project TRUST since 1967

YOUTH DEVELOPMENT MANUAL

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Contents

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INTRODUCTION

The Youth Development manual is just another addition to your toolbox for your time on placement. The content of this manual complements the sessions which you will have undertaken during your time at Training before your departure and its purpose is to give you something to reference when needed.

Volunteers are placed in residential facilities and expected to assist with the day to day care of the children placed there, without always having an understanding of the needs of the children. Please use this information as guidance for your work at your social care project. It is designed to give you a basic and holistic knowledge and understanding of working with children.

If at any time during your time placement, you are having any difficulties at your project you should speak to your host in the first instance for advice and support. In addition, you can contact your Country Coordinator or your country representative.

CHILD DEVELOPMENT

To enhance your knowledge and understanding and contribute positively to a child's progress the following critical stages of development have been compiled.

ALWAYS remember that the children placed in residential care have often been neglected and abused and may be behind in their development - both psychologically and physiologically. Therefore any contribution that you can make to assist them will have amazing dividends in their lives.

You are able to be a KEY person in normalizing their lives so take full advantage of every moment spent with the children placed in your care.

Erikson's Psychosocial Development Theory

Life is a series of challenges and experiences which helps us to grow. Erikson's theory is firmly focused on the idea that 'nurture' is what shapes our personality and our behaviour.

The developmental stages of childhood are critical steps to adulthood. In effect the child is practising for adulthood. Each step of development gives the child something new to do.

There are eight stages in Erikson's theory. At each stage, we are faced with a 'crisis' of two opposing emotions. For example; in the first stage we are faced with TRUST v MISTRUST - the development occurs when a child is able to find a balance between both. The child must learn to trust people, life, and their own abilities and balance this with a healthy capacity for mistrust so as not to put them at risk of being naive, gullible or hopelessly unrealistic.

8 Stages of Erikson's Psychosocial Development Theory

Crisis Stage	Life Stage	Positive Outcomes	Negative Outcomes
Trust v Mistrust	*Infant - feeding, sleeping and being comforted*	*Hope and Drive*	*Withdrawal*
Autonomy v Shame and Doubt	*Toddler - toilet training and walking*	*Willpower and Self-Control*	*Impulsion and Compulsion*
Initiative v Guilt	*Early Childhood - adventure and play*	*Purpose and Direction*	*Ruthlessness and Inhibition*
Industry v Inferiority	*Middle Childhood - achievement and accomplishment*	*Competence and Method*	*Narrow Virtuosity and Inertia*
Identity v Role Confusion	*Adolescent - growing up*	*Fidelity and Devotion*	*Fanaticism*
Intimacy v Isolation	*Young Adult - intimate relationships and social life*	*Love and Affiliation*	*Promiscuity*
Generativity v Stagnation	*Mid-Adult - children and your community*	*Care and Production*	*Overextension*
Integrity v Despair	*Late Adult - life achievement, meaning and purpose*	*Wisdom and Renunciation*	*Disdain*

⚠ *We are only going to cover up to **'Adolescent'** in detail for the purpose of this manual.*

THE INFANT (0 to 2 years)
- Developing a sense of TRUST

The tiny baby is totally helpless and is forced to TRUST someone else for anything and everything. He requires someone else to provide food, warmth and nappy changes.
If these needs are met in a caring, consistent manner, not only does he get his physical needs met, but he also thinks that the world is a comfortable safe place to be and that new experiences are not to be feared.

Every new experience in which this beginning TRUST is being confirmed deepens his ability to TRUST and hope.

It is important to make each baby feel they are important. Talk to them while you are feeding or changing them. Make cooing noises or hum. Holding a baby while feeding is far more beneficial to the feeding process than propping a bottle up on a nappy while the baby lies in the cot. This is not always possible, but at least ensure that the baby is winded and has not regurgitated his feed. Make sure that they are warm, especially their feet.

Mobiles and cuddly toys are good for eye development. If these are not available make pom-pom balls and string them across the cot. Every child should have some cuddling and adult interaction every day.

Handle the babies firmly and boldly. They are pretty agile and seldom break! However dropping them is not a good idea!

THE TODDLER (2 to 4 years)
- Developing AUTONOMY/INDEPENDENCE

Toddlers are Explorers. He is beginning to move around on his own and is less dependent upon other people. He is beginning to crawl and to walk and gets into anything and everything.
His caregivers are starting to make demands on him and he is starting to make simple decisions for himself… Do I obey or not. Do I touch or not.

If he is to become more INDEPENDENT he needs to be able to "test his wings". To master this critical task, the child needs adults who can maintain a balance between encouraging him to try new things, who will support him in success or failure, yet who can set limits that will protect him from continual failure.

The caregivers need to share in the child's joy of growing independence. Caregivers who cherish the child's dignity and individuality and independence can build upon his attitude of trust.

Each child in your care will be at a different stage of his development and no two children will be the same.

EARLY CHILDHOOD (4 to 6 years)
- Developing INITIATIVE

At this stage of the child's life he begins to find out what life has in store for him. He is able to move around and speaks reasonably well and is now moving into new areas of activity and imagination. Early Childhood is a time of testing his skills.

He begins to take responsibility for;

- His body... bathing himself, cleaning his teeth, going to the toilet alone, learning to use toilet paper (unrolling the whole roll or blocking the toilet!!) and feeding himself.
- For his belongings... his toys, shoes, clothes.
- His siblings.
- His actions. He is aware of other children older and younger than he is. How he acts with them and the response it evokes.

At this stage he begins to define what he can and cannot do. The support and encouragement of the caregivers is imperative to the child becoming confident and happy to continue his life journey.

This is the time to allow him to experiment with paint and dough and drawing. Introduce books and pictures, songs and music, ball games, running and skipping, nature exploration in the garden. Each day holds a myriad of new experiences and adventures for the preschool child. You should allow yourself to experience these opportunities with the children in your care.

MIDDLE CHILDHOOD (6 to 10 years)
- Developing INDUSTRY

Peers (children of his own age) begin to be more important to the child than are adults. This is appropriate - from here on throughout his life he will live and work and play more with people of his own age than with people a generation or more older than him.

Peers now begin to make up his support group. The child in Middle Childhood needs friends his own age to help him to establish and to maintain his sense of self-esteem. He identifies with them and he uses them as a measure of his own success or failure.

School provides him with his first occupational skills – reading and writing - and with a new source of discipline and control via his teacher.

The caregiver needs to support the role of the school. Do not do the child's homework for him but set him small assignments to complete himself. Try to encourage him and be patient. Reading and writing are areas where you will be able to encourage his self worth. At this age you are able to encourage children to read by reading to them, allowing them to draw pictures of the stories they have heard. You can introduce letter writing to children in schools in England.

The caregiver will forever be sorting out the squabbles and power struggles between the children. Be consistent and fair and help the children to resolve their own difficulties by giving guidelines. Do not take sides!

Children in this age group often hero worship. Caregivers can introduce them to sport stars and good public role models (TV characters, athletes, musicians, public figures etc). It is important to screen what the children are watching. Try to discourage violent or inappropriate films.

This is the age group that will want to role model what you do so be on guard.

ADOLESCENCE (10 to 19 years)
- Developing IDENTITY

Adolescence can be a confused and difficult time for this age group.

Adolescents increasingly have adult bodies, but they are not given the responsibilities or privileges of adulthood, and at least initially, would not know how to handle those responsibilities if they were given them. They are not yet fully adult; neither are they any longer children.

Adolescents concern themselves with developing a sense of personal IDENTITY; that is to discover whom they are, what they are able to do and how to fit into the world. (Adolescents in residential care have the additional problem of coming to terms with being rejected by their families).

The adolescent needs to have the opportunity to try out different styles of almost everything: clothes, habits, writing styles, patterns of behaviour etc. By trying out different styles he is able to eliminate some and find the ones that he is most comfortable with.

He needs to develop confidence in his own taste, his own style and his own preferences.

The constant changing can be very trying on the caregivers but one needs to respect the importance of coming to terms with who he or she really is. Volunteers are able to identify closely with this stage, as it is one that they have recently experienced. Once again you need to be very aware of the example you set and the knowledge you impart to these young people.

The young people in your care will often take you into their confidence and you need to be aware of imparting values and knowledge that is appropriate to the society in which you find yourself while a volunteer.

Young adults will want to know about your dress code, your music, your family, your dating partners, your attitude to sex, your drinking habits and your experience with drugs. They are also looking to role model someone in their lives who they care about.

Source: http://www.businessballs.com/erik_erikson_psychosocial_theory.htm#erikson_psychosocial_theory_summary

Maslow's Hierarchy of Needs

Abraham Maslow developed the Hierarchy of Needs model in 1940-50's USA, and the Hierarchy of Needs theory remains valid today for understanding human motivation, management training, and personal development. Maslow's ideas surrounding the Hierarchy of Needs concerning the responsibility of employers to provide a workplace environment that encourages and enables employees to fulfil their own unique potential (self-actualization) are today more relevant than ever.

Each of us is motivated by needs. Our most basic needs are innate, having evolved over tens of thousands of years. Abraham Maslow's Hierarchy of Needs helps to explain how these needs motivate us all.

Maslow's Hierarchy of Needs states that we must satisfy each need in turn, starting with the first, which deals with the most obvious needs for survival itself.

Only when the lower order needs of physical and emotional well-being are satisfied are we concerned with the higher order needs of influence and personal development.

Conversely, if the things that satisfy our lower order needs are swept away, we are no longer concerned about the maintenance of our higher order needs.

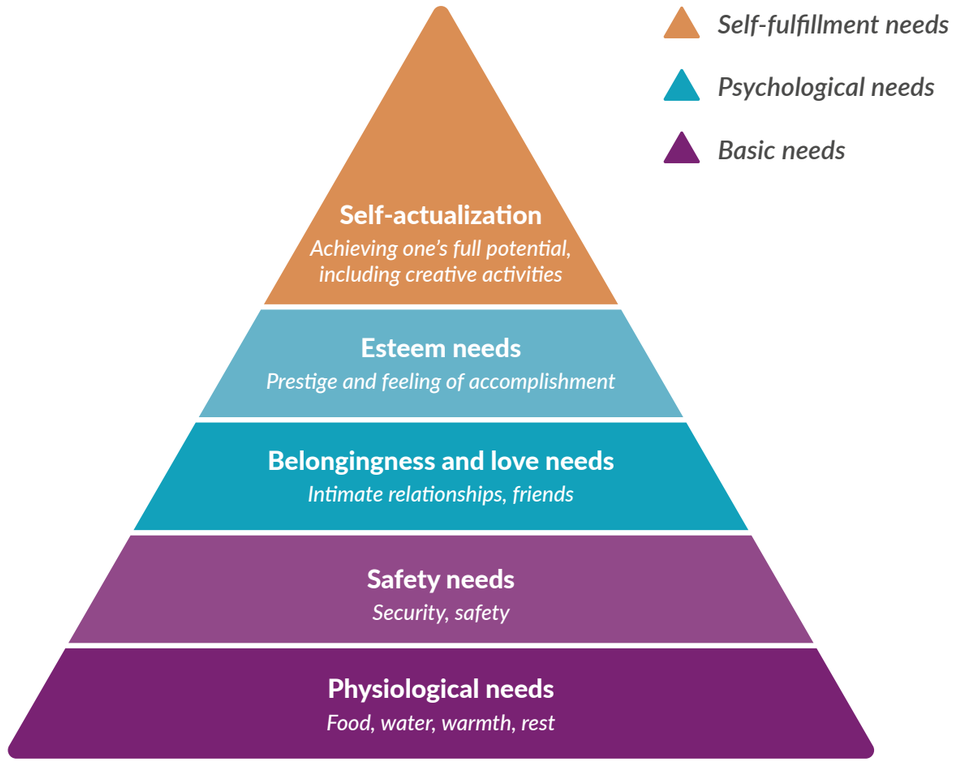
1. Physiological Needs
Air, food, drink, shelter, warmth, sex, sleep, etc.

2. Safety Needs
Protection from elements, security, order, law, limits, stability, etc.

3. Belongingness and Love Needs
Work group, family, affection, relationships, etc.

4. Esteem needs
Self-esteem, achievement, mastery, independence, status, dominance, prestige, managerial responsibility, etc.

5. Self-Actualization Needs
Realising personal potential, self-fulfilment, seeking personal growth and peak experiences.



Virtually all personal growth, whether in a hobby, a special talent or interest, or a new experience, produces new skills, attributes, behaviours and wisdom that is directly transferable to any sort of job role.

Maslow's concept of self-actualisation relates directly to the present day challenges and opportunities for employers and organisations - to provide real meaning, purpose and true personal development for the people they work with; for life - not just for work.

Source: http://www.businessballs.com/maslow.htm

BEHAVIOUR MANAGEMENT

Behavioural Difficulties in Children

According to the United Nations an estimated 10-20% of children worldwide have one or more emotional or behavioural issues. Many disorders found among adults, such as depression, can begin during childhood. Types of behavioural disorders specific to childhood and adolescence include disorders of psychological development, including dyslexia and autism, as well as behavioural and emotional disorders such as attention deficit/ hyperactivity and conduct disorders.

It takes time for children to learn how to behave properly. With help and encouragement from parents and teachers, most of them learn fast. Of course, children are sometimes disobedient. Occasionally a child will have a temper tantrum or an outburst of aggressive or destructive behaviour. Normally, these do not last long and can be dealt with quite easily.

The Signs

Some children carry on behaving badly for several months or longer. Again and again they are disobedient, cheeky and aggressive. Their behaviour is quite out of the ordinary and seriously breaks the rules accepted in their family and community. It is much more than ordinary childish mischief or adolescent rebelliousness. This sort of behaviour will affect a child's development and interfere with their ability to lead a normal life. When behaviour is this much of a problem, it is called a conduct disorder.

Behavioural problems can occur in children of all ages. Very often they start in early life. Toddlers and young children may refuse to do as they are asked by adults in spite of being asked many times. They are rude, swear and have tantrums. Hitting and kicking of other people is common. So is breaking or spoiling things, which matter to others.

But won’t they grow out of it?

About half of the young children who suffer from conduct disorder do improve over the years. However, half get worse. Older children often develop a hostile, aggressive attitude as well as being disobedient and defiant. They get involved in more violent physical fights and may start to use weapons. They may steal or lie, without any sign of remorse or guilt when they are found out. They refuse to follow rules and may start to break the law. They may start to stay out all-night and play truant from school during the day.

Teenagers with conduct disorder quite often get involved in criminal behaviour with their friends. They may steal from cars, houses or shops. They may take risks with their health and safety by taking illegal drugs or having unprotected sexual relations.

How much does this affect the young person and those around them?

A great deal. This kind of behaviour puts a huge strain on the family. Outside the home, children who behave like this will often find it difficult to make friends. Other children often don’t want to know because they are rude and can’t play without getting aggressive. Even though they might be quite bright, they don’t do well at school and are often near the bottom of the class. They may cause trouble in lessons and be asked to leave.

Other people just see a violent, troublesome, irritating youngster. Inside, the young person may feel that they are worthless and that they just can’t do anything right. They often blame others for their difficulties and do not know how to change for the better.

What causes conduct disorder?

There are usually a number of problems. A child is more likely to develop a conduct disorder if they:

- *have always had a difficult temperament;*
- *have learning and reading difficulties – these make it difficult to understand and take part in lessons. Then it’s easy to get bored, feel stupid and misbehave;*
- *are depressed;*
- *have been bullied or abused;*
- *suffer from hyperactivity – this causes difficulties with self-control, paying attention and following rules.*

Parents and carers themselves sometimes can unknowingly make things worse. There are two very common ways of doing this:

1. Giving too little attention to good behaviour:

As a carer, it can be easy to ignore your child when they are being good, and only pay them attention when they are behaving badly. Over time the child learns that they only get attention when they are breaking rules. Most children, including teenagers, need a lot of attention from their parents/carers, and will do whatever it takes to get it. Perhaps surprisingly, they seem to prefer even angry or critical attention to being ignored. It’s easy to see how, over time, a ‘vicious circle’ is set up.

2. Being too flexible about the rules:

Children need to learn that rules are important and that no means no. Keeping this up is hard work for carers. It can be tempting to give in ‘for a quiet life’. The trouble is that this teaches the child to push until they get what they want. Teenagers need to know that people care about them. They must also understand that rules are needed to protect their safety.

Two Common Reasons for Behavioural Problems:

1. Hyperactivity or Attention Deficit Disorder (ADD)

This is a chronic, neurological based syndrome characterised by hyperactivity, distractibility, and impulsivity. ADD refers to the child not being able to concentrate on anything for a normal length of time. A drug called Ritalin is often given as treatment. No one knows for certain what causes ADD. Evidence suggests that it could be a chemical imbalance, however it is frequently hereditary. There is also evidence that it can be the result of social or environmental factors.

CHARACTERISTICS:

- *Fidgets with hands or feet*
- *Easily distracted*
- *Unable to wait turn in games or group situations*
- *Has difficulty following through an instructions or task*
- *Often talks excessively*
- *Doesn’t seem to listen to what is being said*
- *Often losing things*
- *Can put themselves in danger*
- *Disturbed sleep*

2. Bipolar Disorder (Manic-Depressive Illness) In Teens

Teenagers with Bipolar Disorder may have an ongoing combination of extremely high (manic) and low (depressed) moods. Highs may alternate with lows, or the person may feel both extremes at the same time.

Bipolar Disorder usually starts in adult life. Although less common, it does occur in teenagers and even rarely in young children. This illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with Bipolar Disorder in teens.

Bipolar Disorder may begin either with manic or depressive symptoms.

THE MANIC SYMPTOMS INCLUDE:

- *severe changes in mood compared to others of the same age and background*
- *either unusually happy or silly, or very irritable, angry, agitated or aggressive;*
- *unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers;*
- *great increase in energy and the ability to go with little or no sleep for days without feeling becoming tired;*
- *increase in talking: the adolescent talks too much, too fast, changes topics too quickly and cannot be interrupted;*
- *distractibility: the teenager's attention moves constantly from one thing to the next;*
- *repeated high risk-taking behaviour; such as, abusing alcohol and drugs, reckless driving or sexual promiscuity.*

THE MANIC SYMPTOMS INCLUDE:

- *irritability, depressed mood, persistent sadness, frequent crying;*
- *thoughts of death or suicide;*
- *loss of enjoyment in favourite activities;*
- *frequent complaints of physical illnesses such as headaches or stomach aches;*
- *low energy level, fatigue, poor concentration, complaints of boredom;*
- *major change in eating or sleeping patterns, such as oversleeping or overeating.*

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, or even schizophrenia. The diagnosis can only be made with careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist can be helpful in identifying the problems and starting specific treatment.

What can help?

You can do a lot. It helps if discipline can be fair and consistent. Any young person needs praise and rewards when they improve their behaviour. It is often difficult to do this but try your best; it will be very valuable for the child.

If serious problems continue for more than three months, for example in school, it is worth asking a doctor or relevant person in the institution for advice. A specialist may be needed to help find out what is causing the problem and also to suggest practical ways of improving the difficult behaviour.

Depression in children

This is a common mental illness characterised by sadness, loss of interest in activities, decreased energy and recurring feelings of despair. The intensity and frequency of the symptoms differentiate the illness from normal mood swings. Currently 121 million people suffer from depression. Every year one million people commit suicide, 60% of which are the outcome of depressive disorders and schizophrenia. The causes of depression vary from psychosocial factors to genetics, and its first line treatment involves antidepressant medications and psychotherapy.

As many as 20% of children worldwide suffer from behavioural or mental health issues. The UN agencies blame the trend on rapid social and economic changes, as well as on poverty and conflicts.

A big problem according to the World Health Organisation is that nearly two thirds of people with such an illness do not seek help because of the stigma and discrimination attached to mental illness. Furthermore they often will not admit to the fact that they are suffering from depression. In addition, depression is not that well recognised in developing countries and therefore people do not always receive the help they need. A study by the WHO found that of all the countries studied some 25% have no legislation on mental health and 28% have no separate budget for it. The report also says that about 25% of countries do not have the three most commonly prescribed medications for schizophrenia, depression and epilepsy at primary health care level.

"Mental illness is not a personal failure. In fact, if there is failure, it is to be found in the way we have responded to people with mental and brain disorder."

Dr Harlem Brundtland *Director General of the World Health Organisation*

RUNNING A WORKSHOP

Establishing a workshop or club as an extra-curricular activity if you are teaching, or maybe as a core part of your programme if you are caring for children, can be a great way of organising a programme of activities in a focused and structured way.

In many parts of the world, the time and energy needed to organise things such as clubs is sorely lacking. As a volunteer, you can often add something positive through a workshop or club, which your full-time professional colleagues may not have the time for. You will also find, that as a result of having participated in clubs or societies back at home, you have far more ideas on how to organise them than your colleagues.

What are the advantages of setting up a workshop?

Developing Skills and Stimulating Minds

It is important that children are encouraged to develop new skills and talents. A workshop can introduce children to new hobbies and interests. It is vital for young minds to be stimulated, challenged and developed; attending a workshop can achieve these aims.

A little bit of quality

In many of the parts of the world, leisure and free-time activities are a luxury and few people have the opportunity to enjoy them as necessary resources and free-time are scarce. Clubs and societies hardly exist in schools, and in children's homes staff can be stretched to the limit just to feed and clothe the children. As a volunteer you have the energy and ideas to set up a simple workshop. They can provide a much needed focus for children and help alleviate some of their boredom.

A little bit of structure

Creating a club allows you and the participants to develop activities with some kind of structure to them, and allows you to develop ideas properly. Instead of playing football every afternoon, you can organise a club, which has an element of fitness and training to it as well. Instead of remembering little bits of arts and craft ideas here and there, you can develop certain ideas such as colours, form and patterns etc. This way also tends to let you draw out what you know so that you don't use up all your ideas to quickly!

People like to be in clubs

People, especially children, like to belong to a club. It gives a sense of belonging and shared interest and, dare I say, community?

It gives you control

Organising a workshop allows you to have control over the way activities are structured. It also gives you the opportunity to manage any difficult members. You can bar children for a while if they are being difficult.

The dangers of running a club

It can become a gang or clique

Ensure that the people who participate are those that want to participate. Ensure that you have open membership if new people want to join, and ensure that the peer leaders are not secretly controlling membership or dominating activities. You may need to keep an eye out for which table is hogging the best pair of scissors!

What sort of club can you set up?

Setting up a club, and deciding how to do it will all depend on you, on your skills, experience and background. Every year we are amazed at the imaginative ideas of volunteers.

The following are merely food for thought to get you thinking:

Sports club

From specifics like a football or a basketball club to more general aerobics or fitness. Can you remember some training exercises, or find a simple book on aerobics and a good tape of music?

Arts & Crafts

Can you organise craft or art activities with limited resources? Do you have ideas on how you can use empty bottles, newspaper old containers to make things? Can you structure your activities around themes or work towards calendar dates (e.g. Halloween, Christmas)? And can you work towards a good display or show of the work produced?

Music

Do you sing? Can you teach others to sing? Can you take out a musical instrument? Could you improvise with home-made instruments, or try karaoke? If you're musical, think about taking some basic music out with you.

Dancing

Could you build up a set of Scottish dancing working towards a final ceilidh, or a dancing display? Could you teach your flashiest disco moves into an appropriate routine? Do you know how to line dance or ballroom dance? Could you be taught how to do the local dancing.

English club

Can you teach English in a more informal way than through the classroom, either through songs, magazines, newspaper articles, role-play or basic activities? Taking a Sesame Street approach to teaching English, particularly if you a working with young children, could be excellent fun and very popular.

Creative writing and poetry club

Could you encourage people to use their imagination more? Giving children and adults an opportunity to explore their imagination will be very beneficial. Personal writing can also be hugely important to children and adults alike – set up a pen pal scheme with a school in the UK?

Drama

Could you take a group and learn a series of sketches or a play? If the language is a problem, could you teach them mime? What about writing and producing your own play with ideas from the club members? Could you remember any of the drama confidence building activities that you may have had to do at school?

A newsletter or newspaper club

Could you get a group of people interested in getting stories from their community and writing and producing a newspaper or newsletter with various different features and stories of interest to the members?

A photographic club

Very possibly too expensive to run and too much risk for your camera, but you never know.

A film club

If you have access to a video, could you run a series of films (maybe films from your home country?) If you are near a large city, you may find a language institute, a consulate or a British council or equivalent with a library of films you could take out.

An environment club

Is there interest in the local environment? Could you organise fun sessions on why the environment is important? Could you organise street or park cleaning? Could you paint mural on the walls of your school / home or create a garden? How can you make people more involved in their local environment?

Cooking

Could you arrange simple cooking lessons? Could you teach how to make dishes like shepherd's pie or pizza? Or maybe cakes and chocolates? Could you teach how to prepare food safely? Maybe you could work towards a final big meal cooked for many.

Planning your Club; things to consider

Forming a Club identity and keeping interest

If you are forming a club, try to make it distinct from the other activities you may do. You need to avoid as much as possible having people drift in and out particularly if you have spent time developing activities which progress from one meeting of the club to the next.

Attendance

You could think of keeping a record of attendance, and either displaying it on the wall of the club, or else rewarding those who come with gold stars or executive membership (be careful though not to alienate others by doing this).

Where to hold your club

Make sure that you find a suitable location to hold your club prior to setting it up. When you advertise it make sure you remember to tell everyone where it is going to be held.

Membership

Particularly if you are working with young children, you may want to establish some kind of membership. Could you produce membership cards with their names on? Confiscation of the card might also act as a good threat to disruptive members.

Keeping interest

Try to develop positive ways of keeping interest. Build on what you did last time, but add something new each time to prevent boredom. Work towards specific targets like a show, or a display, Christmas or the last day of term. Use those as an opportunity to focus people to want to participate fully.

Involve the club members

Don't feel you have to make all the decisions yourself. Get ideas from the club members about what they want to do and how they want to do it. Give them a voice and make them feel it is their club too.

Know when to stop

Don't be afraid to terminate a club. If the club was learning Scottish dancing and you have done the show and exhausted all your knowledge, feel free to call it a day, and take a break.

Other Considerations to make when planning activities are:

1. Subject:
You will need to think of a subject for the activity or a title for the club.

2. Goal:
You need to think about what the activity is to achieve

3. Target audience:
You need to decide what age group you are running the activity for and approximately how many participants you will have.

4. Number of sessions:
How many sessions do you need to reach the goal, and how often you want to run the sessions.

5. Length of session:
Plan the content and decide how long you need.

6. Planning content of sessions:
What will you include?

7. Aids and resources:
What materials have you got and what do you need?

8. Venue:
Identify and organise this.

9. Budget:
What money you need and where will it come from?

10. Marketing:
How do you get the club publicised?

Good luck!

GRIEF, LOSS AND BEREAVEMENT

Introduction

Occasionally a Project Trust volunteer may look after children or residents who pass away. You can become very attached to those who you look after and the death of someone in your institution can be very upsetting not only to you but to all those who live there. Thinking about how it makes you feel and what you can do to help yourself and others recover is very important.

How you respond to a death or a bereaved person will be very individual and personal. It is important for you to remember that the stages of grief that do not necessarily only relate to a death. You may find that you experience thoughts and feelings of loss because of missing home, moving projects, relationship break-ups, an injury, financial issues – and a number of other situations.

The main theory regarding grief and loss is a method pioneered by a woman called Elisabeth Kubler-Ross who was a Swiss-American psychiatrist. She developed the 'Five Stages of Grief' which have been used in the support and counselling of personal trauma, grief and grieving – mostly associated with death and dying.

Five Stages of Grief

Denial

- Conscious or unconscious refusal to accept the facts or reality of the situation.
- Denial is a defence mechanism and is a completely natural response.
- Some people become locked in this stage when dealing with a traumatic experience that can be ignored – death cannot be evaded or avoided indefinitely.

Anger

- This can manifest in many different ways.
- People can be angry at themselves, and/or with others – especially those who are close to them.
- Knowing that anger is a stage of grief can help you to stay detached and non-judgmental when experiencing the anger of someone who is upset.

Bargaining

- This traditionally involves an element of religion or faith – people often bargain with a God for a different outcome or change in circumstances.
- A trauma less than death will often involve compromise. For example; breaking up with a partner and offering to remain friends to avoid losing that person from your life - offering something in return for a change in circumstances.
- Bargaining or compromise rarely offers a sustainable solution.

Depression

- This stage is preparatory grieving – a practice run for the aftermath.
- Depression involves acceptance of the situation but with an emotional attachment.
- It is the first stage of accepting the reality of the event/incident.
- Feelings involved in this stage; sadness, regret, fear, uncertainty, guilt, despair.

Acceptance

- This varies according to the person's situation – broadly it is an indication that there is some emotional detachment and objectivity about the situation – you begin to understand and acknowledge the events that have taken place.
- People who are dying or have a terminal illness will often reach this stage long before they pass away and before the people that they leave behind. Those around them must follow their own journey through the other stages.

The five stages are NOT a process – there is no progressive, linear journey through the five stages. People will often skip stages, or revisit them. Not everyone will experience all five stages and the stages are not equal in any way. Everyone has an individual response and experience to a trauma or loss.

Be aware of your project partner or colleagues response to trauma or bereavement and try to be understanding of their behaviour – everyone deals with it in different ways.

Related Feelings

Fear

of damage to yourself and those you love, of being left alone or having to leave loved ones, of breaking down/'losing control', of a similar event happening again.

Helplessness

Crises show up human powerlessness as well as strength.

Sadness

For deaths, injuries and loss of any sort.

Numbness

The event seems unreal, something that has not really happened. Some people often see this wrongly and assume the person is 'strong' or uncaring.

Guilt/Regret

For being better off than others – being alive, not injured. Or regret for things not done.

Shame

For having been exposed as helpless, emotional or needing others. For not having reacted as you had wished.

Anger

At what has happened, at whoever caused it or allowed it to happen, at the injustice or senselessness of the incident, at the lack of other people's understanding.

Memories

Of feelings, of loss or of love for others in your life that have been hurt or died.

Let down/Disappointment

for all the plans that cannot be fulfilled.

Hope

For the future/better times.

Longing

For all that has gone or been lost.

Relief

For a family member who maybe suffered before their passing.

Happiness/Laughter

Often an inappropriate but normal reaction – caused by confusion and an inability to process what has happened.

Hurt

Usually alongside anger and disappointment.

Ignored

Possibly because of the way others around you are trying to cope.

Misunderstood/confused

Unable to process the event or make sense of what has happened.

Lonely

Because you feel no one understands what you are going through. Because you cannot bear to be around others.

Exhausted

During a time of trauma or loss you are in a heightened state of awareness and processing intense feelings – being emotionally exhausted can transfer to physical exhaustion.

Some feelings are obviously related to particular stages of grief but it is important to recognise that these feelings can appear at any stage and often you will feel many of the above at the same time – they often go hand in hand.

These are some of the things people often say when someone dies:

"I can't believe it"

It may take a long time to grasp what has happened. Some people carry on as if nothing has happened. It is hard to believe that someone important is not coming back.

"I feel nothing"

The shock can make people numb, you may feel you're in a different world.

"Why did it have to happen?"

Death can seem cruel and unfair, especially when you feel someone has died before their time or when you had plans for the future together.

"I feel such pain"

Physical and mental pain can feel completely overwhelming and very frightening.

"I go over it again and again"

You can't stop thinking about the events leading up to the death.

"If only"

You may feel guilty about things you have said or did or that you didn't say or do.

"I feel so depressed, life has no meaning, I can't go on"

Many people say there are times after a death when they feel there is nothing worth living for and they feel like ending it all.

"I hear and see her, what is wrong with me?"

Thinking you are hearing or seeing someone who has died is a common experience and can happen when you least expect it.

"They said I'd be over it in a few months"

Many people find it takes much longer to learn to cope without someone to love.

"One minute I'm angry and the next minute I can't stop crying"

Many people find the mood swings very frightening.

How to Cope

Main coping mechanisms (negative and positive):

- Removing yourself from the situation – ceasing to socialise.
- Crying or the desire to be alone/seeking privacy from others.
- Substance misuse – alcohol and drugs – losing control – dealing with intense feelings.
- Being practical - Cleaning, tidying, music, reading etc.
- Attending the funeral and talking about what has happened – making the situation more credible – seeking understanding and closure.
- Repeatedly talking about what has happened – sometimes a way of processing the events.
- Sharing your experience with others.

Children's reactions to a death

Children react differently to death in comparison to adults. They often find it difficult to express how they are feeling and can become very confused. Children appreciate having their thoughts and feelings acknowledged – they often find it easier to draw or pay out their emotions – paying attention to this is important. Try to keep them in a normal routine where possible.

There is no 'right way' to react when someone dies and every child will respond differently. If you are caring for a child it may help to know what many children say, think and feel when someone important to them dies, and examples are given below. But don't be surprised if the child you are caring for finds it difficult to express how they feel - remember that many children cope remarkably well.
Help the children to understand death and the emotions and rituals involved – for example the funeral process. You may need to speak with your local community to understand what their traditions/religious views are. It is important that it is not a taboo subject. Try not to lie to children about the reality of loss and grief. Protecting them from it once will only make it harder for them the next time.

Questions to be prepared for...

When are they coming back?

Whatever your age, it can take a long time to believe that someone who matters very much to you is not coming back.

Why did it happen?

Explanations are very important but children may need to ask the same questions over and over again. It will take them time to accept what has happened and the death may seem very unfair to them. They may be very angry that someone they care about has left them.

Will you/I die too?

It is difficult for children to understand why someone dies and they may become frightened about their own death or worry that someone else close to them will die soon.

Where did they go?

Younger children may find it more difficult to grasp that a dead person is not coming back and may ask repeatedly 'Where have they gone?'; expecting to be told of a place that they know about.

I wish I was dead then I could be with them.

Like adults, children may sometimes feel it is not worth living without someone they love. They may imagine that if they die they will be reunited with the dead person, or if they die the dead person will come back to life.

Was it my fault?

However far-fetched this may seem to you, many children worry that something they said or did, or didn't say or do caused the death.

Why are you sad?

It is difficult for children to see people they care about cry and suffer, but it is also important for them not to be shut out and to see that people can survive the sadness. There may also be great comfort in shared grief.

Where does their body go?

Young children may need help to understand that when someone is dead the body no longer works and must be buried or burned.

Will it hurt when they are buried/cremated?

Children may think that being dead is like sleeping. They may need to be told there is not feeling pain after death.

If you do lose someone close to you or go through a traumatic experience whilst on placement, please do not bottle it up – regardless of how insignificant an experience you convince yourself it is. Seek help. Talk to your host/partner/country representative/ Country Coordinator. It may be necessary to seek more professional help which we can assist with. Be fair with yourself – it's important to give yourself time and space.

LIVING IN AN INSTITUTION

The word ‘institution’ isn’t particularly positive and often comes with negative connotations. Definitions include ‘a place for the care or confinement as people known as patients’ or ‘a place for the care of individuals who are destitute, disabled or mentally ill’. Maybe it is best to think of your project environment as a small community?

Living in an institution can be really good fun and a very rewarding experience. You become very close to those with whom you work with and there is great pleasure in seeing their development on a day to day basis. However, living in an institution can often come with some difficulties.

Why might people find it hard when I arrive?

You come in from the outside, full of enthusiasm and youthful ideas.

These may be a threat to the existing staff some of which may feel negative about the organisation they work for, or about authority in general.

You are a novelty to the children.

They may crowd round you and ignore the normal staff. Combat this by including the staff in any activities and doing things together.

You arrive with a high profile but low qualifications.

There may be local staff who have worked for years to get the job you have, or to earn the respect that you have from day one. Your European background may wield unmerited respect and authority but some staff may feel you are hijacking the organisation.

You have freedom and wealth.

You can come and go, travel widely, and at the end return to a society paved with gold; some staff may be jealous or resentful. Therefore, don’t show this off and prove that you are willing to work hard with the others despite your privileged background.

How might the staff react?

- Freezing you out; ignoring you;
- Criticising you or gossiping;
- Comparing you unfavourably with your predecessors.

What should I expect?

Politics

All organisations have internal politics; this is not unique to your project. Learn not to join a faction and certainly stay out of it! Do not join in the gossiping, nobody will trust or respect someone who gossips. Say nothing.

Lack of feedback

Good managers appraise their staff. Bad managers do not. Don't let it dampen your enthusiasm. Actively seek appraisals from the staff at regular intervals to ensure both you and them are happy with your progress and input. Do this professionally in an appointed meeting.

Inability to communicate with you

Very often you may not be told what is going on, changes to the timetable, local holidays. Perhaps there was a staff meeting in another language, perhaps you were not there, perhaps there is a notice on the wall in the staff room – keep aware that this can happen. Arrange, diplomatically, for you to be informed regularly of timetable changes.

Most institutes are conservative places. How can I maintain the respect of the staff, children and community?

Appearance

It is very important to get the respect of fellow staff. Don't be unshaven, wear inappropriate clothing, stained or creased clothes, earrings for men, lots of earrings for women, nose, tongue or other studs, bra straps, low cut tops and tummies.

Tidiness

You will be expected to set an example to the children. Don't jeopardise your standing by leaving your accommodation in a tip.

Being reliable

Complete what you are asked to do and what you say you will do. Be punctual for work and meetings.

Control your socialising

Confine your pubbing/clubbing/drinking to times when you are off duty and off the institution premises. Always turn up sober and on time for work: no hang over and all your planning complete; don't associate with "unsuitable" friends. Don't have visitors during working hours or without permission from the appropriate member of staff.

Qualities that impress your fellow staff members.

Reliability

If you promise to do something, do it.

Honesty

Grit your teeth and CONFESS if you do something wrong. You may be cursed, but if you are honest and confess before anyone finds out it will prove your honesty.

Learn from your mistakes

Try your hardest not to do the same silly thing twice.

Don't side with the students/children against the staff

Never undermine another staff member in front of the children. If you have a concern then deal with is through the correct channels.

Keep a professional relationship with the children/students

ABSOLUTELY no boy/girl friend relationships with the children/students. This can be a repatriation as well as criminal offence.

Follow the rules and regulations of the institute

Get permission approved by the appropriate senior member of staff *eg* visitors of the opposite sex staying overnight. Don't party till all hours: come home at a reasonable time during the week. If one member of staff does not give you permission, do not seek it from elsewhere. Beware of too much alcohol, it causes more trouble than anything else and will lose you the respect of some of the staff.

Commitment

Don't skip your duties or take the easy way out, work hard and offer to help others. Don't ask for unreasonable amounts of time off work for long weekends and holidays, your first commitment should be to your project.

Try to understand why the staff members act the way they do, learn to empathise with their situation.

Put yourself into the shoes of fellow staff

They may be tired, stressed, have had a bad day, depressed. Realise that the management may have different pressures and priorities to you, they may be new to the job, the budget may be tight, the board of governors may be making demands on them. Bear these things in mind and don't be critical without considering these pressures.

General attitudes to foreigners may be different

They may be regarded as wealthy, well-travelled, easy-living and with loose-morals: try not to be the stereotype. For this reason they may not respect you or may treat you as a child, not to be given responsibility.

Attitude to gender may be different

Male and female work and roles may alter.

Appreciate the different culture

The priorities of your host community may be different to what you are used to; attitudes to death, sickness, discipline and cleanliness may be different. Sometimes you will just have to accept that things work differently. Remember that our cultural perspectives have changed and are changing all the time; we are in no place to be judgemental.

How do I cope?

Don't rush in; you will get nowhere

Talk to your representative, the host (if he or she is not involved) or your Country Coordinator.

Bide your time, seek advice, and make sure of your facts. You may have to instruct by quiet example.

Give yourself breaks

Don't get institutionalised. Make sure you spend some quality time out of the institution to come back refreshed. Plan time away.

Find out the daily programme and to whom you refer to for what.

Have your progress appraised.

Meet with your manager and discuss your progress and what they have identified as your strengths and areas for improvement. Communication can prevent problems down the line.

Throughout your year you will be learning about and adapting to your new environment and how to work effectively in your project. You will make mistakes but rest assured they can be rectified. You will have to continually work to build and maintain positive relationships with staff. It is important that you assess your own attitude, opinions and the impression you make on others before you criticise them for the way they are treating you.
Do not give up on people or your work - resolve matters - challenge yourself and make the most of your placement.

COMMON INFECTIONS

Disease	What is it?	Symptoms	How is it spread?	How do you prevent it's spread?	How do you treat it?
Scabies	*Caused by a tiny mite, Sarcoptes scabiei, that burrows into the skin, causing a rash. Found on wrists elbows or between fingers*	*Rash*	*Skin to skin contact*	*Exclude person with it* *Machine wash bed linens and towels (cuddly toys etc. if appropriate)*	*Over the counter insecticide lotion available for killing the mites*
Head Lice	*Tiny insects that live primarily on the head and scalp*	*An itchy head especially behind the ears and at base of head*	*Head to head contact and sharing items like brushes, combs, linens*	*Temporarily exclude infected person from setting* *Screen all people in setting*	*Medicated shampoo* *Fine tooth comb*
Pinworm	*Parasitic worm that lives in the large intestine. Common in school aged children.*	*Anal itching* *Sleeplessness* *Irritability* *Scratching*	*Spread when an uninfected person touches sheets or other articles contaminated with pinworm eggs, then touches the mouth transferring the eggs and swallows the eggs.*	*Exclude the child with pinworm* *Observe proper hand washing.* *Clean and disinfect bathroom* *Vacuum carpeted areas*	*Medicine- by prescription only*
Tuberculosis (TB)	*Infectious disease that affects the lungs*	*Chest pain* *Coughing* *Bringing up blood* *Productive cough (more than 3 weeks)* *Fever, chills, night sweats, weight loss, fatigue*	*Airborne. When those infected cough, sneeze or transmit saliva*	*Mask* *Isolation*	*Antibiotics (6 months)* *Vaccination - BCG*

Disease	What is it?	Symptoms	How is it spread?	How do you prevent it's spread?	How do you treat it?
Diarrhoea (& vomiting)	*Loose and more frequent stools caused by variety of germs, bacteria, viruses and parasites*	*Loose and more frequent stools* *Will often occur alongside vomiting*	*Contaminated food* *From person to person when a person touches the stool of an infected persons or object contaminated with the stool of an infected person*	*Good hand washing* *Disinfect toys, bathrooms and food surfaces* *Care with nappies*	*Lots of liquid* *Diarrolite* *Antibiotics* *If fluid output appears to be more than input for more than 24-48hrs seek medical attention*
Ringworm	*A fungus infection of the scalp or skin* *Causes a reddish ring like rash*	*An itchy flaky rash*	*By direct contact with a person or infected animal. Can also be spread indirectly through contact with articles eg clothes, combs*	*Vacuum carpets* *Wash bathroom surfaces and toys daily* *Dry skin after washing* *Prohibit sharing of personal items* *Hand washing*	*With an antifungus cream*

The following are country specific

Disease	What is it?	Symptoms	How is it spread?	How do you prevent it's spread?	How do you treat it?
Dengue Fever *South America only*	*A common viral infection spread by mosquitoes in tropical and sub-tropical regions*	*High temperature* *Migraine like headache* *Achy joints and muscles*	*Mosquitoes*	*Protective clothing* *Good insect repellent day AND night* *Mosi-net where possible*	*Usually clears up on its own in 1-2 weeks* *Plenty fluids and paracetamol* *If suspect dengue, see doctor – blood tests*
Altitude sickness *Not applicable to all countries*	*Occurs when staying at a higher altitude to what you're used to.* *Caused by a drop of atmospheric pressure meaning slower oxygenation of the blood.*	*Headache* *Dizziness* *Nausea* *Vomiting* ***More severe:*** *Bubbling/ productive cough* *Confusion*	*N/A*	*Not infectious* *Can begin from 8,000ft above sea level.* *If trekking - do not climb any further until resolved. If unresolved in 24-48hours drop by 500m.*	*Rest* *Plenty fluids* *Remain calm* *Body should adjust in 24-48hours*
Bilharzia *Lake Malawi* *Lake Victoria* *White Nile* *Mekong River, Cambodia*	*Infection caused by parasites in fresh water. (Rivers/Lakes) in tropical and sub-tropical regions*	*Flu-like* *Temperature* *Skin rash* *Cough* *Urinary symptoms (cystitis, blood in urine)* *Abdominal pain and cramps*	*The parasites that cause bilharzia are called Schistosomes.* *The parasite burrows in to human skin to lay eggs. The body has an immune response, causing an illness reaction to the eggs.*	*Take precaution when travelling in specified areas, avoid swimming /wading in the lakes/ rivers mentioned (and other fresh water lakes/rivers in particularly impoverished areas.*	*Seek medical attention you will receive a medication called praziquantel. (kills adult worms)*

SAFE WORKING PRACTICES

AIDS and HIV

HIV has become a world problem and has spread to every country in the world. However Sub-Saharan Africa still remains the most affected region.

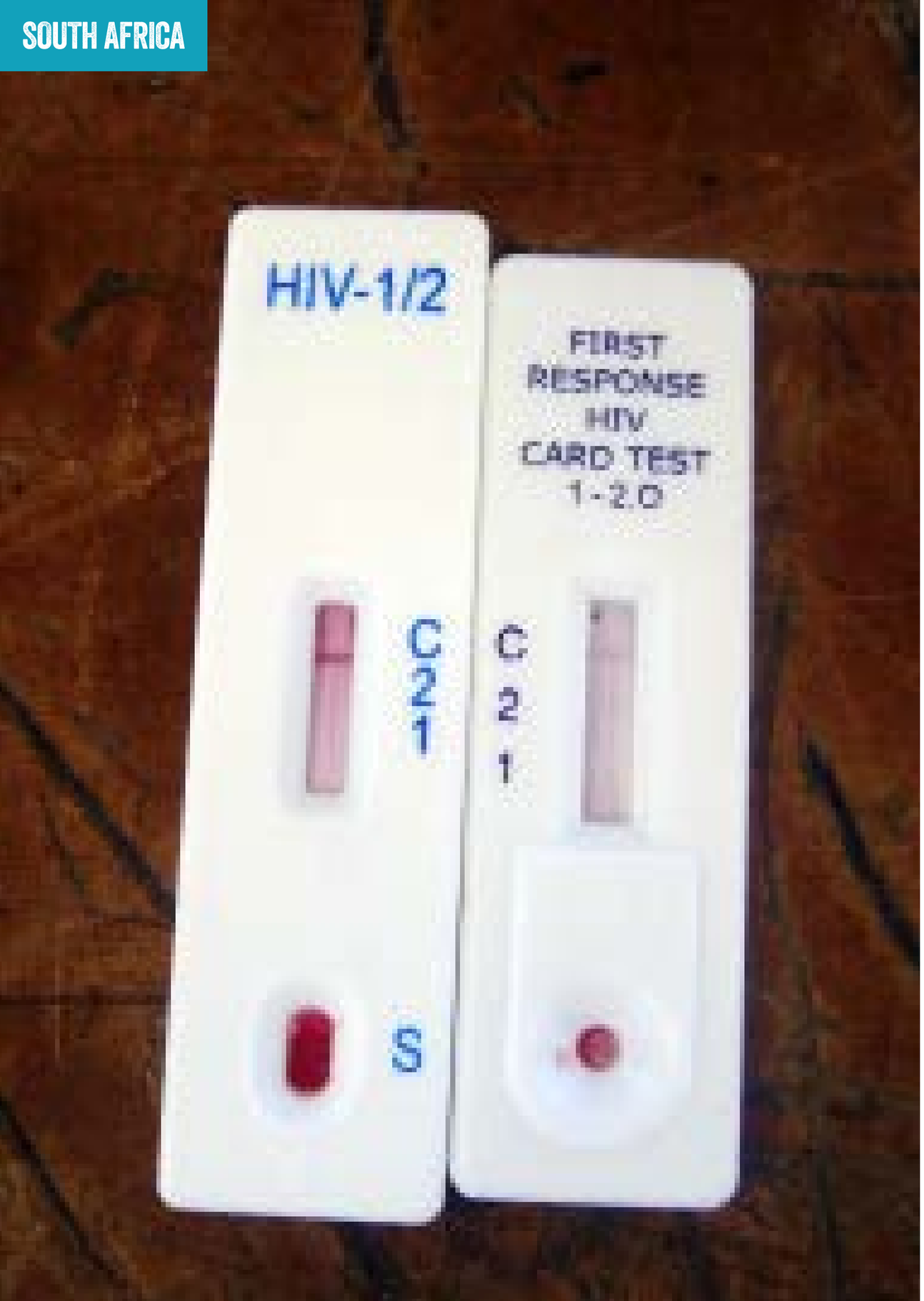
Since the onset of the HIV/AIDS epidemic 20 years ago well over 47 million people have been infected. In one year the mortality rate is 2.5 million per year.

Over 95% of AIDS deaths occur in the developing world, mostly amongst young adults and increasingly in women.

What do HIV and Aids stand for?

HIV – *Human Immunodeficiency Virus*
AIDS – *Acquired Immune Deficiency Syndrome*

- HIV causes AIDS. People do not catch AIDS but become infected with HIV, which may turn into full-blown AIDS at a later stage.
- HIV attacks the immune system leaving the person defenceless against illnesses. The virus enters certain body cells of the immune system, disables them and then is able to produce more viruses. The cells are called CD4, T4 or T helper cells.
- People who carry the HIV virus may remain fit and healthy for many years and therefore many are unaware that they are infected or carry the virus. The length of time between contracting HIV and dying of AIDS varies from person to person and a great deal will depend on the care given to the infected person.
- A person with HIV is said to have AIDS when a high percentage of CD4 cells are destroyed and the immune system collapses. When the CD4 cell count drops below 200 the person is clinically diagnosed as having AIDS.



Understanding AIDS

- AIDS is a disease that attacks the body's protective system making people less able to fight other illnesses.
- AIDS can take up to ten years to develop and an infected person can pass it on even if they show no signs of disease.

How is HIV spread?

Sexual contact

This is the most common method of contracting HIV.

From mother to child during child birth

During birth a mother will bleed which puts the child at risk of blood-to-blood transmission.

Sharing intravenous (IV) drug needles

HIV can live in the small amount of blood that always remains in an IV drug needle and syringe after use. It is a known fact that many drug users share needles. Blood also remains in needles and syringes used to inject vitamins and steroids. Having sex with someone who injects drugs is extremely risky.

Dirty needles used for body piercing

Through infected blood

and other body fluids coming in contact with mucus membranes or injured skin. Infection can only occur if HIV infected blood gains entry into the body. Today great care is taken with blood transfusions and it is highly unlikely that contaminated blood would be used. In South Africa blood donors are exceptionally carefully screened before being allowed to donate blood.

Occasionally through infected breast milk

Although HIV exists in the breast milk of a mother who is HIV infected there is a debate as to whether HIV mothers should or should not breastfeed. People living in poverty do not have availability or accessibility to milk formula and the morbidity rate in these communities is often already high due to other diseases and infections, breastfeeding therefore remains the safer option.

Activities that carry no risk of transmission

Whilst it is very important to understand the ways in which the HIV virus is transmitted, it is equally important to understand the ways in which it is NOT transmitted. Educating people about the way in which HIV is not transmitted may reduce the isolation that HIV infected people face.
There is NO evidence that HIV is spread through everyday casual contact and the virus cannot normally be transmitted in the following ways: -

- *Airborne routes such as coughing, sneezing, laughing, and talking;*
- *Simple skin-contact such as hand shaking, kissing, hugging, and touching;*
- *Through food, water, plates, cups, toilet, baths, pools and showers;*
- *Towels, bed linen and clothes;*
- *Insects such as mosquitoes or ticks.*

Other Contributors to the Spread of HIV

In addition to the physical way in which the virus is spread, it is important to note the cultural issues and beliefs that contribute to the spread of the disease.

Taboo Topics

Traditionally in most African societies, the disease has been seen as external to any physical or sexual contact. In addition it is most often highly taboo to speak of sex and sexual practices, which makes sex education and prevention of risky sexual practices very difficult. Other taboo subjects are promiscuity, prostitution, homosexuality, and drug use.

Language

In South Africa alone there are 11 different languages and very often there are not words and vocabularies for some of the AIDS related terms such as condoms, virus and immunity. When discussing AIDS related matters with patients and families one needs to keep in mind the cultures and language barriers that may alienate the person from the people he/she should be receiving support.

Traditional Healers

A traditional healer is described as “a resource person who is widely used and accepted by the community as an interpreter of what constitutes health and pathology in the African context.” There is a belief that AIDS is a result of sorcery and witchcraft rather than an acceptance of the scientific proof. These beliefs have obvious effects on safe sexual practices.

Condoms

The promotion of condom use has been problematic in Africa. There are many reasons, some culturally specific, why people do not use condoms. The non-use of condoms is generally based on misinformation and superstitious beliefs. Some of these are: -

- *Religious opposition to contraception*
- *Fear of impotence and sterility*
- *Suspicion that the previous apartheid government wanted to control the growth of the black population*
- *Condoms diminish sexual pleasure and enjoyment*
- *Condoms can be harmful to women*
- *Condoms are too small for black men*
- *Condoms are of poor quality when provided free from state sources*
- *Lack of accessibility to condoms*
- *Problem of disposal of used condoms in townships and areas where sanitation is poor or absent*
- *Fear that condoms are used by sorcerers to cast spells on the condom user*

POVERTY and LOW SOCIO ECONOMIC CONDITIONS has a huge effect on the spread of HIV

- *High unemployment, which in turn promotes migrant labour. People then may get involved in multi-partner sexual relationships.*
- *Women and girls forced into prostitution in order to bring in an income.*
- *Poor education and low literacy levels; this keeps people ill informed and fatalistic.*
- *Alcohol and drug use as a means of escaping the hardships of poverty. This in turn lowers inhibitions and encourages promiscuous sexual behaviours.*
- *Break down of family life, traditions and cultures mean people do not have moral guidance or stable social relationships.*

What Can We Do: Caring for Children with HIV

- Treat children who are HIV positive with the same love, care and compassion as other children.
- They should be allowed to go to school, and to learn and play in the same way as all the other children do.
- They should exercise gently and get plenty of rest.
- Take HIV children to the clinic/hospital as soon as they get sick. They can be treated with medicines for their sicknesses and will usually recover. Always make sure that all medication is completed.
- Children who are HIV positive must be immunized 5 times in their first year of life. This is important for all babies, but even more important for HIV infected babies. Immunization will help protect babies from dangerous sicknesses like polio, diphtheria, tetanus, mumps and measles.

Universal Precautions for Childcare Workers

As a care worker you have a responsibility to protect yourself and the children in your care from HIV infection. The virus is in inherently unstable; it does not survive for long outside of the conditions of the body. Therefore, by implementing some basic precautions you can greatly reduce the risk of you and the children contracting the virus. However, the seriousness and fatality of the virus demands respect and you should be exceptionally careful in situations when transmission is possible.

The skin is an effective natural barrier to disease and viruses; you should make an effort to keep your skin healthy. Moisturise dry hands to prevent cracking, cover cuts and grazes with bandages, do not pick or scratch scabs.

The most effective way to reduce the spread of all diseases in any care setting is for the carer to wear gloves at all times. Gloves should be worn when dealing with wounds, vomit, stools and blood. The gloves should be disposed carefully after you have dealt with one incident and before you begin on another. Never reuse gloves. Always wear and carry gloves.

To reduce the risk of spread of HIV in the childcare setting, all childcare providers should routinely follow precautions necessary to prevent the spread of any blood borne infection (including Hepatitis B).

Universal precautions require treating all blood as if it is infected with HIV and taking certain protective steps. Universal precautions include:

- *Do not touch anyone else's blood or share personal items that may contain blood, such as toothbrushes, razors, or pierced earrings;*
- *In emergencies, put something between yourself and blood if someone needs help* ***eg*** *rubber gloves, a towel, shopping bag, jersey;*
- *Keep all wounds covered with a bandage and don't remove scabs;*
- *Clean up blood spills with a bleach solution;*
- *If someone is bleeding and needs help, stay calm and don't panic;*
- *Throw disposable items soiled with blood away in a plastic bag or wrapped in newspaper;*
- *Wash your hands with soap and water as soon as possible if you get blood on them;*
- *In the case of a nosebleed pinch the nostrils to the bridge of the nose using the usual hand protection or guide the patient to do it themselves.*

Anti-retroviral treatment

Treatment with antiretroviral drugs during the early weeks of infection may have a significant effect on the course of HIV infection.

Many of the drugs demand a very structured dosage and timings and must be taken with certain nutritious foods. They also cost a great deal so are not readily available nor an easy medicine to take.

AZT is the most well known anti-retroviral drug. It is often taken by social workers who have experienced a workplace accident (needle-prick or splash). It is also given to HIV- positive mothers when pregnant to reduce the likeliness of passing the virus on to their baby.
There can be some unpleasant side effects to taking the drugs:

- *headaches;*
- *hypertension;*
- *nausea and vomiting;*
- *anaemia;*
- *muscle pain and weakness*

HIV and AIDS have massive emotional and physical implications for people infected by the virus and their carers. We all have a responsibility to spread awareness and understanding of the virus to ensure the spread of the global pandemic decreases and stigmatism towards the disease and those living with the disease declines.

WORKING WITH DISABILITIES

Some people are uncomfortable talking with people with disabilities. This chapter gives you some basic tips to help you be more comfortable interacting with people with disabilities and to help people with disabilities more enjoy interacting with you.

Why are some people uncomfortable interacting with people with disabilities?

One reason is that some people feel sorry for people with disabilities, and assume that they are bitter about their disabilities. This is untrue in many cases. Lots of people with disabilities feel that their lives are enriched by their experiences with disability, and even if given the chance to erase their disability would choose not to.

Another reason that some people are uncomfortable around people with disabilities is that they're afraid that they will "say the wrong thing". However, that's not a big deal to most people with disabilities. What's important is that you respect the person and see them beyond their disability.

One basic question many people have is: What is appropriate terminology, for example, disability, impairment, or handicap? When you're working with someone, you can ask what terminology he or she prefers. When you're speaking in public or writing, you'll need to do a little research to ensure that you use widely-accepted terminology and avoid potentially offensive terminology.

The most important thing to know when interacting with people with disabilities is that they are people. And just like all people, they are very different, including being different in how they are with disability issues.

Some people prefer different terms, some get very upset about terminology, and some don't care. Some people get very upset about accessibility barriers and lash out at those responsible; some are very patient with accessibility barriers and are appreciative and supportive of people and organizations that are trying to fix barriers.

Some people really appreciate the opportunity to talk about their disability and educate others about accessibility issues, and others don't like to talk about it at all. After you know someone a little, you might ask, "I'm curious about your using a wheelchair. Are you comfortable talking about it, or would you prefer not to?"

Interacting with People with Disabilities

Don’t make assumptions about people or their disabilities. Don’t assume you know what someone wants, what he feels, or what is best for him. If you have a question about what to do, how to do it, what language or terminology to use, or what assistance to offer, ask him. That person should be your first and best resource.

Remember that people with disabilities have different preferences. Just because one person with a disability prefers something one way doesn’t mean that another person with the same disability also prefers it that way.

Ask before you help. Before you help someone, ask if they would like help. In some cases a person with a disability might seem to be struggling, yet they are fine and would prefer to complete the task on her own. Follow the person’s cues and ask if you are not sure what to do. Don’t be offended if someone declines your offer of assistance.

Talk directly to the user, not to the interpreter, attendant, or friend. You don’t need to ignore the others entirely; just make sure to focus your interaction with the user. When a user who is deaf has an interpreter, the user will look at the interpreter as you are talking. It might take a little extra effort to remember to face the user rather than the interpreter.

If you will be speaking for some time with a person in a wheelchair, sit down so that you are at eye level with her/him.

Speak normally. Some people have a tendency to talk louder and slower to people with disabilities; don’t. Don’t assume that because a person has one disability, that he also has a cognitive disability or is hard of hearing. For example, a person with cerebral palsy might use a wheelchair, have uncontrolled upper body movements, have difficulty speaking, and yet have very good hearing, cognitive abilities, and intelligence.

Use “people-first” language when referring to people with disabilities. People-first language means put the person first and the disability second. For example, say “a man who is blind” rather than “a blind man,” and “a woman who uses a wheelchair” instead of “a wheelchair-bound woman.” Use people-first language when speaking with people with disabilities, and when speaking and writing about people with disabilities.

Avoid potentially offensive terms or euphemisms. Commonly accepted terminology includes “people with disabilities” and “a person with visual/hearing/physical/speech/cognitive impairment.”

Be aware of personal space. Some people who use a mobility aid, such as a wheelchair, walker, or cane, see these aids as part of their personal space. Don’t touch, move, or lean on mobility aids. This is also important for safety.

Be confident and ask questions about your work. You are learning everyday. Don’t be scared to say that you do not know something – you are not expected to have great expertise or experience.

It is better to ask than never know!

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