FAMILY CASE MANAGEMENT

Family-centered care training for care-providers of children and families living with and affected by HIV

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Balasahyoga is funded by the Children's Investment Fund Foundation (CIFF) and the Elton John AIDS Foundation (EJAF). It is implemented by a consortium of partners that includes Family Health International (FHI) – lead partner, the Clinton Foundation, and CARE in collaboration with Andhra Pradesh State AIDS Control Societies (APSACS).

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CONTENTS

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal clinic
ANM	Auxiliary nurse midwife
AP.	Andhra Pradesh
ART	Antiretroviral therapy
AWW	Anganwadi worker
CCC	Community care center
CHBC	Community and home-based care
CLHA	Children living with HIV/AIDS
CoC	Continuum of care
CSI	Child Status Index
CV	Community volunteer
EPI	Expanded Program on Immunization
FCM	Family case manager
FHI	Family Health International
ICTC	Integrated counseling and testing centers
LSE	Lifeskills education
MTP	Medical termination of pregnancy
OI.	Opportunistic infection
PLHIV	People living with HIV
PPTCT	Prevention of parent-to-child transmission
QA/QI	Quality assurance/quality improvement
SHG	Self-help groups
SSA	Sarya Shiksha Abhiyan
TB.	Tuberculosis
VCT	Voluntary counseling and testing

INTRODUCTION

Family Health International (FHI) is implementing the Balasahyoga program in partnership with the Clinton Foundation and CARE in 11 districts of Andhra Pradesh. Balasahyoga, which refers to "active support to a child" is a care and support program targeting children and families infected and affected by HIV and AIDS to ensure that they receive comprehensive and high quality services that will enable them to lead better lives. The program has adopted a family-centered care approach to caring for the child. Each family is assigned a family case manager who ensures that their needs are addressed comprehensively.

This training curriculum aims to enhance capacities of community workers to effectively manage, prioritize, and care for children and families infected and affected by HIV and AIDS. It provides a quick reference to the principles and processes of effective family case management. It will help project staff provide the best possible services for children and their families.

The curriculum includes many interactive methods and exercises for demonstration. During its development, suggestions and practical experiences from project functionaries and implementers were incorporated. The training content has been used to train over 500 family case managers (FCMs), community volunteers, and project staff.

SAMPLE SCHEDULE

This training curriculum is designed to take place over six days. It can be modified to suit each situation and all relevant needs. A typical structure for presenting the curriculum appears below.

DAY 1
Section 1: Children, HIV, and the Community

- Children, HIV, and the Community
- Child Development and Human Needs

Section 2: Caring for the Whole Family

- What Is the Family Case Management Approach?
- The Job and Qualities of a Good Family Case Manager/Community Volunteer

Day 2
Section 2: Caring for the Whole Family (Continued)

- Family Case Management Steps
- Communicating with Children and Adults
- Needs Assessment Practicum/Child Status Index

Day 3
Section 3: Health Needs of Children Living with and Affected by HIV

- Understanding Essential Healthcare Needs of Children
- How To Do a Basic Physical Assessment of Adults and Children
- Child Status Index
- HIV Testing and Counseling for Adults and Children
- HIV Care and Treatment
- Adherence Support for Children and Adults

Day 4
Section 3: Health Needs of Children Living with and Affected by HIV (Continued)

- Bringing It All Together

Section 4: Psychosocial Support and Education

- Psychosocial Support
- Education and Early Childhood Development

Day 5
Section 5: Practicum

Practicum

Day 6
Section 6: Mobilizing Support Services and Making Referrals

Referrals and Client Tracing

Family Care Supervision System

Section 7: Training Review and Evaluation

Training Review

Final Evaluation

Certificates and Closing

PRE-TEST

Please mark [√] against each of the statements, depending on if you consider it to be TRUE [T] or FALSE [F].

Statement	T	F
1. Children are physically, emotionally, socially, cognitively, and spiritually affected by their parents or caregiver having HIV.		
2. Older children (ages 13–18) often want their parents to tell them what the problems in the family are so they can know the truth and be better prepared.		
3. Children go through stages of physical, intellectual, spiritual, emotional, and social development from birth until adulthood.		
4. Children feel physical and emotional pain as adults do.		
5. 80% of children with HIV need ART before the age of 6 months.		
6. The FCM should mostly talk to the parents/caregivers when making a home visit since children cannot understand the situation.		
7. Care for children and their families must be provided continually through regular needs assessments, caregiving, and follow-up.		
8. From birth, children can communicate their feelings and needs.		
9. You cannot get HIV if you touch an HIV-positive child's unbroken skin.		
10. Active listening and positive body language are essential in providing emotional support to children and adults.		
11. Adults can communicate with children by spending time with them, talking with them using clear language, and by playing with them.		
12. In general, children from age 5 onward understand that death is permanent.		
13. Children do not grieve the loss of their parents.		

Statement	T	F
14. Children need play in order to develop socially, intellectually, and physically, and to develop balance and coordination.		
15. Children with HIV do not need immunizations, de-worming, and growth measurement as other children do because they will die anyway.		
16. Children can and should be taught how to wash their hands and to bathe themselves.		
17. All children need plenty of nutritious foods to grow strong but children with HIV need more because their immune systems are affected by HIV.		
18. Children with HIV can be very good at taking medicines on time if they are taught how to do it.		
19. If the FCM sees a child who is very lethargic this is a serious danger sign that means the child needs to be referred to the hospital immediately.		
20. Children under the age of 5 are in danger of many serious illnesses.		
21. There is nothing we can do about child abuse.		
22. Children, even newborns, feel physical pain. An FCM can help children get medicine to reduce pain.		
23. Children need a lot of love and comfort when they are very sick and near death. They need to know that they are special and that the caregiver loves them very much.		
24. Making a future plan can help parents with HIV to plan for who will take care of their children when they are gone.		
25. FCMs can tell their friends and family about the names and situations of the children they are caring for.		
26. FCMs can and should support people living with HIV (PLHIV) and their families to access opportunities for income generation and other social services.		

Section 1: Children, HIV, and the Community

This section provides participants with foundational knowledge about HIV/AIDS and its impact on children in Andhra Pradesh. It also offers core information about child needs and child development.

SESSION 1.1: CHILDREN, HIV, AND THE COMMUNITY

Learning Objectives:

- Provide an overview of the state of children and HIV, globally.
- Describe the impact of HIV/AIDS on children globally and in Andhra Pradesh.

Time:

30 min

Methodology:

- PowerPoint presentation 1.1, Children and HIV
- Brainstorming and group discussions

Materials Needed:

- PowerPoint presentation
- LCD projector, white board, laptop
- Colored markers

Handout:

- PowerPoint presentation 1.1, Children and HIV

Activities:

1. Start short presentation on global situation of children and HIV. Statistics on the magnitude of the problem provide the backdrop for why Balasahyoga is working on HIV with children.
2. Brainstorm: Ask participants what they know about the impact of HIV on children. Probe in terms of five domains, namely health, psychosocial support, nutrition, education, and safety nets.
3. Relate the discussions during brainstorming to the presentation. Use evidence to present the impact on children globally.
4. In a large group, brainstorm with participants about what problems or issues children infected or affected by HIV in Andhra Pradesh face. Ask them to compare what they mentioned with previous discussions on the impact on children globally.

SESSION 1.2: CHILD DEVELOPMENT AND HUMAN NEEDS

Learning Objectives:

- Explain stages of child development.
- Differentiate between surviving and thriving.
- Demonstrate normal emotions experienced by children of different ages (role play of children's ages) through different situations.
- List domains of child development and related danger signs.
- Define the role of the FCM, supervisors, and project coordinators.

Time:

1 hr 45 min

Methodology:

- PowerPoint presentation 1.2, Child Development and Human Needs
- Brainstorming
- Group work
- Role play

Materials Needed:

- Flipchart
- Marker pen
- Tape
- Colored paper
- Case studies
- LCD and laptop

Handout:

- Understanding Child Development

Activities:

1. Brainstorm: Ask participants who have children to raise their hands. Ask parents to describe when their children changed over time physically, emotionally, socially, cognitively, and spiritually. After this, provide a 10-minute overview of the stages of development.
2. Divide participants into five groups. Give them one age group each (0-2, 3-5, 6-8, 9-12 or 13-18). Then ask each group to pick five words (adjectives) to describe this age group.

a. What do children learn during this developmental stage?

b. How can the child's environment affect what the child learns?

c. What do children need during this developmental phase?

d. What could happen if these needs were not met?

e. What could happen if the child experiences a big loss (such as the severe illness and death of a parent/caregiver), or if the child him/herself becomes ill?

f. As a caring person (FCM) what could you do to help the child and his/her family during this developmental phase?

Allow 15 minutes for group discussion followed by a five-minute presentation by each group.

3. Continue presenting the slides on different age stages of development.
4. All five groups will be provided a case study to do a role play. Ask each group to determine what stage of development the child is in: 0-2, 3-5, 6-8, 9-12, or 13-18. Ask each group to identify which developmental stage the child is in. Ask each group to prepare a five-minute role play on the situation and then ask the other participants to guess the child's age and if there are any developmental danger signs. Allow five minutes for preparation and five minutes each for presentation and discussion.
5. Conclude the session.

SESSION 1.2: NOTES FOR THE FACILITATOR ON CHILD DEVELOPMENT AND HUMAN NEEDS

The Five Domains of Human Needs

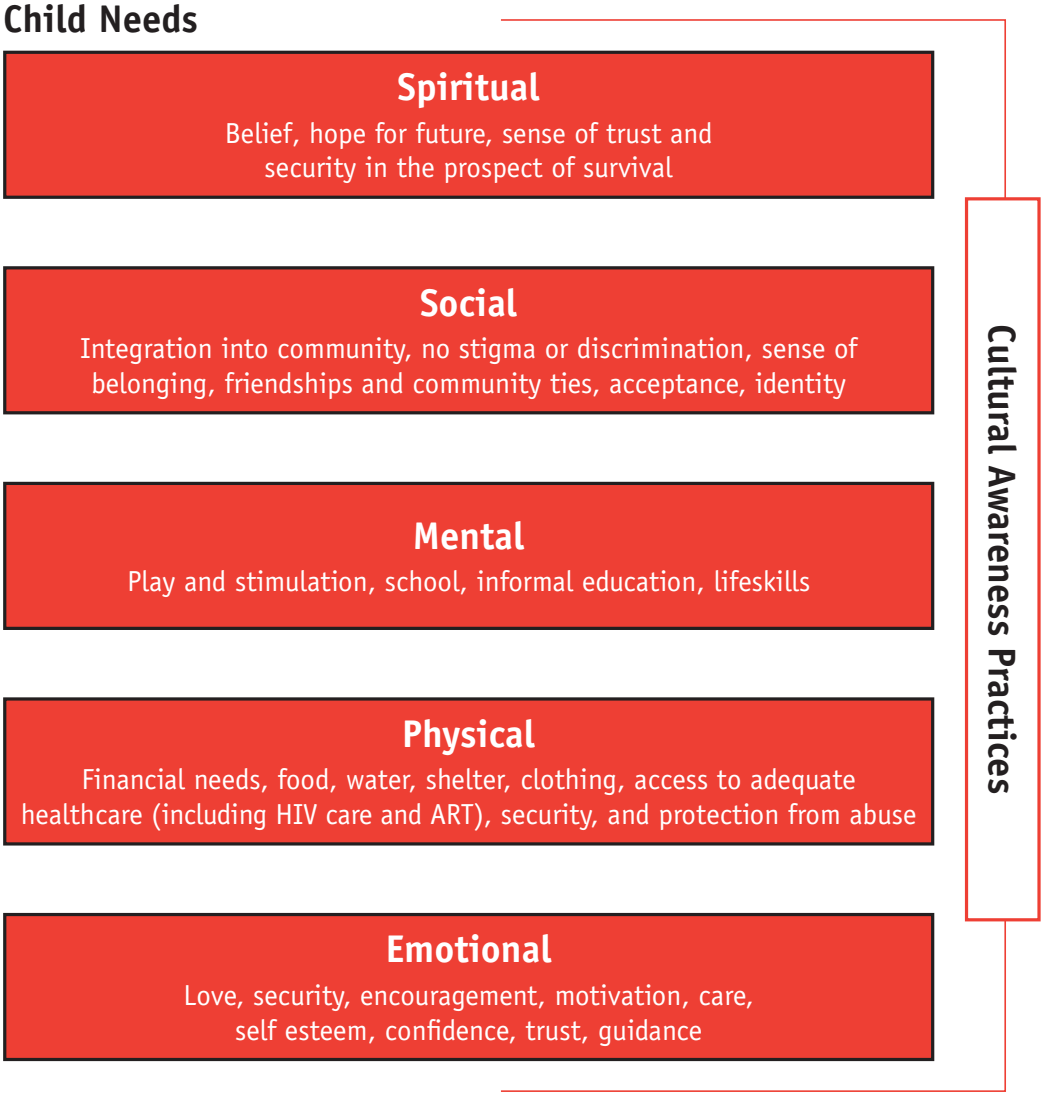
Human Needs Goal: To fulfill human needs as best as possible in order to achieve the highest quality of life possible.

All human needs are interrelated but in order to help us understand the specific needs of humans, we can divide them into five categories:

1. **Emotional Needs**: These needs are related to an individual's feelings, thoughts, emotions, and personality. Humans need to feel loved, respected, and in control of their lives. If they do not, they may feel sad, lonely, and depressed. The emotional wellbeing of humans directly impacts their physical wellbeing. Both children and adults need to feel loved and cared for.
2. **Physical Needs**: These include the needs of the body related to physical survival. Needs such as food, water, air, sleep/rest, medicine, healthcare, and shelter are all vital for the physical wellbeing of the human body. If these needs aren't met over time, a person will die.
3. **Mental Needs**: This is the development of the ability to think, make decisions, and reason. These skills are developed through play, social interaction, teaching by parents and others, school, and work. A child's mind is always developing. It needs nurturing from birth to adulthood. Children have mental needs long before they go to school.
4. **Social Needs**: Humans need to interact with other people. We need social contact with family, friends, and people in our communities. Social interaction helps humans to feel like they are a part of something. Poverty, discrimination, and violence are social problems that can lessen a person's quality of life. People need to have economic stability, to be treated fairly and with respect, and to live without fear of violence.
5. **Spiritual Needs**: This is the belief that we are important in the world and that our lives have meaning. Spirituality can give us a sense of peace with the world and with ourselves. Children need to believe they are special, that they matter to people, and that they are loved from birth through adulthood. They need to know that they matter and are important. People may experience spirituality through religion, which helps them develop a sense of meaning through their love of god(s).

All needs are connected to each other. When our emotional needs are not being met and we begin to feel sad, we can isolate ourselves from other people and limit our social interactions, which can make us feel sadder. When we feel sad, we may not eat well. We may not be interested in taking our medicines, which can impact our physical health. This sadness could lead us to doubt the value of life itself and the meaning of life, reducing our faith in god or our sense of spirituality.

Child Needs


Spiritual
Belief, hope for future, sense of trust and security in the prospect of survival
Social
Integration into community, no stigma or discrimination, sense of belonging, friendships and community ties, acceptance, identity
Mental
Play and stimulation, school, informal education, lifeskills
Physical
Financial needs, food, water, shelter, clothing, access to adequate healthcare (including HIV care and ART), security, and protection from abuse
Emotional
Love, security, encouragement, motivation, care, self esteem, confidence, trust, guidance
Cultural Awareness Practices

SESSION 1.2, HANDOUT 1: UNDERSTANDING CHILD DEVELOPMENT

Child development is the process of physical, mental, emotional, social, and spiritual growth that takes place from before birth up to 18 years in children. Successful completion of each stage helps the child to develop into a mature, well-adjusted, and happy adult.

Every child has the right to be supported throughout developmental stages. However, we cannot offer relevant and meaningful support to children in distress if we do not understand the development stages. It is the level of development and understanding of the child that determines the activities and the nature of support that we give to children.

Stages of Child Development

From birth through adulthood children go through many physical, emotional, social, intellectual, and spiritual changes. They are learning how to use language, how to walk, how to care for others, and how to understand who they are in their family and community. Although children are developing a little bit every day, we can categorize them into six stages of development:

Ages	Stages
0-2 years	Infancy/Toddler
3-5	Early Childhood
6-8	Middle Childhood
9-12	Late Childhood
13-18	Adolescence

The following table explains the main things that happen in each stage of development for children.

Ages and Stages

0-2 years

Children change dramatically from birth to year 2. During this period children develop the ability to crawl, sit up, stand, walk, and run. They start to smile, cry, make sounds, and speak. They understand their name, explore, shake objects, and put things into containers.

To be a happy baby, a child needs to bond with the caregiver by receiving lots of love and attention (hugs, touch, smiles, cooing, and gentle, clear speech). The child is totally dependent on the caregivers for survival. The loved child will develop feelings of **trust, security, and optimism**. If treated poorly, the child may become withdrawn and mistrustful, and may cry a lot and cling, not wanting to let go of someone who is holding him/her. At this age children begin to develop skills in imitation, memory, and thought. The 0-1 child does not understand death but can miss parents or other loved ones when they are no longer there. He/she also can sense the worry and anxiety of others, which can make the child worry.

From 1-2 children begin to speak and understand words and ideas. They enjoy stories and develop friendships. They show pride in accomplishments and like to help with simple tasks. Children also can walk steadily, climb stairs, and run.

From 2 on children begin to become more independent of their parents. They may stubbornly fold their arms to prevent their caregivers from sending them to bed at night. Also, children at this age like to individualize themselves by saying, "No!" This is all normal and part of this developmental stage.

3-5 years

Children at this age have longer attention spans. They act silly, are full of energy, love to talk and ask questions, and love to play. Play for children at this age is very creative: they like to draw, paint, and reveal feelings in dramatic play. They also play with friends but do not like to lose!

At this age children learn how to interact with other people. They begin to share things with others and take turns. They develop language skills as caregivers talk to them, read stories to them, and sing with them. Caregivers can also give children opportunities to take responsibility and make choices.

During this stage the healthfully developing child learns: (1) to imagine and to broaden her/his skills through active play of all sorts, including fantasy, (2) to cooperate with others, and (3) to lead as well as to follow.

Children who have had something traumatic happen to them (such as a death, neglect, or abuse) may feel (1) fearful, (2) responsible for the bad things that have happened to their family – that they caused their parents to die, (3) that they hang on the fringes of groups and isolate themselves from others, (4) dependent on adults more than other children of their age, and (5) restricted both in the development of play skills and in imagination.

From ages 3-4 death is not seen as permanent. Death may be confused with sleeping or confused with punishment for some wrongdoing. The child may think he/she can catch the same thing, e.g., HIV, cancer. The child may think that dead people live underground.

From age 5 on children begin to understand the concept of death. They learn that death is permanent, unavoidable, and universal.

Ages and Stages

6-8 years

Children at this age grow curious about people and how the world works. They show an increasing interest in numbers, letters, reading, and writing. They become more and more interested in accomplishing things and gain more confidence in their physical skills. Children at this age also **use words to express feelings and to help them cope with difficulties.**

Caregivers need to continue to help the child develop additional motor, language, and thinking skills and provide support for further development of language through talking, reading, and singing. Caregivers can also help the child participate in tasks that he/she can successfully master, building his/her confidence and resilience, and helping the child learn cooperation and teamwork.

Caregivers need to continue to provide unconditional love. Children need verbal praise and statements of love from their caregivers. They need to be encouraged to develop a sense of the child's ability to achieve even in difficult situations.

Children at this age who have lost a parent may be withdrawn, shy, and sad. They may not have the same level of self-confidence and hope as their peers.

9-12 years

During these ages the child learns to master the more formal skills of life: (1) relating with peers according to rules, (2) progressing from free play to play that may be elaborately structured by rules and may demand formal teamwork, such as soccer, and (3) mastering social studies, reading, and arithmetic.

Children want to be successful at this age and tend to have positive self images as achievers. They may focus a lot of energy on school work and developing a group of friends through school and their neighborhood. Close friends and what their friends/peers think of them become very important. They are sensitive to comments that express their inability to do something, usually making them feel insecure and full of self doubt.

The child who, because of his successive and successful resolutions of earlier psychosocial problems, is trusting, autonomous, and full of initiative will learn easily enough to be industrious. However, the mistrusting child will doubt the future. The shame- and guilt-filled child will experience defeat and may lack confidence.

From 9 onward, children understand that death can now include them. They also are interested in how death happens and details of funerals.

13-18 years

From 13 to 18 children become adolescents. Their bodies grow quickly, they go through puberty, and they start to become more interested in the opposite or same sex. They are very aware of and concerned about how they look; fashion, make-up, and hair become very important. They develop a deeper understanding of who they are but are also very sensitive to how others perceive them. Friends and how friends interact with them can become more important than interacting with parents/caregivers. Many adolescents push parents away and try to become independent of them. This can be a very challenging time for parents!

For adolescents who may have experienced sadness, uncertainty, guilt, or shame in their childhood, rebellion can take place during these ages. Adolescents who feel loved are more likely to acquire self-certainty and self-confidence.

Adolescents may seek out adults who can mentor them (someone to serve as a source of inspiration), and then gradually develop a set of ideals/morals about the meaning of life, which they can use to guide their own lives.

Section 2: Caring for the Whole Family

This section reviews the family case management approach and core roles, responsibilities, and skills required by family case managers to provide quality care.

SESSION 2.1: WHAT IS THE FAMILY CASE MANAGEMENT APPROACH?

Learning Objectives:

- Define family case management.
- Explain why family case management is so important.

Time:

45 min

Methodology:

- PowerPoint presentation 2.1, What is the Family Case Management Approach?
- Brainstorming using case study

Materials Needed:

- LCD & laptop

Handout:

- Family-centered Care Case Study

Activity:

1. Start by describing to the participants the key topics that will be covered through the session. Use the presentation, Using the accompanying slides introduce family-centered care to participants.
2. Divide the participants into five groups and provide them with the case study. Use the case study as a basis for discussing the family case management approach, with emphasis on the following questions:

   a. Is this family-centered care? If not, why not? If yes, why do you think it is?

   b. Are there any other actions that should be taken by the FCM?

   c. What would you recommend be done to improve this situation?

   The emphasis needs to be placed on the fact that in addition to the children affected by HIV, the needs and issues facing the other members of the household need to be addressed as well.

3. Continue with the presentation.

SESSION 2.1, HANDOUT 1: FAMILY-CENTERED CARE CASE STUDY

Satya is 6 years old and Shanti is 2. They lost their parents to HIV about six months ago. They are staying with their aunt and uncle who have two children, Mallika, age 4, and Sitha, age 7.

The family is very poor and lives in Guntur. The uncle is a farmer and has a hard time earning enough to meet the basic needs of the family. Sometimes he gets part time work as a truck driver and travels all around southeast India.

The FCM comes during the mid-morning of a weekday to provide a follow-up visit. She gives a big hug to Satya and Shanti, asks them how they are doing, and praises them. Shanti is very small for her age. Mallika and Sitha are sitting farther away, working on mending clothes. Mallika has reddish hair and is also very small.

The FCM sits down with the aunt and uncle and asks Satya and Shanti to sit with them. The FCM brings out the previous visit's Family Care Plan and reviews the action steps that they agreed needed to be taken for Satya and Shanti.

The FCM reported she had enrolled Satya in school and would provide support to ensure he could stay in school. She also said that Shanti had been enrolled in the Anganwadi.

The FCM starts the process of identifying any new needs in order to update the Family Care Plan. She asks the family if there are other needs. The aunt says life is hard, they don't have enough money to send their children to school. She says she also wishes her daughter Mallika could join the Anganwadi.

SESSION 2.1: NOTES FOR THE FACILITATOR: WHAT IS FAMILY CASE MANAGEMENT?

For families, the best care is care that addresses the needs of both parents/caregivers and their children at the same time. Sometimes services provide care to only children or only adults and this can make things very difficult for families. For families affected by HIV and AIDS, it means that they will need to go to many different services in different locations, which may cost a lot and may be very confusing.

Family case management means that services and care are provided to parents/caregivers and children jointly.

- For home visits, this means that the FCM and the home-based care team work together, visiting the family affected by HIV at the same time. This enables the team helping the family to see the big picture of what is affecting them and to be better able to help them.
- For ART clinics/community care centers (CCCs), parents and children come to the clinic on the same day for care and the clinic staff sees the family together rather than seeing the parents separately from the children. This helps the clinic caregivers better understand what the family needs and helps the family get holistic care.

The family-centered care approach can also make it easier for parents to disclose their HIV status or tell their child about it because the family as a whole becomes sensitized to HIV, self-care skills, and ART adherence, and more comfortable living with HIV.

Family-centered care is also very important because if services are not well linked, families may not get the services they need in time (e.g., VCT, PPTCT, CHBC, OI, ART). A family-centered care approach implemented within the CoC can save the lives of both parents and children.

SESSION 2.2: THE JOB AND QUALITIES OF A GOOD FAMILY CASE MANAGER/COMMUNITY VOLUNTEER

Learning Objectives:

- Define the core job responsibilities of the FCM and CV.
- Describe the qualities and skills of a good FCM and CV.
- List five key areas of care.

Time:

1 hr

Methodology:

- PowerPoint presentation 2.2, The Job and Qualities of a Good Family Case Manager/Community Volunteer
- Brainstorming
- Role play

Materials Needed:

- Flipchart
- Marker pen
- Tape
- Case studies

Handouts:

- The Job of an FCM/CV and the Qualities Necessary to Do These Jobs
- FCM and CV Job Roles and Responsibilities
- The Qualities of a Good Caregiver

Activities:

1. Introduce the session and the learning objectives to the participants.
2. Brainstorm on who is involved in caring for children under Balasahyoga. The group should be able to recognize that FCM/CV play an important role in care for children.
3. Brainstorm on skills and qualities of a good caregiver, gain agreement, and then pass out a document listing the qualities of a caregiver. Give participants a few minutes to review, then review with participants.

4. Brainstorm with participants on the role of an FCM/CV. Discuss the roles of the FCM/CV and provide the job descriptions handout.
5. Divide participants into three groups. Once participants are in three groups provide them with their role play scenarios (see Session 2.2, Handout 3) and let them know that they have 15 minutes to prepare their role play and 5-7 minutes each to do the role play. Walk from group to group to assist them in preparing a good role play. This is important because in this role play the participants will demonstrate good caregiving behaviors to each other.
6. Once they finish their discussion ask each group to perform their role play in front of the large group. After each performance ask the large group about the quality of care each group demonstrated in the role play.
7. Link the role plays to the importance of the FCM/CV in doing two things: 1) providing the highest quality care they can; 2) protecting the confidentiality of families.
8. Summarize main points.

SESSION 2.2, HANDOUT 1: THE JOB OF AN FCM/CV AND THE QUALITIES NECESSARY TO DO THESE JOBS

A Good FCM/CV Caregiver is...

- caring, loving, and nurturing – he/she knows how to provide care and love to children, and understands what children need to thrive
- able to communicate well with children and adults – respectful in communication and knows how to communicate with children of different ages, including by playing with them
- family centered – does not focus on only the child but assesses the child within the context of the family – assesses the family as a whole
- knowledgeable about child development – understands what children need at different ages in order to develop well and can recognize danger signs when a child is not developing well
- able to protect confidentiality – keeps the information of the family confidential and commits to maintaining confidentiality
- able to recognize danger signs and knows when and where to refer a child – knows what the signs are when a child is sick, sad, or being abused and knows how to refer him/her
- able to identify problems with abuse and knows how to protect a child from further harm
- empowers and supports the family to make their own decisions
- empathetic, non-judgmental, and accepting of the child(ren) and family
- respectful of children and involves them in decision making
- reliable – provides follow-up care on a routine basis. The family knows when the FCM/CV will come and feels they can count on him/her.

SESSION 2.2, HANDOUT 2: FCM AND CV JOB ROLES AND RESPONSIBILITIES

(This may be modified depending on specific project needs.)

Family Case Manager

- Assists in validation of households by visiting homes of children infected and affected
- Makes the initial/first contact with the household to register them, providing each with a unique registration number
- Develops family case files for each household registered in the program
- Identifies and prioritize the needs of children and parents with support from community volunteers
- Conducts a health, nutrition, education, psychosocial, and food security assessment of registered HIV-affected households and develops family plans
- Makes regular monthly visits to each household to monitor status across the five domains and follows up on family plans
- Identifies and refers children to the auxiliary nurse midwife (ANM)/Anganwadi worker (AWW) for immunization per the government Expanded Program on Immunization (EPI) and for other relevant services
- Conducts lifeskills education (LSE) sessions with children
- Accompanies the children and adult members of HIV-affected households when needed to various facility-based services including the CCC, PPTCT, ICTC (integrated counseling and testing centers), Pre-ART Distribution Center, and ART
- Ensures linkages of children and adults registered at CCC, VCT, PPTCT, the Pre-ART Distribution Center, and ART with community-based services
- Provides supportive supervision, mentoring, and training to the community volunteers
- Identifies and refers children to various childcare and protection programs and services in the district
- Identifies and prioritizes the food security and livelihood needs of children and parents with support from community volunteers
- Builds capacities of households to develop home-based kitchen gardens and farmyard production for nutrition supplementation and income generation
- Mobilizes communities to take up community-based grain banks and demo-plots

- Supports the registered HIV-affected households to develop linkages with existing rural livelihood programs and other social security schemes of the government, under the guidance and coordination of the district program officer of care
- Maintains, collates, and analyzes reports and submits them to field supervisor/s
- Conducts regular home visits to provide community- and home-based care and support services for children infected and affected by HIV and their family members
- Supports FCM in all tasks
- Provides basic/lay counseling on positive living, acceptance, and adherence
- Refers/accompanies HIV-affected and infected adults and children to facilities
- Identifies and refers children to ANM/AWW for immunization per the government EPI program and for other relevant services
- Supports the FCM in facilitating LSE sessions with children
- Ensures enrollment of children in education programs and builds capacities of households to develop home-based kitchen gardens and farmyard production for nutrition supplementation and income generation
- Mobilizes communities to take up community-based grain banks and demo-plots
- Identifies and refers children to various childcare and protection programs and services in the district
- Maintains family case register and prepares reports for the FCM on a regular basis

SESSION 2.2, HANDOUT 3: THE QUALITIES OF A GOOD CAREGIVER

Role Play Scenarios

Sharad and Ravi

A new family has joined the Balasahyoga program. The clients are Sharad and his son Ravi. Sharad has been enrolled in the ART center for three months now. Sharad's wife is no longer living – she passed away last year.

Ravi is 11 years old and very shy.

When you, the FCM, come to Sharad's home to assess how he and his family are doing you find that Ravi looks very sad. He is sitting in a corner and does not want to talk much.

You assess Sharad first. He asks to be assessed privately without his son in the room. He does not want Ravi to know he has HIV.

After you finish assessing Sharad's needs you ask to talk with Ravi. You sit with Ravi and ask how he is feeling and he says just OK. You ask why he feels only OK and Ravi says that he gets teased at school all the time. Children in his class won't play with him. They point at him and say he's an AIDS child. Ravi asks you: "Does my father have AIDS? I know he does. I want to know the truth."

How would you handle this situation?

Please prepare a 7-minute role play describing how you would manage this situation. Try not to spend too much time on the assessment of Sharad so you can focus on the conversation with Ravi.

Kamala, Sitha, and Radhika

You are a Balasahyoga field supervisor. You are on a routine supervision visit with a FCM who is very new in her job. You are observing the FCM providing care to a family with two children and their mother, Kamala. Kamala is a 40-year-old widow who is HIV-positive. One of her daughters, Sitha, is 5 years old. Sitha has HIV and has been on ART for one year. The other daughter, Radhika, is 2 years old. Radhika has not yet been tested for HIV.

While you are observing the home visit you notice that the FCM spends most of her time focused on Kamala. She assesses her physical, emotional, social, mental, and spiritual needs. She provides Kamala with symptom care (for mild skin infection) and ART adherence counseling. The team also asks briefly about how Sitha and Radhika are doing but they don't follow up with in-depth questions.

Overall, you notice that the FCM did a great job assessing Kamala's needs and providing care to her but you feel that something was missing. What did the FCM miss?

Please prepare a 7-minute role play describing how you, as the supervisor, would manage this situation. In the role play, act out two scenes 1) the home visit (quickly) and 2) the supervisor meeting with the FCM team back at the office after the home visit.

The Drink Shop

After you leave the house where you have provided a home visit to Sharad and Ravi, you stop at a nearby drink shop for some water before you go to your next client. While you are sitting having your drink, the drink seller says: "Hey, I saw you come from Sharad's house. Is it true he has HIV?" Some other people sitting around join the conversation and say: "Well you know, his wife died of HIV last year, and his son has it, too. I tell my children to stay away from that house."

What would you do in this situation? What will you say to the drink stall owner and the neighbors?

Please prepare a 7-minute role play describing how you would manage this situation.

SESSION 2.3: FAMILY CASE MANAGEMENT STEPS

Learning Objectives:

- List the core steps involved in assessing the needs of children and families.
- Describe criteria for child eligibility in the Balasahyoga program.
- Explain how to register a household and ensure client informed consent.
- Explain how to prioritize children for care.
- Practice completing Family Care Plans.
- Describe the importance of the Child Status Index.
- Describe how to use the Child Status Index form.
- Describe how to prioritize frequency of visits.
- Explain the importance of routine care and follow-up.
- Practice the entire process using case studies and role plays.

Time:

4 hr

Methodology:

- Brainstorming
- Group work

Materials Needed:

- PowerPoint presentation 2.3, Family Case Management Steps
- Whiteboard
- Marker pens
- Family folder

Handouts:

- The Steps Involved in Conducting a First Visit
- The Steps Involved in Conducting a Follow-up Visit
- Family Case Management Case Study
- Prioritization Tool for FCM Visit
- Family Care Plan Format
- Child Status Index (see page 66)

Activities:

1. Explain that the CV and FCM need to have three qualities in order to provide basic support to families and children infected and affected by HIV/AIDS. They need 1) to be kind, warm, and dedicated to caring for children and families infected and affected by HIV/AIDS; 2) to know how to communicate in a friendly and appropriate way with adults and children and 3) to be able to assess the needs (based on the five human needs) of children and adults in the family every time they visit the home of a client. **Explain that since you have already covered 1 and 2, you will now focus on 3: how to assess needs of children and families infected and affected by HIV/AIDS.**

2. Ask the participants to explain home care to children and families. Ask them to explain the major steps of the process. Lead the participants so that they describe that we can divide the visit to a family into three categories: 1) what we need to do before a visit (in this case to a new family); 2) what we need to do during the visit; 3) what we need to do after the visit; and 4) a follow-up visit to our client, which takes us back to step one. Ask participants to share a bit of what they do before they visit a family for the first time. What do they need to do to prepare? Then, ask the trainees to think about what they normally do during a visit and then ask what they do after they leave the home and go back to the office (Note: Since caring for families is likely new to most participants, provide participants with the handout that describes steps to take before, during, and after a visit). Using the case study of Supriya that appears in the PowerPoint presentation, run through the steps in doing an assessment. Use body language and small demonstration throughout the presentation of the steps while you go through them so participants can better imagine what you are describing. Ask participants to ask questions while you review the steps so confusion can be clarified as you go. When discussing what is done during the visit, present on the cycle of the needs assessment: FCMs assist families by helping them identify their needs across the five domains (health, psychosocial, nutrition, food security, and education), plan for how they will address these needs, and then help the family to address their most urgent needs.

   This process follows these steps:

   a. Assess and identify needs
   b. Develop a care plan
   c. Implement the plan
   d. Reassess needs and update the care plan

3. Make sure this four-step process is written up on flip chart paper and hung on the wall so all participants can see. The four-step process can be drawn as a cycle. This is important so

you can emphasize the point that the process is repeated on every visit. After this, introduce Handout 1, The Steps Involved in Conducting a First Visit.

4. Use the case study to further brainstorm on what steps need to be taken. Introduce family care plans and next steps that will be undertaken by the FCM. Emphasize that family care plans are developed with the families, including children, and not by the FCM alone. After this, introduce Handout 2, The Steps Involved in Conducting a Follow-up Visit.
5. Discuss the steps, which are different in the follow-up visit compared with the first visit. Ask participants to read Session 2.3, Handout 3: Family Case Management Case Study. In groups of two (one FCM and one client), practice following the steps of a first visit, in relation to this case study.
6. Ask participants to practice following the steps of a first visit and practice preparing the **Family Care Plan.** Use the first visit checklist to guide the visit. Rotate after 10 minutes so all have a chance to practice completing the Family Care Plan.
7. Introduce the prioritization tool for the household visit. Brainstorm on the need for prioritization and its importance in reaching households at the right time. It is important to emphasize the reason/logic of prioritization and to underscore that the list only mentions minimum frequency. They can visit more frequently.
8. Summarize main points and close.

SESSION 2.3, HANDOUT 1: THE STEPS INVOLVED IN CONDUCTING A FIRST VISIT

What should a FCM do before, during, at the end of, and after a first home visit?

Remember: Most clients will receive home visits, but not all. Some will be met in a place of their choosing, and the steps below will need to be adapted to this situation. You need to ensure that monthly contact is made with the client and that a **home visit is made within three months** of first contact with the family if the family is not willing to have home visit initially.

I. BEFORE THE VISIT

- ☐ Set a time and date for the visit.
- ☐ Prepare forms and materials.
- ☐ Arrange transport.

II. DURING THE VISIT

The first visit has five main parts: 1) introduction; 2) family/child history-taking; 3) family needs assessment; 4) making a care plan and deciding on actions to be taken; and 5) setting a time for the next visit.

*** If adults/child in critical condition, arrange referral immediately.**

1. INTRODUCTION

- ☐ Introduce yourself and the work of an FCM.
- ☐ Make friendly conversation with the family members for a few minutes.
- ☐ Explain the assessment process.
- ☐ Ask if the family needs urgent help with anything.

2. CHILD AND ADULT HISTORY-TAKING

- ☐ Tell the family that all information they provide to you is confidential.
- ☐ Start history taking: relevant project forms can be used (These do not all have to be done in one visit).
- ☐ Communicate respectfully and warmly with the client while conducting the family history.
- ☐ Thank the family for the information.

3. FAMILY NEEDS ASSESSMENT

Start with the physical needs assessment. This should be conducted for any adult living with HIV and for all children.

A. Ask about current or recent health problems.

- ☐ Pain; fever; diarrhea; constipation; nausea/vomiting; lack of appetite/nutrition; painful mouth/throat; skin problems/itchiness; inability to sleep; fatigue.
- ☐ If a child is under age 5, watch for any danger signs, and refer immediately if identified.
- ☐ **Ask to see the person's ART Book**; ask if he/she is enrolled in the CCC or the ART Center if there is no ART book.
- ☐ Ask about/to see any **medicines being taken** (e.g., for symptoms, ART, cotrimoxazole, TB medicines).

B. Vital Signs: Prepare supplies for vital signs and physical exam.

- ☐ Wash hands.
- ☐ Check temperature using back of hand to forehead method.
- ☐ If trained, check pulse and respiration.

C. Conduct a basic physical assessment.

- ☐ Head, face, eyes, mouth
- ☐ Lymph nodes around the neck and under the arms
- ☐ Skin

D. Provide care.

- ☐ Discuss findings with the family and make recommendations on care needed.
- ☐ Provide care, needed medicines/supplies from the **home-care kit,** and care education. You can also help with medical referral if needed.
- ☐ Wash hands.

E. After providing care.

- ☐ Provide adherence counseling as needed.
- ☐ Ask about infant feeding if a child is under 6 months; counsel as needed.
- ☐ Check to see how well the child is growing; if not, refer and follow up.
- ☐ If there is an HIV-exposed child under 18 months, find out if he/she is on cotrimoxazole and adherent.

- ☐ If there is an HIV-exposed child under 18, counsel parents regarding HIV testing.
- ☐ Provide HIV prevention support as needed.

F. Ask about nutritional and food security needs.

- ☐ Ask about enrollment in Anganwadi Center (only for children 3-6 years old).
- ☐ Check growth chart (only for children younger than 6).
- ☐ Use the Nutritional Assessment Form (only for children younger than 6).
- ☐ Administer the Household Food Security Assessment format.
- ☐ Provide nutritional counseling.
- ☐ Enroll in cooking demonstration sessions.

G. Ask about emotional, social, and spiritual needs.

- ☐ Ask about emotional wellbeing of adults and children; provide counseling as needed.
- ☐ Ask about stigma and discrimination.
- ☐ Ask about economic situation.
- ☐ Assess family hygiene.
- ☐ Review schooling; are all children enrolled?
- ☐ Does there appear to be any child or other abuse in the family?
- ☐ Does the caregiver want to develop a Future Plan?
- ☐ Ask about spiritual support needs.
- ☐ What services is the family already accessing?
- ☐ Providing counseling, information, and support based on findings.

4. FAMILY CARE PLAN

- ☐ Summarize main needs.
- ☐ Help the family and children to prioritize those that are most important.
- ☐ Complete the Family Care Form, including actions, who is responsible, and next steps.

5. END OF VISIT

- ☐ Ask the client and caregiver if they have any other questions or requests.
- ☐ Summarize the visit findings and next steps.
- ☐ Thank the family and let them know you will do your best to support them.
- ☐ Leave needed supplies (e.g., medicines).

- ☐ Arrange and help with referrals if necessary.
- ☐ Schedule a time and date for your next visit.

III. AFTER THE VISIT

- ☐ Review family file forms to ensure they are correct.
- ☐ Record medicines or supplies that were given to the family in the log book.
- ☐ Place the family file in the locked filing cabinet where files are kept.
- ☐ **Follow up on any referrals.**
- ☐ **Debrief** with your supervisor as needed.

*** If an adult/child is in critical condition, arrange for a referral immediately.**

Making a Care Plan

(Note: The care plan should be made sometime during the first visit and updated at each follow-up visit.)

Based on the findings of the needs assessment, repeat the main needs that the family raised. If the family can read, write the needs of the family on a piece of paper and ask them if the list is correct. Ask the family to prioritize which needs they would like to address first (which ones are more urgent).

Involve the child in all decisions when appropriate. Listen to the child's wants, needs, and fears with an open mind.

- ☐ Show the care plan form to the family and explain how it will be used. On each visit, the family care team will re-review the plan and update it based on what's been achieved and if there are any new problems/needs.
- ☐ Write the prioritized needs on the care plan form. Go through each need one by one, asking the family what actions they think could be taken to address each need. Provide information that you have about services available that could help meet their needs. Then, decide who will be responsible for which activity and decide what the target completion date will be. The family and you will divide up tasks based on who can do what (you may help with getting the services, providing resources the family needs, providing counseling, etc).
- ☐ Note in your family file what you will need to follow up on for the family.
- ☐ Take care of any immediate needs that you can: food, hygiene supplies, etc.

SESSION 2.3, HANDOUT 2: THE STEPS INVOLVED IN CONDUCTING A FOLLOW-UP VISIT

I. BEFORE THE VISIT

- ☐ Set a time and date for the visit.
- ☐ Prepare forms and materials.
- ☐ Arrange transport.

II. DURING THE VISIT

The follow-up visit has five main parts: 1) introduction; 2) review the previous Family Care Plan; 3) reassess family/child needs; 4) prepare an updated Family Care Plan; and 5) set a time for the next visit.

*** If adults/children are in critical condition, arrange referrals immediately.**

1. INTRODUCTION

- ☐ Warmly greet the family and children.
- ☐ Make friendly conversation with the family members for a few minutes.

2. REVIEW THE PREVIOUS FAMILY CARE PLAN

- ☐ Review the previous Family Care Plan with the family; assess what has been done or not done.

3. REASSESS FAMILY/CHILD NEEDS

Start with the physical needs assessment (assess on every visit)

A. Ask about current or recent health problems of adults and children.

- ☐ Pain; fever; diarrhea; constipation; nausea/vomiting; lack of appetite/nutrition; painful mouth/throat; skin problems/itchiness; inability to sleep; fatigue
- ☐ If a child is under 5, ask if the child is HIV-exposed/infected or on ART; if there are HIV-infected adults watch for danger signs, refer immediately if identified.
- ☐ Ask to see ART Book; ask if enrolled in CCC or ART Center if there is no ART Book.
- ☐ Ask about/to see any **medicines being taken** (e.g. for symptoms, ART, cotrimoxazole, other TB medicines)

B. Health Check: Vital Signs

- ☐ Wash hands.
- ☐ Check temperature using back of hand to forehead method.
- ☐ Check respiration.

C. Conduct a basic physical assessment.

- ☐ Head, face, eyes, mouth
- ☐ Lymph nodes around the neck and under the arms
- ☐ Skin

D. Provide care and health information.

- ☐ Discuss findings with family and make recommendations on care needed.
- ☐ Provide care or care education or help with medical referral if needed.
- ☐ Wash hands.

E. After providing care.

- ☐ Provide adherence assessment if on cotrimoxazole, TB treatment, or ART.
- ☐ Pill count; check time medications are taken daily; check for side effects.
- ☐ PPTCT: If HIV exposed child under 18 months, check if they are taking cotrimoxazole and if he/she is adhering; counsel parents regarding HIV testing.
- ☐ Assess infant feeding for child under six months; counsel as needed.
- ☐ Provide HIV prevention support and condoms as needed.

F. Assess nutritional and food security status.

- ☐ Assess for enrollment in Anganwadi Center (ages 3-6).
- ☐ Growth monitoring (monthly for all children 0-5; twice yearly for children living with HIV and AIDS (CLHA) ages 6-18).
- ☐ If a child is not growing well, develop a plan of action and follow up.
- ☐ Provide nutritional counseling; refer for nutritional cooking demonstrations.
- ☐ Assess food security status/progress in food security program (e.g., kitchen garden).

G. Ask about safety net.

- ☐ Ask about economic, housing situation.
- ☐ Check if the family is enrolled or needs support to enroll in self-help groups (SHG)/ micro enterprise.
- ☐ Assess for enrollment, progress in other schemes: widow, subsidized rice, etc.

H. Ask about psychosocial needs.

- ☐ Ask about emotional wellbeing of adult and children; provide counseling as needed.
- ☐ Check for LSE enrollment/plan for enrollment.
- ☐ Check for any problems related to stigma and discrimination.
- ☐ Assess for caregiver/parent future planning: guardian, disclosure, will, etc.

I. Ask about education.

- ☐ Ask for enrollment in school for school-going children.
- ☐ Are they going to school regularly? If not, assess the reasons.

4. PREPARE UPDATED FAMILY CARE PLAN

- ☐ Summarize main needs.
- ☐ Update Family Care Plan.
- ☐ Help family and children to prioritize what is most important.
- ☐ Complete the Family Care Form, including actions, who is responsible, and next steps.

5. END OF VISIT

- ☐ Ask the client and caregiver if they have any other questions or requests.
- ☐ Summarize the visit findings and next steps.
- ☐ Thank the family and let them know you will do your best to support them.
- ☐ Arrange and help with referrals if necessary.
- ☐ Schedule a time and date for your next visit.

III. AFTER THE VISIT

- ☐ Review family-file forms to ensure they are correct.
- ☐ Place the family file in the locked filing cabinet where files are kept.
- ☐ Follow up on any referrals.
- ☐ Debrief with your supervisor as needed.

SESSION 2.3, HANDOUT 3: FAMILY CASE MANAGEMENT CASE STUDY

Satya is 6 years old and Shanti is 2. They lost their parents to HIV about six months ago. They are staying with their aunt and uncle who have two children, Mallika, age 4, and Sitha, age 7.

The family is very poor and lives in Guntur. The uncle is a farmer and has a hard time earning enough to meet the basic needs of the family. Sometimes he gets part time work as a truck driver and travels all around southeast India.

The FCM comes during the mid-morning of a weekday to provide a follow-up visit. She gives a big hug to Satya and Shanti, asks them how they are doing, and praises them. Shanti is very small for her age. Mallika and Sitha are sitting farther away, working on mending clothes. Mallika has reddish hair and is also very small.

The FCM sits down with the aunt and uncle and asks Satya and Shanti to sit with them. The FCM brings out the previous visit's Family Care Plan and reviews the action steps that they agreed needed to be taken for Satya and Shanti. The FCM reported she had enrolled Satya in school and would provide support to ensure he could stay in school. She also said that Shanti had been enrolled in the Anganwadi.

The FCM starts the process of identifying any new needs in order to update the Family Care Plan. She asks the family if there are other needs. The aunt says life is hard, they don't have enough money to send their children to school. She says she also wishes her daughter Mallika could join the Anganwadi.

SESSION 2.3, HANDOUT 4: PRIORITIZATION TOOL FOR FAMILY CASE MANAGER VISIT TO HOUSEHOLDS

This tool is intended to guide family case managers and community workers in prioritizing their field visits, so that households with greater need are visited more frequently. **FCMs would visit each household at least once a month in the first six months after enrollment of the family in the program.** Beyond this visit, more visits should be planned based on Criteria 2.

1. FCM, along with community volunteer, makes the initial visit to all the households.
    a. Builds rapport with the household.
    b. Prepares the family file. (Color code the family file: orange for priority family and green for standard family.)
    c. Prepares a family care plan.
    d. Based on the family care plan, identifies which households fall into the priority category and which will require less frequent visits.
2. A subsequent visit by the FCM team (either the FCM or the CV) to the households would be prioritized. The following households would be given priority for follow up visits:

Whom to visit	Frequency	What will be done during the visit
Child-headed households	Once a fortnight	• Regular follow-up
Child recently tested HIV-positive (less than 3 months)	Once a fortnight until registered at ART Center	• Registration at ART Center • Motivating other family members for testing
Child recently started on ART (< 6 months)	Once a fortnight for the first 6 months. If possible, the FCM should visit the household just after the ART °prescription has been made to assess how well the caregiver and child understand adherence.	• Adherence monitoring • Adherence counseling
Child on ART (>6 months)	Once a month	• Adherence monitoring • Adherence counseling

Whom to visit	Frequency	What will be done during the visit
Danger signs in children. e.g., high fever, acute severe malnutrition, child not taking food, etc.	Once a week until child recovers	• Immediate accompanied referral to the nearest health provider e.g., PHC/CCC/ Private Practitioner
Adult recently tested HIV-positive (less than 3 months)	Once a fortnight until registered at ART Center	• Registration at ART Center • Discordant couple counseling • Motivating other family members for testing • Positive prevention
Adult recently started on ART (< 6 months)	Once a fortnight for the first six months. If possible, FCM should visit the household just after ART prescription has been made to assess how well the caregiver and child understand adherence.	• Adherence counseling
Discordant couple (as soon as you come to know)	Once a week for the first month followed by a visit at least once a month	• Awareness about risks of transmission • Awareness of safe sex practices including FP choices • Awareness of positive living • Awareness of importance of early treatment, including ART and PPTCT • Disclosure of status
HIV-positive pregnant women	Once a month until delivery	• Linking to PPTCT plus an outreach worker • Infant feeding advice • IFA supplementation for mother • Encouraging spousal testing
Lactating HIV-positive women with a child less than 6 months old	Once a month until child is 6 months old	• Linking to PPTCT plus an outreach worker • Infant feeding advice • Encouraging spousal testing
Elderly caregivers/ grandparents of children infected or affected by HIV	Once a month	
Recent death in the household	Once a week for one month immediately after death	• Bereavement counseling

Whom to visit	Frequency	What will be done during the visit
Highly and moderately food insecure households	Once a fortnight	
Adult/Child on TB Treatment	Once a month for the entire duration	• Adherence counseling

Others you may visit could include children who are not attending school regularly; children who have never enrolled in school; and children with emotional problems (withdrawn, self-isolated, sad, anxious).

Note: The prioritization of families is not always fixed. For some it will change over time.

SESSION 2.3, HANDOUT 5: FAMILY CARE PLAN

Family Care Plan

Household Code: _____

Head of Household Name: _____

Prepared by (Name) FCM/CW: _____

Date	Need No. #	Main concerns or needs	Actions to address needs (Direct care or referral)	Person(s) responsible	Date when action taken/ completed	Outcome/ Follow-up

SESSION 2.4: COMMUNICATING WITH CHILDREN AND ADULTS

Learning Objectives:

- Explain ways in which children communicate at different ages.
- Demonstrate how to communicate with children of different ages.
- Explain the difference between adult and child communication.

Time:

2 hr 45 min

Methodology:

- Brainstorming
- PowerPoint presentation 2.4, Communicating with Children and Adults
- Role plays
- Group work

Materials Needed:

- LCD and laptop
- Colored markers
- Flipchart paper

Handout:

- Communicating with Children
- Communicating with Children: Role Play Scenarios

Activities:

1. Ask participants to form a circle. Tell them you are going to whisper a sentence into the ear of the first participant. Each participant will then whisper the sentence to the person sitting next to him/her. The sentence can only be whispered one time, and the person receiving the message cannot ask for clarification. As the facilitator, ensure the message makes it to each participant and that it is whispered only once to each person. After the message has reached the last person, ask that person to say the sentence he/she heard aloud. Then, share the sentence you whispered to the first participant with the group. Discuss briefly what was learned from the activity. Focus on the dangers of one-way communication and of how information can be changed when it goes through many people. This is because we each have a different "filter" for hearing information.
2. Introduce the session to the participants. Start the presentation.

3. Discuss and brainstorm with participants on kinds of nonverbal communication. Ask participants to pair with other participants and to communicate "I love you" between adults and "I love you" between an adult and a child, first verbally and then non-verbally. Emphasize that the majority of communication (80 percent) is nonverbal (and even more so for children).
4. Brainstorm with participants on what some of the characteristics and aspects are of good communication and bad communication. List these and then discuss the slides describing the same. Discuss active listening and what it entails.
5. Divide all participants into four groups to enact a role play (Session 2.4 Handout 2). Groups A and B are FCMs and Groups C and D are clients. Participants will be paired together with one acting as the FCM and the other as the client. For this role play to be successful, you need to bring each group up separately to hear their instructions from the facilitator. First ask Groups C and D to come up together. Tell them that they will be clients who want to get tested for HIV and would like some more information from the FCM in order to feel confident of their choice. Tell Groups C and D to try hard to ask many questions about testing to the FCM. Then ask them to sit down and pair with an FCM **after** instructions are given to the FCMs. Next, ask Group A to come up to talk with you. Secretly tell Group A participants that they will be "bad" FCMs. When the client asks them questions, they will not answer them well, they will look bored, check their watches, etc. Remind Group A FCMs that they cannot tell their clients about their assignment until the end of the exercise. Ask Group A to find clients to pair with. Then, ask Group B to come up to the front of the room. Tell Group B that they will be excellent FCMs: they will demonstrate good verbal and non-verbal communication skills; they will actively listen to their clients; and they will do their best to support them. Then ask them to go find a client to pair with. Once everyone is matched up, ask participants to start the role play (give them about five minutes). Walk around the room during the role play to observe the interactions between participants. After the role play has been concluded, ask the clients to describe negative experiences they had with their FCM. Ask participants to describe how it made them feel. Emphasize the impact of FCMs being distracted, bored, etc. when with their clients. Then ask clients for examples of good communication, again emphasizing the positive impact of good communication skills on clients.
6. Brainstorm if child communication is different from adult communication. Describe the different age groups of children and what kind of communication is appropriate for each group. The key message should be that communication varies, even among children based on their age and stage of development.

7. Divide participants into five groups and assign one case study to each group. All groups get 10 minutes to prepare and 5 minutes to perform. After each role play, discuss their feedback with the larger group. The key message that needs to be covered through the role plays is age-appropriate communication. Depending on the age groups of each of the children in the different role plays, the FCM needs to be able to communicate effectively.
8. Summarize the session by defining the role of the FCM in communication.

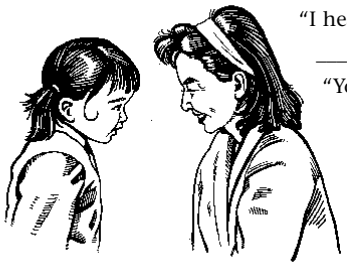
BRIGHT FUTURES TOOL FOR FAMILIES

Communicating with Children

Children develop a sense of their own self-worth and of how you feel about them from how you communicate with them. This tool offers information and ideas that may help foster communication between you and your child.

LISTENING TO CHILDREN

- Listen with your feelings and your eyes, not just your ears. Watch for and respond to your child's attempts to communicate.
- Your child will often express himself indirectly, especially when he is experiencing strong emotions. His actions usually reflect feelings more effectively than words (e.g., he may slink away when ashamed or jump up and down when proud).
- The best listening is silent listening. Keep your eyes on your child, and do not engage in other activities while you are listening.
- During early childhood, children often express themselves through stories about other people, imaginary friends, or animals who do things that the children would like to do or are afraid of or feel guilty about doing.
- If you sense that your child is feeling a certain emotion, she probably is. Ask her about it, or guess, and request feedback.
- Rephrase what your child is saying to reflect both its content and its feelings without adding your own interpretation. Say something like,



"I hear you saying _____ _____."

"You seem to feel _____ _____."

Be aware that your posture and tone of voice can affect how your child communicates with you. You may need to help your child put words to the feelings that he is expressing through body language or actions. Pausing before immediately suggesting solutions or giving directives allows your child a chance to solve the problem on his own.

- When listening to your child, try not to let your own emotions show to an extent that may limit your child's sense of being free to express herself. Be nonjudgmental about your child's expression of feelings, even when limits for her actions are needed.

TALKING TO CHILDREN

- Keep praise, instructions, and corrections short, simple, and specific, even for very verbal children. This increases the chances that your child will get the message rather than get distracted.

(continued on next page)

Communicating with Children (continued)

- Give praise or thanks for small, specific actions, rather than making generalizations that your child may not believe (e.g., "You combed your hair so well!" rather than, "You're the best girl in the world!").
- Ask a follow-up question to show you are really interested.
- Aim for praise to outnumber correction by 10 to 1.
- Provide comments to your child frequently to let him know you are thinking about him.
- Use plenty of nonverbal praise such as touches, hugs, winks, pats, or stickers.
- Praise your child's actions to other adults when she can hear you to reinforce its impact.
- Correct your child in private when possible, especially away from peers or siblings.
- Praise your child for not misbehaving in a way he might have considered (e.g., "I am proud of you for staying calm," "Thank you for not touching the plates at the store.").
- Avoid diminishing praise by adding a complaint or criticism to it (e.g., "Thanks for cleaning up your room! Why don't you do this every time I ask?").
- Use statements that begin with "I" to show your own reaction and avoid being discounted (e.g., "I really like the way you were sharing your crayons with your sister.").
- Share your own feelings both as a model and to let your child know she is not the cause of all your upsets.
- As your child gets older, work toward having her assess her own performance (e.g., "What do you think of your drawing?").

Cite as: Howard BJ. 2002. Communicating with children. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

SESSION 2.4, HANDOUT 2: COMMUNICATING WITH CHILDREN ROLE PLAY SCENARIOS

1. Prita lives with her grandmother. She is 1 year old and is walking. She is smiling but is shy of you, the FCM. What will you do to communicate with this child to begin to develop trust with her and show her you care? Please prepare a 5-minute role play showing how you will communicate with a 1-year-old.
2. Haroon is 4. He is active and likes to draw, run, and play games. You come to visit Haroon's mother and see him playing outside the house with a ball. How will you as the FCM communicate with Haroon to let him know that you like him? Please prepare a 5-minute role play to show how you will communicate with Haroon.
3. Gita is 7. She is a bit shy and likes to draw. She's busy drawing a picture when you come to the house. She is doing well in school and likes math. How will you communicate with Gita? Please prepare a 5-minute role play to show how you will communicate with Gita.
4. Manoj is 11. He loves school and learning about science, especially about animals. He's very interested in animals and takes care of a dog and frog as pets. He always wants to learn more about animals and how to care for them. How would you communicate with Manoj at this age? Please prepare a 5-minute role play demonstrating how you would communicate with Manoj.
5. Mandeep is 15. He is very interested in hanging out with his friends and does not spend much time with his parents. He is trying to decide what to do with his future. His parents want him to start working in the family store and get married soon but he wants to study more. How would you as the FCM communicate with Mandeep? Please prepare a 5-minute role play demonstrating how you would communicate with Mandeep.

Section 3: Health Needs of Children Living with and Affected by HIV

This section reviews the essential health needs of children, physical assessments, HIV testing, care and treatment, and adherence issues.

SESSION 3.1: UNDERSTANDING ESSENTIAL HEALTHCARE NEEDS OF CHILDREN

Learning Objectives:

- Describe basic physical needs of all children.
- List essential health services needed by all children: immunizations, deworming, Vitamin A supplementation, growth monitoring, regular health checks.
- List five danger signs that require immediate referral in children under 5.

Time:

1 hr

Methodology:

- Brainstorming
- PowerPoint presentation 3.1, Understanding Essential Healthcare Needs of Children

Materials Needed:

- LCD and laptop

Handouts:

None

Activities:

1. Focus participants' attention on children's need for health services. Ask: **What essential health services do children need?** List answers on a flipchart. Answers should include: Antenatal care, immunizations, deworming, Vitamin A supplementation, growth monitoring, and regular health checks.
2. Start presentation. Link the presentation with the flipchart.
3. Ask about danger signs. A danger sign is a health abnormality that requires immediate referral to a health facility. Tell participants that children under 5 are especially vulnerable to diseases that can be serious and if not treated can make them very sick or lead to death. Problems that can be very serious for children are: convulsions, diarrhea, fever, difficulty breathing, malnutrition, and childhood diseases. Ask participants what they think are other danger signs that they might see in children under 5 and list their ideas on flipchart paper. The FCMs will need to look out for and ask the family of children under 5 if:
    a. The child is unable to drink or breastfeed.
    b. The child vomits everything.
    c. The child has had convulsions with the illness.

d. The child is having difficulty breathing, is breathing quickly, or is bluish.

e. The child has chronic diarrhea (more than three days).

f. The child is lethargic or unconscious.

g. The child is pale and/or looks very thin for his/her age.

h. The child is in severe pain.

4. Remind FCMs that if they see these danger signs they need to refer the child to the hospital immediately. Brainstorm with participants on other possible roles of an FCM in supporting a child's normal growth and development.

SESSION 3.2: HOW TO DO A BASIC PHYSICAL ASSESSMENT OF ADULTS AND CHILDREN

Learning Objectives:

- List key steps in assessing physical needs.
- Practice making a step-by-step assessment of needs, determining danger signs, facilitating access to services, and ensuring medicine adherence.

Time:

1 hr 30 min

Methodology:

- Demonstration
- PowerPoint presentation 3.2, How To Do a Basic Physical Assessment of Adults and Children
- Group practice

Materials Needed:

- LCD and laptop

Handout:

- Doing a Basic Physical Assessment (long and short versions)

Activities:

1. Refer to the flip chart pasted on the wall describing the steps of a home visit, which was discussed the previous day. Mention that a physical assessment is part of a needs assessment during a home visit.
2. Demonstrate how a physical assessment is conducted: 1) handwashing, 2) checking vital signs, 3) conducting a physical, 4) handwashing, and 5) if needed, care provision (which may require further handwashing – e.g., cleaning a wound).
3. Ask participants to get into pairs and follow the facilitator as each step is demonstrated, practicing on their partner.
4. After this is done, ask all pairs to practice the whole process on each other. The individual in the pair who was the FCM during the previous step should now be the client so each participant has the chance to practice. Walk around the room and observe the practice of each pair. Correct their practice as needed and answer questions.
5. Tell participants that they will continue to practice throughout the training and during the practicum at the end of the training.
6. Summarize and close the session.

SESSION 3.2, HANDOUT 1: DOING A BASIC PHYSICAL ASSESSMENT-LONG VERSION

After you have *observed, asked, and listened*, you will need to *look and feel* to gain a better understanding of the symptoms faced by your client and to understand what is normal physically for your client.

Explain to your client that you would like to physically examine him/her to get a better idea of how he/she is doing. Ask your client if it is OK if you touch them. If your client agrees, start the basic physical assessment. *Pay special attention when you do the basic physical assessment to the areas of the body where your client says he/she is having a problem.*

Doing the physical assessment is very important because it helps you to know what is normal for your client. If you know what is normal, you will also be better able to recognize what is abnormal – that is, if there is something wrong with your client.

The steps below explain how to do the basic physical examination and what to do if you find certain physical problems.

1. Vital Signs

- Check temperature by:
  - Placing the back (not palm) of your hand on your forehead and the client's forehead. Leave your hands there until you begin to feel differences between the temperatures of your head and theirs. The temperature between you and the client will feel the same if you are both normal. If the client has a fever, you will feel a difference; his/her forehead will feel hotter than yours. The greater the difference you feel between yourself and the clients, the higher your client's temperature likely is. This is not an exact method but if you do not have a thermometer it can give you an idea if your client has a fever.
- Check the breathing (respiration rate) of your client:
  - The respiration rate is the number of breaths a person takes per minute. To check the rate of your client, count the number of breaths he/she takes in one minute by counting how many times his/her chest rises. You may put your hand on the belly of the client to feel the movement.
    - Respiration rates may increase with fever, illness, and with other medical conditions.
    - When checking respiration, it is important to also note whether a person has any difficulty breathing. *(At rest, a normal respiration rate for a healthy adult ranges from 13 to 20 breaths per minute. A respiration rate over 25 or below 12 breaths per*

minute when at rest is a sign that the client is in ill health and that he/she needs to be referred to the hospital. If the client is having difficulty breathing, this is very serious and means that he/she needs to be referred to the hospital urgently.)

2. Physical Exam

Start with the head and then work your way down to the eyes and mouth.

- Observe the person's face in general.
  - Does the skin color look normal?
  - Does the person look very pale, almost blue?
  - Does the person's face look yellow?

    (A bluish face, particularly lips, is a danger sign. Arrange immediate transfer to the hospital. A yellow face possibly indicates problems with the liver. Refer the client to the hospital.)
- Now, look into the person's eyes. See if his/her eyes
  - are yellow
  - are very red
  - have unusual spots
  - have sores near/around them
  - show a pink rash near/around them
  - are sunken

    (If you see any of these problems it is a sign that something is wrong and you need to refer the person to the hospital.)
  - Gently pull down the lower eyelid to see the color of the skin. If it is very light (pale), and not pink/red, then this could be a sign of anemia.

    (If you think the person may have anemia, refer him/her to the hospital. This could be a danger sign if the person is taking ARVs.)
  - Ask the client if:
    * his/her eyes are very itchy
    * he/she is having any difficulty seeing
    * he/she feels pain in his/her eyes

      (If the person says yes to the above, this is a sign that something is wrong and you need to refer the person to the hospital.)

- Now, look at the person's mouth.
  - Are his or her lips very dry or cracked?

    (If the person has dry lips, teach your client and his/her family how to keep the lips moist.)
  - Does the person have any blisters or ulcers on his or her lips?

    (If the person has blisters, ask if they are painful. If yes, refer the person for treatment for pain. Also ask if the person has other blisters on the body and if they are painful. If so, this is a sign that something is wrong and that you need to refer the person to the hospital.)
- Now, ask the person to open his/her mouth.
  - Look at the person's tongue.
    * Are there white, patchy spots on the person's tongue?
    * Can he/she swallow easily or not? If not, is the person able to eat? Drink? Take medicines?

      (If the person has white, patchy spots on his or her tongue, refer him/her to the doctor and also teach the PLHIV and family members how to provide mouth care. If it is painful for the person to swallow, eat, drink, and/or take medicines, this is a danger sign, and you need to refer him/her to the hospital.)
  - Look at the person's gums and teeth.
    * Are the gums red and bleeding?
    * Does the person have any tooth pain (tooth decay)?
    * Does the person have bad breath?

      (If the person has these problems, please show the client and family members how to keep the mouth and teeth clean through regular brushing and gargling with salt. Also, refer the person to the hospital if he/she has tooth pain/decay or bleeding gums.)
- Feel the lymph nodes, first along the side of the neck.
  - Feel for a hard lump under the ear and the jaw.
    * If you feel nothing, this is normal.
    * If you feel small hard lumps:
      - √ Ask the client if it is painful for you to touch them.
      - √ Note if the hard lumps are only on one side, or on both sides of the neck.

(If a person has this problem, it could be normal, or it could be the sign of an infection. If the client also has other symptoms [fever, difficulty swallowing, cough], this is a sign that something is wrong and you need to refer the person to the hospital.)

- If you feel/see large hard lumps:
  - Ask the client if it is painful for you to touch him/her.
  - Note if the hard lumps are only on one side, or on both sides of the neck.
  - Ask if it is also difficult for the client to swallow.

    (If the client has this problem, this is a sign that something is wrong and you need to refer the person to the hospital.)
- Feel for a hard lump in the underarms of your client.
  - Ask the client if it is painful for you to touch him/her.
  - Note if the hard lumps are only on one side, or on both sides.

    (If the client has this problem, it could be normal, or it could be the sign of an infection. If the client also has other symptoms (fever, skin infection near the underarm, sore breasts/nipples – if female; cough), this is a sign that something is wrong and you need to refer the client to the hospital.)

- Look at and feel the skin of the client.
  - Note: If you observe a rash on the trunk, arms, or legs this could be the sign of a serious problem. Please refer your client to the hospital as soon as you can.
  - Look at the skin of the trunk, front, and back.
    - Does the skin look dry and scaly?

      (If the client has dry skin, teach your client and family how to keep the skin moist.)
    - Does the client have a rash? Lumps? Is he/she itchy?
  - Does the client have a wound or abscess? Are they infected? (Pus, red, swollen?)
    - Does the client have blisters that are all together on one part of the back or stomach? Are these blisters painful?

      (Provide appropriate care for the skin problem [see self-care book]. If there is a wound that is very infected, this is dangerous, especially if the client also has a fever. Refer the client to the hospital.)

— Look at and feel the arms, hands, and legs of the client.

* How do the person's nails look? Are they an abnormal color (blue, red, black?)
* Does the skin look dry, scaly?
* When you do the dehydration skin-test, does the skin return quickly to its normal place or not?

  (If the person has dry skin, moisten the skin with a little water, then apply petroleum jelly. Teach your client and family how to keep the skin moist. If the dehydration skin-test shows that the client is dehydrated, you will need to encourage him/her to drink ORS and refer the client to the hospital as soon as possible.)
* Does he/she have a rash? Lumps? Is he/she itchy?
* Does he/she have a wound or abscess? Are they infected? (Pus, red, swollen?)
* Does he/she have blisters that are all together on one part of the back or stomach? Are these blisters painful?

  (Provide appropriate care for the skin problem [see self-care book]. If there is a wound that is very infected, this is dangerous, especially if the person also has a fever; refer the client to the hospital.)
* Discuss: Once you have completed the basic physical examination, explain clearly, using common language to tell your client what you have found. Discuss with the PLHIV and the family what you think needs to be done.

Normal Vital Signs	
Age	**Respiratory rate/min**
< 1 day	40-60
1-2 days	40-60
3-6 days	40-60
1-3 weeks	40-60
1-2 months	23-39
3-5 months	23-39
6-11 months	23-39
1-2 years	22-31
3-4 years	20-27
5-7 years	18-24
8-11 years	17-22
12-15 years	14-21
15-18 years	13-21
> 18 years	12-20
Pregnant women	12-20

- Decide/Do: Take action as agreed mutually by the PLHIV, family, and you.

Follow up and repeat: When you visit your client again, refer to the findings and actions to be taken as decided at the last visit. Review how the client feels now; ask about what action was taken, and then do another basic physical assessment to compare the wellbeing of the client today with his/her wellbeing at the last visit.

SESSION 3.2A: CHILD STATUS INDEX

Learning Objectives:

- Describe the importance of the Child Status Index.
- Explain how to use the Child Status Index form.
- Practice use of the form.

Time:
45 min

Methodology:

- Group practice

Materials Needed:

- LCD and laptop
- Whiteboard
- Markers

Handout:
Child Status Index and Child Status Record

Activities:
Introduce the Child Status Index (CSI). Provide the Child Status Index tool and discuss the different domains and scoring with participants. Emphasize that it is best if the form is completed in the home so that the FCMs do not forget anything regarding the wellbeing of the child. Describe what an important tool the CSI is for tracking changes (improvements or otherwise) in children. Explain that it is a "thermometer" for FCMs in telling how well each child they care for is doing. Tell them that this needs to be used for all children in the household once every six months. The use of the index will help them in assessing if the services provided by them are leading to changes in the children.

CHILD STATUS INDEX (CSI)

DOMAIN	1 — FOOD AND NUTRITION		2 — SHELTER AND CARE		3 — PROTECTION	
	1A. Food Security	1B. Nutrition and Growth	2A. Shelter	2B. Care	3A. Abuse and Exploitation	3B. Legal Protection
GOAL	*Child has sufficient food to eat at all times of the year.*	*Child is growing well compared to others of his/her age in the community.*	*Child has stable shelter that is adequate, dry, and safe.*	*Child has at least one adult (age 18 or over) who provides consistent care, attention, and support.*	*Child is safe from any abuse, neglect, or exploitation.*	*Child has access to legal protection services as needed.*
Good = 4	Child is well fed, eats regularly.	Child is well grown with good height, weight, and energy level for his/her age.	Child lives in a place that is adequate, dry, and safe.	Child has a primary adult caregiver who is involved in his/her life and who protects and nurtures him/her.	Child does not seem to be abused, neglected, do inappropriate work, or be exploited in other ways.	Child has access to legal protection as needed.
Fair = 3	Child has enough to eat some of the time, depending on season or food supply.	Child seems to be growing well but is less active compared to others of same age in community.	Child lives in a place that needs some repairs but is fairly adequate, dry, and safe.	Child has an adult who provides care but who is limited by illness, age, or seems indifferent to this child.	There is some suspicion that child may be neglected, over-worked, not treated well, or otherwise maltreated.	Child has no access to legal protection services, but no protection is needed at this time.
Bad = 2	Child frequently has less food to eat than needed, complains of hunger.	Child has lower weight, looks shorter and/or is less energetic compared to others of same age in community.	Child lives in a place that needs major repairs, is overcrowded, inadequate and/or does not protect him/her from weather.	Child has no consistent adult in his/her life that provides love, attention, and support.	Child is neglected, given inappropriate work for his or her age, or is clearly not treated well in household or institution.	Child has no access to any legal protection services and may be at risk of exploitation.
Very Bad = 1	Child rarely has food to eat and goes to bed hungry most nights.	Child has very low weight (wasted) or is too short (stunted) for his/her age (malnourished).	Child has no stable, adequate, or safe place to live.	Child is completely without the care of an adult and must fend for him or herself or lives in child-headed household.	Child is abused, sexually or physically, and/or is being subjected to child labor or otherwise exploited.	Child has no access to any legal protection services and is being legally exploited.

DOMAIN	4 — HEALTH		5 — PSYCHOSOCIAL		6 — EDUCATION AND SKILLS TRAINING	
	4A. Wellness	4B. Health Care Services	5A. Emotional Health	5B. Social Behavior	6A. Performance	6B. Education and Work
GOAL	*Child is physically healthy.*	*Child can access health care services, including medical treatment when ill and preventive care.*	*Child is happy and content with a generally positive mood and hopeful outlook.*	*Child is cooperative and enjoys participating in activities with adults and other children.*	*Child is progressing well in acquiring knowledge and life skills at home, school, job training, or an age-appropriate productive activity.*	*Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job.*
Good = 4	In past month, child has been healthy and active, with no fever, diarrhea, or other illnesses.	Child has received all or almost all necessary health care treatment and preventive services.	Child seems happy, hopeful, and content.	Child likes to play with peers and participates in group or family activities.	Child is learning well, developing life skills, and progressing as expected by caregivers, teachers, or other leaders.	Child is enrolled in and attending school/training regularly. Infants or preschoolers play with caregiver. Older child has appropriate job.
Fair = 3	In past month, child was ill and less active for a few days (1 to 3 days), but he/she participated in some activities.	Child received medical treatment when ill, but some health care services (e.g. immunizations) are not received.	Child is mostly happy but occasionally he/she is anxious, or withdrawn. Infant may be crying, irritable, or not sleeping well some of the time.	Child has minor problems getting along with others and argues or gets into fights sometimes.	Child is learning well and developing life skills moderately well, but caregivers, teachers, or other leaders have some concerns about progress.	Child enrolled in school/training but attends irregularly or shows up inconsistently for productive activity/job. Younger child played with sometimes but not daily.
Bad = 2	In past month, child was often (more than 3 days) too ill for school, work, or play.	Child only sometimes or inconsistently receives needed health care services (treatment or preventive).	Child is often withdrawn, irritable, anxious, unhappy, or sad. Infant may cry frequently or often be inactive.	Child is disobedient to adults and frequently does not interact well with peers, guardian, or others at home or school.	Child is learning and gaining skills poorly or is falling behind. Infant or preschool child is gaining skills more slowly than peers.	Child enrolled in school or has a job but he/she rarely attends. Infant or preschool child is rarely played with.
Very Bad = 1	In past month, child has been ill most of the time (chronically ill).	Child rarely or never receives the necessary health care services.	Child seems hopeless, sad, withdrawn, wishes could die, or wants to be left alone. Infant may refuse to eat, sleep poorly, or cry a lot.	Child has behavioral problems, including stealing, early sexual activity, and/or other risky or disruptive behavior.	Child has serious problems with learning and performing in life or developmental skills.	Child is not enrolled, not attending training, or not involved in age-appropriate productive activity or job. Infant or preschooler is not played with.

Child Status Record

Child's Name: _____ Age in years: _____ Gender: F/M ___ Child ID:_____

Location: District _____ Ward/Division:_____ Village/Neighborhood:_____

Caregiver's Name: _____ **Relationship to Child:** _____

I. CSI SCORES:	**Date:**	**Evaluator's Name or ID:**
Domains	***Scores** (Circle One)*	**Action taken today:**
1 — FOOD AND NUTRITION		
1A. Food Security	**4 3 2 1**	
1B. Nutrition and Growth	**4 3 2 1**	
2 — SHELTER AND CARE		
2A. Shelter	**4 3 2 1**	
2B. Care	**4 3 2 1**	
3 — CHILD PROTECTION		
3A. Abuse and Exploitation	**4 3 2 1**	
3B. Legal Protection	**4 3 2 1**	
4 — HEALTH		
4A. Wellness	**4 3 2 1**	
4B. Health Care Services	**4 3 2 1**	
5 — PSYCHOSOCIAL		
5A. Emotional Health	**4 3 2 1**	
5B. Social Behavior	**4 3 2 1**	
6 — EDUCATION AND SKILLS TRAINING		
6A. Performance	**4 3 2 1**	
6B. Education and Work	**4 3 2 1**	
Source(s) of information: *(Circle all that apply)*	Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other *(Specify)* : _____	

II. IMPORTANT EVENTS: *(Check any events that have happened since the last CSI assessment if applicable.)*			**Comment(s)** *if necessary:*
	___ Child left program	___ Family member died	
	___ Child pregnant	___ Change in caregiver/adoption	
	___ Child died	___ Change in living location	
	___ Parent ill	___ Community trauma (violence, famine, flood, etc.)	
	___ Parent/guardian died (specify who) _____	___ Other (Specify) _____	

III. TYPES OF SUPPORT/SERVICES PROVIDED *(at present):*	**What was provided?**	**Who provided services?** (e.g., NGO, neighbor, teacher, church, or other)
A. Food and nutrition support (such as food rations, supplemental foods)		
B. Shelter and other material support (such as house repair, clothes, bedding)		
C. Care (caregiver received training or support, child placed with family)		
D. Protection from abuse (education on abuse provided to child or caregiver)		
E. Legal support (birth certificate, legal services, succession plans prepared)		
F. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)		
G. Psychosocial support (clubs, group support, individual counseling)		
H. Educational support (fees waived; provision of uniforms, school supplies, tutorials, other)		
I. Livelihood support (vocational training, micro-finance opportunities for family, etc.)		
J. Other:		
Suggestions for other resources or services needed:		

SESSION 3.3: HIV TESTING AND COUNSELING FOR ADULTS AND CHILDREN

Learning Objectives:

- Describe the strategy used in identifying children for HIV testing.
- List steps to follow in referring children for testing.
- Describe the process of disclosure.

Time:

30 min

Methodology:

- PowerPoint presentation 3.3, HIV Testing and Counseling for Adults and Children
- Brainstorming

Materials Needed:

- LCD and laptop
- Whiteboard
- Markers

Handout:

HIV Testing and Counseling

Activities:

1. Start by asking the participants to list the possible reasons for early testing of children and identification of HIV. Write their responses on the whiteboard.
2. Start the presentation. Refer to the reasons mentioned on the whiteboard during the presentation.
3. Walk participants through the steps in the testing algorithm for children as well as adults.
4. Explain disclosure of status, including the risks and benefits of it.
5. Summarize and close.

Disclosure is a process. It doesn't need to happen all at once. This means there can be separate decisions about who should be told (and when and how and by whom), and how much information should be shared (how much detail). For example, very young children can be told using simple words that they have a chronic illness without mentioning HIV. As they grow older and become better able to understand and cope with the consequences of knowing their HIV status, children can be given more information.

If a child's HIV test comes back positive, keep in mind that there is no ideal age for children to learn their HIV status. The right time for this will depend on the child's age, maturity, and understanding.

With disclosure, one important rule to remember is: "Do not lie to the child." You may avoid going into details or saying everything all at once, but if you lie and the child finds out anyway (which often happens), the child may not trust you about other things in the future. Another rule is that you should always reassure the child that he or she is not alone, and that you will help in any way you can. You may also want to remind the child that having HIV is not a punishment – that is, it is not his/her fault.

After giving a child some new information, be sure to ask, "Is this clear?" or "Do you have any questions?" This may also be a good opportunity to check that the child has understood the information correctly.

Some things you may say to an HIV-positive child without disclosing full details:

If the child is sick: "You are sick right now, but we will give you medicine to make you feel better. The (HIV) test told the doctor what medicines you need."

If the child is not yet sick: "Inside your body there is a very small virus called HIV. We don't want it to make you sick. So we have encouraged your parent/caregiver to give you healthy food. And, when you need it, we will give you some special medicines. They will help you be strong."

For both sick and well children: "Lots of people have this, adults and children alike. It is not your fault. We (your family, the health workers, etc.) will help you. You can still go to school and play sports and do other things you enjoy. We love you and will take care of you. If you ever have any questions about this, you can always come and ask me."

When to Begin Disclosure

Disclosure may start as early as 5-7 years of age, but it must be done gradually and in a culturally sensitive manner, and with the consent and participation of the parent or caregiver. By disclosing

"gradually," this means sharing information within the immediate family first, and then slowly sharing with other people – as family members (including the child) see fit.

Basic issues to consider when working with families with HIV-infected children on matters of disclosure include the needs, feelings, and beliefs of the family and child.

Who Else Should Know?

Once the child is told about his or her HIV status – even just a little bit of information – the next question usually is, "Who else should know?" To the degree possible, the child should participate in (and have some control over) disclosure to others in the community. At least in the beginning, practice "shared confidentiality." This means that, unless it is absolutely necessary to tell someone of the child's status (for example, at a health center or clinic), it is optional. (If you don't want to tell someone, you can simply say, "This is a private issue.")

Once you start telling a lot of people, you lose control of who knows and who doesn't. This may be fine, but probably not in the beginning, and not until the child is comfortable with others knowing. Therefore, disclosure should be thought through very carefully before it takes place.

Note: If the child's HIV test comes back negative, you have an excellent opportunity to talk about HIV prevention with the child's family (and with the child directly, if he/she is an adolescent), e.g., abstinence, PPTCT, etc.

SESSION 3.4: HIV CARE AND TREATMENT

Learning Objectives:

- List the key services that need to be provided to women throughout the ANC period and to HIV exposed/infected children.
- Explain the importance of cotrimoxazole prophylaxis.
- Describe why palliative care and treatment are essential services for children and adults with HIV.
- Describe the mortality risk of children with HIV.
- List danger signs among children born to HIV-positive women, indicating a need for immediate referral.
- Describe the role of the FCM in ensuring client access to and retention in key services.

Time:

1 hr 15 min

Methodology:

- Brainstorming and open discussion
- PowerPoint presentation
- Case study

Materials Needed:

- LCD and laptop

Handout:

- Continuum of Care for Pregnant Women, HIV-exposed Children, and HIV-positive Children

Activities:

1. Explain that you will now talk about the continuum of healthcare needs in pregnancy, child birth, and infancy. Next, review the session learning objectives so participants know what will be covered.
2. Ask participants if they think HIV moves faster in children than it does in adults. If participants say it is faster in children, agree with them. Say that children's immune systems are so vulnerable when they are born that HIV can make children sick and kill them much faster than adults. Share the statistics with the participants about child mortality and HIV using the PowerPoint.

3. Use the case study of Lakshmi, which appears in the PowerPoint slides for this session, as a constant reference to discuss what kind of care and support should be provided to pregnant women, HIV-positive pregnant women, an exposed child, and an HIV-positive or negative child. Brainstorm on what care needs to be provided to all participants.
4. Discuss cotrimoxazole prophylaxis and why it is so important in the context of HIV.
5. Ask participants to recall the danger signs to look for.
6. Summarize the session and discuss the role of the FCM in the whole process.

SESSION 3.4, HANDOUT 1: CONTINUUM OF CARE FOR PREGNANT WOMEN, HIV-EXPOSED CHILDREN, AND HIV-POSITIVE CHILDREN

Pregnant Women	HIV-positive ANC	HIV-exposed Child	HIV-infected Child
• Early registration of pregnancy • At least three antenatal visits • ANC visits include: – Health check-ups – Pregnancy progress monitoring – Family planning advice – HIV testing – Infant feeding advice – Iron and folic acid supplementation – Tetanus toxoid injections	• Pregnancy options (MTP up to 20 weeks) • Safe sex counseling • Information on HIV care • Assessment and treatment of STIs • Institutional delivery; family planning options • NVP at start of labor • Infant feeding advice • Immunization • Cotrimoxazole prophylaxis and counseling • ART adherence counseling if initiated on ART during pregnancy	• NVP within 72 hrs of birth • Start cotrimoxazole prophylaxis at 6 weeks. Train the caregiver to administer. Check adherence at each visit. • Immunization – check card • Growth monitoring – check chart for each child. • **Exclusive** breast feeding and NO mixed feeding until 6 months; then wean and provide no more breast milk. • Education and support is provided to families in preventing childhood illness through hygiene and sanitation. • Provide nutrition counseling. • **HIV testing at the end of 18 months** (or at ~6 weeks when PCR available). • **Look for danger signs! Refer if child is very sick.**	• Immunization – check card • Growth monitoring – check chart for each child. • Provide nutrition counseling. • Support **cotrimoxazole prophylaxis**; counsel the caregiver in how to administer. This is very important! • **Refer the child to the ART Center** if not already on ART for baseline CD4 count. • **Watch out for danger signs.** Refer the child if he/she is very sick! • Ensure that the ART-eligible child is re-tested for **CD4 every three months.** • Check **ART adherence** and ensure caregiver understands how to give medicines. • Check the ART Center booklet every time a visit is made.

SESSION 3.4, HANDOUT 1, CONTINUED: CONTINUUM OF CARE FOR PREGNANT WOMEN, HIV-EXPOSED CHILDREN, AND HIV-POSITIVE CHILDREN

HIV-positive Child

1. Immunization – check card
2. Exclusive breastfeeding for up to 6 months. Continued breastfeeding up to the age of 2 or beyond.
3. Growth monitoring – check chart for each child.
4. Provide nutrition counseling.
5. Watch for danger signs and refer the child if he/she is very sick!

SESSION 3.5: ADHERENCE SUPPORT FOR CHILDREN AND ADULTS

Note to the Facilitator: Before you begin this session, give the participants sweets (three pieces per person). Tell them that they are to take the sweets as if they were antiretroviral drugs. Instruct them to take one dose in the morning at 9:30 am, and one in the evening at 9:30 pm. Tell them that you will check on their adherence at the beginning of the next day's session.

Learning Objectives:

- Define adherence.
- Name common ARVs used in AP for children and adults.
- List common side effects and ways of managing common side effects in the home.
- Recognize key danger signs related to ART.
- Describe the role of the FCM in supporting adherence.
- Practice providing medicine adherence support for cotrimoxazole, TB therapy, and ART to children and adults.
- Understand the role of key adherence tools like an ART calendar and pill boxes.

Time:

35 min

Methodology:

- Case study
- PowerPoint presentation 3.5, Adherence Support for Children and Adults
- Discussion

Materials Needed:

- Sample pill box

Handouts:

None

Activities:

1. After a recap of the previous day, remind the participants of the sweets that you gave them the previous morning. They had been asked to take them at 9:30 in the morning and at 9:30 in the evening.
2. On the day of this session, ask all trainees to stand. Say, "If you remembered to take your ARV drugs yesterday and today, keep standing. If you forgot, sit down. If you remembered

to take your ARVs at exactly the right time (9:30 in the morning and in the evening) keep standing. If not, sit down. If you have ever been 100% adherent to any prescribed medication (e.g., antibiotics)…have never forgotten a dose…always took medicines at the right time, stay standing. If not, sit down." Then, ask participants to list reasons why they forgot their ARVs or other medicines. List these reasons on flip chart paper. Then, ask those who remained standing the longest what helped them remember to take their medicines on time.

3. Ask participants if they know what adherence is? Explain that it means taking the right amount of medicine on time and in the right way every day for as long as the medicine is prescribed. The lives of children with HIV depend on taking the medicines correctly 100% of the time. If the drugs stop working for them, there may not be alternatives. Ask participants if they know of any children who are taking cotrimoxazole, TB medicines, and/or ART? Ask participants to share what they see these children and their families doing to remember to take their medicines on time. Then ask FCMs what they can do to help children remember to take their medicines on time.
4. Continue with the PowerPoint presentation.
5. Summarize and close.

SESSION 3.6: BRINGING IT ALL TOGETHER

Learning Objectives:

- Practice communication skills, case management steps, and physical assessment and basic symptom/side effect care learned in three days through role play.
- Receive feedback from trainers and peers.

Time:

2 hr 30 min

Methodology:

- Role play

Materials Needed:

- FCM visit checklist
- Family Care Plan
- Physical assessment steps

Handouts:

- Practicing Case Management, Communicating with Children, and Doing a Basic Physical Assessment (The last three handouts appear in previous sessions and should be used again. Practicing Case Management follows.)

Activities:

1. Divide the participants into five groups.
2. Distribute the role play scenarios to the groups. Give each group 20 minutes to prepare and 10 minutes each to do the role play.
3. Get feedback (positive followed by negative) from the participants after each role play and discuss.
4. Summarize the feedback after all role plays.

SESSION 3.6, HANDOUT 1: PRACTICING CASE MANAGEMENT

ROLE PLAY SCENARIOS

1. Anju was born about 18 months ago. Her mother Kamala was lucky because she was able to access PPTCT services at the hospital in Guntur. Both Anju and Kamala are taking cotrimoxazole. They are very good about taking their medicines together every day. Anju is not yet on ART and has mild symptoms (diarrhea, lack of appetite). Anju seems to be growing fine and is not sick too often but Kamala does not know about her daughter's HIV status. She is very scared to test her daughter because she does not think she can face the answer if her daughter is HIV-positive.

   What is the problem here? As the FCM, what can you do to help? Please act out a 10-minute role play, and use all the members of your team in the play. Use the FCM visit checklist to guide the steps of the visit. If it is a routine visit, complete the Family Care Plan after conducting the needs assessment and providing care.

2. Amresh is 10 months old. He has a cough and his chest is moving fast (up and down quickly) as if he is having difficulty breathing. You feel his forehead and compare it to yours. He feels very hot. Amresh's mother had HIV. She died a few months ago and Amresh's grandmother is now taking care of him. The grandma is not sure whether he has a serious problem. To her, it looks like the same problems many infants have. You ask if she has been giving Amresh his cotrimoxazole. She says her memory is not so good. She often forgets.

   What is the problem here? As the FCM, what can you do to help? Please act out a 10-minute role play. Use all the members of your team in the play. Use the FCM visit checklist to guide the steps of the visit. If it is a routine visit, complete the Family Care Plan after conducting the needs assessment and providing care.

3. Radhika is 4 years old. She has been on ART since she was 3. She is taken care of by her grandma, grandpa, and her father. She also has a 7-year-old sister and 12-year-old brother. When you visit her house, her father is not there; he is a migrant worker and gone for the harvest. While at the house you talk with Radhika and her grandparents. You ask how she is doing and ask to see her ART Book. You notice that there are a lot of ARV medicines left over for the month (still in the bag). You begin to ask the grandparents about how Radhika is taking the medicine and realize that the grandparents are not so clear. This makes you worry because if Radhika develops resistance to the medicines they will not work for her anymore!

   What is the problem here? As the FCM, what can you do to help? Please act out a 10- minute role play, and use all the members of your team in the play. Use the FCM visit checklist to guide the steps of the visit. If it is a routine visit, complete the Family Care Plan after conducting the needs assessment and providing care. Use the home-based care kit as a prop and other supplies to as needed for the role play.

4. You visit Gautam. He is a 2-year-old with HIV but does not seem very active. He looks very small for his age. He lives with his uncle and aunt, since both his mum and dad are dead. This is your first visit to the house. You notice that the aunt and uncle do not sit very closely to Gautam. They seem scared of him. The aunt and uncles' own children, aged 3 and 5, sit with the aunt and uncle. As the FCM, you assess Gautam's physical needs. You ask the aunt and uncle to show you the child's immunization card and growth chart. They tell you they don't have one for the child – they did not know that the child would need these things. You ask the aunt and uncle if their own children were immunized and they say yes.

   What is the problem here? As the FCM, what can you do to help? Please act out a 10- minute role play and use all the members of your team in the play. Use the FCM visit checklist to guide the steps of the visit. If it is a routine visit, complete the Family Care Plan after conducting the needs assessment and providing care. Use the home-based care kit as a prop and other supplies as needed for the role play.

5. Manju is 3 months old. Her mother, Sitha, did not know about PPTCT services so the child was born at home with a TBA. Neither Sitha nor Manju received nevirapine. The family was just enrolled in the Balasahyoga program so this is the first time visiting. When you assess Manju you find she is very small and suffers from diarrhea frequently. You ask Sitha how she is feeding the baby, if she is she providing only breast milk or if she also gives other fluids. Sitha says she gives water to her baby when she cries. The baby definitely seems dehydrated. You also ask about cotrimoxazole. Sitha has not heard of this medicine before and says she is not giving any medicines to her child. You check the immunization card and it seems that Manju is receiving her immunizations on time. You are happy to see this and praise Sitha for ensuring her child is immunized. However, Manju does not seem to have a growth chart. Sitha also seems sickly. She is very thin. You ask if she is on ART, she says she is not.

   What is the problem here? As the FCM, what can you do to help? Please act out a 10-minute role play. Use all the members of your team in the play. Use the FCM visit checklist to guide the steps of the visit. If it is a routine visit, complete the Family Care Plan after conducting the needs assessment and providing care. Use the home-based care kit as a prop and other supplies to as needed for the role play.

Section 4: Psychosocial Support and Education

This section will address the emotional impact of HIV on children; discuss the process of disclosure to children; and explain how to recognize signs of behavioral and physical abuse in children. It will also help counselors advise caregivers on how to stimulate learning and development in children, and help them ensure that their children stay in school.

SESSION 4.1: PSYCHOSOCIAL SUPPORT

Learning Objectives:

- Describe the emotional impact of HIV on children.
- Explain ways in which children express sadness and grief.
- Describe the process of disclosure to children.
- Explain how to assist caregivers in future planning.
- List danger signs related to the emotional suffering of children.
- List steps to follow in providing emotional comfort to children.
- Practice providing comfort and lay counseling.
- Differentiate between abuse and discipline.
- List danger signs related to abuse.
- Explain why institutional care is the last resort for children.
- Describe support for children in alternative care.

Time:

3 hr

Methodology:

- Brainstorming
- PowerPoint presentation 4.1, Psychosocial Support
- Small group discussions
- Role play

Materials Needed:

- Colored markers
- Flipchart paper

Handouts:

- Children Learn What They Live
- Protecting Children from Abuse

Activities:

1. Ask participants if they remember from the previous session some of the especially difficult times for children affected by and living with HIV. List these on flip chart paper, then show

the slides summarizing these events. Ask participants if they remember from Session 1.2 Child Development and Human Needs what the difference is between children of different ages and their response to traumatic events in their lives (e.g., loss of a parent). Again, show the relevant slides summarizing how children respond to problems at different ages.

2. Ask participants to **define psychosocial support**. Show them the definition described in the PowerPoint. Ask participants to name the key supports and interventions needed by children at different ages. Show the corresponding slides.
3. Summarize that all children need psychosocial support, but that those who have gone through traumatic events in their lives need more. State that psychosocial support is needed to help build a specific capacity in children that helps them cope with traumatic events in their lives. Ask them what this capacity is. They should say: **resilience**. Ask a participant to define resilience. Then ask participants how parents/caregivers and FCMs can build a resilient child, one who is self-confident, generally happy, and very curious and engaged with the world around him/her? Write responses down on flip chart paper. Participants should say that a child needs to receive stable, loving care from an adult who is responsible for caring for him/her (such as a parent of an appointed caregiver, like a grandmother). They should also say that praise for children is essential for building self confidence among them. Show the relevant slides that summarize this.
4. Ask participants why love, praise, and encouragement are important for child development. Ask participants if they can remember being scolded as a child and how they felt. Ask participants to write down one time they were scolded badly, who scolded them, and how it made them feel. Next, ask participants to write down a time when they received praise, who gave it to them, and how it made them feel. On the flipchart write the heading "Scolding" on the left-hand side and the heading "Praise/Encouragement" on the right-hand side. Write the feelings raised by participants under the heading "Scolding" and then "Praise/Encouragement."
5. Ask participants what children will be like if they are always scolded and criticized. What kind of adults will they become? Give participants Handout 1 and read the poem aloud:

   A child who lives with criticism learns to condemn

   A child who lives with hostility learns to fight

   A child who lives with ridicule learns to be shy and to ridicule others

   A child who lives with shame learns to feel guilty

   A child who lives with tolerance learns to be patient

   A child who lives with encouragement learns to be confident

   A child who lives with praise learns to appreciate

A child who lives with fairness learns justice

A child who lives with security learns to have faith

A child who lives with approval learns to like himself and to be confident

A child who lives with acceptance and friendship learns to find love

Mention that nurturing a child is like a farmer trying to grow rice. He needs to spend a lot of time preparing the soil, making sure that the rice paddy has enough water, and protecting the rice plants from mice, grasshoppers, and other insects. In the same way, parents and caregivers are expected to provide for their children, nurture them, and protect them from harm.

6. Introduce the concept of parenting: one or more **adults who are responsible to provide for the needs of their child/ren in a loving and nurturing environment.** Use the relevant slides.

   Emphasize that parents have a **responsibility** to look after their children and **provide** for their needs in a **nurturing** environment.

   Also stress that sometimes not all children are able to live with their parents (due to death, separation, employment), so caregivers act as parents and are therefore expected to provide for the needs of the children under their care as loving parents should.

   Ask participants to share where they think children in the communities they work want to live if they cannot live with their parents. Do they want to live with their extended family (e.g., grandparents, aunt and uncle), with another family in their community, or in an orphanage? Tell participants that studies around the world show that **nearly 100% of children want to live in a home in their community, not in an orphanage**. Ask participants why children raised in families are better adjusted to society than those raised in institutions. Write these responses on the flipchart. Mention that within a family or home setting, a child is able to form a relationship or bond with an adult or an older family member, which provides the basis for the child to feel secure and loved. These are all the key ingredients for a resilient and healthy child. In an institution, however, one adult may be looking after many children and may not be able to give each one the love and bonding needed to feel secure. In addition, **children say they want to be with their sisters and brothers**. Research shows that children who are able to stay with their siblings after their parents die are much more likely to be resilient than children who are separated from their siblings.

7. Brainstorm with the group about who else can provide emotional support to children. Write their responses on the flipchart. Mention that while parents/caregivers have a responsibility to provide their children with emotional support, they don't always know how to or cannot do it alone, so it is important that children are linked to others in the community who can

provide them with emotional support. Providing these social ties to the child also helps to strengthen the family unit.

8. Break the group into three smaller groups. These groups will list all the types of skills, knowledge, and attitudes parents need to be good caregivers. Group 1 will list all the skills, Group 2 will list all the knowledge, and Group 3 will list all the attitudes. Give flipcharts and markers for each group to write down their ideas. Allow about 10 minutes for the groups to work together, then ask each group to make a short presentation.

9. With all participants back in the larger group, mention that most people want to be good parents or caregivers, and want to have all the skills, knowledge, and attitudes listed on these flipcharts. Ask: "As an FCM, how can you help parents obtain these desired results?" *(Point to the lists on the flipchart)*. Ask the participants to brainstorm ways they can help parents achieve these results in parenting groups or during home visits. Write their responses on a flipchart. Mention the fact that some technical assistance partners run parent/caregiver trainings. Stress that these are very important for building their capacity in providing the care possible to their children. Discuss the different ways to do the same in Slides 20-21. Conclude the session by summarizing what children need to thrive: tender loving care from parents/caregivers, and social ties. FCMs play a very important role in helping children receive better care to build their resilience.

10. Take out three bottles; one with water and two with soda or tonic water. Ask for three volunteers to shake both bottles. Ask one volunteer to open the plain water bottle: say that this is like a child just after a traumatic event: he/she may feel flat and empty and not able to deal with problems and emotions. Ask the two volunteers to open the soda very quickly. The water will burst out. Explain that this is what it is like to have so many emotions bottled up; they sometimes explode when we keep them bottled up. This is why children who have been through difficult times sometimes get so angry. It is not because they are naughty or bad children but because they have too many difficult emotions inside of them to handle. Ask the two volunteers to open the soda very slowly. The water should not burst out but come out slowly. This is what it is like when a child can manage difficult emotions and let them out constantly so they do not built up or make the child numb. The goal of providing emotional support is to help children express their feelings so they can better cope with them. Using slides, mention various emotional danger signs and what to do if identified.

11. Conduct a role play. All participants will work in groups of three. This is a rotating role play. Each participant will have a chance to practice as the FCM, child, and observer of the emotional comfort and lay counseling session. Walk around the room, observe practice, and provide comments on how participants can improve their work. At the end of the rotating role play, ask participants for feedback on how it went and then summarize main points.

12. Now, tell the participants that you will talk about a very important aspect of care for children: future planning. Tell them it includes how to disclose HIV status to children. Go through relevant slides. Summarize the key areas of support each FCM will provide for children of different ages/stages.
13. The last section focuses on child abuse. Go through slides to define child abuse, discuss signs of abuse, and discuss the role of the FCM in protecting children from abuse. Use relevant handouts for references.
14. Summarize all the key learning points with participants.

MAIN LEARNING POINTS

1. Children need love, praise, and encouragement to thrive and become confident adults.
2. Parents/caregivers have a responsibility to look after their children and provide for their needs in a nurturing environment.
3. Children need to have good social ties with those in their community to feel emotionally secure.
4. Community volunteers and FCMs play an important role in helping children access appropriate parental care.

SESSION 4.1, HANDOUT 1: CHILDREN LEARN WHAT THEY LIVE

A child who lives with criticism learns to condemn

A child who lives with hostility learns to fight

A child who lives with ridicule learns to be shy and to ridicule others

A child who lives with shame learns to feel guilty

A child who lives with tolerance learns to be patient

A child who lives with encouragement learns to be confident

A child who lives with praise learns to appreciate

A child who lives with fairness learns justice

A child who lives with security learns to have faith

A child who lives with approval learns to like himself and to be confident

A child who lives with acceptance and friendship learns to find love

Author unknown

SESSION 4.1, HANDOUT 2: PROTECTING CHILDREN FROM ABUSE

Child Abuse

Definition: Child abuse is an act of omission or commission that endangers or impairs a child's physical or emotional health and development. It is the physical and/or emotional maltreatment of children. This problem is as old as humanity and occurs in all races, religions, cultures, and economic groups. Although it is an old problem, it is only relatively recently that societies have come to recognize it as a serious problem with far-reaching consequences.

Forms of Abuse

1. Physical Abuse: This is when children are hurt or injured by caregivers or other people, causing cuts, bruises, and fractures or other physical harm. Physical abuse can also include giving children substances such as alcohol or medicines (overdose) to make the children sleepy so that they will be no trouble at night (e.g., could be done by a couple going out with friends).

Signs and Effects of Physical Abuse

Clear cuts and bruises can be seen on the child. In serious cases, a child could be handicapped (missing an eye or a finger). Children who are physically abused can also become withdrawn, lose confidence in themselves, and lack social skills. Such children could also become abusive themselves (always involved in fights at school and at play). When they become parents, they could abuse their own children.

2. Emotional Abuse: This includes the constant criticism and belittling of a child, or ignoring the child and withholding praise and affection. This is a failure to provide the psychological nurturing necessary for a child's physical and emotional growth and development. In cases of verbal abuse, children are constantly being shouted at and humiliated or frightened. This largely relates to the relationship between a caregiver and a child and the parents' or caregivers' inability to express affection and to understand what it is to be a child. Unlike other abuse, emotional abuse does not leave physical injuries or scars and is often not easily recognized.

Signs and Effects of Emotional Abuse

Emotional abuse leads to emotional disturbances including:

- Lack of confidence and self-esteem
- Withdrawal
- Insecurities that could lead to violence
- Lack of social skills
- Bed-wetting and thumb-sucking in younger children
- Poor performance at school

3. Neglect: This is a continued failure to provide a child with the basic necessities of life and the supervision needed for a child's optimal growth and development, and a failure to use available resources to meet these needs. Examples of neglect include not taking a child for medical treatment when a clinic is free and close by, and failure to provide food, shelter, safety, care and attention, resulting in retarded physical, intellectual, and emotional growth.

Unlike other forms of abuse, neglect relates to what the caregiver does *not* do rather than what actions he or she *does* take. If reflects the overall level of a family's response to their situation and their failure to meet the child's needs. Neglect could be the result of factors including a lack of personal competency, a lack of parenting skills, an inability to plan, low self-esteem, social isolation, lack of support networks, a history of abuse in the family, and excessive consumption of alcohol or drugs.

Signs and Effects of Neglect
Neglected children could:

- Be malnourished
- Become children who live on the street
- Be sickly
- Be untidy
- Appear sad and generally withdrawn
- Lack self-esteem
- Be performing quite badly at school

Such children are very vulnerable to all forms of abuse because they lack parental guidance and protection.

4. Bullying: This is physical and emotional abuse, including a child being called names, being pushed around or teased, having rumors spread about him/her, or having his/her possessions taken away. The child feels afraid, anxious, and worthless. Bullied children lose confidence and self-esteem, which may have long lasting effects on their development and could affect their lives as adults. Orphans are particularly vulnerable to being bullied by peers. It may take some time for them to readjust into the school environment after the death of a parent. Some children even prefer to be transferred to another school.

Why do People Bully Others?
Bullies have problems of their own:

- They may have been bullied themselves.
- They may be scared of being picked on so they do it first.
- They may not like themselves and they take these feelings out on others.
- Friends may put them up to it.

5. Sexual Abuse: Of all the forms child abuse, perhaps the most difficult for people to face is sexual abuse. This is exploitation of a child by an adult or older person for the sexual stimulation or gratification of that person. Misuse of power and distortion of the adult/child relationship are the main factors.

All sorts of people from all walks of life are capable of abusing children sexually. They can be a family member, a close relative, a family friend, a community leader, or even a priest.

Forms of Sexual Abuse

Sexual abuse includes:

- Sexual intercourse with children or the rape of a child
- Incest (sexual intercourse between family members)
- Touching of private parts
- Child prostitution, in which children are paid to have sex with someone
- Pornography, in which a child is either shown pornographic pictures or forced to pose erotically for pictures or forced to perform sexual acts in front of an audience
- Forced early marriages
- Sodomy (anal sex)

Short-term Effects of Child Sexual Abuse:

- Sexually transmitted infections (STI) and HIV infection
- Unwanted pregnancies
- Depression
- Social withdrawal/isolation
- Unusual fear of adults
- Sexual interest
- Poor school performance

Long-term Effects:

- Poor sexual relations in adulthood

- Fear of involvement in a sexual relationship
- Could become perpetrators of sexual violence themselves
- Poor social relations
- Depression

Whether or not the child consents, sexual activity between an adult and a child under 16 years of age is always abusive. It is the responsibility of adults to protect children, and abusive adults must take full responsibility for seeking to engage in sexual activities with children.

As we are aware it takes more than just an act or policy to make humans realize the importance of looking after and safeguarding the development of our children. We need to inform and equip people about child sexual abuse. Many people are still blinded by cultural beliefs and half-truths about sexual abuse.

6. The Abusive Parent: Crises such as the loss of a job, divorce, illness, or work stress are factors that can result in a parent losing control and abusing a child. Parents can over-react when they can no longer cope with the stress of a situation. The abuse is the result of anxiety and frustration felt by the parent. Abusive parents may have some of the following characteristics:

- Has unrealistic expectations of their child's behavior
- Appears not to trust anyone
- May be over-critical of the child and may be unable to discuss the child in a positive way
- Believes in harsh punishment and does not hug or touch the child. Appears to lack a normal understanding of the child's emotional or physical needs
- Reacts with impatience or completely ignores the child
- May be isolated from support groups such as family, friends, or social groups
- May be reluctant to give any information concerning the child's condition or may give unreasonable responses to questions about the child
- Appears hostile or overreacts when questioned about the child, or shows no concern, being more occupied with his/her own problems
- Fails to take the child to proper medical care or chooses to go to a different hospital/doctor each time. Refuses to consent to any diagnostic studies of the child's behavior
- Difficult to locate, fails to keep appointments, has little social contact and does not participate in any school activities

- General behavior is irrational, may appear cruel and lacking in self-control, and generally not conducive to child rearing
- May misuse drugs or alcohol

Discipline is action intended for the purposes of:

- Teaching a child
- Putting a child in the right channel for the child to grow up responsibly
- Controlling the behavior of the child
- Instilling good behavior and conduct
- Correcting mistakes

Definition: Discipline is the act of exercising mental or moral training by castigating, chastising, penalizing, punishing, rebuking, reprimanding, or reproving. Examples of discipline as forms of punishment include:

- Beating
- Denial of food
- Isolation (child not allowed to be with other children)
- Ignoring the child
- Warning the child by talking about possible consequences of whatever the child has done if the action is repeated
- Harshness
- Shouting
- Using abusive language
- Giving too much work to do
- Locking the child outside at night
- Confining the child to the home

The Difference between "Abuse" and "Discipline":

From the above lists of abuse and discipline we can see the thin line that divides the two concepts, "Discipline" and "Child abuse." This line depends on the kind of person imposing the discipline and what that person is feeling (the motive for punishing), and when, where, and how the punishment is carried out. Therefore, discipline can be differentiated from abuse by using the following criteria:

- **Why?** Is it to deter the child from bad behavior?
- **How?** Is it to improve the behavior?
- **When?** Is it just after and related to the child's "bad" action?
- **Where?** Is it in an appropriate place?
- **Who does it?** Is the person concerned about the child?
- **What?** Is what is used to discipline the child harmful to the child?

Discipline is separated from abuse when the action/punishment is given without love. Most of the time children can feel that the abusive person does not love them.

Source: *Facilitator's Manual/Psychosocial Support for Orphans and Vulnerable Children, FHI/Zambia*

SESSION 4.2: EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Learning Objectives:

- List the types of things caregivers can do to better stimulate development and learning in children 0-5.
- Practice counseling caregivers in child development techniques.
- List the steps in enrolling and supporting children to stay in school.
- Describe how to ensure children benefit from the Sarya Shiksha Abhiyan (SSA) program, a Government of India initiative on primary education.

Time:

45 min

Methodology:

- PowerPoint presentation 4.2, Education and Early Childhood Development
- Case study
- Group presentation

Materials Needed:

- Colored markers
- Flipchart paper

Handout:

None

Activities:

1. Introduce learning objectives for the session to the participants.
2. Give a short presentation on the impact of HIV on learning abilities in children across developmental stages, and the process for enrollment into formal and non-formal schools.
3. Divide participants into groups and discuss the case study provided to them. Follow this with a discussion of the role of the FCM in the case scenario.
4. Summarize the session.

Section 5: Practicum

The materials in this section are designed to enable participants to put all the skills they have developed to use through real or simulated home visits.

5.1 Practicum - 4 hr

SESSION 5.1: PRACTICUM

Learning Objectives:

- Practice skills learned through the training in a real or simulated home visit with individual feedback from peers/supervisors after the visit.
- Show compassionate care to children and their families.

Time:

4 hr

Methodology:

- Home visit

Materials Needed:

- First-visit checklist
- Physical assessment steps
- Family Care Plan
- Child Status Index

Handouts:

- None

Activities:

Practicum, as explained below

Instructions for Practicum

- All participants will take part in a home visit to practice new family-centered care skills under the watchful eye of the supervisors/their peers.
- The visit to each house will include two to three participants. The supervisors will observe only during the home care visit, although in some situations they may provide on-the-job mentoring.
- All families should have given consent for visits and should know that you are there to learn.
- The visits will be made from 9 am to 1 pm.
- During the practice sessions, participants should demonstrate the skills they learned in the training based on the real needs of the client visited.
- All participants should carry their necessary handouts as per instructions in the handout.
- After the participants are back from the field visit, feedback should be taken from each group.
- The home visit steps should be summarized to close the session.

SESSION 5.1: NOTES FOR THE FACILITATOR

The purpose of the practicum is to provide training participants with an opportunity to practice applying newly acquired knowledge, skills, and attitudes under the supervision of trainers in the home of a person living with and affected by HIV and AIDS.

Practicum homes are identified confidentially through PLHIV groups and/or pre-existing Balasahyoga relationships with households. As a trainer, you must ensure that all who are asked to participate are 100% comfortable to refuse participation in the practicum, and that no pressure is put on them. Participation in the practicum must be completely voluntary. The number of PLHIV homes needed will depend on the number of training participants. Trainees will be paired up for the practicum so each home is only visited by two trainees and one supervisor. For example, if the total number of trainees is 20, 10 homes will be needed for the practicum.

If it is not possible to identify individuals who want a home-care visit, then the practicum will need to be done during a highly structured simulation. If some individuals in the community agree, they can come to the training site where a home-care environment can be organized to simulate a real home care visit.

The training facilitators who supervise the training participants during the practicum will use the FCM visit steps and QA/QI tool as a guide in observing the work of the trainees during the practicum. Keep in mind that some of the trainees may be conducting a home visit for the very first time, so try to ensure that they feel supported and not judged by the trainers.

Please use the FCM visit steps checklist (See Session 2.3) to assess the quality of the home visit. The checklist is a guide and not all of it may apply to the visit you observe, as not all services are needed by children and families on a given visit.

After observing the work of the home care team, provide them with supportive feedback in a private place back at the training site. Supportive feedback means that you encourage the home care team and do not criticize or blame them. You should ask them about what they thought about the quality of the service they provided to the client and then provide them with specific, detailed feedback about what they did well and what they need to improve. Take notes on what was discussed on the visit steps checklist and provide the trainees with the completed form so they can keep it as a reference.

To organize the participants for the practicum, try preparing the following table to help place participants in their practicum groups:

Sample Practicum Timetable

Time	8:15 - 9:30	9:30 - 10:45	10:45 - 12:00
Supervisors	Trainee Teams	Trainee Teams	Trainee Teams
Names			

Preparing the Trainees for the Practicum

The evening before the practicum, provide instructions to participants on how it will be organized. Review the following information with them:

- Learning objectives and practicum overview: Tell trainees that the practicum will be their opportunity to put their learning to practice by conducting a real home visit. Trainees will be placed in teams of two to visit a home. The team will conduct a visit as if it is the first home visit. They will need to perform all the core steps of a home visit, including a needs assessment, taking a basic history, conducting a physical assessment, and providing care, the Child Status Index, and developing a family care plan.
- The home visit will be supervised by one of the trainers. The supervisors will observe only, although they may offer support during the practicum as needed. After the home visit, the trainees and supervisor will return to the training site where immediate feedback will be given to trainees privately. **The trainees need to bring all key forms for the home visit practicum.**

(Note: You will need to review practicum logistics the morning of the practicum for about 15 minutes before leaving for the first group of home visits, as some trainees may still have some questions or be unclear on the process.)

Section 6: Mobilizing Support Services and Making Referrals

Section 6 addresses how to refer clients to the services they need. It also provides details on the roles of project coordinators, supervisions, and FCMs and explains supportive supervision.

SESSION 6.1: REFERRALS AND CLIENT TRACKING

Learning Objectives:

- Describe the referral process to the CCC and the ART Center.
- Differentiate between different types of referrals.

Time:

45 min

Methodology:

- Brainstorm
- PowerPoint presentation 6.1, Referrals and Client Tracking

Materials Needed:

LCD and laptop

Handout:

- Balasahyoga referral slips

Activities:

- Give a short presentation on referrals and types of referrals (routine, emergency, and accompanied).
- Describe the steps of a visit to ART and CCC centers.
- Discuss the referral slips and how they will be used.
- Discuss and problem-solve barriers to successful referral.
- Summarize and close.

Referral Slip

Client ID:

_____

Referred from (organization):

_____

Date: _____

REFERRED FOR (check boxes)	
ANC	
PPTCT	
VCT	
Pre-ART	
ART	
CD4	
OI	
TB screening	
Nutrition assessment	
Growth monitoring	
Immunization	
Other (specify)	

Referral Slip

Client ID:

_____

Referred from (organization):

_____

Date: _____

REFERRED FOR (check boxes)	
ANC	
PPTCT	
VCT	
Pre-ART	
ART	
CD4	
OI	
TB screening	
Nutrition assessment	
Growth monitoring	
Immunization	
Other (specify)	

SESSION 6.2: FAMILY CARE SUPERVISION SYSTEM

Learning Objectives:

- Describe the roles of the project coordinator, supervisors, and FCMs in supervision.
- Define the purpose of supportive supervision.
- List supervision tools to be used in the program.

Time:

30 min

Methodology:

- PowerPoint presentation 6.2, Family Care Supervision System
- Brainstorming

Materials Needed:

- LCD and laptop

Handouts:

- Family Case Management Supervisor Checklist
- Supervision and Mentoring

Activities:

1. Through presentation and discussion, explain supportive supervision to participants.
2. Introduce the Family Case Management Supervisor Checklist that is to be used during home visits by the field supervisors.
3. Summarize the session.

SESSION 6.2, HANDOUT 1: FAMILY CASE MANAGEMENT SUPERVISOR CHECKLIST

The supervisor checklist form is to be used as a guide in reviewing the performance of Family Case Management (FCM) teams during home visits. The checklist is a guide. Not all of it may apply to the visit you observe, as not all services may be needed by the client on a given visit.

After observing the work of the FCM teams, provide supportive feedback to the FCM team in a private place. Supportive feedback means that you encourage the team and do not criticize or blame them. Ask them about what they thought about the quality of the service they provided to the client and then provide them with specific feedback about what they did well and what they need to improve. Keep notes of what was discussed on this form and bring the supervision findings from previous visits with you every time you supervise the team so you can refer back to the feedback you provided to the team on previous visits.

Supervision of each FCM needs to be done at least once in 3 months by the Project Coordinator and once a month by the Field Supervisor.

Date and time of visit: _____ District: _____

Names of FCM: _____

Name of supervisor: _____

I. PRE-VISIT	
The family is enrolled in the program and has signed the consent form	Yes ☐ No ☐ NA ☐
Prepared and brought correct client file and relevant forms with them	Yes ☐ No ☐ NA ☐
Prepared and brought essential supplies (e.g., Salter scale, MUAC)	Yes ☐ No ☐ NA ☐
Made an appointment with the client. The client is aware of and has agreed to the visit.	Yes ☐ No ☐ NA ☐
The FCM has checked whether or not it is OK to discuss HIV status in the presence of the family.	Yes ☐ No ☐ NA ☐
The home visit was prioritized based on the prioritization list.	Yes ☐ No ☐ NA ☐
Comments:	

II. DURING THE VISIT	
A. Introduction:	
Warmly greets the family members, both adults and children.	Yes ☐ No ☐ NA ☐
Introduces you and anyone else who is new to the family members.	Yes ☐ No ☐ NA ☐
Respectfully communicates with both the adults and children in the family.	Yes ☐ No ☐ NA ☐
Sits at the same level and faces them.	Yes ☐ No ☐ NA ☐
Makes general conversation with the family if appropriate before starting to discuss health and other concerns of the client.	Yes ☐ No ☐ NA ☐
Involves child as much as possible in the discussions.	Yes ☐ No ☐ NA ☐
Communicates with the child in age and stage appropriate manner.	Yes ☐ No ☐ NA ☐
If this is a follow up visit, has good rapport with the family members.	Yes ☐ No ☐ NA ☐
If any danger signs are present, they are responded to immediately.	Yes ☐ No ☐ NA ☐
Comments:	
B. If follow-up visit, review family care plan:	
FCM reviews family care plan with all the family members.	Yes ☐ No ☐ NA ☐
FCM assesses what has been done and what still needs to be done and notes the reasons.	Yes ☐ No ☐ NA ☐

C. Family and child history-taking (If it is a follow-up visit skip Section C.)	
If this is a first visit, explains clearly the purpose of taking information and completing forms.	Yes ☐ No ☐ NA ☐
Assures family of confidentiality regarding the information they share.	Yes ☐ No ☐ NA ☐
Asks the family if there is any urgent issue they would like to raise before proceeding.	Yes ☐ No ☐ NA ☐
Collects information based on household and individual profiles.	Yes ☐ No ☐ NA ☐
Is able to collect information based on household and individual profiles but does not let form completion distract from smoothly communicating with and providing care to the client.	Yes ☐ No ☐ NA ☐
D. Health	
Asks about clients' general health status, both adults and children.	Yes ☐ No ☐ NA ☐

Conducts a complete history.	Yes ☐ No ☐ NA ☐
Asks about improvement or worsening of problems identified in the previous visit.	Yes ☐ No ☐ NA ☐
Asks about other problems, such as:	Yes ☐ No ☐ NA ☐
Pain	Yes ☐ No ☐ NA ☐
Diarrhea	Yes ☐ No ☐ NA ☐
Fever	Yes ☐ No ☐ NA ☐
Skin problems	Yes ☐ No ☐ NA ☐
Nausea/vomiting	Yes ☐ No ☐ NA ☐
Painful mouth	Yes ☐ No ☐ NA ☐
Cough or difficulty breathing	Yes ☐ No ☐ NA ☐
Inability to sleep	Yes ☐ No ☐ NA ☐
Inability/lack of desire to eat	Yes ☐ No ☐ NA ☐
Constipation	Yes ☐ No ☐ NA ☐
Emotional state (sadness, anxiety, etc.)	Yes ☐ No ☐ NA ☐
Asks to see patient CCC/ART card and reviews for time of next visit.	Yes ☐ No ☐ NA ☐
Asks the client about medicines he/she is currently taking.	Yes ☐ No ☐ NA ☐
Washes hands before and after conducting the physical exam.	Yes ☐ No ☐ NA ☐
Assesses vital signs.	Yes ☐ No ☐ NA ☐
Temperature	Yes ☐ No ☐ NA ☐
Breathing	Yes ☐ No ☐ NA ☐
Conducts a basic physical examination.	Yes ☐ No ☐ NA ☐
Eyes	Yes ☐ No ☐ NA ☐
Mouth	Yes ☐ No ☐ NA ☐
Lymph nodes (neck, underarms)	Yes ☐ No ☐ NA ☐
Thoroughly examines the skin.	Yes ☐ No ☐ NA ☐

Provides symptom care/nursing care needed by the client as identified by the client's concerns, history, and the physical exam.	Yes ☐ No ☐ NA ☐
If the client is in serious condition, is able to recognize the serious condition and respond appropriately.	Yes ☐ No ☐ NA ☐
If the client is at the end-stage, the home-care team provides end-of-life care to the client (ensures client is comfortable, ensures pain medicine as needed, provides emotional comfort to the client and family, talks to the client about death if he/she wants to, etc.)	Yes ☐ No ☐ NA ☐
Detailed Medicine Check/Adherence Support:	
Asks client to show medicines he/she is currently taking.	Yes ☐ No ☐ NA ☐
Asks client if he/she is having any problems remembering to take medicines.	Yes ☐ No ☐ NA ☐
Asks if the client is experiencing any side effects. Provides counseling on side effects if identified.	Yes ☐ No ☐ NA ☐
If the client is taking ARVs, asks to see his/her pill box to see if he/she has forgotten to take any pills. Also, asks to see the client's ARV calendar to review if the client is using it correctly.	Yes ☐ No ☐ NA ☐
Provides respectful corrective adherence reinforcement skills if required (e.g., how to use pill box, reminder calendar, use of family member as treatment supporter) and refers to ART/CCC for further adherence counseling if indicated.	Yes ☐ No ☐ NA ☐
Assesses if the medicines are kept in a safe and appropriate place.	Yes ☐ No ☐ NA ☐
Assesses family members for HIV testing and counseling status; provides information on the benefits of testing.	Yes ☐ No ☐ NA ☐
Provides HIV prevention information to the family as needed (e.g., safer sex counseling, information on family planning, PPTCT)	Yes ☐ No ☐ NA ☐
If needed, correctly arranges for referral for client to CCC or district-level hospitals.	Yes ☐ No ☐ NA ☐

Comments:	
E. Nutrition and Food Security	
Nutritional assessment tool used for children in the family.	Yes ☐ No ☐ NA ☐
Household is assessed for food security.	Yes ☐ No ☐ NA ☐
Enrollment of child in Anganwadi is assessed.	Yes ☐ No ☐ NA ☐
Growth monitoring is done for eligible children in the family.	Yes ☐ No ☐ NA ☐
Correctly performs nutritional assessment:	
Correct use of Salter Scale	Yes ☐ No ☐ NA ☐
Correct use of MuAC	Yes ☐ No ☐ NA ☐
Correct height assessment	Yes ☐ No ☐ NA ☐
Correct computation of BMI	Yes ☐ No ☐ NA ☐
FCM is able to make correct care decision based on nutritional assessment findings.	Yes ☐ No ☐ NA ☐
Correctly identifies nutritional danger signs.	Yes ☐ No ☐ NA ☐
Assesses progress of food security interventions.	Yes ☐ No ☐ NA ☐
F. Psychosocial Support Skills	
Asks the adults and children how they were feeling emotionally.	Yes ☐ No ☐ NA ☐
Listens carefully and respectfully to the client's worries and concerns.	Yes ☐ No ☐ NA ☐

Demonstrates correct counseling skills.	Yes ☐ No ☐ NA ☐
Correct nonverbal communication: nodding, eye contact, reflecting the mood of the client, facing the client.	Yes ☐ No ☐ NA ☐
Listens and does not interrupt the client.	Yes ☐ No ☐ NA ☐
Asks open-ended questions.	Yes ☐ No ☐ NA ☐
Reflects on and paraphrases the statements of the client.	Yes ☐ No ☐ NA ☐
Asks the client what he/she would like to do in response to the problem they have raised.	Yes ☐ No ☐ NA ☐
Does not advise the client to do anything. Does not use sentences like, "You should do this."	Yes ☐ No ☐ NA ☐
Summarizes the conversation, including the actions that the client has decided to take and what the FCM team will do—if anything— to support the client in the action he/she has decided to take.	Yes ☐ No ☐ NA ☐
If the client is a child, is able to provide age appropriate counseling.	Yes ☐ No ☐ NA ☐
Informs adults and children about LSE and plans for enrollment.	Yes ☐ No ☐ NA ☐
The FCM team informs the client and caregiver about the PLHA and Caregiver support groups, including the date and time of the next meetings.	Yes ☐ No ☐ NA ☐
Discusses future planning with the client if requested regarding preparing a will, securing property, and identifying a future caregiver for the children.	Yes ☐ No ☐ NA ☐
Comments:	

G. Education	
Asks the family about school enrollment status of child.	Yes ☐ No ☐ NA ☐
Asks about regular attendance in school.	Yes ☐ No ☐ NA ☐
H. Safety Net	
Assesses for enrollment in livelihood schemes and social welfare.	Yes ☐ No ☐ NA ☐
Asks if the family is getting benefits regularly from the schemes.	Yes ☐ No ☐ NA ☐
I. Family Care Plan	
Helps family and children to prioritize most important needs.	Yes ☐ No ☐ NA ☐
Summarizes main needs for the family.	Yes ☐ No ☐ NA ☐
Completes family care form, including actions, who is responsible, and next steps with the family.	Yes ☐ No ☐ NA ☐
Comments:	
End of Visit	
Summarizes main findings and action decided on during the visit.	Yes ☐ No ☐ NA ☐
Asks the client and family if there is anything else they need help with.	Yes ☐ No ☐ NA ☐
Schedules a time and date for the next visit.	Yes ☐ No ☐ NA ☐
Provides contact information of FCM team if relevant (i.e. first visit).	Yes ☐ No ☐ NA ☐
Thanks the family for the visit.	Yes ☐ No ☐ NA ☐

III. POST-VISIT (AFTER THE VISIT)		
The FCM team:		
3.1	Reviews history record form to ensure it is correct.	Yes ☐ No ☐ NA ☐
3.2	Places the client's form in the **locked file cabinet** where client forms are kept.	Yes ☐ No ☐ NA ☐
3.3	Notes the actions to be performed by the FCM team and plans for that.	Yes ☐ No ☐ NA ☐
Comments:		

Overall positive feedback and suggestions for improvement discussed with and agreed to by the FCM team:

_____

_____

_____

SESSION 6.2, HANDOUT 2: SUPERVISION AND MENTORING

All feedback needs to include both positive and constructive comments. The technique used is known as the sandwich technique: first, give specific positive feedback, then give constructive feedback (see below), and finally conclude with positive feedback. This is a way of empowering others and enabling them to hear and take action on constructive feedback.

The Six Steps in Giving Constructive Feedback

1. Choose appropriate timing.

- Choose a private moment – do not give feedback in public.

2. Convey your positive intent.

- Begin with a neutral statement about the topic.

  "Let's take a look at...." or "I'd like to discuss...."

- Point to a common goal.

  "We need to get our statistical reports on time so we can use them to assess how well we're serving the community."

3. Describe specifically what you have observed.

- Focus on the behavior or action, not on the person.
- Avoid "you" statements.

  Say it like this: "The reports were not submitted on time."

4. State the impact of the behavior or action.

- Link the behavior to program goals.

  "If we don't get the reports on time, the MIS reports will be out of date by the time we get them back. Then, we won't be able to use the information to improve our community services."

5. Ask the other person to respond.

- *"What do you think?"* "What is your view of the situation?"
- Listen attentively, with encouragement.

6. Focus the discussion on solutions (the constructive part).

- Explore solutions jointly. Try to avoid imposing the solution. However, you should be able to suggest a solution if the person cannot.

Section 7: Training Review and Evaluation

Section 7 summarizes the training, asks participants to reflect on what they've learned through the training course, and provides a course evaluation and closing.

SESSION 7.1: TRAINING REVIEW

Learning Objective:

- Reflect on the main learning points throughout the training.

Time:

45 min

Methodology:

- Quiz

Materials Needed:

- Colored markers
- Flipchart paper
- Prizes for two teams

Handouts:

- None

Activities:

1. Explain to participants that to reflect on the main learning of the training, they will be divided into two teams. Each team will devise two questions from each session alternatively based on what they consider to be the most important learning from the sessions.
2. Each team will have 60 seconds to provide their answer to the question asked by the other team. The facilitator will track the points won by each team (one point per question) and will decide who gets points when partially correct answers are given. You should correct answers as needed to ensure participants have the right information in hand.
3. After the quiz is completed, provide feedback to the teams on the questions asked and answered. Give prizes to the winning team and the losing team.
4. Summarize and close the review session.

SESSION 7.2 FINAL EVALUATION

Learning Objectives:

- Participants will explain changes in their knowledge, skills, and attitudes as a result of the training.
- Participants will provide feedback on the effectiveness of the training.

Time:

30 min

Methodology:

- Test

Materials Needed:

None

Handouts:

- Post-test questionnaire
- Training Evaluation Form

Activities:

1. Distribute the post-test questionnaire to participants.
2. Give participants about 20 minutes to complete the test.
3. After participants have completed the test, provide them with the training evaluation form. Explain that the purpose of the evaluation is to measure the effectiveness of this training and to collect suggestions for future modification of the training. Assure all participants that it is not an examination and will not be graded or linked with the person filling out the questionnaire.
4. Thank all the participants for their cooperation and close the training program.

SESSION 7.2, HANDOUT 1: POST-TEST AND EVALUATION

The post-test form is the same as the pre-test form.

TRAINING EVALUATION FORM

Please circle the most appropriate response:

1. The training venue was:

Very good Good Acceptable Poor

2. The training methodology was:

Very good Good Acceptable Poor

3. The training content was:

Very good Good Acceptable Poor

4. The handouts were:

Very good Good Acceptable Poor

5. After completing this training, do you feel that you have acquired basic skills to start providing care and support to children and families affected by HIV?

- ☐ I feel ready to provide care and support to children and families affected by HIV.
- ☐ I feel mostly ready to provide care and support to children and families affected by HIV.
- ☐ I feel somewhat ready to provide care and support to children and families affected by HIV.
- ☐ I do not feel ready at all to provide care and support to children and families affected by HIV.

6. What do you think were the *most useful* or interesting parts of the training?

_____

_____

_____

7. What were the *least useful* or interesting parts of the training?

_____

_____

_____

8. Please make suggestions on what you think should be improved in this training. Your feedback will be very helpful in improving it for next time!

_____

_____

_____

SESSION 7.3: CERTIFICATES AND CLOSING

Learning Objectives:

- Participants will share their feelings about what they will do in the community with the learning from this training.
- Participants will receive certificates in family case management.

Time:

30 min

Methodology:

- Brief presentation
- Game

Materials Needed:

- Ball of string

Handouts:

- Certificates

Activities:

1. Introduce the "one thing I'll do after the training" exercise. Ask participants to stand in a circle. Explain that to close the training, all participants will share one thing they'll do in their community to support vulnerable children and families. Each participant will share his/her idea when given the ball of string. Once the participant has shared an idea, he/she will throw the ball of string to someone else. The result of this activity is a web of string that connects all the participants.
2. Summarize by stating that if one person loosens or breaks the bonds of string, our connection weakens. Similarly if FCMs, their clients, and the community are not united and not making linkages with each other and supporting each other, then the overall effect of all their efforts lessens. All people have the same needs, all people are connected, and the training participants can do a great deal to empower others by working in partnership with others to support children, PLHIV, and families.

3. Ask for participants to return to their seats and then begin the final part of the program: closing speeches and certificates.
4. Distribute certificates to all participants.
5. Introduce closing speakers. The speakers will need to focus on summarizing the importance of the training in addressing the needs of vulnerable children and families. They should inspire the trainees to do their best when they are working in the community.

SESSION 7.3: NOTES TO THE FACILITATOR

Closing Program:

At the end of the training program, the facilitator can invite guests, a chief guest, and key people from a particular area/organization to close the training program. For this session you can:

1. Make a small closing program, depending on the situation.
2. Make arrangements for a few people to offer remarks about the program.
    a. Organizer
    b. Guest
    c. Key people
    d. Representative of participants

Certificate Distribution:

1. Certificates will be developed according to the program policy.
2. If you do provide certificates, consider inviting locally important people who can facilitate improved care for children, PLHIV, and families. They can give the certificates to participants. This may be a good way of involving them in local Balasahyoga activities.

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Using a family-centered care approach, Balasahyoga family case managers ensure that the needs of a child's family are addressed comprehensively. Use of this training curriculum will improve case managers' capacities to manage, prioritize, and care for children and families infected and affected by HIV and AIDS. It provides a quick reference to the principles and processes of effective family case management and includes many interactive methods and exercises for demonstration. It will help Balasahyoga staff offer the best possible services for children and their families.

Balasahyoga is a care and support program that provides comprehensive and high-quality services to children and families infected and affected by HIV and AIDS in 11 districts of India's Andhra Pradesh state.

For more information, see www.fhi.org/en/CountryProfiles/India/res_Balasahyoga.htm.

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