

Young Children with Special Needs

TRAINING FOR EARLY CHILDHOOD CAREGIVERS AND TEACHERS



MODULE 5 RESOURCE GUIDE

Young Children with Special Needs

TRAINING FOR EARLY CHILDHOOD CAREGIVERS AND TEACHERS

This guide is part of a series of manuals that focuses on six topics in Early Childhood Development (ECD): different programming approaches, basic concepts, assessments, early childhood environments, children with special needs and child protection, and the health, safety and nutrition of young children. The series was prepared within a three-year CRS-led project called “Strengthening the Capacity of Women Religious in Early Childhood Development,” or “SCORE ECD.” Funded by the Conrad N. Hilton Foundation, the project helps Catholic sisters in Kenya, Malawi, and Zambia in their work with children aged 0-5 years and their families. The project is being implemented from January 2014 to December 2016.

CRS referred to a wide range of documents in preparing this curriculum. Please see “Reference Documents” section in Module 1 facilitator or resource guide for the full list.

Written by Selamawit Tadesse, in cooperation with CRS SCORE ECD team.

Edited by David Snyder

Cover photo: Sister Agnes Wamuyu, General Secretary of the Association of Sisterhoods of Kenya, and Brian Njoroge, 4, in his home in Nairobi, Kenya. Brian is developmentally delayed, but he has improved dramatically since he first started working with the sisters in SCORE-ECD in 2014. *Photo by Philip Laubner/CRS*

Copyright © 2016 Catholic Relief Services

Any reproduction, translation, derivation, distribution or other use of this work is prohibited without the express permission of Catholic Relief Services (“CRS”). Please obtain permission from pqpublications@crs.org or write to:

Catholic Relief Services
228 West Lexington Street
Baltimore, MD 21201-3443 USA

Table of Contents

RESOURCE GUIDE 5: YOUNG CHILDREN WITH SPECIAL NEEDS	1
Purpose	1
SESSION 1: YOUNG CHILDREN AND DISABILITY	3
Learning objectives	3
Definition of disability	3
Early identification and screening of disability	5
Barriers that affect children’s development	6
Understanding inclusion and its benefits	7
Types of disability, early warning signs, and intervention	9
Ideas for supporting children with disabilities and their families	17
SESSION 2: VULNERABLE CHILDREN: YOUNG CHILDREN LIVING WITH AND AFFECTED BY HIV AND AIDS	21
Learning objectives	21
Orphans and other vulnerable children-OVC.....	21
Facts about HIV and AIDS: Transmission, testing, prevention, and care.....	22
HIV testing, prevention, and care.....	22
The impact of HIV and AIDS on children: Key impacts related to Early Childhood Development.....	23
Supporting young children living with or affected by HIV: A holistic approach.....	25
Psychosocial support: Understanding young children’s reactions to loss and grief	27
Young children’s developmental reaction to death and grief	28
SESSION 3: RIGHTS AND PROTECTION OF YOUNG CHILDREN.....	33
Learning objectives	33
Categories of children’s rights.....	35
Parents and caregivers’ rights and responsibilities	35
Child abuse and protection	37
Signs of possible abuse or neglect and reporting suspected cases	37
Positive discipline	40
Gender roles.....	41
Speaking on behalf of young children: Advocacy.....	42
Basic guideline for advocacy	42
Ideas for working with parents, caregivers, or teachers	43
REFERENCES.....	45

RESOURCE GUIDE 5: CHILDREN WITH SPECIAL NEEDS AND CHILD PROTECTION

Resource Guide 5 is one of six ECD Resource Guides from the CRS SCORE ECD curriculum. The six series are:

1.	Approaches to Early Childhood Programs
2.	Introduction to Early Childhood Development
3.	Assessing Young Children's Development
4.	Quality Early Childhood Environments for Young Children
5.	Children with Special Needs and Child Protection
6.	Health, Safety, and Nutrition.

SAMPLE REVIEW

"The SCORE ECD curriculum is very unique; it includes the spiritual development of children 0-5 years and also caters for children 0-2 years. It is a resource document that the sisters will be proud to use...many children infected and affected with HIV and AIDS and children with disabilities will benefit from it." (Reviewer: SCORE Coordinator/Sister Association/AWRIM, April, 2015)

"The curriculum actually expands on most ECD subjects like spirituality, play, ECD standards, protection, vulnerable children, and disability and nutrition." (Reviewer: SCORE Coordinator/Sister Association/ZAS, April, 2015)

"I found the curriculum clear and comprehensive. I liked the examples and the exercises. I really liked the inclusion of children's rights in *Module 5*. I think it is a really important concept for adults to understand." (Reviewer: Member of the CRS/SCORE ECD Advisory Committee, September, 2015)

Resource Guide 5: Young Children with Special Needs

PURPOSE

The purpose of this guide is to increase participants' understanding of the special needs of children with disabilities and children living with HIV/AIDS, and what caregivers can do to support their full growth, development, and learning. It is also expected that the participants will learn about the rights of young children and improve their work on child protection.

This guide is divided into three sessions:

- **Session one** focuses on young children with disabilities¹, the definition and types of disabilities, barriers to the participation, development, and learning of children with disabilities, and the importance of early identification and intervention that is inclusive and involves families and communities.
- **Session two** focuses on young vulnerable children infected and affected by HIV and AIDS, the transmission of HIV/AIDS to young children, its effect on their development and learning, and ways to support their needs at the individual, family, and community level.
- **Session three** focuses on the major categories of children's rights and caregivers' roles and responsibilities to protect those rights. It also includes ideas on how to identify possible signs of abuse and neglect, how to take appropriate steps to report suspected child abuse or neglect, and how to advocate for young children's rights and protection against any kind of abuse, neglect, or violence.

¹ Most *Session One* materials were adapted from the *Volunteers' Orientation Guide on How to Care for Children with Disabilities* by Pact-Yekokeb Berhan Program (2014), with the permission of Dr. Lucy Y. Steinitz, Senior Technical Advisor for Protection, Program Impact & Quality Assurance Department/CRS.

Session 1: Young Children and Disability

LEARNING OBJECTIVES

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

- Identify appropriate terminologies to use when referring to young children with disabilities.
- Identify ways to screen disability in young children using early disability screening tools.
- Identify barriers to development and learning for children with disabilities.
- Describe the meaning of inclusion and its benefits to children with disabilities.
- Describe how to recognize physical-motor, hearing, and visual impairments and developmental delay in young children.
- Identify ways to support children with disabilities at individual, family, and community levels.

DEFINITION OF DISABILITY²

“People with disabilities are not without abilities.”

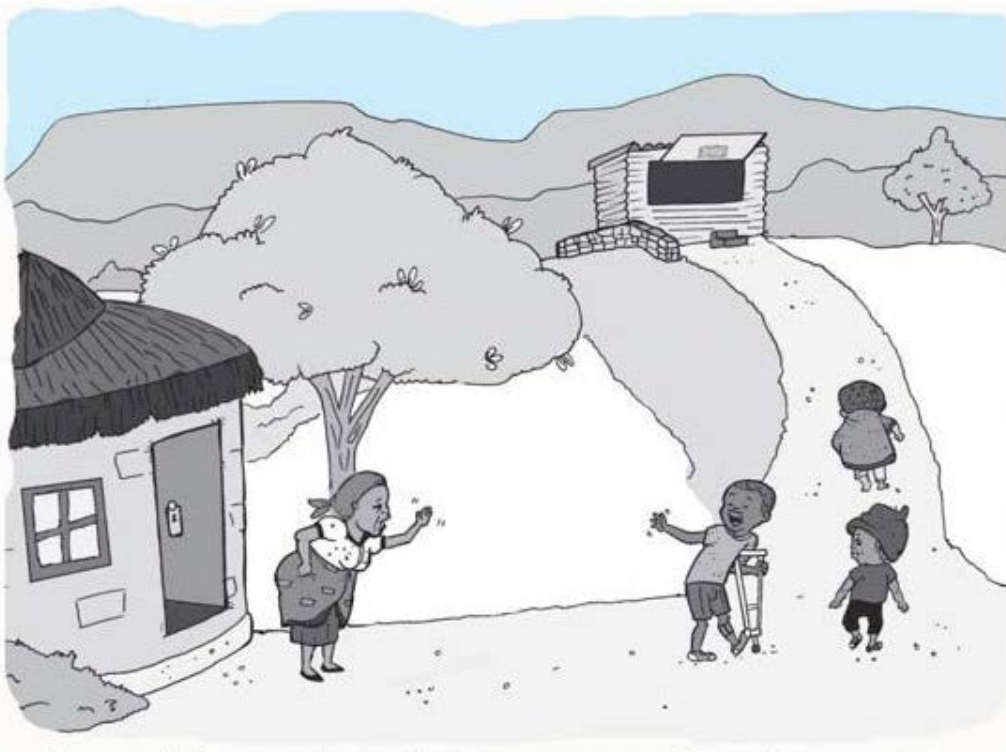
Sister Margaret Aringo, Former Chair, Association of Consecrated Women in East and Central Africa (ACWECA)

It is very important to focus on what children or adults with disabilities can do, rather than on what they cannot do. It is also important to remember that children are first and foremost children, whether they have a disability or not.

Everyone can be prone to disability. If we do not have a disability today, we may have one tomorrow for various reasons such as illnesses and accidents. All communities include people with impairments and that is common and normal in our lives. But it is not normal for a person to be discriminated against and excluded because he/she has some kind of impairment.

A child with a severe disability can have a very close and meaningful spiritual life and relationship with God. Parents and caregivers should never think of disability as a punishment—God loves all of His children and a child with a disability is special.

² Carter (2015); Pact-Yekokeb Berhan Program (2014); UNESCO (2001; 2009).



Invite children with disabilities to join in with regular activities.

The words people use to describe disability can affect the psychological wellbeing of the person with a disability. For example, people may refer to a child who has difficulty in hearing and speech as “deaf and dumb,” or a child who has small physical stature as a “midget” or a “dwarf.” These kinds of remarks damage the self-concept of children with disabilities. People also use the words “disability,” “handicap,” and “impairment” interchangeably when they address disability, but these words have different meanings. Understanding the meaning of impairment, disability, and handicap can help us to address children with disabilities with a positive and respectful regard.

WHAT ARE “IMPAIRMENT,” “DISABILITY,” AND “HANDICAP”?

The United Nations Educational, Scientific and Cultural Organization (UNESCO) defines impairment, disability, and handicap as the following:

“IMPAIRMENT”

“Any temporary or permanent loss or abnormality of a body structure or function, whether physiological or psychological. An impairment is a disturbance affecting functions that can be mental (memory, consciousness) or sensory, internal (heart, kidney) or external (the head, the trunk, or the limbs)” [UNESCO, 2009, p.6]. Some examples are a child who is born with a deformed foot/feet or leg/legs, a child born with eyes that do not see well, or children born healthy but who have impairments due to injury or childhood illnesses.

“DISABILITY”

“A restriction or inability to perform an activity that another person mostly can do; disability mostly results from impairment” (UNESCO, 2009, p.6).

“HANDICAP”

“This is the result of an impairment or disability that limits or prevents the fulfillment of one or several roles regarded as normal depending on age, sex, social, and cultural factors” (UNESCO, 2009, p.6).

In summary, “**impairment** refers to a problem with a structure or organ of the body, **disability** is a functional limitation with regard to a particular activity, and **handicap** refers to a disadvantage in filling a role in life relative to a peer group” (Carter, 2015).

EARLY IDENTIFICATION AND SCREENING OF DISABILITY

All children, with or without disabilities, experience barriers. A child’s personal condition or his/her environment can be a barrier. Barriers hinder children with disabilities from full participation in mainstream services such as schools and recreational centers. Due to barriers, children with disabilities can be prone to physical and psychological abuse, neglect, or violence as well as limited or no social services such as healthcare, nutrition, and education. Barriers must be removed so that children with disability can survive, thrive, and develop to their full potential.

Barriers can sufficiently be reduced or removed when all concerned parties (e.g., families, schools, healthcare services) are involved and help children with disabilities to grow and develop holistically in their physical-motor, social-emotional, spiritual-moral, and cognitive-language development. For example, early detection and intervention on some illnesses (e.g., tuberculosis, meningitis, malaria, HIV/AIDS) can prevent disability or even death in children. An important step in early intervention is to regularly observe children’s development whether at home, school, or a health care clinic. Through observation, signs of potential disability or developmental delay can be detected for the child. It is important not to wait until the child reaches school age. The World Health Organization’s (WHO) *10-Point Disability Screening Tool* below helps childhood care providers identify potential disability in children aged two and above.

THE WORLD HEALTH ORGANIZATION 10 POINT DISABILITY SCREENING TOOL

These questions have been used by the World Health Organization to identify potential disabilities in children over age two. If the caregiver answers “yes” to any of these questions, then refer the child to the clinic for assessment.

1. Does the child appear to have difficulty with hearing?
2. Compared with other children, does the child have difficulty seeing, either in the day or at night?
3. Does the child sometimes have fits, become rigid, or lose consciousness?
4. Is the child struggling to do things like other children his/her age?
5. Compared with other children, did the child have any serious delay in sitting, standing, or walking?
6. Does the child have difficulty in walking or moving his/her arms, or does he/she have weakness and/or stiffness in the arms or legs?
7. When you tell the child to do something, does he/she seem to understand what you are saying?
8. Is the child struggling to speak? (Can he/she make himself/herself understood in words? Can he/she say any recognizable words?)
9. For the three- to nine-year-old ask: Is the child’s speech in any way different from normal (not clear enough to be understood by people other than his/her immediate family)?
10. For two-year-olds ask: Can he/she name at least one object (for example an animal, a toy, a cup, a spoon)? Is the child slower in any way than other children of his/her age?

CRS, Lesotho, *Ngoana eo keoa Mang? A Teachers Resource Guide (2012)*.

BARRIERS THAT AFFECT CHILDREN'S DEVELOPMENT

Children with disabilities face barriers in their homes, schools, and communities. Let us see some examples of barriers³ below:

Physical barriers: Obstacles that affect walking or managing things physically (e.g., walking long distances can be troublesome for a child who is very young, physically disabled, or malnourished).

Unfavorable early childhood centers: An early childhood center becomes a barrier when its program does not include children with disabilities or does not have space and learning materials conducive for children with disabilities (e.g., an adjustable toilet, availability of Braille, caregivers/teachers do not have special needs training).

Health barriers: A child with chronic illnesses such as HIV/AIDS or a brain seizure problem may not attend daycare or preschool regularly, misses play activities with friends, or may be isolated and marginalized.

Resource barriers: The child has limited access to special schools or assistive devices such as hearing aids or a wheelchair, which may or may not be available in the community (Note that schools with special education classes are more often available these days, but some children may still need a special school, such as those who have an intellectual disability or who are blind or deaf.)

Poverty: Children who live in poor families grow up lacking adequate nutrition, sanitation, health care, and in most cases, live in insecure and unsafe environments. Unless improved, these factors can cause potential developmental delay in children. The situation can have more serious impacts on children with disabilities because they have extra needs that require additional resources and specialized services.

Attitudinal barriers: Families, teachers, friends, etc. may have the wrong or a negative outlook towards a child with a disability. For example, parents may believe that their child with a hearing problem cannot learn and therefore they keep him/her at home; but we know that sign language helps children with hearing impairments to learn and function well in society. Foster parents who care for a blind child may not send the child to school believing that he/she cannot read and learn; but we know that blind children can read and learn well using Braille. Most caregivers also feel ashamed of their child's disability (e.g., how the child looks, moves, or talks) and may hide him/her from family members, neighbors, or the community at large. This kind of belief and attitude prevent the child from having education as well as making friends. It can also cause low self-esteem in the child, which in turn inhibits the child from striving to achieve. He/she can be depressed and withdrawn and ultimately become even more disabled. ECD program staff can also be barriers to inclusion if they hold an unfavorable attitude towards children with disabilities.

Gender barriers: Societal attitude towards girls can be a barrier. For example, traditional families usually keep girls away from school and mentor them to manage home affairs. Girls with disabilities, in addition to being kept at home, get less attention from their caregivers, mostly hidden and kept away from family members and neighbors. The attitude is that compared to girls without disabilities, girls with

³ Pact-Yekokeb Berhan Program (2014); Hesperian (2009); UNESCO (2001; 2009).

disabilities have little value and cannot establish their own independent life. This barrier prevents girls with disabilities from going to school or meeting or playing with friends. Some families may even totally abandon girls with disabilities, exposing them to further neglect and abuse such as beatings, sexual exploitation, or being deprived of food, water, or medicine.

Stigma and discrimination: Discrimination and belittling are common barriers that children with disabilities face in their day-to-day life experiences. The way people refer to children with disabilities can have a stigmatizing effect. For example, saying, “Pass this ball to the disabled child,” or “Be careful when you play with the HIV positive child,” is humiliating to children with special needs. It also causes other children to be afraid of children with special needs and exclude them from play activities. In addition to negative remarks, incorrect social values about disability also stigmatize children. These incorrect values and beliefs include:

- The child was punished for something he/she did wrong.
- The disability was caused by witchcraft.
- The child’s disability is contagious and he/she must not come in contact with others.

These beliefs contribute to unfair treatment of special needs children and their exclusion from school, group play, or other community functions. Early childhood caregivers and service providers need to consciously strive towards accepting, respecting, and treating children and adults with special needs as their equal.

Communication barriers: This includes barriers preventing children from interacting easily with people at their home, school, or community. The reason may be due to child’s physical or intellectual impairment, or differences in language or culture. Early childhood caregivers or teachers should recognize differences in children and provide them with the appropriate support. For example, caregivers or teachers can allow adequate time and guidance for children with speech problems to express their thoughts without stress and discomfort.

The above are just some of the many barriers faced by children with disabilities in families, schools, and communities. **Usually the psychological or attitudinal barriers are the biggest and most important to overcome, so it is best to start there.**

To remove barriers, caregivers, teachers, and child development and health care service providers need to create an early childhood environment that is **inclusive**.

UNDERSTANDING INCLUSION AND ITS BENEFITS⁴

“Inclusion” is the effort to include everyone in family and community activities irrespective of age, disability, gender, HIV status, religion, or ethnic and language background. Inclusive environments provide the child with the opportunity to be appreciated and treated with dignity regardless of who he/she is and where he/she comes from, or what he/she can or cannot do.

This means the rights of children with disabilities are fully recognized—they can engage in all aspects of life activities (e.g., parish life, school, and recreational activities) and enjoy the same provisions their peers are receiving in everyday life (e.g., health, education). The role of families and communities is to ensure that children with disabilities participate in play, receive appropriate social services such as education and health care, and be active members of any social activity.

⁴ Byington (2010); Catholic Relief Services, Vietnam (2007); Catlett (2009); U.S. Department of Health and Human Services and US Department of Education (2015).

THE MOST IMPORTANT THING TO KNOW ABOUT DISABILITY!

The most important thing to know about disability is to never make assumptions. Someone with a disability can be physically very fit and strong and/or highly intelligent.

The most important thing to change about disability is attitude. Focus on what the person CAN do, not on the impairment or problem.

The most important thing to do is to seek diagnosis (testing) and treatment immediately. Many forms of disability can be prevented or improved with early intervention.

Pact-Yekokeb Berhan Program (2014).

Inclusive early childhood programs help young girls and boys with disabilities to:

Become active members of the program and participate in several activities appropriate to their needs.

- Make friends and play with children and adults other than their sisters/brothers, parents, or relatives.
- Experience learning through varied mechanisms (toys, group play, manipulating objects) adjusted to their physical and developmental needs.
- Have other children recognize that all children and adults are different and their differences must be respected. Families will also get a chance to do other household or social and economic activities while their children are spending time in an inclusive program.

Inclusive child care services can be delivered at different places, including:

- Homes
- Schools
- Child care centers
- Preschool classrooms
- Faith-based programs
- Recreational programs
- Health care clinics
- Early intervention centers
- Rehabilitation centers



Illustration: CRS Lesotho

In an inclusive environment, a caregiver or a teacher:

- Recognizes that each child is unique and treats every child with equal respect and empathy.
- Raises awareness about children with special needs through book reading, puppets, and playing, and speaks out against misconceptions and myths about children with disabilities.

- Models for children the right behavior on how to respectfully interact and talk with children with disabilities at the level of the children’s understanding. For example, be honest and use direct and simple explanations and encourage children with and without disabilities to play together with guidance.
- Ensures that all children in the ECD environment receive equal treatment and services appropriate to each child’s context (e.g., abilities, personality, culture, language, religion).
- Reaches out to marginalized children in the surrounding community and facilitates inclusion.

Note: Many examples of inclusive ECD activities that caregivers and teachers can provide for children with disabilities are suggested throughout this series of ECD resource guides.

TYPES OF DISABILITY, EARLY WARNING SIGNS, AND INTERVENTION⁵

Types of disabilities vary and “*children with disabilities include those with health conditions such as cerebral palsy, spina bifida, muscular dystrophy, traumatic spinal cord injury, Down syndrome, and children with hearing, visual, physical, communication and intellectual impairments*” (WHO & UNICEF, 2012). This session does not cover all of these types/areas of disability. Therefore, for additional information or training, users of this guide are advised to seek further guidance/training from appropriate resources and experts on the area. This guide covers basic information on the types of disabilities described below:

1. Hearing impairment
2. Visual impairment
3. Physical impairment
4. Developmental or cognitive impairment

HEARING IMPAIRMENT

There are two kinds of hearing impairment: 1) deafness, and 2) hard of hearing. Deafness occurs when children have a complete loss of hearing. Hard of hearing occurs when children hear only partially. Hearing impairment is often identified when the child reaches school age. This is because *all* babies use body language and voices to communicate with the caregiver. To identify hearing loss early, caregivers and teachers need to talk with children verbally (e.g., use of words) and non-verbally (e.g., make body gestures using fingers and hands, moving the body in different directions such as nodding or making facial expressions).

CAUSE OF HEARING IMPAIRMENT

Children can become deaf at or after birth. Childhood diseases, ear infection, or injury can cause deafness. It is important for caregivers and teachers to find out the hearing status of a child early and provide the necessary and appropriate support on time. Hearing loss can be detected through audiometric test at a health clinic and it is often classified as mild, moderate, severe, or profound.

⁵ Catron & Allen (2008); Pact-Yekokeb Berhan Program (2014); Dodge, Rudick, & Berke (2011); Gonzalez-Mena & Widmeyer Eyer (2012); Hesperian (2009); Salend (2001); UNESCO (2001; 2009); WHO & UNICEF (2012); Wittemer & Petersen (2014).

EARLY IDENTIFICATION

If screened early, some types of hearing loss in children can be treated medically or with hearing aids or sign language training. When families or teachers suspect hearing problems in children, it is important to seek a direct or referral medical intervention from the nearby health clinic or hospital. Early intervention can help children to learn and participate in social activities without having difficulty or being labeled or picked on by peer groups.

SIGNS OF POSSIBLE HEARING LOSS

A very young child may have a hearing problem if he/she **does not show** most of the following behaviors when hearing loud sound:

- Moves his/her arms and legs
- Changes the look on their face
- Becomes very still
- Make a sound himself/herself
- Smiles, frowns, or laughs
- Turn towards the sound, or tilts his/her head to listen
- Be startled, opens their eyes wider, or blinks

Note: If a caregiver gets no reaction at all, even for a loud noise and also a high-pitched noise that takes place away from the child's line of vision, it is possible that the child is completely deaf.

Older children with *hearing loss* may do some or all of the following:

- Show difficulty in following directions and listening to verbal messages.
- Use limited vocabulary and have speaking difficulty. Look at the age of the child because toddlers also have limited vocabulary—watch for milestones.
- Ask peers or adults to repeat what they are saying.
- Avoid activities that require speaking or listening such as story times, or imitates others and uses a lot of gestures for communication, or appears to be confused.
- Listen to a radio with high volume.
- Speak in a loud voice when talking to someone.
- Tilt the head to one side.
- Complain of headaches, noise in the head, and stuffiness in the ears.

HOW DOES A CHILD WITH HEARING IMPAIRMENT COMMUNICATE?

Some ways that a child with a hearing problem may communicate with people include:

Oral communication and lip reading: Children with mild and moderate hearing problems (partial hearing ability) may communicate using speech and/or lip reading. The child's speaking may not be clear; therefore, it is important not to push the child to talk or sing in a more clear way because the experience can be stressful and the child can feel frustrated and pull out from any activity.

Manual communication: Children who use manual communication are using sign language and finger spelling and they can learn them at school from trained caregivers/ teachers or at specialized services for the hearing impaired. Different countries have different types of sign language and schools may or may not have the capacity to teach sign language to the hearing impaired children. It is important to educate children with hearing impairment in sign language so that they can communicate with people and learn without difficulty. Family members will also benefit from learning sign language because it promotes positive child-caregiver interaction. Children and caregivers can also use finger spelling for things that do not have sign names.

Total communication: This includes both oral and manual communications.

The intellectual abilities of children with hearing impairments are identical to those of children with hearing. Teachers and caregivers can support the development and learning of children with hearing impairment in many ways.

SUPPORTING A CHILD WITH HEARING IMPAIRMENT

- Conduct or promote early detection and treatment of disability.
- Use hands-on teaching/learning methods that allow children to feel and experience an idea.
- Use visual aid to give children the context of what they are learning (e.g., pictures, drawings).
- Use cues to make your instruction understood well by the child (e.g., speaking slowly, finger spelling, sign language, role-play, act out, or facial expressions while looking at the child).
- Become trained or use specialists to train the child in sign language; facilitate caregivers' training in sign language.
- Help the child to get hearing aids, if needed.
- Provide an interpreter for a child who speaks with sign language to communicate with other children or caregivers/teachers.
- Arrange seating in individual or group activities to suit the child with a hearing problem (e.g., let the child sit face-to-face with you so that he/she can read your lips).
- Facilitate group play to encourage communication between hearing children and children with hearing impairments (e.g., teach hearing children sign language). This will minimize social exclusion.

EXAMPLES OF SIGN LANGUAGE



I Love You



“Make the sign for ‘mother’ by placing the thumb of your right hand against your chin. Your hand should be open, in a “five shape” (American sign language) [UNESCO, 2009, p.33].



“Make the sign for ‘father’ by placing the thumb of your right hand against your forehead. Your hand should be open. Some people wiggle their fingers slightly while doing the signs mother and father, but you don’t need to” (American sign language) [UNESCO, 2009, p.33].

Note: Different countries have different forms, guidelines, and procedures for sign language. Always refer to national standards and polices for use of sign language in a given community.

VISUAL IMPAIRMENT

Visual impairment includes low vision and blindness. A person who is **blind** cannot see while a person with **low vision** can see partially. It is not possible to correct low vision using ordinary eye glasses.

CHALLENGES OF CHILDREN WITH VISUAL IMPAIRMENT

- Difficulty in moving around easily without help from the caregiver (through training, the child eventually can become independent)
- Rely mostly on hearing and verbal communication abilities when interacting with others (e.g., difficult for the child to understand non-verbal communication of others (facial expressions and body language)
- Rely on Braille for written communication (e.g., written communication with friends who use regular print is difficult). Braille is the main medium for reading and writing for people who are blind and for those who have low vision.

CAUSES FOR VISUAL IMPAIRMENTS

Visual impairment can be caused by many factors, including “Albinism (born with little or no color in one’s eyes, skin, and hair), cataracts, diabetes-related eye diseases, glaucoma, river-blindness (transmitted by river area blackflies), short-sightedness, long-sightedness, hereditary eye diseases, and trachoma (caused by a contact with eye discharge from the infected person on towels, handkerchiefs, fingers, etc.” (UNESCO, 2009, pp. 43-45).

WARNING SIGNS OF POSSIBLE VISION PROBLEMS IN YOUNG CHILDREN

Children who may have vision problems may exhibit some or all of the following:

- Does not close his/her eyes in bright sunlight or does not turn his/her head toward the sunlight
- Shows no reaction with eyes when an object is waved from side-to-side in front of the child’s eyes or face (e.g., eyes do not follow the movement)
- Slants his/her head
- Repeats unusual movement over and over, like poking his/her eyes, flapping his/her hands, and rocking his/her body
- Trips over repeatedly and collides with things; not confident in walking like dragging feet, checking steps
- Unable to see things that are far away
- Brings things very close to face/eyes; rests the head on a desk when writing or coloring

HOW TO SUPPORT A CHILD WITH VISUAL IMPAIRMENT

- Intervene early.
- Encourage and help the child to explore his/her surroundings. Talk about what you see and encourage him/her to touch and hold things.
- Encourage a child to touch different kinds of things with different texture and strong but pleasant smells such as fruits, vegetables, or flowers and ask him/her to explain and describe what different objects feel like.
- Provide the child with varied sensory manipulative materials to study and describe and act on them repeatedly until he/she internalizes information. All children need a lot of practice before they learn new skills. First, a child learns to do the skill with help, then he/she remembers how to do it all by himself/herself, and finally, they use the skill in new situations.
- Encourage other children to play together with the visually impaired child to support each other. Young children learn best from their peers.
- Take the child to different places as much as possible, when collecting water or gathering wood, or going to the market, to school, or religious services and community meeting and events. Along the way, describe what you see and encourage the child to listen to sounds and to touch and smell things. Introduce the child to the people and animals you meet and teach him/her how to greet people.
- Cover all open wells, ditches, and holes to make the area outside the child's home safer before the child starts moving independently from place to place. Show the child where these things are and explain what they are and why they are here. Teach the child how to move independently using a white-cane or a stick, i.e., by moving that stick slowly and gently from side-to-side in front of him/ her when he/she walks alone outside of the home.
- When the child is old enough for schooling, make sure the child joins a school that is able to teach him/her. Find out ahead of time if the child will be better served in a specialized school for the blind (consult your district service for children with special needs) or in an inclusive classroom in the child's own local school. Help the child to get the material he/she needs for learning, including reading of Braille (a special print using raised dots that blind people can feel). Refer to a district or local directory prepared for special needs children to learn how to get braille materials.
- Make children with low vision sit in a way that they can see the speaker's face (e.g., storyteller) clearly; also, use a large picture book during the story reading.
- Introduce the child to adults who are blind or who have a visual impairment but are successful in life, with a job, an education, a good family life, etc. Ask that person to offer words of encouragement to that child. Above all, help the child to develop good self-esteem, see himself/herself as capable by emphasizing all the things that he/she CAN DO.

PHYSICAL IMPAIRMENT

Physical disability hinders the child's motor ability, which is the skill to control muscle flexibility and movement. Physical impairment can be permanent or temporary. Two types of impairments hinder flexibility of muscle and movement: *orthopedic impairment* and *health impairment*.

Children with orthopedic impairment may have club foot, be missing some part/s of the body (e.g., arm, leg), have limp legs caused by polio, or amputations and disfigurement due to accidents or burns. Children with health impairment are those who have chronic health problems such as a heart condition, tuberculosis, chronic fever, asthma, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes.

SIGNS THAT A CHILD MAY HAVE PHYSICAL-MOTOR PROBLEMS

Young children with physical-motor problems may exhibit some or a combination of the following:

- Arms or legs may lack flexibility or may be weak, and body posture is limp.
- The body lacks coordination of movement; the child moves his/her body slowly and awkwardly.
- Physical exercise becomes painful for the child and he/she complains.
- Reaching and picking up things may not be achieved by age one.
- Motor milestones of a toddler may not be achieved by the time the child is two (e.g., walking independently; kicking a ball).
- Motor milestones for preschoolers (age three to five) may not be achieved (e.g., climbing stairs; running without repeated fall; hold crayons and writing)

Note: The presence of one or two of the above indicators does not necessarily show physical impairment. Observe the child regularly and determine if the child exhibits many of the symptoms for a longer time.

SUPPORTING A CHILD WITH PHYSICAL-MOTOR IMPAIRMENT

- Allow the child to have ample opportunities for play-oriented sensory-motor experiences (e.g., abilities to touch, smell, see, taste, hear).
- Allow the child to complete an activity by giving him/her a guided instruction.
- Acknowledge the effort of the child to construct or complete a given task.
- Refrain from doing tasks for the child or giving frequent prompts; instead, encourage the child to practice a given skill repeatedly until he/she masters the skill independently. This will give the child a sense of self-accomplishment and motivation for further trial.
- Provide physical support for children who have difficulty in sitting and standing (Appliances that can support the child's trunk and lower body as designed per the child's size and special needs are helpful.)

INTELLECTUAL OR COGNITIVE IMPAIRMENT

A *cognitive impairment* can be present at birth or acquired early in life. It delays the ability of a child to learn and to cope within society. A child may be a slow learner, or may forget things easily. The cognitive impairment can be mild or moderate. This means that the child can learn most of the things that other children learn. However, children in these two categories need extra time and help to learn independent daily living skills, including social skills.

A third category is *profound cognitive delay*. A child with a profound cognitive delay will be able to learn some things, but will always be dependent on another person for many activities of daily life.

Developmental impairment can be caused by problems during pregnancy, HIV and AIDS, lack of oxygen during labor and birth, premature birth, iodine deficiency and

malnutrition, health and environmental problems including whooping cough, measles, meningitis, and exposure to lead and mercury poison. Other causes include social problems such as physical, mental, or sexual abuse, deprivation of love and affection, uncaring institutionalization, or genetic conditions such as Down Syndrome. These health conditions can be avoided by good prenatal and antenatal care which includes maternal health and nutrition during pregnancy, childhood immunizations, child's health and nutrition, and decreasing the exposure of young children to diseases such as malaria and trachoma and childhood injury. Early medical assessment, stimulation, and education campaigns are important interventions.

HOW TO IDENTIFY CHILDREN WITH COGNITIVE DEVELOPMENTAL IMPAIRMENT

Assessing a child's cognitive functioning is very difficult for young children. The younger a child is when tested, the less chance for predicting the results. For example, in the first three years, it is difficult to determine a mild cognitive handicap. These mild concerns may not be identified until a child reaches school age and is faced with the challenges of reading, writing, and math. Early observation and descriptive medical evaluation are the most helpful screening methods.

Children with cognitive developmental delay do not learn as quickly as other children. But still, they **can and do learn**. For example, most children are able to sit up by themselves when they are six to eight months old and start walking when they are 12-15 months old. They will also start speaking words soon after age one, and by the age two they will start to say some simple sentences. But for a cognitive delayed learner, these things will come later. It may take extra effort, but learning still takes place. If the developmental delay is severe or profound, the child may never learn some developmental and life skills.

Warning signs for cognitive developmental delay should be used with caution, as there is much variation in children's development [**Note:** Refer to *Developmental alerts* in this guide for warning signs of cognitive developmental delay by chronological age.] For example, some children may exhibit quite an obvious developmental delay through their appearances and behaviors; however, some physical appearances can also make a child appear to have a developmental delay. Therefore, it is important to conduct careful observation and follow up of a child before making any conclusion.

SUPPORTING CHILDREN WITH COGNITIVE DEVELOPMENTAL DELAY

It is important to remember that children with cognitive developmental delay have feelings like everyone else. They want to feel worthwhile, loved, and respected, and they want to have an important role in the family. Therefore, caregivers should be prepared to repeat or reinforce learning for these children and help them focus on what they can do well; for example, by helping out their family members. It is also important that children with cognitive developmental delay go to school, wherever possible. This may be in a specialized education classroom with a teacher trained to work with children who have cognitive delay. Such resources need to be identified in the community.



Illustration: CRS Lesotho

Ideas for fostering learning skills for children with cognitive delay include:

- Decide which skill to teach and divide each new skill into small-step activities the child can learn in a day or two, then go on to the next step.

- Be patient and observant. Children need to process information according to their abilities. Give the child time to think and practice, and help the child to improve the skills.
- Talk a lot to the child, using clear, simple words. Repeat the instruction with a slow deliberate voice and make sure the child looks at you as you speak; use gestures to reinforce understanding.
- When you are helping a child learn a new skill, guide the child's movements with your hands. It works better to gently guide the child than to tell him/her how to do something such as, "No, do it like this!"
- Use a mirror to help a child learn about his/her body and to use his/her hands and fingers. The mirror helps the child see and recognize parts of his/her body. It is useful for children who have difficulty relating to different parts of their body or knowing where they are.
- Use modeling and imitation (copying). To teach a new skill or action, do something first and encourage the child to copy you. Repeat the actions until learned. This is a good way to teach the child sounds, words, and physical activities.
- Praise the child for his/her efforts and for what they have accomplished.

Note: Definitions and intervention may vary according to national standards for disability intervention. The information in this manual is a general guide.

EXAMPLES OF INTERVENTION SERVICES FOR YOUNG CHILDREN WITH DISABILITIES

- Early identification
- Screening and assessment
- Assistive devices
- Vision and hearing evaluations and follow up services
- Family counseling
- Medical and health care services
- Home visits
- Nutrition supervision
- Physical therapy
- Occupational therapy
- Psychological services for psychosocial support
- Speech and language therapy
- Transportation

IDEAS FOR SUPPORTING CHILDREN WITH DISABILITIES AND THEIR FAMILIES



A child with a physical disability playing with a puzzle in Sisters' Inclusive Early Childhood Center in Kenya, SCORE ECD Project.

Family is the young child's greatest resource. Building on the strengths of the family directly supports the development and learning of the child with or without a disability. Early intervention approaches recognize the critical role of the family. Children with disabilities and their families have physical, social-emotional, and psychological and spiritual support needs that must be addressed.

One way to assist families who have children with disabilities is by creating a **community care system**⁶.

COMMUNITY CARE SYSTEM

1. Start a support group of parents and caregivers of children with disabilities working together.

Working together provides an opportunity to share feelings and information, exchange ideas about activities to help the children and the best ways to adapt activities for a particular child, and make the community become friendlier, safe, and more supportive for children with disabilities.

To start a support group:

- Find two or more parents or caregivers who want to start a group. If you do not know other parents/caregivers whose children have a disability, you may want to include adults with disabilities, friends, community workers, and others. A health worker may know of parents in nearby communities.
- Plan when and where to meet. It helps to find a quiet place, like a school, health post, cooperative, or place of worship.
- At the first meeting, discuss why you are meeting and what you hope to do. Probably

⁶ Pact-Yekokeb Berhan Program (2014).

one person will be the leader of the first few meetings. But it is important that no one person makes decisions for the group. Everyone should have a chance to talk, but try to keep the discussion focused on the main reasons for the meeting. After the first few meetings, take turns leading the group. Having more than one person lead each meeting will help to share responsibilities among the groups.

2. Provide in-home support and referrals for children with disabilities and their caregivers.

A volunteer social worker can provide support through home visits:

- Provide supportive counseling, positive stimulation, and emotional comfort to the child and his/her parent or caregiver.
- Share information with families that *all children are special and that it is important for families and other adults to appreciate the uniqueness of each child and their special needs*, while at the same time appreciating the abilities of the whole child. This information will help families focus on what the child **can do** instead of what he/she **cannot do**.
- Share information with families about disability, its causes, and the importance of early intervention. Families of children with disabilities may lack knowledge about the causes of disability and think it is caused by a curse from God. Families may have been also using traditional medicine, which may have adverse effect on the child's health. Communication and information-sharing helps families to realize which practices are harmful and which are not, and consequently change behaviors.
- Provide contact information on appropriate and locally available support and resources for children with disabilities and show families the ways and means to access these resources, or how to use referral systems to get special support from health care services, counselors, rehabilitation centers (e.g., for adaptive and prosthetic devices or sign language training), inclusive early educational centers, etc.
- Spend time in the home with the child, or arrange for others to do the same, so that the parent/ caregiver can take some time off, go to the market, and/or attend to other needs.
- Help the child join with other children in the neighborhood as much as possible; for example, for play, in the church or mosque, or at community events.
- Work with local providers—most importantly the local school—to make sure that the child has access to educational opportunities to the extent possible for that child. Inclusion for education may mean some accommodation by the school; for example, to move the child's classroom to the ground floor, or assign other children to help the child with the disability get to and from the school, etc.



Illustration: CRS Lesotho

3. Plan and facilitate a community care network for supporting children and adults with disabilities in the community.

Step 1:

Ask a group of interested community members to join the group for the training and reflect on the idea of establishing a small sub-committee for helping children with multiple disabilities. The objective of this sub-committee is to provide a network of information and specialized resources, and to facilitate support and the coordination of care for local children with disabilities and their families.

Step 2:

Invite a professional from the Bureau of Women, Children, and Youth Affairs, the local Health Post, the Office of Labor and Social Affairs, or a disabled person's organization to help the sub-committee to plan and start the process of mobilizing the community to achieve their objective.

Step 3:

Give these individuals a piece of paper and ask them to write down what they can personally contribute by way of time, knowledge, skills, or other resources, that could help children with disabilities and their families. This information is important to have, even if all the members do not end up serving in the sub-committee.

Step 4:

Capture the promises on a flipchart, without repeating the points.

Step 5:

Establish a sub-committee of three to five persons that can create and coordinate the process of establishing a care system in their community. Sub-committee members should come together and decide a meeting date and venue to start their work.

Step 6:

Decide on an action plan: What does the sub-committee want to do first, then second, then third? Who should take the lead and what is the time-line?

Step 7:

Conclude by thanking everyone for their participation and commitment to contribute to their community's development.

Session 2: Vulnerable Children: Young Children Living With and Affected by HIV and AIDS

LEARNING OBJECTIVES

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

- Describe the term “orphan and vulnerable” and factors leading to OVC as relates to the human immunodeficiency virus (HIV) and AIDS factor, describing its mode of transmission, prevention mechanism, and care.
- Describe how HIV and AIDS infection of children in the early childhood years differ from HIV infection in adults.
- Describe the ecological effects of HIV and AIDS on young children and their families.
- Identify sustainable ways of supporting children and families infected and affected by HIV and AIDS using a holistic analysis approach.
- Identify ways to help vulnerable children cope with emotional problems related to grief.

ORPHANS AND OTHER VULNERABLE CHILDREN-OVC⁷

Vulnerable Children (VC) refers to children under the age of 18 whose safety, psychosocial or physical wellbeing, or development is at risk due to inadequate care, protection, or access to essential resources or services.

VC are defined as orphaned, living in poverty, receiving inadequate adult support because of death, abandonment, economic distress, or chronic illness, or living outside of family care. Other contributing factors are living with HIV/AIDS, being directly affected by armed conflict, living as displaced persons/refugees, being part of a marginalized group, living with little or no food security, health care, education, or other essential resources and services, or in some other way suffering from a collapse of traditional social safety nets in their families and communities.

People providing care for children living with HIV and AIDS include:

- Grandparents
- Older siblings or child-headed households
- Extended family members
- Foster parents
- Foster parents in addition to mothers and fathers
- Caregivers in residential care or orphanages

⁷ United States President's Emergency Plan for AIDS Relief (2006).

FACTS ABOUT HIV AND AIDS: TRANSMISSION, TESTING, PREVENTION, AND CARE

MODES OF HIV TRANSMISSION IN CHILDREN⁸

- Directly from mother to child during pregnancy (in utero), at delivery, and through breastfeeding
- Sexual abuse by HIV infected adults
- Transfusion of infected blood or blood products
- Direct exposure to HIV-infected blood, whether through the use of contaminated body piercing or cutting objects such as razor blades and needles. Baby boys who are circumcised by traditional healers are at risk of being infected from unsafe use of equipment.

HIV is not spread through hugging, sharing a cup, dancing, shaking hands, kissing, touching, sharing food, playing together, coughing or sneezing, mosquito bites, or from toilet seats.

HIV TESTING, PREVENTION, AND CARE⁹

People living with HIV and AIDS (PLHIV) will need regular access to health care treatment and follow up. This is important for many reasons:

- HIV positive children and families can be encouraged and monitored for constant intake of medicine, which leads to better health. Voluntary screening, combined with **antiretroviral treatment (ART)**, decreases infection rates.
- Early diagnosis can be possible for infected babies within two days or by two months after birth. Many babies exhibit infection signs during the first year of their lives.
- Weight gain and growth can be monitored for HIV positive children who are taking **antiretroviral (ARV)** drugs. Early ART treatment can ensure positive health and development for HIV positive children, including improving or preventing damages related to brain development. Therefore, it is important to motivate and counsel parents to take their HIV positive children to the health clinic regularly.
- Mothers and fathers who are infected can be treated and counseled on time. Medical treatment and counseling enables them to prevent the transmission of HIV to their babies and be healthy enough to continue taking care of their children's development. For example, pregnant women who are taking ART constantly can prevent transmitting HIV virus to their babies during pregnancy, delivery, and breastfeeding.
- Other diseases that can deteriorate the health of HIV positive parents and children can also be prevented. For example, co-trimoxazole (Bactrim or Septrim) protects young children from some infections like pneumonia, malaria, or diarrhea. This medicine, coupled with ART, helps HIV positive children stay healthy.

8 Deiner (2009); Malawi Ministry of Gender, Children and Community Development ECD Advanced Training Manual (2012); PEPFAR AIDSTAR (2011); Sherr (2005).

9 Catholic Relief Services (2009); Deiner (2009); PEPFAR AIDSTAR (2011).

THE IMPACT OF HIV AND AIDS ON CHILDREN: KEY IMPACTS RELATED TO EARLY CHILDHOOD DEVELOPMENT¹⁰

HIV and AIDS make children more vulnerable for many reasons. A child affected by HIV is more likely to be a victim of abuse, live in institutional care or on the street, or engage in dangerous and/or exploitive labor. Children living with an ill caregiver or who have been orphaned due to AIDS have a greater risk of abuse and exploitation, school dropout, and psychosocial distress. In addition, children affected by HIV are more likely to become infected with HIV, especially adolescent girls who have lost a mother and are more likely to engage in sexual behavior that may put them at risk.

Children living with HIV are also greatly impacted. Besides a large percentage of children not being diagnosed with HIV or treated for HIV, children who live with HIV sometimes have the added burden of being rejected by their families and/or abandoned to orphanages, further contributing to impaired cognitive and physical development. Without due attention, social isolation can damage the wholesome development of young HIV infected children. Therefore, it is important for caregivers to make sure that children in their care are not marginalized. Group play is a good place to check whether peers are treating HIV positive children fairly or otherwise and provide the appropriate guidance as needed. Child- friendly and age-appropriate activities such as role-play and book reading are useful ways of teaching children about HIV and promoting inclusion. The chart below shows some descriptions of the key impacts that are related to ECD:

A DESCRIPTION OF KEY IMPACTS RELATED TO EARLY CHILDHOOD DEVELOPMENT

IMPACT OF HIV ON CHILDREN	EFFECTS ON CHILD'S DEVELOPMENT
Poor parenting: Caregivers, especially mothers who are sick or neglectful, may give little or no attention to the child.	<ul style="list-style-type: none"> The child misses early caregiver-child interaction and stimulation, which leads to the child's insecure attachment and eventually failing to thrive.
HIV infection: Infected mothers who are not receiving proper treatment for HIV transmit HIV virus to the child at delivery or during breastfeeding.	<ul style="list-style-type: none"> The child gets HIV infection; exposed to frequent infection, poor health and even death, unless treated on time.
Death or sickness of a parent: Children become orphaned and may not have a substitute caregiver whom they can trust and depend on during their childhood. They may also be separated from their sisters and brothers and live in orphanages/foster homes.	<ul style="list-style-type: none"> The child's emotional wellbeing is affected due to separation or loss of family members; the child may have low self-esteem and behavioral problems. The child's essential needs for nutrition, health care, attachment, protection, and education might not be met in orphanages with poor resources and care.
Poverty: Poor families do not have the resources and access to meet the special needs of HIV positive children such as nutritious food and specialized health care. For example, undernourishment makes HIV positive children unable to tolerate ART medication.	<ul style="list-style-type: none"> The child can be exposed to undernutrition, severe illness, developmental delay, or even death.
Stigma and discrimination: Mostly, family and community members socially isolate HIV infected caregivers and children thinking mistakenly that the virus can be spread among them. Families may also reject their own HIV positive children and/or abandon them to orphanages.	<ul style="list-style-type: none"> The child misses social play and the opportunity to make friends and fully develop their social skills. The child has impaired cognitive and physical development.
Single parenting: Single parents may not spend adequate time playing with and talking to their children because often they are busy with multiple responsibilities for the family. Therefore, HIV positive children being raised by a single parent may not have the opportunity to develop secure attachment behavior.	<ul style="list-style-type: none"> The child's attachment needs may not be fully met.

¹⁰ Atwine, Cantor-Graae, & Bujunirwe (2005); Berens & Nelson (2015); Cluver, Orkin, Boyes, Gardner, & Meinck (2011); Cluver, Orkin, Boyes & Gardner (2012); Guo & Sherr (2012); Nelson, Zeanah, Fox, Marshall, Smyke, & Guthrie (2007); Operario, Underhill, Chuong, & Cluver (2011); PEPFAR AIDSTAR (2011); UNICEF.

IMPACT OF HIV ON CHILDREN	EFFECTS ON CHILD'S DEVELOPMENT
<p>Child-headed households: Older children, whose parents died from HIV, become the head of the household and take care of their younger siblings.</p>	<ul style="list-style-type: none"> • Young children do not receive the proper guidance and care they need in order to thrive and develop to their full potential. • Childhood experiences become stressful for all children involved.
<p>Elderly caregivers: Young orphan children infected with HIV may be raised by elderly grandparents. Although grandparents raise the child with loving care, they may lack the resources and the energy needed to meet all aspects of the child's development. They need additional resources and psychosocial support from family members or community support systems.</p>	<ul style="list-style-type: none"> • The child may lack day-to-day caregiver-child interaction and stimulation that meets his/her learning and developmental needs.
<p>Physical and psychosocial abuse: Due to stigma, HIV positive children can be isolated and neglected by families and other members of society. Exclusion further exposes them to various types of psychosocial and physical abuse, e.g., sexual abuse, violence (See <i>Session 2</i> of this guide for information on how to help children who are sexually abused.)</p>	<ul style="list-style-type: none"> • The child has low self-esteem; becomes depressed, aggressive, or withdrawn.

OBSERVED HEALTH AND DEVELOPMENTAL SIGNS AND SYMPTOMS OF HIV IN CHILDREN: THE EXPERIENCE OF WOMEN RELIGIOUS IN MALAWI, KENYA, AND ZAMBIA

Source: *Women Religious congregations from Kenya, Malawi, and Zambia, SCORE ECD project*

Below are the common observations of sisters in Malawi, Kenya, and Zambia on health and developmental signs and symptoms of HIV in young children:

- They are frequently ill. They easily get sick with different ailments such as coughing, malaria, and diarrhea. As a result, they often cough constantly.
- They usually have skin rashes that do not heal. They also have swollen glands.
- They have sores and cracks around the mouth; ear discharges and ear infections can affect both speech and hearing for young children.
- They are often malnourished; they may not eat well due to illness or lack of different kinds and nutritious food in the household.
- They usually look small for their age and they fail to grow or thrive.
- They show slow mental process and fall behind their peers in solving learning tasks. Maternal chronic illnesses and malnutrition during pregnancy and illnesses such as malaria, meningitis, or severe malnutrition can cause mental slowness or developmental delay in the child.
- They do not often engage in peer play, mostly due to lack of energy and illness; they want to be alone.
- They are usually not happy; peers shun them due to their physical appearance (e.g., skin rashes).

SUPPORTING YOUNG CHILDREN LIVING WITH OR AFFECTED BY HIV: A HOLISTIC APPROACH



A holistic intervention is highly significant for orphans and vulnerable children, such as children affected and infected by HIV and AIDS. Children orphaned by AIDS and children living with HIV suffer greater psychosocial problems than other children (Cluver, Kganaka, Boyes, & Park, 2012). Their lives are challenged by multiple social and psychological problems such as rejection, stigma, discrimination and marginalization, loss of assets (loss of land leading to inability of the family to grow food), lack of basic needs, dysfunctional families, and emotional distress such as depression, aggression, anxiety, and anger.

In order to have wholesome growth and development, children affected by HIV need to be supported at various levels¹¹, specifically: 1) child level, 2) family level, and 3) community level.

1. Supporting at the child level

- Early screening and testing for HIV
- Constant checkup and proper medical care
- Constant monitoring and follow up for children on ART and other treatments
- Adequate and nutritious food that helps them fight diseases; caregivers should be encouraged to use local or traditional food (see *Resource Guide, Module 6* for general guidelines about good nutrition)
- Warm, responsive caregiver-child interaction and stimulation that nurtures their early developmental needs, such as attachment and coping with death, loss of parents, and subsequent grief (see section *Psychosocial support: Understanding young children's reactions to loss and grief* in this guide).
- Developmentally and culturally appropriate activities (play, education, counseling) that help them develop self-help and learning skills and cope with emotional stress and anxiety related to being HIV positive
- Supporting the caregivers to disclose HIV diagnosis to the child at the appropriate age



Illustration: CRS Lesotho

¹¹ Catholic Relief Services (CRS 2009); Mallmann (2003); UNICEF Unite for Children; USAID (2011); USAID-Botswana (2008); PEPFAR AIDSTAR (2011).

2. Supporting children at the family level

- Constant support, encouragement, and follow up with HIV infected family members to take ART therapy and other treatment.
- Encourage and educate caregivers to be a responsive caregiver with whom the child can form a secure attachment. Securely attached children are more likely to be physically, intellectually, spiritually, and socially healthy, and more resilient to the damaging effects of poverty, illnesses, or violence.
- Support to families to identify and overcome barriers to care and support of their children and other members of the family as well.
- Support and education to the family to ensure food security in the household, especially nutritious food; life skills and livelihood training (e.g., income generating projects).
- Prevention education and resources for members of the family who are HIV negative.
- Support and encourage family caregivers on positive parenting; help them to identify their own positive traditional caregiving practices and give positive feedback and encouragement for these practices.
- Provide caregivers information on developmental milestones and explain why monitoring their children's development is important.
- Encourage and help caregivers to create home-based, developmentally appropriate child activities using materials and toys that are available at the home. Children with HIV benefit from community-based child care, games, and playground so they can have friends and less stigma.
- Refer caregivers to available health and social services including social protection programs.
- Encourage families to enroll their children who are affected by HIV/AIDS in early childhood centers like any other child in the household.



Illustration: CRS Lesotho

3. Supporting children at the community level

- Provide ART to children, family members, and others who need it so that they stay healthy and fulfill their roles and responsibilities in the community.
- Constant support and education for early testing and treatment for HIV at the local or mobile clinic in the village or hospital.
- Encourage community participation and organize community support groups in HIV and AIDS care like spiritual counseling and play therapy; connecting families to social welfare systems (Elderly caregivers and child headed household benefit most from such arrangements, e.g., children can attend school and elderly parents can get extra help to care for children.)
- Organize daycare service in the community that includes children living with HIV.
- Make it possible for preschool-aged children living with HIV/AIDS to go to preschool like any other children in their neighborhoods.
- Organize and support families for household food security through income generating projects; help them connect to village savings and loan groups to access cash and knowledge on micro-finance management.

HOLISTIC APPROACH IN ACTION: CARING FOR CHILDREN AFFECTED BY HIV

EXPERIENCE OF THE EVANGELIZING SISTERS OF MARY, KENYA

Contributed by Evangelizing Sisters of Mary, Kenya, SCORE ECD project

Sister Veronica and her congregation provide spiritual and social support to single mothers in the slum areas of Nairobi, Kenya. Most of the mothers in this area are unemployed, and hence are engaging in commercial sex work to earn income for their families. Many mothers have at least two children with different fathers who are not supporting them in any way.

Sister Veronica encountered the case of a young, unemployed, HIV positive mother who was pregnant with her fourth child. The mother had attempted to carry out an abortion and had attempted suicide. She did not want to give birth to another child because she did not have any source of income to support the family.

After several discussions with Sr. Veronica, the woman decided to maintain her pregnancy, enrolled in a PMTCT program, and later gave birth to HIV-free twins. However, she later died from AIDS-related illnesses. Her surviving children (ages two, three, and six years) live with their relatives and the congregation supports them.

REFLECT AND DISCUSS

1. Based on the story, what you've recently learned, and your experiences, what are the unique challenges facing these orphaned children?
2. What challenges are likely to be the most pressing?
3. Using a holistic approach, identify several actions you could take at various levels (e.g., child level, family level, and community level) to support these vulnerable children.

Note: Women Religious in Kenya, Malawi, and Zambia place a special focus on preventing the spread of HIV and AIDS, and also caring for people who are already infected with the HIV virus, while working to eliminate stigma and discrimination.

PSYCHOSOCIAL SUPPORT: UNDERSTANDING YOUNG CHILDREN'S REACTIONS TO LOSS AND GRIEF

WHAT IS PSYCHOSOCIAL SUPPORT?

- Creating a giving and stimulating environment to allow children to express their feelings—Psychological
- Creating an environment for reintegration (supports addressing psychosocial problems)—Social
- Enhancing the resilience of the individual in being able to cope with psychosocial problems—Support (*Malawi Ministry of Gender, Children and Community Development, 2012*).

Children whose family is affected by HIV face serious emotional problems due to multiple deaths in the family. They hurt emotionally as they witness the continuous suffering and death of their loved ones (siblings, parents). By providing psychosocial support, caregivers or close relatives can help children prepare for the loss as well as cope with subsequent grief.

Sometimes customs and traditions exclude children from participating in the grieving process. Thinking that they are protecting children from emotional distress, family members keep children away from funerals and/or do not tell them the truth about their loss of parents, friends, or loved ones. In situations like this, young children's

emotions are ignored and they are expected to do their daily activities without the chance to deal with their grief and emotional pain, which subsequently affects their development and learning.

YOUNG CHILDREN'S DEVELOPMENTAL REACTION TO DEATH AND GRIEF¹²

Young children have difficulty understanding the death of their loved ones. How they understand and react to death and grief depends on their developmental level. For this reason, in order to help grieving children we need to first know how the child understands death and respond to grief.

Infants (birth to two years): Infants and toddlers do not yet have the ability to understand the meaning of death. Developmentally, they are just beginning to learn the meaning of separation. During this age range, they heavily trust the caregiver and rely on him/her to explore their world without fear. If the caregiver is absent, the child may become anxious and fearful upon separation or loss of the caregiver. Constant daily life routine is their security base, therefore a sudden change in their relationship with caregivers or their routines and schedules causes them great discomfort.

Emotional responses: Their reaction to loss includes behaviors such as irritability and tantrums, excessive clinging, constant crying, a change in sleeping and eating habits, and decreased activity and weight loss.

Preschool-aged children (three to five years old): This age group is known for their imagination. They see death as temporary and think that a dead person will come back as in a game. Therefore it is common for a preschooler to ask for the missing/deceased person again and again. Children in this age group also think that they are the ones that caused the death of the person and suffer from feelings of guilt.

Emotional responses: Preschoolers react to loss through various emotional feelings and behaviors. Due to the shock and inability to cope with the pain, they might act as if nothing happened. They often cope by imitating adult's behavior. When they see adults calm and happy, they also feel happy and secure. When adults cry or show a troubled face, preschoolers can also be distressed and may throw tantrums or cry continuously. Other emotions that this age group exhibits in reaction to loss of loved ones include frightening dreams and nightmares, anxiety, sadness, anger, confusion, difficulty eating, inability to sleep without a light on or someone else present, regressive behaviors such as excessive clinging, bed wetting, thumb sucking, inconsolable crying, fear of being left alone, loss of bowel/bladder control, or communicating with "baby-talk." Caregivers can help preschoolers to express their thoughts and feelings using their words, drawings, or fantasy play.

¹² Cluver, Kganaka, Boyes, & Park (2012); Mallmann (2003); PEPFAR AIDSTAR (2011); Speier (2005); Stein (2003); USAID (2011); VITAS Healthcare.

HELPING VULNERABLE CHILDREN COPE WITH LOSS AND GRIEF¹³

Caregivers and early childhood practitioners can provide psychosocial support to help the child get through the difficult time of grief. Some suggestions are:

- **Recognize children's feelings.** Children's feelings are real and adults should regard them as such. Help grieving children to express their feelings through a variety of ways such as reading books, talking, puppet storytelling, drawing, clay modelling, and dramatic play.
- **Be patient and answer children's questions honestly.** Tell children the truth in simple and direct explanations about the loss of their loved ones. Treat children's questions with respect and be consistent in your answers when children ask you the same questions over and over again. Conflicting messages and telling half-truth makes children more anxious and confused and delays the healing process. For example, avoid telling a child that his/her deceased mother has gone to sleep. This kind of information causes the child to expect that his/her mother will come back.
- **Pray with the child.** Prayer comforts children. Young children, ages four to six, see God as a person. With adults' help, children can learn how to pray. Allow children to take part in religious and traditional rituals after death such as attending prayer service. When children see and hear adults praying with words of comfort and hope, children will also feel calm and reassured. Prayer such as "God, thank you for listening to us in this hour of sadness and thank you for comforting us and taking care of us" can help reduce anxiety and fear in children and help them develop trust in God.
- **Communicate in a language children understand.** When you talk with children, give information at the level the child can understand. For example, to explain about death for young children, use concrete examples such as a dead animal. Use simple words and body language when you communicate with the child. Cuddling, hugging, and hand-holding reinforce your words and give the child more reassurance. Most importantly, talk and play with children in their dominant language.
- **Communicate disclosure of HIV status as appropriate to child context.** Remember that there is no one standardized way for conducting disclosure of HIV status to young children or adults. You need to work on the timing and nature of disclosure according to the child's specific situation such as health condition, age, developmental level, and home situation. Disclosure requires deep empathy and long periods of time, thus it is advisable to establish an empathic and consistent relationship with the child and *carefully* start with a gradual partial disclosure where *you provide the child health information without telling him/her that he/she has HIV*, opening the process to full disclosure when the child is mature enough to understand the information.
- **Provide a reliable substitute caregiver.** Children need a reliable caregiver whom they can depend on for care and a sense of security throughout their childhood. If both parents of a child die, provide a substitute caregiver who can meet the child's needs during and after the mourning process. The substitute caregiver needs to create a normal routine for the child with consistent emotional support. This will help the child feel less anxious and regain his/her sense of security and control. Encourage grandparents/close relatives to become reliable attachment figures for orphan children.
- **Communicate trust and promise only what you can do.** If you know that you will have to leave the child for some time, prepare them for it in advance. Tell them that you

Respond to your child when crying



Illustration: CRS THRIVE

¹³ Catholic Relief Services (2009); Malawi Ministry of Gender, Children and Community Development (2012); Mallmann (2003); PEPFAR AIDSTAR (2011); National Association of School Psychologists/NASP (2003); Speier (2005); Stein (2003); The Pennsylvania Child Welfare Training Program; USAID (2011).

will be going away, where to, for how long, and who will look after them while you are away. When you leave, it is likely that the child will be very distressed and may have a tantrum. Do not punish this. Always leave the child with someone they know well.

- **Help the child cope with fear of sleeping.** If the child is afraid to sleep alone allow them to sleep with another person initially and gradually adapt them to sleeping alone. Read or tell calming stories during sleep time or find what comforts the child and apply them accordingly.
- Dreams and nightmares are real for the children, therefore do not ignore them. Ask the child to share their nightmares with you. Take them seriously and reassure them that their fears are imaginary.
- **Minimize stress.** The child may find some situations stressful and difficult to deal with such as moving to a new school, being separated from siblings, leaving the family, etc. Try to minimize these by not uprooting them from the community they know. Make any changes in a gradual way.
- **Create memory books.** Memory books can also help children express their feelings about tragic events easily and these activities can be added in play corners. Memory boxes and books also help parents who are positive with HIV to talk to their children about their conditions, family histories and memories, and values and traditions. Young children who lost their parents can especially benefit from such activity and support and be able to know about their family and have a sense of belonging.
- **Inclusion in group play.** The child may be afraid of going out to play and become isolated. Help children cope with this fear by talking to them about their fears and physically walking with them to the playground and play with them. Also, gradually foster *peer support* for group play. Friends encourage the child to relax and become more playful.
- **Help the child adjust to a new environment.** Allow the parent or caregiver of the child into the classroom for an initial period of time. Gradually reduce the amount of time you allow the person to stay. If they wish to, allow the child to bring an object with them that represents the lost person.



Illustration: CRS Lesotho

A stressed child will find it difficult to cope with changes or new situations in the classroom (e.g., a new leader, a change of routine, etc.). In these cases, the child might become inactive and/or cry. It is very important that you remain patient and calm and do not punish the child.

Provide basic needs. Make sure that the child feels safe and secure and provide his/her basic needs such as nutritious food, health care, education, etc.

Support caregivers and extended family members of the child. Try to ensure sustainable livelihood and health care for family members as well as for their inclusion in all activities in and around their communities.

Support caregivers by sharing information on how they can help their children cope with loss and grief. One way to do this is by preparing a simple information card for counseling caregivers, as shown below:

INFORMATION CARD

HOW TO TALK TO CHILDREN ABOUT DEATH

Answer honestly

- Tell the child the truth about how the parent or relative died. For example, “Your mother died from a serious illness,” or “Your granny died because she was very old.”
- It is not helpful to tell the child a confusing story, for example, “Your mother has gone on a slow train and will take a long time to return.”

Help children express their feelings and thoughts

- Sometimes it is enough to sit with the child and listen.
- You can also help by saying, for example, “I know you miss your mother very much.”
- Allow the child to cry. If you feel that you also want to cry that is okay.
- This can be part of the healing process for both you and the child.

Allow children to express their sadness

- This sadness may appear as anger or naughtiness.
- Comfort rather than punish a naughty child and explain that when children are feeling sad they often behave this way. You can say, for example, “It’s not that you’re bad, it’s just that you’re sad!”



Source: *Say and Play*, Jonathan Brakarsh, Project Concern International (2009). User of this manual is recommended to use the manual *Say and Play* when working with young vulnerable children with psychological and social needs. http://www.coregroup.org/storage/HIV_AIDS/PCI-SayAndPlayKit.pdf

Session 3: Rights and Protection of Young Children

LEARNING OBJECTIVES

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

- Describe the major categories of children's rights.
- Describe the roles and responsibilities of caregivers in protecting the rights of children.
- Identify possible signs of abuse and neglect in young children.
- Describe appropriate steps to report suspected child abuse or neglect, or get help themselves.
- Describe ways of advocating for the protection of young children against any kind of abuse, neglect, or violence.

GIRLS' RIGHT TO EDUCATION

Contributed by Assumption of Sisters, SCORE ECD Coordinator, Kenya

Maasai traditional children's song

"Mpapai Lai"

*Mpapai lai ajoki nchooki esipata ainchooki alo sukul
mikincha maishira tenato sukul mpapi nikilam osina*

"Please! Father, give me my right,

Allow me to go to school

Father, if you educate me I will help you in the future."

(This Maasai song in Kenya is sung by girls pleading to their fathers to send them to school.)

Maasai traditional children's game

Mpapa: Natito kore duo iyie?

Entito: Mpapa nena nanu

Mpapa: Supa oleng

Entito: Mpapa aidetidetua duo ashomo sukul

Mpapa: Kanyo ina nijeito? Miloaikata Sukul amu aitorono sukul!

Entito: Aa mpapa imeturo no amu kiaku oitangani olmalimui

Mpapa: Tiarayu mashosh ake!

Entito: Nelo entito aishirita

Meaning

Father: Young girl where are you?

Girl: Father, I am here (She bends her head to greet the father.)

Father: How are you?

Girl: Father, today I dreamed of having gone to school.

Father: What? Don't say this again. You will never go to school, school is not a good place to be.

Girl: No, no, school is not bad; when one goes to school, she becomes a teacher, a doctor, etc.

Father: Stop talking or I will beat you!

(Girl goes away crying)

This Maasai game reminds the parents that they have the duty to educate the child as it is their right to go to school.

All children around the world have the same rights. The United Nations Convention on the Rights of the Child describes the rights in detail. Many countries in the world have ratified the UN Convention on the rights of children and signed an agreement that commits the government to ensuring that every child has those rights. Among African countries, Kenya and Zambia have ratified and signed an agreement on the UN Convention on the Rights of the Child, while Malawi ratified it. (United Nations Treaty Collection https://treaties.un.org/Pages/ViewDetails.aspx?mtdsg_no=IV-11&chapter=4&lang=en)

The UN Convention says that children need:

- Food, shelter, basic health care, and clean water
- Protection from abuse, neglect, and exploitation
- Opportunities to play and learn so that they can develop to their full potential
- To have a say in the decisions that affect their lives

CATEGORIES OF CHILDREN'S RIGHTS¹⁴

THE RIGHT TO SURVIVAL

- All children have the right to a name and nationality.
- All children have the right to grow peacefully in a caring and secure environment.
- All children have the right to basic necessities of life, for example, food, shelter, and clothing.
- All children have the right to be taken care of by parents or family members.

THE RIGHT TO DEVELOP

- All children have the right to a basic education.
- All children have the right to play to socialize in a safe environment.

THE RIGHT TO PROTECTION

- All children have the right to have their health protected through immunization and appropriate health care.
- All children have the right to be protected from abuse and exploitation.
- All children have the right to be treated fairly and humanely.
- All children have the right to be employed or engaged in activities that are not harmful to their health and development.

THE RIGHT TO PARTICIPATION

- All children have the right to express their opinions.
- All children have the right to be listened to.
- All children have the right to be consulted according to their own understanding.

PARENTS AND CAREGIVERS' RIGHTS AND RESPONSIBILITIES

Parents and caregivers also have rights related to their children. They have the right to:

- Live at home with their child or decide where their child will live
- Be involved with their child's life even if the child does not live with them
- Have their child carry the family name
- Say how their child will be brought up, including moral and cultural values and beliefs
- Decide on the religion of their child
- Make decisions about their child's education
- Discipline their child
- Not have the child adopted without consent

¹⁴ CRS, Lesotho (2012).

PARENTS AND CAREGIVERS RESPONSIBILITIES FOR ENSURING THE RIGHTS OF THE CHILD

The expected roles of parents and caregivers in ensuring children's rights are:

- To give their child a name and register him/her to get a birth certificate
- To provide a place to live, food, and clothing for their child
- To love and care for their child
- To protect their child from abuse or harm
- To guide and support their child's growth, development, and learning
- To discipline their child

FATHERS' ROLE IN PARENTAL RESPONSIBILITIES

Early childhood care and responsibilities are often linked to the mother, and fathers' roles are overlooked. Fathers have a very important role to play in the lives of their children. Studies of early childhood development and education have shown that children whose fathers are involved in their lives do better at school and feel more confident. Children with little or no contact with their fathers are more likely to use drugs and abuse alcohol, and boys are more likely to turn to crime and violence.

Children will feel more secure when their fathers protect them, love them, and take part in their lives, especially during the early years.

FATHER'S ROLE IN CHILD DEVELOPMENT



The fathers' roles in nurturing their child's development can be, but is not limited to, the following:

- Comfort their child when he/she is sad or needs reassurance.
- Listen to and take an interest in what their children do and say.
- Be a good role model for their children; help the child in his/her learning life or educational experiences.
- Make time for their children. Do activities around the house and help with feeding, washing, and dressing their children and also play with their children.
- Allow their children to express their feelings when they are sad or hurt.
- Find non-violent ways to discipline their children [**Note:** *If hitting a child causes harm to the child it can be considered abuse. Using vulgar words on the child can lead to emotional abuse.*]

CHILD ABUSE AND PROTECTION

Parents and caregivers have the responsibility to protect their children from harm and neglect. However, child abuse and neglect happens all over world, in all kinds of families and in all types of settings. Every child is at risk for possible child abuse or neglect. Children cannot defend themselves and they rely on their parents and caregivers and other adults in their lives to protect them.

WHO ABUSES CHILDREN?

The person most likely to abuse or neglect a child is the parents or caregiver. Other people who may abuse children include step-parents, adoptive parents, foster parents or relatives, or boyfriends or girlfriends of parents. People who are not related to the child sometimes abuse or neglect children as well, such as another person living in the child's home.

ABUSIVE CHARACTERISTICS INFLUENCING YOUNG CHILDREN'S DEVELOPMENT AND LEARNING¹⁵

- *Physical abuse*: Kicking, biting, shaking, stabbing, or pinching a child. Spanking may be classified as abuse if the child is bruised or injured; poor physical care such as dirty clothing.
- *Sexual abuse*: Intrusion, molestation with genital contact, or another forms of sexual acts; exposing a child to pornography.
- *Emotional abuse*: Rejecting, isolating, terrorizing, ignoring, or corrupting a child; confinement, verbal abuse, withholding sleep, food, or shelter; exposing a child to domestic violence, refusing to provide psychological care, or allowing a child to engage in substance abuse or criminal activity.
- *Neglect*: Refusal or delay in providing health care, nutrition, shelter, clothing, affection and attention, education; inadequate supervision or abandonment. Families who are poor often have a more difficult time providing what children need. However, it is important to understand that this does not mean that the child is being neglected.

SIGNS OF POSSIBLE ABUSE OR NEGLECT AND REPORTING SUSPECTED CASES

Children can be abused physically, emotionally, and sexually. Neglect is also another form of abuse. There are many signs of abuse and some of the common ones are listed below. It is important to remember not to make assumptions as sometimes there are also other reasons why children may show some of these signs.

¹⁵ Charlesworth (2012); CRS, Lesotho (2012); CRS Policy on Protection from Abuse and Exploitation (2014); CRS Protection Approach (2015-2018, 2015).

SIGNS OF POSSIBLE ABUSE OR NEGLECT¹⁶

PHYSICAL ABUSE	EMOTIONAL ABUSE
You might notice:	You might notice:
<ul style="list-style-type: none"> • Bruises in unusual places or unexplained bruises 	<ul style="list-style-type: none"> • Poor appetite
<ul style="list-style-type: none"> • Fractures not from normal play accidents 	<ul style="list-style-type: none"> • Bed wetting or toilet accidents
<ul style="list-style-type: none"> • Cuts, welts, or other marks in the shape of an object, like a belt or cord 	<ul style="list-style-type: none"> • Failure to thrive
<ul style="list-style-type: none"> • The child's explanation of what happened does not match the type of injury 	
<ul style="list-style-type: none"> • Pale or bluish skin 	
<ul style="list-style-type: none"> • Seizures/temporary muscle stiffness 	
<ul style="list-style-type: none"> • Loss of consciousness 	
The child might:	The child might:
<ul style="list-style-type: none"> • Watch out for danger 	<ul style="list-style-type: none"> • Be depressed
<ul style="list-style-type: none"> • Not make friends 	<ul style="list-style-type: none"> • Have low self-esteem
<ul style="list-style-type: none"> • Vomit 	<ul style="list-style-type: none"> • Be emotionally unstable
<ul style="list-style-type: none"> • Have fits 	<ul style="list-style-type: none"> • Have poor social skills
<ul style="list-style-type: none"> • Act aggressively 	<ul style="list-style-type: none"> • Have problems with peers
<ul style="list-style-type: none"> • Be depressed 	<ul style="list-style-type: none"> • Act aggressively
	<ul style="list-style-type: none"> • Become withdrawn
	<ul style="list-style-type: none"> • Attack peers
SEXUAL ABUSE	NEGLECT
You might notice	You might notice:
<ul style="list-style-type: none"> • The child has difficulty walking or sitting 	<ul style="list-style-type: none"> • The child is underweight
<ul style="list-style-type: none"> • Stained or bloody underclothing 	<ul style="list-style-type: none"> • Failure to thrive
<ul style="list-style-type: none"> • Injuries to the genitals 	<ul style="list-style-type: none"> • Developmental delays
	<ul style="list-style-type: none"> • Speech problems
	<ul style="list-style-type: none"> • The child is not dressed appropriately for the weather
The child might:	The child might:
<ul style="list-style-type: none"> • Have low self-esteem 	<ul style="list-style-type: none"> • Act tired or hungry
<ul style="list-style-type: none"> • Be depressed 	<ul style="list-style-type: none"> • Have low self-esteem
<ul style="list-style-type: none"> • Be aggressive or withdrawn 	<ul style="list-style-type: none"> • Be overly passive
<ul style="list-style-type: none"> • Act out sexual or seductive behavior 	<ul style="list-style-type: none"> • Become easily frustrated or angry
<ul style="list-style-type: none"> • Masturbate excessively 	<ul style="list-style-type: none"> • Ask for lots of help, or be dependent on the caregiver
<ul style="list-style-type: none"> • Run away 	<ul style="list-style-type: none"> • Be inattentive, impulsive, or aggressive
	<ul style="list-style-type: none"> • Have poor peer relationships

¹⁶ CRS, Lesotho (2012).

Children need to know that they have the right to say “no” to anyone who tries to touch or hurt them, even if it is a member of their family. If a child is scared, an appropriate response is for the child to run away and go and tell someone that they trust.

Parents and caregivers need to know that there are safe places for victims of domestic and child abuse. Examples of such places are:

- Church leader
- Local chief’s office
- Child and gender protection unit found in local community services
- The police station
- Department of Social Welfare and social workers based in the local district health centers (hospitals) countrywide.
- Any person they trust to report any abuse

HELPING CHILDREN TO TALK ABOUT SEXUAL ABUSE THROUGH A STORY

Child sexual abuse happens in all countries and communities. Child sexual abuse is when a child is exposed to sexual behavior that is not appropriate for their age. Children can’t always talk easily or openly about child sexual abuse. Storytelling can help children talk about what they feel and experience (Brakarsh, 2009).

Use the following story messages to discuss child sexual abuse:

Card 1: Before you start this story, draw a picture of a grown man (the uncle) and a five-year-old girl (Miriam). They should be clothed. To illustrate what is happening, point to the various body parts on each picture, as the story requires.

Card 2: Draw two dolls on a piece of paper or make them out of fabric.

When you ask a child to whisper in your ear and share a secret, give one doll to the child and keep one for yourself. Encourage the child to use the doll to speak to your doll—the ‘listening doll.’

Explain that this doll loves to listen to children. She takes all the children’s secrets and helps to make things better.

Card 3: Story

This is a story about a five-year-old girl called Miriam.

Miriam is very unhappy. Do you know why? (The children answer.)

She has an uncle who lives in her house. This uncle touches her here and here (point to breasts and pubic area on Miriam’s picture) and she has to touch him here (point to pubic area on the uncle’s picture) almost every day. Sometimes she is scared and cries.

Her uncle gives her sweets to make her feel a little better. He tells her, ‘This is our special secret. Don’t tell anybody.’ Do you know what a secret is? (The children answer.)

Do you think Miriam told anybody that her uncle was touching her here and here (point to breasts and pubic area on Miriam’s picture)?

Miriam is too scared to tell anybody. Miriam thinks, ‘Am I doing something bad?’ But she doesn’t want to keep this secret. Sometimes she cries at night because she doesn’t know what to do. She wants her uncle to stop. But she is too scared to tell anybody.

What should Miriam do?

Card 4: Questions

Do you know children who this has happened to?

Do you have a secret that is scaring you or making you sad?

Can you come and whisper it in my ear?

Who else can you talk to if you have a secret that is scaring you or making you sad? Let's make a list.

Remember, you can also come to me after class today or go to any of your helpers and tell them.

Is it okay with you if I go and find some helpers to take care of the things we have talked about?

How can children help each other?

Source: Brakarsh, J. (2009). *Say and play Tulande no kwangala: A tool for young children and those who care for them*. Zambia: Project Concern International. http://www.coregroup.org/storage/HIV_AIDS/PCI-SayAndPlayKit.pdf

POSITIVE DISCIPLINE¹⁷

Harsh punishments are harmful to children and affect the way they develop and learn. These include hitting, locking the child in a room, forcing the child to stay outside the house, threatening or shaming the child, or keeping food and water from the child.

Children do misbehave but there are other ways to discipline them without hurting or shaming them, for example:

- Stop the child from doing what he/she must not do.
- If the child persists, talk firmly but kindly to tell him/her to stop their unwanted behavior.
- Have the child sit out of a game or activity for a few minutes (not in another room, and someone should stay with him/her). Follow up by talking about the behavior.



"Avoid harsh punishment" - *Say and Play* by Jonathan Brakarsh (2009)-

¹⁷ CRS, Lesotho (2012).



Let boys and girls play together.

GENDER ROLES¹⁸

Gender describes the differences in the way that men and boys and women and girls are expected to do things and behave, e.g., their dress, the work they do, and the way that they speak. Gender discrimination means that men and women or boys and girls are treated differently. Society stereotypes gender roles. A gender stereotype is the belief that boys and girls are expected to behave in a certain way. Adults influence children's ideas of how they are supposed to behave according to their gender, and these expectations and influences start early. Some examples of these expectations include:

- Boys don't cry
- Girls play with dolls, make up kits, and play dishes
- Boys play with tools, construction sets, and doctor kits
- Boys are smart in mathematics
- Women are responsible for raising children
- Men are breadwinners
- Men are strong
- Women do the house work
- Men do not cook and sew

These kinds of remarks send messages to children about what is expected of their role as a boy or a girl. It can stop children from doing what they want to do. Early childhood caregivers and teachers can expand children's ideas about gender roles by:

- Treating girls and boys equally
- Modeling expanded gender roles (e.g., females fixing broken chairs, desks)
- Avoiding messages that show or indicate to children stereotyped gender roles (e.g., guiding girls to play with dolls and boys with construction tools).
- Avoiding linking occupation to gender (e.g., instead of saying "policeman," say "police officer," or say "firefighter" rather than "fireman").

¹⁸ CRS, Lesotho (2012); Gonzalez-Mena & Widmeyer Eyer (2012).

SPEAKING ON BEHALF OF YOUNG CHILDREN: ADVOCACY

Some of the roles of people working with children are to advocate for the rights and protection of young children. Their purpose is to be the voice for children and bring their needs to the attention of the public (e.g., informing community leaders and policy makers) for better care and provisions, protection, and education. There are many areas that people can influence policies and practices related to the wellbeing of young children. Some examples are advocating for:

- Children who witness and are victimized by violence
- Quality early childhood services for all young children
- Children with disabilities or orphan and vulnerable children
- Children who are hungry and have inadequate health care
- Children who live in insecure living situations

Advocacy requires good preparation of facts about the issue.

BASIC GUIDELINE FOR ADVOCACY¹⁹

First, identify the problem or concern

- What is the problem or the issue that young children in your community are facing?
- Find out *the facts* about the issue or the problem that you have identified in young children in your community. Does the problem exist in your community?

Second, make your case—the most important part of your advocacy

- Why are you interested in the issue? For example, you have seen many preschoolers being beaten harshly by their teachers and you are concerned for their wellbeing.
- What is your position? For example, do you want to stop corporal punishment being used in a preschool setting?
- What is some of the evidence that can convince your audience that the problem at hand is highly significant and needs their attention? For example, are teachers punishing preschoolers severely and damaging children's safety and wellbeing in your community?
- What kind of evidence can you collect and document to support your position? Interviews, medical reports, eye witness accounts, photo, evidence from court, studies conducted showing that corporal punishment damages children's development, etc.

Third, make your recommendation/s for action(s)

- What should be done? List your recommendation for the solutions. Prioritize your recommendations.
- Who (person/s) or what (institution/s) is **the primary audience** that can take up the issue and execute the recommended action/s?
- Is there a person, organization, or government ministry that can be made responsible

¹⁹ Tadesse (2014).

for action on each recommendation? For example, is the Ministry of Education the right institution to bring this issue up with?

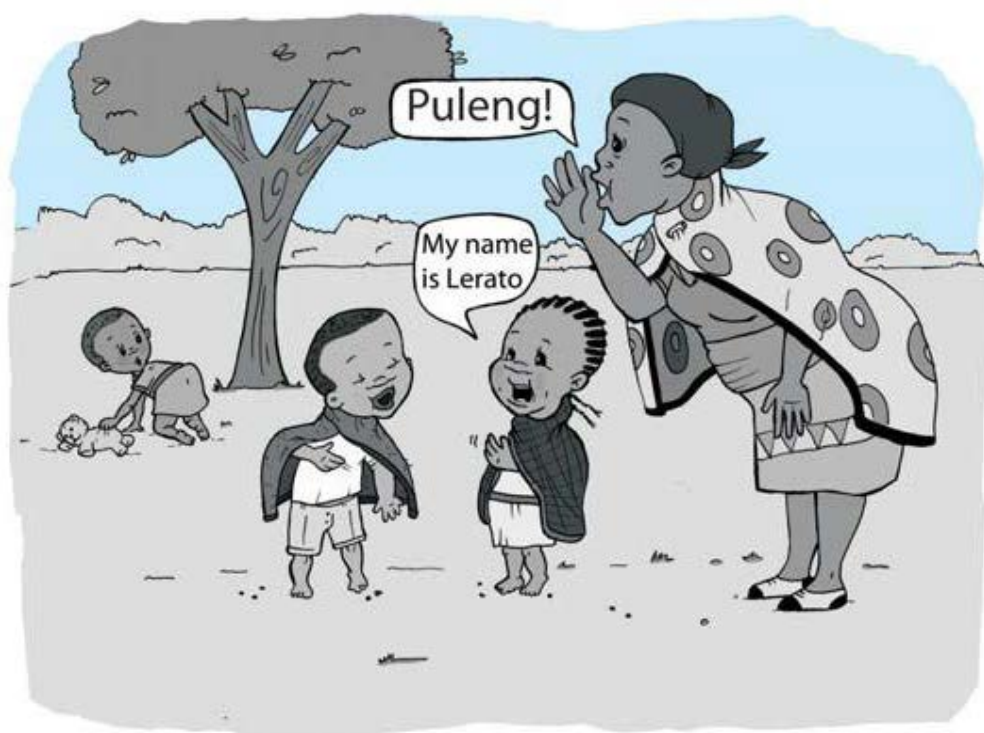
- Organize your findings and make them ready for dissemination.

Fourth, disseminate your information. Based on your findings, share your information using a variety of channels and formats such as:

- Brochure with summary of the key messages about the issue
- Interview with the media using key message points
- PowerPoint presentation highlighting the problem and suggested recommendations
- Video footage or stock photographs to facilitate media coverage
- Short article published in newspapers/magazines
- List of spokespeople according to their specialty areas
- Community forums such as church group meetings and farmers' cooperation; government ministries
- Organized events in parishes, community gatherings, schools, etc.
- Network with other child welfare services in the community

IDEAS FOR WORKING WITH PARENTS, CAREGIVERS, OR TEACHERS²⁰

HOME VISITS



Give your child an identity.

Use the following flip book messages to discuss the topic **birth registration**. When you visit, include both parents, if applicable. Ask whether the children in the family have been registered and have birth certificates. If not, find out why not. Families often don't realize how important this is.

²⁰ CRS, Lesotho (2012).

Explain the importance of giving the child a legal identity and that without this he/she may not be able to go to school, inherit property, or have access to some health and social services.

If children are not registered, provide information to the family on how to register their child and get his/her birth certificate from the relevant local community services.

PUNISHMENT



Discipline your child without hurting her.

Include in the discussion all parents and caregivers responsible for children in the household.

Ask the parents or caregivers what they consider as misbehavior of their child and ask for examples of the kinds of things he/she does.

Discuss possible reasons for the misbehaviors and how the parents or caregivers respond. Ask how the parent or caregiver disciplines the child and discuss how the child might feel. Make the point that physical and other harsh punishments are harmful to the child and will affect the way he/she develops and learns.

Encourage parents or caregivers to discipline appropriately and discuss more positive discipline methods, such as removing the child from the activity for a few minutes.

Note: See *Resource Guide, Module 2* for more information on *Guidance and discipline: Supporting positive behavior in young children*.

References

SESSION ONE: YOUNG CHILDREN WITH DISABILITIES

- Byington, T. (2010). Inclusion in Early Childhood Programs, Area Extension Specialist, Early Childhood Education <https://www.unce.unr.edu/publications/files/cy/2010/fs1067.pdf> Fact Sheet-10-67 University of Nevada Cooperative Extension.
- Catholic Relief Services (CRS), Vietnam (2007). *How to guide inclusive education for children with disabilities*. CRS, Vietnam, CRS. Retrieved from <http://www.bettercarenetwork.org/sites/default/files/attachments/Inclusive%20Education%20for%20Children%20with%20Disabilities.pdf>
- Carter, S. L. (2015). *Impairment, Disability and Handicap*. Department of Pediatrics, EMORY University of School of Medicine. <http://www.pediatrics.emory.edu/divisions/neonatology/dpc/Impairment%20MX.html>
- Catlett, C. (2009): What do we mean by "Early Childhood Inclusion?" Finding a shared definition. IMPACT. Retrieved from <https://ici.umn.edu/products/impact/221/2.html> or http://npdci.fpg.unc.edu/sites/npdci.fpg.unc.edu/files/resources/EarlyChildhoodInclusion_0.pdf
- Catron, C.E. & Allen, J. (2008). *Early childhood curriculum: A creative-play model*. (4th ed.). Upper Saddle River, NJ: Pearson.
- Dodge, D. T., Rudick, S., & Berke, K. (2011). *The creative curriculum for infants, toddlers & twos: Volume 1 the foundation*. (2nd ed.). Washington D.C., DC: Teaching Strategies.
- Gonzalez-Mena & Widmeyer Eyer, D. (2012). *Infants, toddlers, and caregivers: A curriculum of respectful, responsive care and education*. (9th ed.). Boston, MA: McGraw-Hill.
- Hesperian (2009). *Disabled village children: A guide for community health workers, rehabilitation workers, and families*.
Hesperian http://hesperian.org/wp-content/uploads/pdf/en_dvc_2009/en_dvc_2009_fm.pdf
- Pact-Yekokeb Berhan Program (2014). *Volunteers' orientation guide: How to care for children with disabilities in Yekokeb Berhan/Pact program for highly vulnerable children*. Addis Ababa, Ethiopia: Pact, ChildFund, fhi360, and USAID.
- Salend, S. J. (2001). *Creating inclusive classrooms: Effective and reflective practices*. (4th ed.). Upper Saddle River, NJ: Merrill Prentice Hall.
- UNESCO (2009). *Teaching children with disabilities in inclusive settings: Embracing diversity-toolkit for creating inclusive, learning-friendly environments*. UNESCO Asia and Pacific Bangkok, Thailand: Regional Bureau for Education. Retrieved from <https://www.google.com/#q=Teaching+children+with+disabilities+in+inclusive+settings:+Embracing+diversity-toolkit+for+creating+inclusive%2C+learningfriendly+environments>
- UNESCO (2001). *Understanding and responding to children's needs in inclusive classrooms: A guide for teachers*. <http://unesdoc.unesco.org/images/0012/001243/124394e.pdf>
- U.S. Department of Health and Human Services and US Department of Education (2015). Draft policy statement on inclusion of children with disabilities in early childhood programs. <http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/inclusion-policy-statement-draft-5-15-2015.pdf>
- Wittemer, D.S. & Petersen, S.H. (2014). *Infant and toddler development and responsive program planning: A relationship based approach*. Boston, MA: Pearson.
- WHO & UNICEF (2012). EARLY CHILDHOOD DEVELOPMENT and DISABILITY http://apps.who.int/iris/bitstream/10665/75355/1/9789241504065_eng.pdf

SESSION 2: VULNERABLE CHILDREN: YOUNG CHILDREN LIVING WITH AND AFFECTED BY HIV AND AIDS

- Atwine, B., Cantor-Graae, E., & Bujunirwe, F. (2005). Psychological distress among AIDS orphans in Rural Uganda. *Science & Medicine*, 61 (3): 555-564.
- Berens, A., & Nelson, C. (2015). The science of early adversity: Is there a role for large institutions in the care of vulnerable children? *The Lancet*. S0140-6736(14)61131-4.
- Brakarsh, J. (2009). *Say and play*. Lusaka, Zambia: Project Concern International and United States Agency for International Aid (USAID).
- Charlesworth, R. (2012). *Understanding child development*. (7th ed.). United States, USA: Delmar Learning.
- Catholic Relief Services (CRS, 2015). *Promoting protection: An Overview of our approach (2015-2018)*. Baltimore, MD: CRS.
- Catholic Relief Services (CRS, 2009). *AIDS & Relief: Psychosocial care and counseling for HIV-infected children and adolescents-a training curriculum* (Revised edition). Baltimore, MD: CRS.
- Cluver, L. D., Kganaka, M., Boyes, M. E., & Park, M. (2012). Healthy minds: Psychosocial interventions for school-aged children affected by HIV/AIDS. In J. Heymann, L. Sherr, & R. Kidman (Eds). *Protecting childhood in the AIDS pandemic: Finding solutions that work* (pp. 119-143). New York: Oxford University Press.

- Cluver, L., Orkin, M., Boyes, M.E., & Gardner, F. (2012). AIDS-orphan-hood and caregiver AIDS-sickness-status: Effects on psychological symptoms in South African youth. *Journal of Pediatric Psychology*. DOI: 10.1093/jpepsy/jss004. (IF 2.943)
- Cluver, L., Orkin, M., Boyes, M.E., Gardner, F., & Meinck, F. (2011). Transactional sex amongst AIDS-orphaned and AIDS affected adolescents predicted by abuse and extreme poverty. *Journal of Acquired Immune Deficiency Syndromes*. 58: 336-342.
- Deiner, P.L. (2009). *Infants and toddlers development and curriculum planning* (2nd ed.). United States of America, USA: Delmar Cengage Learning.
- Guo, Y. & Sherr, L. (2012). The impact of HIV/AIDS on children's educational outcomes: A critical review of global literature. *AIDS Care*, 24(8): 993-1012.
- Malawi Ministry of Gender, Children and Community Development (2012). *National Early Childhood Development Advanced Training Manual*. Ministry of Gender, Children and Social Welfare of Malawi, World Bank, UNICEF, & Save the Children Federation, Lilongwe, Malawi.
- Mallmann, S. (2003). *Building resilience in children affected by HIV/AIDS*. Namibia: Maskew Miller Longman, Catholic AIDS Action Namibia.
- National Association of School Psychologists (NASP, 2003). *Helping Children Cope With Loss, Death, and Grief Tips for Teachers and Parents*. Bethesda, MD: NASP www.nasponline.org
- Nelson, C., Zeanah, C., Fox, N., Marshall, P., Smyke, A., & Guthrie, D. (2007). Cognitive Recovery in Socially Deprived Young Children: The Bucharest Early Intervention Project. *Science*. 318 (5858), 1937-1940.
- Operario, D., Underhill, K., Chuong, C., & Cluver, L. (2011). HIV infection and sexual risk behavior among youth who have experienced orphan-hood: Systematic review and meta-analysis. *International AIDS Society*. 14:25.
- PEPFAR AIDSTAR (2011). *Equipping parents and health providers to address the psychological and social challenges of caring for children living with HIV in Africa: An AIDSTAR-one activity final report*. Retrieved from: http://ovcsupport.net/wp-content/uploads/Documents/Equipping_Parents_and_Health_Providers_to_Address_the_Psychological_and_Social_Challenges_of_Caring_for_Children_Living_with_HIV_in_Africa_1.pdf
- Sherr, L. (2005). *Young children and HIV/AIDS: Mapping the field*. Working Paper 33. Hauge, Netherland: Bernard van leer Foundation. Retrieved from: http://www.ecdgroup.com/docs/lib_003664801.pdf
- Speier, A.H. (2005). *Psychosocial issues for children and adolescents in disasters*. (2nd ed.). Washington D.C., USA: U.S. Department of Health and Human Services-Substance Abuse and Mental Health Services Administration.
- Stein, J. (2003). *Sorrow makes children of us all: A literature review on the psycho-social impact of HIV/AIDS on children - Working Paper No. 47*. Cape Town, South Africa: Center for Social Science Research University of Cape Town. Retrieved from: <http://cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/wp47.pdf>
- The Pennsylvania Child Welfare Training Program. *Children's Reactions to Loss: Common Behavior Patterns of the Grieving Process*. Retrieved from: http://www.nrcpfc.org/ifcpc/Resource_Guide_1/Resource_Guide1_Handout5_ChildrensReactionstoLoss.pdf
- UNICEF. *Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS*. Unite for Children, UNICEF NYHQ2009-1911 Pirozzi Retrieved from: Retrieved from: http://www.unicef.org/aids/files/Taking_Evidence_to_Impact_w_Logos_FINAL.pdf
- United States President's Emergency Plan for AIDS Relief (2006). *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partner: The President's Emergency Plan for AIDS Relief*. Office of the U.S. Global AIDS Coordinator, USA.
- USAID (2011). *Foundation for the future: Meeting the psychosocial needs of children living with HIV in Africa*. AIDSTAR-One. Retrieved from <http://www.slideshare.net/AIDSTAROne/aidstarone-meeting-the-psychosocial-needs-of-children-living-with-hiv-in-africa>
- USAID-Botswana (2008). *Providing psychosocial support to orphans and vulnerable children*. United States President's Emergency Plan for AIDS Relief (PEPFAR), Botswana. http://www.socialserviceworkforce.org/system/files/resource/files/TAKING_EVIDENCE_TO_IMPACT_FINAL.pdf
- VITAS Healthcare (n.d.). *Children's developmental stages: Concepts of death and responses to grief*. <http://www.vitas.com/hospice-care-services/bereavement-and-grief-resources/child/development-stages>

SESSION 3: RIGHTS AND PROTECTION OF YOUNG CHILDREN

- Brakarsh, J. (2009). *Say and Play*. Lusaka, Zambia: Project Concern International and United States Agency for International Aid (USAID).
- Catholic Relief Services (CRS, 2015). *Promoting protection: An overview of our approach (2015-2018)*. Baltimore, MD: CRS.
- Catholic Relief Service (CRS), Lesotho (2012). *Ngoana Eo Ke Oa Mang? Parent and family caregiver manual*, CRS, Lesotho, CRS, Baltimore, USA.
- Catholic Relief Services (CRS). Policy on Protection from Abuse and Exploitation (2014). *A draft introduction to CRS' protection policy messages: A half-day optional orientation*. Baltimore, MD: CRS.
- Charlesworth, R. (2012). *Understanding child development*. (7th ed.). United States, USA: Delmar Learning.
- Gonzalez-Mena & Widmeyer Eyer, D. (2012). *Infants, toddlers, and caregivers: A curriculum of respectful, responsive care and education*. (9th ed.). Boston, MA: McGraw-Hill.
- Tadesse, S. (2014). *Advocacy and young children: Lecture 209 early childhood development course*. Towson, MD: Towson University.



Catholic Relief Services, 228 W. Lexington Street, Baltimore, MD 21201, USA
For more information, contact pqpublications@crs.org.