CARE GIVERS TOT TRAINING
OVERALL CAREGIVERS TRAINING GOAL

• To enhance the knowledge and capacity of caregivers of children and adolescents infected with HIV on the chronic care needs of HIV infected young clients and how to support them towards the achievement of retention and viral suppression
BASIC FACILITATION SKILLS
Session Objectives

• To learn the tips for effective group facilitation.

• Learn basic group facilitation methods.

• Learn basic skills for effective facilitation
**Introduction**

- **Facilitation** - This is a process of leading a session in a participatory way to make learning easier.

  - A **facilitator** should be a skilled person who guides a group of people in discussing issues, ideas, feelings, thoughts etc in a structured manner within a specified time frame in order to achieve desired results.

  - A facilitator keeps discussions focused.
Tips for Effective Group Facilitation

• The role of a facilitator is to keep the conversation going and give everyone an opportunity to speak.

• It is important to facilitate rather than lecture, preach and dictate.

• When we facilitate, we create chances to caregivers to learn for themselves and about themselves and to do something with the knowledge they gain.

• If we just lecture or do all the talking ourselves, then the caregivers become passive observers who do not really feel, think and make the issues being discussed their own.

• If we engage caregivers actively, we can make them feel, think and take issues in their lives seriously.
Facilitation Methods

**Brainstorming**

- Is a free flowing exchange of ideas in a given topic.

- A question is asked, a problem posed or an issue raised and participants suggest answers or ideas.

- All suggestions are written down for the group to see.

- No editing comments or criticism is allowed.

- At the end of brainstorming, the groups evaluate the ideas together to identify those they consider most useful.
Facilitation Methods – Cont.

• **Case Studies** - These can be used in an exercise as a way of describing a situation and providing a focus for discussion, however participants can be used to make up their own stories.

• **Story Telling** - This is a traditional method of providing information and discussion topics which can be told in a story telling format using the local culture as a base for the story.
Facilitation Methods – Cont.

**Role plays**

- This is where participants act out their own stories or they act out their analysis of an issue as away of reporting back what they have discussed.

- This also makes things real.

- It imitates someone else character and describes real life situations.
Facilitation Methods – Cont.

- **Guest speaker** - These are people who can bring a topic alive by discussing personal experiences and sharing feelings e.g. PLHIV, recovering or recovered alcoholics.

- **Video shows** - These are taped materials shown in a community to pass relevant and important information e.g. ART adherence.

- **Lectures/presentation** - A short presentation of ideas and information on a topic by a skilled person, ideally reinforced with visual aids and questions to draw out participants own ideas on the topic.
Skills for Effective Facilitation

• **Confidence:**
  - Confidence draws attention and guarantees self-satisfaction on one's performance.
  - It shows a good command of the subject matter and reassures the participants and the facilitator.

• **Manage group dynamics:**
  - Use groups to get everyone involved and allow more detailed discussion.
  - Decide on the size of group e.g. buzz groups (groups of 2 or 3s). Fewer groups save reporting time, smaller groups increase participation.
  - Give a clear explanation of the group’s task, time and reporting method.
  - Always form new groups each time so that trainees get to work with different people.
Skills for Effective Facilitation Cont.

• **Conflict resolution:**
  - Start by organising the flow of discussion by describing the problem and draw out possible facts about the problem.
  - Brainstorm the solutions and draw out all possible solution and make a decision.
  - Get agreement on what is to be done then plan for action on **who, when, what** and **how**.

• **Focusing the audience:**
  - As a facilitator; start with a clear focus “what is it that you want trainees to discuss?”
  - Make a discussion topic very clear so that everyone can contribute effectively and set time limits.
Skills for Effective Facilitation – Cont.

• **Drawing out:-**
  
  ➢ Provide or draw out information.
  
  ➢ It is important to have all facts and opinions in the open. This makes it easier to come to a decision.
  
  ➢ Sometimes you need to provide information to help people decide.

• **Making a round:-**

  ➢ Give each participant a chance to share their views over a given topic in a sequential manner.
  
  ➢ It is important to bring participants attention together as it helps them to learn from and understand one another.
THANK YOU
MODULE 1:

HIV and AIDS
Module Objectives

• By the end of this module the caregivers should be able to:
  ➢ Define HIV and AIDS.
  ➢ Discuss modes of transmission.
  ➢ Describe HIV disease progression and disease prevention.
  ➢ Identify ARV drugs taken by HIV clients.
  ➢ To identify opportunistic infections which occur due to lowered immunity occasioned by HIV infection.
Definitions

- HIV stands for Human Immuno-deficiency virus. HIV is a tiny germ that attacks the defense of the body and makes it weak.

- AIDS stands for Acquired immune deficiency syndrome. It is the advanced stage of HIV infection.
HIV Transmission

- Direct contact with the blood and body fluids of HIV infected person
- Having sex with HIV infected person without using protection.
- A woman living with HIV during pregnancy, labor and delivery.
- Through breastfeeding.
HIV Progression

• After HIV virus enters the body it starts to multiply and destroy the body’s defense system (CD4) reducing the body’s ability to fight infections thus leading to AIDS.

• CD4 are cells found in the immune system help us fight infections when they are attacked by the HIV virus they weaken and reduce in number thus weakening the body’s immune system.

• When the CD4 weakens the body is prone to Opportunistic infections and the virus multiplies itself leading to detectable Viral load.

• This is why everybody tested for HIV and found to be positive has to be started on ARVs drugs which manage the virus and keeps it at undetectable levels keeping a person healthy.
HIV Prevention

- Abstinence of sexual activity all together
- Being faithful to one uninfected partner
- Prevention of mother to child transmission (PMTCT) of HIV
- Mothers get tested for HIV during pregnancy, those found positive are given ARVs to prevent their unborn babies from getting infected
- Hospital delivery under skilled birth attendant
HIV Prevention Cont.

• Exclusive breast feeding and monitoring of the child in first six months of life and continued monitoring until the child is 18 months old.

• Prevention of unwanted pregnancies

• Use of HIV Prophylaxis drugs within 72 hours of accidental exposure and rape cases

• Practicing safer sex by use of condoms.

• Prevention with the positive practices
How you can prevent other infections

- Wash the hands carefully
- Use safe drinking water: drink boiled water or tea when possible.
- Avoid re-infection & transmission to partners by using condoms
- Apply local antiseptic to minor wounds
- Store Water
- Sleep under a treated mosquito net
- Cover food
- Wash Fruits & vegetables with clean water
- Eat well cooked Food
Prophylaxis

• Prevent opportunistic infections from invading a person body.

• Cotrimoxazole is most commonly used. It helps prevent infections such as, some types of pneumonia, diarrhea, and meningitis.

• There are other drugs which health care worker can prescribe such as fluconazole, isoniazid to prevent TB infection
Anti-Retroviral Drugs

• ARV Drugs are medicines taken by a person living with HIV to control HIV in the body.

• There are many types of ARV drugs and is given in combination of 3 drugs. Some examples of ARVs are:-
  - Abacavir (ABC), Lamivudine (3TC), Nevirapine (NVP),
  - Efavirenz (EFV), Lopinavir/ritonavir, Tenofovir(TDF)
  - Common 1st line given to children below 3 years is ABC+3TC+LPV/r
  - 1st line ART for children older than 3 years is ABC+3TC+NVP, AZT+3TC+ NVP.

• The number. of tablets (dose) of ARVs will be adjusted as child grows and puts on weight

• Many ARV drugs are available as fixed dose combination (2 or 3 drugs in one tablet)
Importance of Anti-Retroviral Drugs

• Achieve and maintain viral suppression
• Preserve or restore immune function
• Maintain same drug therapy for many years without resistance

Note
• The doctor will prescribe the ARVs that are required for the child or the adolescent.
• The ARVs are different depending on the age and other acquired diseases.
• It is important to take the ARVs as prescribed
ARV Drugs Side Effects

- Skin rash
- Nausea and vomiting
- Diarrhea
- Excessive tiredness and muscle pain
- Headache
- Dizziness
- Sleep disturbance or nightmares
Opportunistic Infections

• These are infections that take advantage of the weakened immune system. They include
  ➢ • Tuberculosis.
  ➢ • Pneumonia
  ➢ • Diarrhea
  ➢ • Skin conditions
  ➢ • Cancers etc.
  ➢ • Meningitis

Note: These diseases are curable except some types of cancers
THANK YOU
MODULE 2:
ADHERENCE TO HIV CARE
Session Objectives

• By the end of the session, the participant will be able to:
  ➢ Define adherence
  ➢ Discuss the levels and components of adherence
  ➢ Determine knowledge on good adherence practices
  ➢ Outline the importance of adherence and relate it to their own life situation
  ➢ Explain the different ways of promoting adherence
Definition of Terms

• Adherence:
  ➢ Adherence means following doctor’s instructions with clear understanding and taking responsibility for their personal health.
  ➢ It is strictly sticking to the dosage and the prescribed schedule of taking medication.
  ➢ It also means sticking to other treatment schedule including hospital visits, doctors’ appointment and nutrition advice.

• Non Adherence
  ➢ Non-adherence is when a patient does not take drugs as advised and as discussed with the health care provider
Components of Adherence

• Adherence to ARVs and Opportunistic infections medicines
• Adherence to clinic visits – keeping all clinic appointments is very important
• Adherence to laboratory monitoring; Viral load and other tests requested by the doctor
• Adherence to support groups either facility or community based
• Adherence to preventive measures; sex education
• Adherence to good nutrition
Levels of Adherence

• Enrolment into Care

- This is the phase where a child/adolescent has tested positive for HIV and are to be enrolled into HIV care.
- All persons testing positive for HIV are eligible for ART.
- The essential package of care for children and adolescents includes:
  - Counseling and psychosocial support
  - Prevention with positives
  - Cotrimoxazole prophylaxis
Levels of Adherence cont.

- Screening for Tuberculosis, prevention and treatment among PLHIV
- Preventing malaria
- Vaccination and immunization
- Nutrition assessment and support
- Reproductive health and family planning
- STI Screening
- Screening for cervical cancer (For the sexually active)
Levels of Adherence cont.

• ART Initiation

- ART is a lifelong treatment, adherence is fundamental
- Your child/adolescent should adhere to any other medicines prescribed by the doctor
- Your child/adolescent should avoid self-medication and over the counter medication
- ART should be initiated in;
  ✓ All HIV-infected children and adolescents.
  ✓ Your child and adolescent should continue with adherence counseling and psycho-social support
Importance of Adherence

• Clinical
  - Significant clinical improvement with resolution of OIs, improved quality of life and decreased mortality.
  - No new OIs
  - Reduction in treatment failure

• Immunological
  - Increase in CD4 count

• Virological
  - Reduction of Viral Load to undetectable levels within 6 months
Consequences of Non-Adherence

- Treatment failure
- Limited options for future therapy
- Susceptibility to potentially fatal opportunistic infections
- High viral load increases probability of HIV transmission
- Unnecessary healthcare costs
Tools of Adherence

- Watches or wall clocks
- Radio or television
- Phone with alarm
- Prayer times
- Treatment supporter or buddy or DOTS
- Pill boxes
- Appointment card or calendar
Barriers to Adherence

• Lack of disclosure to children and significant other
• Stigma and discrimination
• Medicine fatigue
• Socio-economic issues: lack of finances
• Distance to facility
• School/work schedules
• Health care provider/patient communication barrier
• Negative or poor attitude towards care and medication
• Multiple opportunistic infections (pill burden)
THANK YOU
MODULE 3:

DISCLOSURE
Session Objectives

By the end of the session the participants will be able to:

• To define disclosure
• To discuss the process of disclosure
• To identify benefits and disadvantages of disclosure
• To identify barriers of disclosure and how to deal with them
Definition of Disclosure

• Disclosure is to reveal, make known, make public or to share personal information with someone.

• In the case of disclosure in the context of HIV:
  ➢ Disclosure is the process of informing a child or an adolescent of her/his HIV status.
  ➢ It may also involve the sharing of HIV status of the caregiver and other family members.

• Disclosure is optimal when the process is initiated by the caregiver with support from a health care worker.

• Disclosure is an ongoing process and NOT a one-time event.
The Process of Disclosure

• Before starting the process it’s important to understand the following:-
  ➢ When
  ➢ Where
  ➢ Who
  ➢ How
Disclosure Triangle

- Caregiver
- Healthcare worker
- Child or Adolescent
Levels of Disclosure

• Non disclosure
  ➢ This is the failure or refusal to declare or reveal ones HIV status

• Partial disclosure
  ➢ This refers to telling the child only some information about her or his illness
  ➢ This takes place between 6-9 years.
  ➢ At this point HIV is not mentioned. It protects the child and family against unplanned disclosure.
Levels of Disclosure

• Full disclosure
  - Families and caregivers must decide at what point full disclosure is necessary.
  - Mostly done when the child starts asking specific questions related to their illness such as “how did I get the disease?”
  - Mainly occurs between 10-12 years.
Forms of Disclosure

• Self Disclosure
  ➢ This is the process of communication by which a person reveals his or her HIV status to another person eg family member, sexual partners. b.

• Supported Disclosure
  ➢ The care giver reveals the HIV status to the child in the presence of the Health care provider who is ready to help manage the outcome.

• Accidental Disclosure
  ➢ Occurs when the child gets to know their HIV status from another source not the care giver or health care worker
Benefits of Disclosure

• Disclosure allows people to better cope with HIV
• Family-centered disclosure helps build trusting relationships and improves healthy communication between parents and children
• Disclosure can help increase self-esteem among children and adolescents
• Disclosure helps adolescents make informed safe-sex decisions when contemplating sexual intercourse with a partner
• Helps to avoid anxiety of accidental disclosure
• Enables adolescent to access psychosocial support from peers or family
• Easier access to health care hence this may help in access knowledge for prevention measures.
Benefits of Disclosure

• Enhances good adherence to care and medications
• Assists most children to cope with the diagnosis, open up, minimize anxiety, and reduce self-stigma and depression
• Enables one to discuss safer sex and family planning choices with one’s partner(s)
• Empowers one to refer a partner for HIV counseling and testing and to care and treatment if needed.
• Gives one freedom to ask a friend or a relative to be a treatment buddy
• Enables one to access peer support groups and community organizations
• Empowers one to serve as a role model for other people on disclosure
Disadvantages of Disclosure

- Assumptions made about sexuality, promiscuity or lifestyle choices
- Children may blame parents for infidelity and knowingly infecting them
- Discrimination by family, school and community
- Discrimination at work including possible loss of a job
- Distancing, fear, rejection or abandonment by partner, family or friends/classmates
- Blame by partner/family for “bringing HIV in to the household”
Disadvantages of Disclosure

- Physical, emotional and sexual abuse
- Self-stigma
- May lead to anxiety, self-blame, depression and suicidal ideations
- Poor adherence in some instances (due to loss of hope)
- Loss of economic/subsistence support from family members
Barriers to Disclosure

- **Individual:**
  - Self-blame, anxiety, cognitive capacity and developmental stage, too sick

- **Caregiver:**
  - Fear of isolation, belief that child is too sick/weak/young/small to receive the necessary information

- **Health care provider:**
  - Lack of skills, hesitant to address disclosure & challenge secrecy

- **Social-cultural:**
  - Stigma, discrimination, taboos and religion
THANK YOU
MODULE 4: NUTRITION
Module Objectives

• By the end of the session care givers will be able to:
  ➢ Describe the meaning and importance of good nutrition
  ➢ Identify food groups and their use
  ➢ Explain relationship between good nutrition and HIV
  ➢ Discuss good nutrition practices
Definition of Nutrition

• Nutrition means how the food we eat:
  ➢ Provides energy
  ➢ Makes our bodies grow
  ➢ Keeps them healthy

• Good nutrition refers to a balanced selection of variety of foods and taken in the right amount
Importance of Good Nutrition

- Build and strengthens immunity
- Prevent infections
- Delay HIV progression to AIDS
- Helps in drug absorption and reduce side effects
- Promote growth and development
- Helps maintain healthy weight
Types of Food Groups

• Energy giving foods:
Types of Food Groups Cont.

- **Body building foods**: These are foods that are useful for growth and the repair of body cells they mainly found in animals and plants.

![Diagram showing body building foods](image)
Types of Food Groups Cont.

- **Protective foods:** These foods include vegetables and fruits. They protect the body against diseases and provide vitamins and minerals. They also assist in digestion.
• **Water**: is essential for blood and other liquid and cells of the body. It also helps in removal of waste products out of the body. It’s important to drink plenty of clean safe water daily.
Appropriate Food Plate

- Fruits & Vegetables (Vitamins)
- Bread, rice, Potatoes & other starchy foods (Carbohydrates)
- Meat, Fish, Eggs, Beans (proteins)
- Milk & Dairy foods
- Fats & Sugars
Relationship Between Good Nutrition and HIV

Eat well to meet Nutritional needs

Good Nutrition Status

HIV/AIDS

Strengthened Immunity

Reduce vulnerability to Infections, slower progress to HIV
Frequency of Meals

- **Breakfast**
- **Morning snack**
- **Lunch**
- **Afternoon snack**
- **Supper**
## Desired Feeding Patterns in Children

<table>
<thead>
<tr>
<th>Age</th>
<th>Types/texture</th>
<th>Frequency</th>
<th>Amount of food an average child will usually eat at each meal*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td>Exclusive breastfeeding</td>
<td>On demand</td>
<td></td>
</tr>
<tr>
<td>6-8 months</td>
<td>Start with thick porridge and well mashed foods</td>
<td>2-3 meals per day, continue breastfeeding and add 1-2 nutritious snacks</td>
<td>Start with 2-3 tablespoonful per feed increasing gradually to 1/2 of a 250ml cup</td>
</tr>
<tr>
<td>9-11 months</td>
<td>Finely chopped or mashed foods and foods that baby can pick up</td>
<td>3-4 meals plus breastfeeding and 1-2 snacks may be offered</td>
<td>1/2 of a 250 ml cup/bowl</td>
</tr>
<tr>
<td>12-23 months</td>
<td>Family foods, chopped or mashed if necessary</td>
<td>3-4 meals plus breastfeeds depending on the condition of the child, 1-2 snacks may be offered</td>
<td>1/2 of a 250 ml cup/bowl</td>
</tr>
</tbody>
</table>
Nutrition in older Children

• Encourage children on healthy eating habits

• Seek periodic Nutrition assessment, counseling and support

• Monitor weight on a monthly basis and in case of weight loss seek early intervention.

• As children grow their energy needs increases hence increase energy intake by eating three meals and two snacks; enriching your meals with milk, peanut butter etc.

• Encourage responsive feeding practice and not force feeding, feed slowly and patiently
Nutrition in older Children

• Eat fruits and vegetables which are rich in Vitamin A

• Children should take iron rich foods from plant and animal sources to fill in the nutrient gap as they grow up

• Encourage vitamin A supplementation from 6 months up to 5 years

• Reduce on sugary foods

• Don’t take any micronutrient supplements unless it is prescribed

• For HIV-infected children with no AIDS-related symptoms 10% more energy equivalent to 1 cup of porridge)
Nutrition for Adolescents

- Encourage adolescents on healthy eating habit
- Seek periodic nutritional assessment, counseling and support
- Monitor weight on monthly basis
- Increase energy intake by:
  - Eating three meals
  - Two snacks
  - Enriching your meals with milk, peanut butter
- They should not skip meals
Nutrition for Adolescents

• Eat fruits and vegetables every day
• Reduce on sugary foods
• Don’t take any micronutrient supplements unless it is prescribed
• HIV-infected adolescents with no AIDS-related symptoms 10% more energy equivalent to 1 cup of porridge)
• HIV-infected adolescents with AIDS-related symptoms (20-30% more energy equivalent to two more of porridge)
Key Messages

• Breastfeeding for two years or longer helps a child develop and grow strong and healthy.

• Starting other food on top of breast feeding at 6 months helps the child to grow well.

• Foods that are thick enough to stay in the spoon give more energy to the child.

• Animal-source food are good especially for children to help them grow strong and lively.

• Nuts and seeds are good for children.

• Dark green leaves, yellow colored fruits and vegetables help the child have healthy eyes and fewer infections.
Key Messages

- A growing child needs 2-4 meals a day plus 1-2 snacks, if hungry. Give a variety of foods.

- A growing child needs increasing amounts of food.

- A young child needs to learn to eat encourage

- Encourage children to drink and eat during illness and provide extra food after illness to help them recover quickly.

- They should eat small frequent meals, increase consumption of fluids during illness such as diarrhea to avoid dehydration and take energy dense meals.
THANK YOU
MODULE 5:
CARE FOR THE CARER AND PALLIATIVE CARE
Session Objectives

• By the end of this unit the participants will be able to:
  ➢ Describe the basic Levels of Interventions in Palliative Care
  ➢ Identify any referral and support Networks
CARE FOR THE CARER
Definition of a Care Giver

• A care giver is: -

  ➢ A person who takes responsibility for someone who cannot care for themselves.

  ➢ They may be a family member, a trained professional or another individual.

  ➢ Depending on culture there may be various members of the family engaged as caregivers.
Groups of Caregivers

- **Primary Care Givers (also known as principal care giver)** - People who provide the day-to-day home-based care activities for Children living with HIV they include:

  - Relatives
  - Spouses/partners
  - Faith –Based organization members
  - Friends and volunteers
  - Other support group members
  - Community Health Workers
• **Secondary Care Givers** - People thought as ‘specialists’ of certain types of care who are trained for the care they provide. They include:

- Health professionals
- Social workers
- Spiritual counselors
- Behavioral specialists
- Nutritionists
Role of Caregivers

• Providing HIV and AIDS care and support (feeding, bathing, toileting) where need arise

• Giving medication, monitoring the use and educating on adherence to treatment

• Supervising of ART, TB, other medication and other treatments

• Providing education on nutrition, hygiene and preventive care

• Linking clients with other care members as need arise i.e. link with appropriate spiritual care team, counselor, other care members

• Doing Follow-ups on the child’s or the adolescents school performance
<table>
<thead>
<tr>
<th>Ways of Identifying Stress and Burnout among Care Givers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Giver</strong></td>
</tr>
<tr>
<td>• Difficulty getting along with people</td>
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<tr>
<td>• Loss of concentration and excessive fatigue</td>
</tr>
<tr>
<td>• Sleeplessness</td>
</tr>
<tr>
<td>• Depression</td>
</tr>
<tr>
<td>• Bowel disturbance</td>
</tr>
<tr>
<td>• Tearfulness</td>
</tr>
<tr>
<td>• Feelings of inadequacy, helplessness and guilt</td>
</tr>
<tr>
<td><strong>Secondary Care Giver</strong></td>
</tr>
<tr>
<td>• Loss of interest in and commitment to work</td>
</tr>
<tr>
<td>• Neglect of duties and loss of punctuality</td>
</tr>
<tr>
<td>• Tendency to withdraw from clients and colleagues</td>
</tr>
<tr>
<td>• Feelings of inadequacy, helplessness and guilt</td>
</tr>
<tr>
<td>• Loss of sensitivity in dealing with clients</td>
</tr>
</tbody>
</table>
Support Interventions for Care Giver and Family

• Offer basic training to care givers on skills of caring for the HIV infected children and adolescents

• Facilitate a safe environment for the care giver i.e. availability of protective items i.e. gloves or clean intact polythene paper

• Discuss with the care giver the need to regularly attend psychosocial group meetings to discuss stress issues

• Discuss activities of daily routine with care giver and identify feeling of work overload consider options of distribution of care based on patient needs

• Infection prevention
Prevent Contacting Infection through:

- Use of protective items i.e. Wearing gloves
- Covering provider’s open wounds when handling the client with open wounds
- Hand washing before and after attending to the client.
- Disinfection of soiled cloths and linen before washing using disinfectant such as properly diluted jik.
- Use of marking tosh aprons where necessary.
Options for Coping with Care Issues for Care Givers and Family

- Share problems with close friend or relatives including support group members
- Discuss with care giver the need to identify a care giver buddy or mentor who has successfully been a care giver to share frequently
- Join health insurance scheme i.e. NHIF or have merry go round with contributions which all members can afford.
- Avoid too much exposure to stressors by sharing role with other potential care givers e.g. health care workers, social workers
• Use options that focus on solution to problems rather than emotions

• Act as a facilitator for care rather than taking responsibility for everything through role division

• Practice self-care by regularly making time for relaxing and enjoyable activities

• Get appropriate rest and listen to what your body is telling you.

• If very stressed and unable to cope seek professional help.
Communicating with Children

• When talking to the child, get down to their physical level by:
  - Sitting on a seat of similar height
  - Go down to the mat when working with child
  - Be involved in the activities of the children e.g. when drawing on the soil or playing with toys.
  - Use the simple language which the child can understand and always ask open ended question
  - Do not be in a hurry
  - Use graphics to explain
The Needs of a Caregiver include:

- **Psychological needs**
  - Such as Safety, Love, belonging.
  - Which can be handled in support groups, mentorship program and with peer caregivers.

- **Socio-economic needs**
  - Community group formation
  - Merry go round and table banking
  - Discussion and initiation for food security and safety
  - Joining a medical cover e.g. National Health Insurance Fund (NHIF)
• Physiological needs

- School performance follow-up with school head teacher
- Support from other existing groups in the community such as faith based organizations, NGOs and CBOs
Children as Care-givers

• The child may be forced to play the role of a caregiver to:
  - The parents
  - Siblings
  - Other adults

• This depends on the cognitive maturity of the child

• Caring skills

• They mature faster

• They develop skills for survival
Challenges faced by the child as Caregiver/Child headed home

- Interference with normal development
- Reduced access to social services
- Reduced time to play and be a child
- Poverty due to poor resource mobilization
- Prostitution as a way to get resources
- Poor concentration in school
- Resentment to other siblings
- Social isolation from peers
- Stigma associated with HIV and AIDS
PALLIATIVE CARE
Definition

• It is an approach to care that aims to improve the quality of life of patients and their families facing challenges associated with chronic illnesses.

• It includes control of:
  - Pain
  - Other symptoms
  - Psychological, social, and spiritual problems
The Aim of Palliative Care

• To affirm life and regard dying as a normal process by involving the client, relatives and care giver sensitizing them on chronic care outcomes like death

• To identify and provide relief from pain and other distressing symptoms that occur at different stages of chronic ailments

• To integrate the psychological and spiritual aspects of patient care

• To offer a support system to help patients live as actively as possible until death

• To offer a support system to help the family cope during the patient’s illness and in their own bereavement
Conditions that Require Palliative care

- Sickle cell disease
- Chronic renal failure on dialysis
- Cancers
- AIDS stage of HIV
- Complicated Diabetes mellitus
- DVT and heart conditions
Pain

• Pain is what the patient says is hurting them and it exists whenever they say they have pain.

• The aim of palliative care is to allow patients to be pain free or for the pain to be sufficiently controlled that it does not interfere with their ability to function or their quality of life.

• Pain Assessment

- It is important to ask about pain in every patient.

- A person who has had pain for a long time may not show the usual signs of being in pain (facial expression, sweating).

- Some signs like facial expressions (as shown below) can be good pain indicators.
Paediatric Pain Assessment Faces

0  1  2  3  4  5  6  7  8  9  10

NO PAIN  MILD PAIN  MODERATE PAIN  SERIOUS PAIN  SEVERE PAIN  WORST PAIN POSSIBLE

Alert Smiling  No eye closure  Frown  Intense stare  Bruised eyes  Agonizing screams
NO PAIN  CAN BE IGNORED  INTERFERES WITH TASKS  INTERFERES WITH CONCENTRATION  Unbearable  Face distorted beyond recognition

Death Imminent
How you can ask and rate pain in children

- Where the pain is and what does it feel like?
- How long has the pain been there?
- What makes pain better or worse?
- Does the pain get worse with movement?
## What to do to help relief pain for client

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<thead>
<tr>
<th>Simple Pain relief</th>
<th>Illustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure that the patient has their pain medication</td>
<td></td>
</tr>
<tr>
<td>Try gentle massage on pain area</td>
<td></td>
</tr>
<tr>
<td>Rocking on a chair as a pain relief strategy</td>
<td></td>
</tr>
<tr>
<td>Cold/warm compress to relief pain</td>
<td></td>
</tr>
</tbody>
</table>
Use of distractions i.e. music /radio

<table>
<thead>
<tr>
<th>Find the most comfortable position for the patient</th>
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</thead>
<tbody>
<tr>
<td>Prayer and other religious or cultural practices (if appropriate)</td>
</tr>
</tbody>
</table>

**NB:** If the pain is not improving refer the patient to a hospital
Levels of Palliative Care Interventions

Home Care Level

- Home care level is offered to a person with a life chronic illness that is aware of his / her illness and under medication.

- When the symptoms become, severe or need skilled personnel intervention the care giver seek facility based care

Facility care level

- It is a continuation of what was being offered at the home care level but in a more intense way.

- This should include providing time-limited support for the severe illness i.e. fever with convulsions, severely dehydration
Referral and Networking

• The provision of comprehensive palliative care requires the input of a multidisciplinary team

• Link client to different team members as need arise

• Be careful when dealing with groups in the community to prevent exploitation or causing more harm to the client
THANK YOU
MODULE 6:

ADOLESCENT AND SEXUAL REPRODUCTIVE HEALTH
Module Objectives

• By the end of the session the participants will be able to:-
  ➢ Define the term adolescents
  ➢ Define the term sexuality
  ➢ Discuss adolescent health problems
  ➢ Discuss the importance of focusing on young people
  ➢ Discuss drug and substance abuse among the adolescents
Definitions

• **Sexual Reproductive Health:**
  - Is a state of complete physical, emotional, spiritual and social wellbeing in all matters of reproductive health and not just absence of disease.

• **Adolescence:**
  - Is a stage of self-discovery, exploration and continued sexual development, is also a period when sexual initiation occurs at the age of between 10-19yrs (WHO).

• **Sexuality:**
  - This is more than sexual feeling and intercourse, it includes feeling of oneself as a sexual being, feeling attractive, behaving, dressing and communicating in a sexy way.
Adolescents

- Have the right to a healthy sex lifestyle.
- They should be equipped with knowledge and skills to protect themselves and others.
- Be prepared to discuss issues of sexuality in a non-judgmental and constructive manner.
- Adolescents are up to three times likely to experience pregnancy related complications than older women.
- High fertility levels as well as high teenage pregnancy rates have serious negative consequences.
- Early pregnancy disrupts the pursuit of education and limits future opportunities for social and economic development.
Adolescents

• One in twenty adolescents worldwide contracts STI each year.

• 5 young people under the age of 24 yrs are infected with HIV every minute and 7000 infected every day.

• Young people can make safe and responsible decisions on adolescent sexuality if informed with accurate information and range of skills such as decision making, communication and negotiation skills and have access to comprehensive Reproductive Health Services.
Adolescent’s Sex and Reproductive issues

• Lack of accurate information about sexual development
• Infections – HIV and other STI’s
• Menstrual problems
• Sexual activities among the youth
• Teenage pregnancies
• Contraceptive and condom use
• Abortions
• Early and forced marriages
Solutions to Adolescent’s Needs

• Health education (home, school, churches, mosques and other organized groups)

• Provision of youth friendly services in health facilities.

• Networking with other youth related groups
Drugs and Substance Abuse

Some common types of drugs abused include:

- Tablets
- Bhang
- Alcohol
- Cigarette
- Miraa
- Heroin
Alcohol and Substance Abuse among Adolescents

• The most common risky behaviors among today’s youth.

• More young people often use tobacco products and consume alcohol socially.

• Screening for substance use among adolescents living with HIV is important.

• Substance abuse leads to poor adherence and negative medical consequences for youth and adolescents living with HIV.
Signs of Substance Abuse in Adolescents

- Changes in school performance (falling grades, skipping school, sluggish)
- Changes in peer group (hanging out with drug-users, antisocial, older friends)
- Breaking rules at home, school, in the community
- Extreme mood swings, depression, irritability, anger, negative attitude
- Sudden increases or decreases in activity level
- Withdrawal from the family and keeping secrets
Signs of substance abuse in Adolescents

• Changes in physical appearance (weight loss, lack of cleanliness, strange smells)

• Red, watery, glassy eyes or runny nose not due to allergies or cold

• Changes in eating or sleeping habits

• Lack of motivation or interest in things other teenagers enjoy (hobbies, sports)

• Lying, stealing, hiding things

• Using street or drug language or possession of drug paraphernalia/items
What to do with these Adolescents

• Clinic staff should ask clients about their substance-using patterns

• Provide them with non judgemental education on the negative health effects of the substances, as well as to provide a baseline for their patterns of substance use.

• Reassure the adolescents that their conversation is confidential so that the YLH will not fear repercussions from their caregivers.

• Educating teens on the adverse effects of substance use and abuse may guide them to make safer life choices.

• Refer appropriately
THANK YOU
MODULE 7:

LOSS AND GRIEF
Module Objectives

• By the end of the session the participants will be able to;
  ➢ Define terms used in loss and grief
  ➢ Describe the stages of grief process
  ➢ Explain factors that influence the grieving process
  ➢ Discuss signs of loss and grief
  ➢ Explain how to cope with loss and grief
Definitions

• Bereavement
  ➢ Bereavement is the state of having suffered a loss and includes the period of adjustment in which the person learns to live with the loss.

• Loss
  ➢ Is the experience of separation from something of personal importance.
  ➢ The separation from loved ones or the giving up of treasured possessions can create change in a familiar pattern of existence.
• **Mourning**

  ➢ Is “the psychological process (or stages) through which the individual passes on the way to successful adaptation to the loss of a valued object/person.

• **Grief**

  ➢ It is “the subjective state that accompany mourning, or the emotional work involved in the mourning process.

  ➢ Grief work and the process of mourning can collectively be referred to as the *grief response*
Stages of the Grief Process

• Stage I: Denial
  - The individual does not acknowledge that the loss has occurred.
  - He or she may say, “No, it can’t be true!” or “It’s just not possible.”
  - This stage may protect the individual against the psychological pain of reality.

• Stage II: Anger
  - This is the stage when reality sets in.
  - Feelings associated with this stage include sadness, guilt, shame, helplessness, and hopelessness.
  - Self-blame or blaming of others may lead to feelings of anger toward the self and others even to God.
Stages of Grief Process Cont.

• **Stage III: Bargaining**
  
  ➢ The individual attempts to strike a bargain with God for a second chance or for more time.

  ➢ The person acknowledges the loss or impending loss but holds out hope for additional alternatives as evidenced by statements such as, “If only I could . . .” or “If only I had . . .”, could it be true...

• **Stage IV: Depression**

  ➢ This is a very painful stage, during which the individual must confront feelings associated with having lost someone or something of value (called *reactive* depression)
Stages of Grief Process Cont.

• Stage V: Acceptance

- At this time, the individual has worked through the behaviours associated with the other stages and either accepts or is resigned to the loss.

- Anxiety decreases, and methods for coping with the loss/situation have been established.

- The client is less preoccupied with what has been lost and increasingly interested in other aspects of the environment.

- The person may become very quiet and withdrawn, seemingly devoid of feelings.

- These behaviours help the client accept the new situation.
Factors Influencing Grieving Process

<table>
<thead>
<tr>
<th>Factors</th>
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<tbody>
<tr>
<td>• Relationship with the deceased</td>
</tr>
<tr>
<td>• Unfinished business</td>
</tr>
<tr>
<td>• Timing of death</td>
</tr>
<tr>
<td>• Multiple losses</td>
</tr>
<tr>
<td>• Availability of outlets for expression of grief</td>
</tr>
<tr>
<td>• Availability of support systems</td>
</tr>
<tr>
<td>• Worries about the future</td>
</tr>
<tr>
<td>• Practical issues (e.g. during the funeral)</td>
</tr>
</tbody>
</table>

123
<table>
<thead>
<tr>
<th>EMOTIONAL</th>
<th>BEHAVIORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>Helplessness</td>
<td>Searching and calling out</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Sleep and appetite disturbance</td>
</tr>
<tr>
<td>Relief</td>
<td>Avoiding reminders of the deceased</td>
</tr>
<tr>
<td>Yearning</td>
<td>Dreaming of the deceased</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Carrying objects belonging to the deceased</td>
</tr>
<tr>
<td>Shock</td>
<td>Wearing clothes belonging to the deceased</td>
</tr>
<tr>
<td>Anger</td>
<td>Crying and sighing</td>
</tr>
<tr>
<td>Freedom</td>
<td>Absentmindedness</td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
</tr>
<tr>
<td>Numbness</td>
<td></td>
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</table>
## Signs of Loss and Grief Cont.

<table>
<thead>
<tr>
<th>COGNITIVE</th>
<th>PHYSICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disbelief and Preoccupation</td>
<td>• Hollow stomach</td>
</tr>
<tr>
<td>• Confusion</td>
<td>• Lack of energy</td>
</tr>
<tr>
<td>• Hallucinations</td>
<td>• Tightness of chest</td>
</tr>
<tr>
<td>• Denial</td>
<td>• Dry mouth</td>
</tr>
<tr>
<td>• A sense of presence of the deceased</td>
<td>• Breathlessness</td>
</tr>
<tr>
<td></td>
<td>• Oversensitivity to noise</td>
</tr>
<tr>
<td></td>
<td>• Felling of panic</td>
</tr>
<tr>
<td></td>
<td>• Depersonalisation</td>
</tr>
<tr>
<td></td>
<td>• Muscle weakness</td>
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</tbody>
</table>
Coping with Loss and Grief

• Look and respond to grief reaction such as denial, disbelief, confusion, shock, sadness, bargaining, yearning, anger, humiliation, despair, guilt, and acceptance.

• It is important to keep communication open. But if the child does not want to talk, you can ask, “Would you like to talk now or later?”

• Help the child accept his/her own loss or situation.
How to Make Grief Counseling Effective

- Help the child identify and express feelings
- Assist the child to continue with positive living
- Facilitate emotional relocation to accept the new situation
- Provide time to grieve
- Interpret ‘normal behavior’
- Allow for individual differences
- Provide continuing support
- Examine defences and coping styles
- Identify sickness and refer
THANK YOU
MODULE 8:

GENDER BASED VIOLENCE
Module Objectives

• By the end of this session you should be able to:
  ➢ Define Gender and Gender Based Violence
  ➢ Describe the forms, causes and triggers of GBV
  ➢ Discuss the consequences of GBV
  ➢ Discuss what to look for when you suspect GBV and what to do
Definitions

Gender: It is socially constructed differences and relations that exist and are evidenced in the identities, roles, responsibilities, opportunities and attributes assigned to girls, boys, women and men in society.

• Gender Based Violence: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.”
Forms of Gender Based Violence

- **Physical Violence**: Beating, Pinching, Slapping, Choking, Pushing etc
- **Sexual Violence**: Rape, defilement, sodomy, sexual assault, sexual harassment.
- **Economic Violence**: Denying/Withholding of resources
- **Psycho-Social Violence**: Emotional and Mental torture
- **Socio-cultural Violence**: Negative cultural practices
Causes of Gender Based Violence

- Gender inequality
- Attitudes of disrespect—especially towards women and girls (Stereotype)
- Desire for power and control
- Politics— a weapon of ethnic cleansing
- Traditional tensions
- Cultural Issues and Practices
- Masculinity
- Religious beliefs
- Alcohol and drug abuse
- Lack of a capable legal system—Impunity
Triggers of Gender Based Violence

- Idling
- Personal frustrations
- Peer pressure
- Drug abuse/alcoholism
- Criminal scenes and environs
- Media and Internet
Consequences of GBV

• Neo-natal outcome

- Physical health outcomes
- Injuries from lacerations and fractures
- Unplanned pregnancies
- STD’s including HIV
- Pelvic inflammatory diseases, Headaches
- Self-injurious behaviors (smoking, unprotected sex)
- Disabilities
• Mental outcomes

- Depression
- Fear
- Anxiety
- Bed Wetting
- Low self esteem
- Sexual dysfunction
- Eating problems
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
Fatal Outcomes

• Fatal Outcomes
  - Suicide
  - Homicide
  - Maternal death
What to look for when Screening for GBV

- Social withdrawal
- Depressed moods
- Truancy
- Reported care of virginal discharge or STI
- Change of behavior by the learner
- Pregnancy by the girl child
- Drug and substance abuse
Components of GBV Response Network

**Reporting System**
- This enable the victims and their advocates to report crimes or violation.

**Referral System**
- Learners are directed or referred to the services they need

**Direct Support**
- The learners can talk to the teacher, held develop a plan, support where possible or refer appropriately
THANK YOU
MODULE 9:

STIGMA AND DISCRIMINATION
Module Objectives

By the end of this session you should be able to:

- Define stigma and discrimination
- Describe the concepts and manifestations of Stigma and discrimination
- Discuss the effects of stigma and discrimination
- Discuss how to reduce stigma and discrimination in HIV
Definitions

- **Stigma**: Refers to the unfavorable attitudes and beliefs directed toward someone or something. According to UNAIDS (Joint United Nations Programs on HIV/AIDS) it is a Process of devaluation of people either living with or associated with HIV.

- **Discrimination**: Refers to the treatment of an individual or group based on prejudice or bias.
Causes, Forms/Types and Effects of Stigma and Discrimination

Stigma Tree
Causes of Stigma

• Insufficient knowledge, wrong beliefs and fears about
  
  a) How HIV is transmitted
  
  b) The life potential/capacity of PLHIV hope for living for long (no immediate death)

• Pre-existing stigma based on moral judgments and superiority complexes about people who we assume have been sexually promiscuous or use illegal drugs

• Gender and poverty biases

• Fears about infection by disease and death
Forms of Stigma

- **Self-Stigma**: it is blaming and isolating oneself as a reaction to real or imaginary stigmatization from the society.

- **Physical stigma**: violence, harassment, abuse, not sharing utensils, refusing to buy merchandise/goods.

- **Social stigma**: name calling, finger pointing, teasing, ridicule, blaming, judging, gossiping, isolating, neglecting, rejecting, backbiting, making assumptions, shaming, use of language like victims.

- **Stigma by association** – family, orphans or friends of children and adolescents Living with HIV are also stigmatized.
Effects of Stigma

• Refusal to take medicine
• Feat in seeking the necessary treatment and care
• Refusal to play with other children or adolescents
• Nonperformance in School
• Reluctance in going to School
• Deter children and adolescents Living with HIV from adopting risk-reduction practices that may label them as HIV-infected
• Isolation, rejection, loneliness, self-pity, death, abuse by community, relatives, reluctance to take medication
Effects of Stigma Cont.

• Fear of disclosure
  ➢ Disclosure can encourage adolescent sexual partners to test for HIV
  ➢ Disclosure can help prevent the spread of HIV to sexual partners
  ➢ Disclosure allows children and adolescents to receive support from your family and friends
  ➢ Disclosure can enhance early treatment and adherence.

• Limits association especially fear to join a support group for psychosocial support

• Stress and depression among children and adolescents
How to deal with Stigma

• As a caregiver, you should: -

  • Acceptance the child’s and adolescent’s status
  • Talk about HIV/AIDs to the community members
  • Allow the children and adolescents to join support groups both at health facility and community level
  • Involve the head teacher on the issues of care of the child and adolescent Living with HIV
How to Deal with Stigma Cont.

• At the individual level;

  ➢ As a caregiver, support the mature children and adolescent to:
    ✓ Accept their HIV status
    ✓ Have self-awareness
    ✓ Develop skills to positively confront stigmatizers or stigmatizing events
    ✓ Join a pediatric or adolescent support group
    ✓ Join together to challenge stigma and discrimination
    ✓ Develop networks so as to demand recognition and defend their rights
How to Deal with Stigma Cont.

• Health facility

- Within the health facility, we will ensure:
  - Sensitization and empowering health care workers to deal with attitude towards children and adolescents Living with HIV
  - Use positive images of HIV pictorials
  - Have pediatric and adolescent friendly services
  - Peer educator engagement
  - Health talks at all departments
How to Deal with Stigma Cont.

• Community level

➢ At the community level, the caregivers and the health care workers will engage in:

✓ Community mobilization and sensitization targeting the entire community and gatekeepers

✓ Forming community based psychosocial support groups and networks

✓ Strong involvement of existing community structures

✓ Promotes the active involvement of PLHIV in local activities to foster positive perceptions of people living with HIV

✓ Peer education
THANK YOU
Sitting Arrangement
END