for life
- ✖ Reinforce that successful **ART** requires **adherence** 100% of the time.

Tips for parents to make taking ARVs easier:

- ✖ Explain, even to a very young child that the medicine you are giving them will help them. Use simple language that the child will understand. Be reassuring
- ✖ If the child does not want to drink the medicine, make up a game that will encourage them to take it
- ✖ If the medicine has an unpleasant taste, prepare the child in advance so that they know what to expect
- ✖ If tablets are too big to swallow, crush them, or break them in half to make them easier to take
- ✖ If the child vomits within 30 minutes, reassure him or her and repeat the dose. If the child vomits more than 30 minutes later, it is likely that the medicines will have been absorbed by this time and there is no need to repeat the dose
- ✖ Always praise the child after taking the medicine, and if possible give him or her a reward or treat.

Tips for parents to help a child remember to take ARVs everyday at the right times:

- ✖ Make a timetable or chart with a list of the pills and time
- ✖ Work out how to tell the time at home, using: a watch or clock, a cell phone, or watching the sun in the sky
- ✖ Carry some pills with you all the time in case something stops the child from getting home on time
- ✖ Store pills where they will be noticed at the right time, for example with a breakfast plate or toothbrush. If possible, keep pills in a container with compartments and fill this pill box once a week
- ✖ If pills taste bad, some pills can be broken or crushed or dissolved in water, juice or milk to make them easier to swallow. Follow pills with something sweet, like honey, or something salty to help take the bad taste away
- ✖ All family members can support the child to take their medicine by giving little rewards, a certificate saying, "...is a champion!", or singing a song congratulating the child. Make a star or sticker chart or use a calendar

- 
- ✘ Older children can keep a diary about their difficulties and feelings about taking the medicines. They can share this with anyone they want to, or keep it private. A treatment diary can also help identify problems with **adherence** and help find solutions
 - ✘ Make sure you are ready to collect the pill supply every 28 days
 - ✘ Designate at least one family member who agrees to help remind the child to take their pills.

18. Disclosure in Children and Young People

Here, a child is someone below the age of 5. 'Young person' refers to anyone of school going age.

What is disclosure? Disclosure in children with HIV refers to the parent or caregiver telling the child about their illness and about their need to take medication. This can reduce any fears the child may have and help them understand and take charge of their health, as well as ensuring they do not infect others.

Disclosure also means the decision by someone who is HIV positive to tell others about their condition.

How to disclose: there is need to take into consideration the child's age, level of emotional maturity and any family dynamics that may affect this. In the beginning, the exact diagnosis is less important with young children. As they mature, they should be fully informed of the nature and consequences of their illness and encouraged to actively participate in their own medical care. Older children and young people who are recently diagnosed may already have understood that they are ill and finding out about their HIV positive status may come as a relief.

For older young people who are aware of their status, disclosure also means the decision to tell others their status.

How can CHWs help? CHWs can discuss and plan the disclosure process with parents or caregivers. The child's developmental age and emotional/mental health need to be considered and a number of visits may be made to assess the child's knowledge and coping capacity. Older children are better able to understand the nature and consequences of their illness and efforts must be made to help them cope with their condition. Ideally, disclosure should be conducted in a controlled situation with parent(s) and caregivers.

- ✖ CHWs should help prepare caregivers for answering any questions the child may have, bearing in mind that children are very intuitive and may often have picked up the fact that they are unwell before they are formally told
- ✖ Children are able to understand different things at different points in their development. It can be difficult to understand everything at once – especially something that is emotionally charged. In general, younger children, if they are ill, are most interested in learning what will happen to them in the near future. They need not be informed of the actual diagnosis, but the illness should be discussed with them. If children are informed of their diagnosis, effort should be made to address any fears or misperceptions they may have about their condition
- ✖ CHWs should always consider the views of the child's caregivers; they may be reluctant to tell their children about their status because of the implications for their own status and the fact that the virus is primarily sexually transmitted.

Why disclose? There is evidence that children who are informed of their HIV status cope better with their illness and can participate in their own treatment. Being aware of their positive status can also improve self esteem and confidence. School age children and adolescents should be informed of their status so that they can make appropriate decisions about treatment.

Children who are ill, particularly those who need to be hospitalised should also be informed of their HIV status as there is a strong chance that they will accidentally learn their status in a hospital setting.

Disclosure should:

- ✘ Help the child understand their illness and be a two-way conversation
- ✘ Respect the child's feelings and emotions
- ✘ Take into account the wishes of the family.

Disclosure to children is a sensitive process rather than a one-time event and CHWs have an important role to play in helping parents and caregivers disclose to their children in a positive and supportive way.

- ✘ Knowing their HIV status can encourage children to take their treatment as they should (adhere) as they know the medicine is to keep them healthy
- ✘ Keeping the information that a child is HIV positive from them can lead to distrust and confusion and leaves them unprepared to deal with related issues that will later arise in their lives, such as possible stigma and sexual activity.

The Role of CHWs in Disclosure to Children

CHWs can:

- ✘ Encourage parents and caregivers to disclose to children at the appropriate time
- ✘ Help parents or caregivers to plan for disclosing; to think ahead about questions the child may ask and how they can be answered
- ✘ Provide leaflets and drawings that help the caregiver explain HIV and **ART**
- ✘ Answer caregivers and children's questions about the disease – what the infection is all about, and how it makes you sick
- ✘ Parents/caregivers may ask CHWs to be present for support when they disclose, but it is important that it is the parents who actually give the child the information
- ✘ Help the child to understand the benefits (and risks) of treatment
- ✘ Help the child and caregivers decide to whom the child should disclose
- ✘ Help prepare caregivers and children to deal with others' reactions to their status
- ✘ Recognise signs of depression and denial and make necessary referrals for mental health support.



How not to disclose: Just as there are recommended ways to disclose, there are also ways not to disclose. It is best NOT to disclose: by accident or without planning ; as a punishment; after the child already knows; When the child is dying.

Disclosure to others

Disclosure may be **full** or **partial**. Full disclosure means that HIV status is made public, with no attempt to keep the knowledge from others. This is common in HIV activists, or champions, but may not suit everyone.

Partial disclosure is more common and means people are told on a 'need-to-know' basis. Thus health care providers and family members may know, but it is the child's decision who to tell or not to tell. It may be helpful if teachers are aware of a child's HIV status, but it is the child's choice. However, if disclosure is on a partial basis, then those who are told should be advised that they should keep this knowledge to themselves.

Disclosure by young people

Factors to consider:

- ✖ Disclosing can help people accept their HIV-positive status and reduce the stress of coping on their own
- ✖ Disclosure can help people access the medical services and other support they need
- ✖ Disclosure can help people to protect themselves and others. Openness about their HIV-positive status may help women to negotiate safer sex
- ✖ Disclosure can help reduce the stigma, discrimination and denial around HIV
- ✖ Disclosure promotes responsibility. It may encourage the person's loved ones to plan for the future.

However, disclosure can also have negative consequences including: problems in relationships with sexual partners, family, friends, community members, employer or colleagues and rejection.

- ✖ CHWs should help clients think through the pros and cons carefully and to plan ahead before they disclose their HIV-positive status. Encourage them to think of the implications of disclosing and to consider how those they opt to disclose to may react. They should be sure it is what they want to do. And they should plan how they will do it
- ✖ For adolescents, there is the difficult decision of whether or not to tell friends or dating partners, who may seem important at the time, but may soon move on and may or may not keep the confidentiality
- ✖ Encourage them to develop a "plan" for disclosure, that includes any preparations that need to be made before disclosure; decide who they will inform first, how and where the disclosure will take place, and what the level of disclosure will be
- ✖ Disclosing gradually rather than to everyone at once may be better
- ✖ It is important to choose the person/people to disclose to carefully: they should be accepting, mature, empathic and supportive
- ✖ Make sure that the time and place are right for disclosure
- ✖ Identify sources of support, such as groups for people living with HIV, church members or counselling organisations.²

2 Adapted from http://www.health24.com/medical/Condition_centres/777-792-814-1767,22202.asp

19. Immunisation (vaccination)

What is immunisation/vaccination? Immunisation protects children (and adults) against harmful infections before they come into contact with them in the community. It uses the body's natural defence - the immune system - to build resistance to specific, potentially dangerous infections.

A vaccine contains either a very small dose of a live, but weakened form of a virus, or a very small dose of killed bacteria or small parts of bacteria, while others contain a small dose of a modified poison produced by bacteria. This dose stimulates the immune system to develop antibodies against the disease.

When are they administered and for which diseases? Vaccines are commonly given for eight diseases - diphtheria, tetanus, whooping cough, polio, measles, mumps, rubella, and TB.

Where is it administered and by whom? Vaccines are administered at local clinics and sometimes in schools, under special vaccination programmes.

Why is immunisation important? Immunisation helps children stay healthy by preventing serious infections and their complications.

How can CHWs facilitate this process

Children who are HIV-infected or who may have been HIV exposed should not be given the BCG vaccination at birth.

Children who are HIV-infected:

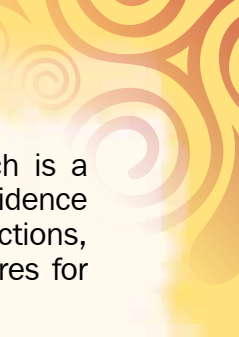
- ✘ Are more likely to develop active TB disease, which may progress more quickly, after being exposed to someone with active TB
- ✘ May experience more frequent episodes of Influenza infection. Vaccines are effective, even in HIV-positive children, and are recommended where they are affordable
- ✘ May experience severe forms of disease from measles wild-type virus infection.

Childhood immunisations in HIV positive children should be administered with the following modifications:

- ✘ BCG vaccination can be given up the age of 16. When considering BCG vaccination at a later age, check whether the child is suffering from HIV related illnesses (symptomatic HIV infection). If the child is ill the vaccination should not be given until the child is better
- ✘ Measles vaccine can be given to symptomatic HIV positive children, at nine months
- ✘ HIV-infected children should be vaccinated against measles, but if this has not been done and they are in contact with measles, they can receive a measles vaccine to prevent the disease within six days of being exposed to the virus
- ✘ If an HIV positive child has not been given the chickenpox vaccine but is exposed to the virus, the vaccine can be given within three days of exposure.

Prophylaxis (preventative treatment)

- ✘ All HIV positive and possible HIV exposed babies should be given Cotrimoxazole prophylaxis starting at six weeks of age. Daily Cotrimoxazole is effective against a



kind of pneumonia (PCP) common in HIV infected people and children which is a significant cause of illness and death in infants with HIV. It reduces both the incidence and severity of PCP and also provides protection against common bacterial infections, toxoplasmosis, and malaria. CHWs can remind mothers to attend health centres for Cotrimoxazole prophylaxis

- ✖ Preventing TB – Isoniazid prophylaxis (IPT) against TB should be given to all children below five years old who are exposed to smear-positive TB in their household, for a period of six months. Active TB disease must be ruled out first. CHWs can assist caregivers by providing this information if someone in the household is being treated for TB.

20. Psychosocial Support to Children and Young People

Psychosocial support is the effort to meet the ongoing emotional, social, and spiritual needs of children and ensuring that they have love, care and protection. All children need psychosocial support for their psychological and emotional wellbeing, as well as their physical and mental development, especially those dealing with the reality of living with HIV.

Psychosocial support includes:

- ✖ ensuring the meaningful participation of children in issues that affect them
- ✖ listening and responding to their problems
- ✖ allowing children to express their feelings and needs
- ✖ helping children appreciate their history and identity
- ✖ encouraging them to set goals and reach their potential
- ✖ ensuring children have positive, nurturing relationships and connections in their lives
- ✖ Providing life skills for children and youth
- ✖ Providing children with safe spaces to play.

Spiritual Care

If a child has a strong sense of God and spiritual belief, then offering to pray with them can be a way of supporting them. Pastors and church groups can also be valuable sources of support, but you need to be sure that the particular pastor does not view HIV as a punishment from God, as this will increase the child's feelings of guilt and stigma and isolation.

Bereavement care

Children and young people may have difficulty in expressing their feelings about grief and loss. Children who have been bereaved need a sensitive and understanding environment both at home and at school. Initially, numbness and disbelief may set in, followed later by feelings of grief. This is delayed reaction.

Remember that young children may believe they were responsible for the death or that they could have prevented it and harbor extreme feelings of grief and fear. CHWs should refer children experiencing these deep emotions to the relevant bereavement support services.

Crying, rocking or shaking and even anger may be expected immediately after a bereavement. However, if these responses are prolonged or extreme, then consider referring for additional support.

Grief can also be expressed in the body: this can include shortness of breath; a tight chest; dry mouth; muscle weakness; stomach aches and dizziness. A young person may also express grief through behaviour changes, such as having nightmares, being aggressive, getting poor grades at school, being withdrawn or starting to bed wet; have outbursts of anger, loss of appetite; be easily annoyed, or experience restlessness and sleeplessness or excessive tiredness.

Helping children and young people cope with grief

CHWs can apply the tips below to their communication with children, and also advise parents and caregivers to use them when talking to their children about the death of a relative, parent, or when talking about the possibility of the child or parent's death.

CHWs can encourage young people to talk about and recognise their feelings by gently asking them questions. But make sure you have plenty of time for this process as it is important that the child does not feel rushed and has time to explore their feelings and emotions. Some children communicate more easily than others; some need gentle drawing out.

Reassurance that their feelings – whatever they are - are normal, is also important.

Tips for talking to children about death or dying

- ✖ Start by asking about the person who has died. "What was it that you loved or valued about that person? Why were they so important to you?"
- ✖ Then ask them to think back to before the person died – "Were they sick for a long time? What feelings did you have during this time?"
- ✖ "How did you learn that they had died?" "What feelings did you have when you heard about their death?" "Can you name those feelings?" "Do you still have those feelings, or have they changed in any way?" "Can you name those new feelings?"
- ✖ Tell the child that you are always available if they want to talk about their feelings or about the person who has died. If, for more than six months after a bereavement a young person continues to show significant physical or behavioural signs of grief then you should refer them for additional counseling and care
- ✖ Children think in exact terms. Therefore, use the words 'death', 'dying' etc. Avoid using terms like 'gone away' or 'lost'
- ✖ It is often easier for children if they are given information in small chunks. Too much information at one time can be overwhelming
- ✖ Repeat information, if necessary
- ✖ Reassure them that their feelings are OK. Feelings are not right or wrong, but they are real
- ✖ Do not try to distract the child from what he or she is feeling
- ✖ Depending on the individual child, they may need to be held, allowed to cry and to express their thoughts, feelings and fears
- ✖ Reassure the child that his or her basic needs will be met, and where possible, that their basic routines will not undergo major changes.

Factors that indicate children need individual support

- ✖ Lack of social support from a supportive nurturing adult
- ✖ Bereavement overload: too many losses in a short period of time
- ✖ Secondary losses: loss of financial security; having had to move away from friends and social support structures
- ✖ Additional stress factors at the same time: added responsibilities, such as a sick parent or being in a child-headed family

Some signs that children need to be referred for specialised support

Change in personality: the child becomes very introverted and has difficulty in expressing feelings. Alternatively, the child becomes very extroverted and shows inappropriate expression of feelings such as outbursts of anger; destructive behaviour towards themselves or others.

- ✖ Change in social behaviour: the child withdraws from former friends and social activities or gets over-involved. Extreme cases involve theft, vandalism, delinquent behaviour
- ✖ Academic performance: A drop in performance, or working too hard. Difficulty concentrating, causing problems in class etc
- ✖ Change in physical, medical condition: Worsening of existing conditions and or development of psychosomatic symptoms (symptoms that arise from the mind instead of the body), especially copying the symptoms of the person who has died
- ✖ Use or abuse of alcohol and/or medicines; sexual misbehaviour or acting out sexually; talking about or referring to suicide; giving away possessions.

21. Nutritional Management

What is paediatric nutrition? This means providing children's bodies' with the essential nutrients for growth. Nutrition is the process of getting food into the body and using it as raw materials for growth, fuel for energy, and vitamins and minerals that keep your body healthy and functioning properly.

Infancy and early childhood are critical periods of growth and development and when nutritional needs can be very high due to rapid growth. Children of all ages must get the right nutrition to help them to grow and develop properly. They should be encouraged to eat a varied diet to provide them with all of the nutrients they need. But remember that breast milk contains all the food elements a baby needs, including water, up till the age of six months.

Poor nutrition weakens the immune system and predisposes children to common infections and, for those who are HIV-infected, to opportunistic infections.

Caregivers and parents need to help children develop healthy eating patterns from an early age. It is important that the food and eating patterns to which they are exposed – both at home and outside – promote positive attitudes to good nutrition. Both over and underweight can have important health and social consequences for a child.

Besides helping children maintain a healthy weight, good nutrition is essential for the body and all its systems to function at their best for a lifetime. The benefits of good nutrition are found in physical and mental health; a healthy diet provides energy, promotes good sleep, and gives the body what it needs to stay healthy. When you know the benefits of good nutrition, it's easier to make sure children eat healthily.

A balanced diet should contain:

Micronutrients - Vitamins and Minerals

- **Select from yellow, white and green vegetables regularly** - Yellow: pumpkin, Carrot, butternut; White: cauliflower, white cabbage, onions, parsnip; Green: spinach, pumpkin leaves, rape or any dark green leafy local vegetable.

Body-building Foods (Proteins)

- Meat, fish, eggs, beans, nuts, groundnuts, milk and milk products, sesame, peas, lentils, peanut butter.

Fats

(children also need some fats to be healthy)

- Membranes that contain fats surround all the cells of the body; the brain needs fatty acids; and fats are also needed to signal hormones.

Functions of each Nutrient

Carbohydrates (starches and sugars) - provide the energy the body needs to function. The body needs these foods every day. The main form of energy is found in carbohydrates, which the human body can easily digest. About half of your child's daily diet should come from carbohydrates.

Carbohydrates are broken down into other forms of energy - glucose, fructose or galactose. If your child does not get enough carbohydrates, the body can make glucose from protein or fat. If he or she gets too many carbohydrates, the body will store them as fat.

Good sources of carbohydrates are 100-percent whole grain breads and cereals, roller meal, millet and sorghum and starchy vegetables such as sweet potatoes and pumpkin.

Important: Sugary foods (soft drinks, sweets, tea with sugar, jam, biscuits and cakes) raise blood sugar levels very fast and make the child feel 'high', followed by feeling tired shortly after. These should only be eaten in small quantities, occasionally.

Proteins and Fats - Proteins build and repair the various parts of your child's body. The protein in foods is broken down into individual amino acids. Muscles use lots of protein, and children need to replenish that protein through their diet. His or her body also needs protein to build the immune system, hormones, nervous system, and other organs.

While the body needs some fats, foods that are very high in fats can reduce your child's energy levels. Fats are slow to digest and do not provide the body with a steady source of energy.

Micronutrients - vitamins and minerals - Vitamins and minerals are just as important as carbohydrates, proteins and fats, though they are only needed in small amounts. They usually function as co-enzymes, which means they help some of our body's chemical reactions happen a lot faster. For example, vitamin C helps keep connective tissue strong and your immune system working.

Calcium has several functions in a child's body, but it is best known as the mineral that is stored in bones and teeth. Healthy bones are necessary throughout life and become more important as we grow older. Many bone conditions that may develop later in life can be avoided by ensuring children have enough calcium in their diet. Milk and other dairy products contain calcium and should be taken every day.

Most of the food a child eats contains varying amounts of all three of these nutrition components. Good nutrition means getting the right balance of carbohydrates, fats and proteins, plus all the required vitamins and minerals.

Nutrition guidelines recommended for adults are not appropriate for most children under the age of five. This is because young children only have small tummies and so need plenty of nutrients in a small amount of food to ensure they grow properly.

Good Nutrition Means Good Health

Fortunately, whatever their age, children can easily get a balanced diet – and reduce their risk of becoming overweight (obese) – by eating a variety of foods from the four main food groups:

- ✖ **Bread, other cereals and potatoes** – these starchy foods, which also include pasta and rice, provide energy, fibre, vitamins and minerals
- ✖ **Fruit and vegetables** – these provide fibre, vitamins and minerals and are a source of antioxidants. Fruit is best when eaten raw and fresh, but make sure it has been washed or peeled
- ✖ **Milk and dairy foods** – these provide calcium for healthy bones and teeth, protein for growth, plus vitamins and minerals
- ✖ **Meat, fish and alternatives** – these foods, which include eggs, nuts, beans and pulses, provide protein and vitamins and minerals, especially iron.

Choosing foods from each of these groups will ensure that children receive all the vitamins and minerals they need for good nutrition and health.

However, foods from a fifth food group that includes fatty and sugary foods like biscuits, cakes, soft drinks, chocolate, sweets, crisps and pastries, that add little nutritional value, should be limited.

It is also important to ensure that children do not get too much salt. Remember that all processed foods contain significant amounts of 'hidden' salt. While adults should have no more than 6g of salt a day (slightly over a level teaspoon), children need even less as they have smaller bodies.

Young children should not eat too many fibre-rich foods, either, as these may fill them up so much they cannot eat enough to provide them with adequate nutrients.

Diet for sick children

When a child is very ill, getting them to eat can be difficult. It is therefore important that what they do eat contains all the nutrients they need, and if possible some that help to boost the immune system so they get well. Offer only small amounts, often, and make sure the child takes enough fluids.

Immune-boosting nutrients are found in...

Nutrient	Source
Vitamin A	eggs, milk, and orange/yellow fruits and vegetables
Vitamin B6	meat, whole grains, vegetables
Vitamin C	masau, oranges; lemons, all berries
Vitamin E	nuts, grains, vegetable and oils
Selenium	meat and poultry
Zinc	lean meats, dairy products, whole grains, beans and nuts
Probiotics	Fermented milk products such as lacto and yoghurt

Effects of HIV on Nutrition

HIV-infected children are at increased risk of malnutrition for many reasons. People living with HIV also have about a 10% higher calorie need than uninfected people. Other risks are:

- ✘ Low birth weight
- ✘ • Unsuitable infant feeding practices and poor weaning practices (timeliness, adequacy of foods, hygiene, meal frequency, feeding methods)
- ✘ Reduced food intake because of disease in the mouth and throat (thrush, or sores)
- ✘ Loss of appetite associated with illness
- ✘ Increased loss of nutrients because of the body's failure to absorb them, or because of diarrhoea
- ✘ Increased metabolism because of HIV infection or other infections.

HIV-infected children are at also additional risk due to inadequate child care, if the mother is sick or deceased and to household food insecurity.

Tips for Good Nutrition in Children Living With HIV

- ✘ Give the child small meals five-to-six times per day in small, easy to handle portions and offer seconds; too much food on a plate may put the child off
- ✘ Introduce new foods along with a food you know the child likes; if the new food is refused try again a few weeks later
- ✘ Involve the child in food preparation, shopping and washing up, provided they are fit enough and not feeling nauseous

- ✖ Provide at least five portions of fruit or vegetables every day
- ✖ Try to give at least one of these in one portion per day: chicken, meat, fish, eggs, peanut butter, dry beans or nuts. Add cooking oil or fish oil while cooking
- ✖ Bread, samp, rice, mealie meal or other cereal mixed with any of the above and/or sour milk should be eaten - as much as the child wants
- ✖ Oral vitamin A supplementation is important as it helps increase immunity to infections.

Avoid giving sweets, chocolates and soft drinks as these create sugar spikes in the blood and may take away the child's appetite for healthier foods.

To stay healthy, a child living with HIV also needs to:

- ✖ Drink enough clean water
- ✖ Go for regular check-ups
- ✖ Take preventive treatment for opportunistic infections such as TB
- ✖ If taking **ARVs**, take them exactly as prescribed by the doctor
- ✖ Get enough rest and exercise
- ✖ Speak to other people living with HIV by joining a support group, or being able to talk to family and friends about their worries.

When a child is unwell

When infants and children are unwell, for whatever reason, they are more vulnerable and at increased risk of becoming under-nourished. To ensure the nutritional needs of ill children are met, there is need to seek medical assistance.

Parents and guardians also need to:

- ✖ Regularly monitor growth (weight and height) to recognise growth failure, malnutrition, and their possible causes
- ✖ Promote good food hygiene and food handling practices to make food safe and prevent food-borne infections
- ✖ Tailor make a food plan for your family and increase the variety of foods given to the child, emphasising the use of locally available fresh foods.

22. Hygiene and Universal Precautions

Good hygiene is important for maintaining the health and well-being of all household members. However, it is especially important to protect the health of children and adults living with HIV. Personal hygiene means cleaning and caring for our bodies. Home hygiene means taking simple steps to prevent the spread of germs and maintain a healthy environment.

- ✖ Cleaning and airing the house and bedding
- ✖ Clothing should be washed frequently and bed sheets should be changed and washed at least twice a month to stop bad smells
- ✖ Washing hands with soap and water, or ash, after using the toilet after changing a baby's nappy, helping a child to the toilet etc. and before preparing food and eating
- ✖ Cover your nose and mouth with a tissue, when coughing or sneezing, or cough or sneeze into your elbow or clothes to stop germs from spreading
- ✖ Spitting should be discouraged
- ✖ Keep the toilet and its surroundings clean and free from flies
- ✖ Wash soiled linen with hot water and soap
- ✖ Keep garbage in a covered bin and empty it regularly
- ✖ Only use drinking water from a protected well or tap
- ✖ Drinking water in both rural and urban areas should be boiled. Store drinking water in a clean and covered container
- ✖ Make sure all food preparation surfaces and utensils are clean
- ✖ Clean vegetables with running water (from a tap or poured from a cup or container) rather than soaking them in a bowl
- ✖ Cover and store food away from insects and pests
- ✖ Fruits and vegetables should be checked regularly to see if they are 'over-ripe'
- ✖ Eat cooked food while it is still hot and avoid reheating food.

Universal precautions

Universal Precautions are simple infection control procedures that reduce the risk of transmitting germs through exposure to blood, body fluids and contaminated medical or other types of equipment.

CHWs should make parents and primary caregivers aware of universal precautions when caring for their child. There is an extremely low risk of getting HIV through caring activities if universal precautions are taken:

- ✖ Wash hands with soap and water before and after caring
- ✖ Wear gloves or cover hand with plastic bags when contacting blood or body fluids
- ✖ Keep wounds covered (both those of the caregiver and the client)
- ✖ Clean up blood, faeces, urine with ordinary household bleach
- ✖ Wash cutlery, linen, bath, etc with ordinary washing products
- ✖ Keep clothing and sheets stained with blood, diarrhoea or other body fluids separate from other household laundry
- ✖ Use a piece of plastic or paper, gloves or a big leaf to handle soiled items

- ✘ Do not share toothbrushes, razor blades, needles or other sharp instruments that pierce the skin
- ✘ Properly disinfect tools used for caring such as razors, needles and spit jars
- ✘ Wash your hands with soap and water after changing soiled bed sheets and clothing and after any contact with body fluids.

Case Studies for CHW training

These case studies are part of the training of CHWs. If there is sufficient time, divide the group into two and allocate a case study to each group. Ask them to role-play it, with one person acting as the CHW. Then the group should discuss the different options that could be tried, with help from the facilitator.

In the event that there is insufficient time, read out each case study and discuss the options with the group.

Case Study 1 - IMPACT

When you first visited the family, the older child, Norbert, had painful sores in his mouth from thrush and he was not able to eat. You discussed the possibility of HIV infection with his mother and she agreed that she and the child would go for an HIV test.

The results for both were positive. You assisted them with registering at the clinic for ART and are now making your first follow up visit since they began treatment. The baby seems much better, but the mother still has a bad cough.

When you count her pills you find that she has half as many as she should have. When you ask her about this, she says that her husband refused to go for a test but said they could share her tablets. She is therefore only taking half the dose she should.

As a CHW, how would you approach this case?

Case Study 2 - PMTCT

Amai Rutendo is a new client. Her husband works away from home in the mines and only comes home occasionally.

They have one child who is now six years old. Mai Rutendo has had two miscarriages, one still birth and one baby who died a few weeks after birth, since Rutendo was born. She is very distressed about her failure to have another child.

Amai Rutendo does not look well. She and her husband are anxious to have more children. Neither of them has been for an HIV test and when testing is mentioned, Amai Rutendo looks frightened. She tells you her mother-in-law has never been happy about their marriage and that she is suggesting the husband gets another wife who can give him a son. Amai Rutendo says that if she is found to be HIV positive that will be the end of their marriage.

As a CHW, how would you approach this case?

True or False Questionnaire

Tick the box – True or False depending on which you think is the correct answer

Question	True	False
1. Children with TB are likely to be HIV positive		
2. A child below 6 weeks of age should not be given ARVs		
3. HIV cannot be transmitted by mosquitoes		
4. A low CD4 count means a person's treatment is working well		
5. TB is an opportunistic infection		
6. Missing doses of ARVs can cause drug resistance		
7. You cannot tell if a baby is HIV positive or not until they are 10 months old		
8. Exclusive breastfeeding means giving a baby no other foods, even water		
9. PMTCT means the mother is only given ARVs while she is pregnant		
10. Co-infection with malaria in pregnancy can cause problems with the pregnancy		
11. HIV positive women need to use condoms during pregnancy and breastfeeding		
12. Men have no role to play in PMTCT		
13. If a mother gets an STI during pregnancy she is more likely to transmit HIV to the baby		
14. Gender-based violence encourages the spread of HIV		
15. Effective PMTCT depends on pregnant women and girls accessing antenatal counselling and HIV testing		
16. HIV can be transmitted by using contaminated razor blades		
17. Dual protection means using two condoms at the same time		
18. The IMPACT programme helps women and girls access HIV treatment		
19. Without treatment, all babies born with HIV will die before the age of 12		
20. HIV progresses to AIDS at different rates in different people		

Service Referral Form (to be completed by the referring NGO)

We are referring our client

Name:

To your institution for

Service Required:
.....
.....

Once you have provided the services needed, please complete the tear off slip below and give it to the client to return to us for our records. Thank you for your assistance.

Date: / /

Community health workers Signature:

.....



NGO Stamp

We
..... (name of service provider)
confirm that we have provided
..... (name of client)

with the following services:

.....
.....
.....
.....
.....



**Institutional
Stamp or
signature**

Date: / /

(Please return the signed form to your Community Health Worker)



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