

## 16

## CHILDREN AND HIV

**Key points:**

1. ARVs help children infected with HIV to live longer and healthier lives.
2. We need to campaign for better treatment for children.
3. Children are badly affected by HIV and AIDS with the loss of parents and caregivers.
4. Social grants help to look after children who live in poverty.

In 2011, there were 330,000 HIV positive children in South Africa. In most developing countries, children are not the priority of ARV programmes. With ARVs, children infected with HIV live much longer and healthier lives. But an estimated 90% of HIV positive children worldwide are not receiving ARVs. Young children ideally need medication in syrup or powder form. Most ARVs for children are only

available in tablets, which make it difficult for caregivers to give the correct dose and are also difficult to swallow. This means that children often get too little or too much of the medicine. Apart from those children infected with HIV, there are thousands who are affected by HIV because of the loss of caregivers and family members.





## ABOUT THIS CHAPTER

The aim of this chapter is to understand how HIV and AIDS affect children in South Africa.

### This chapter covers:

- Children with HIV and AIDS
- Starting children on ARVs
- Preparing the caregiver to start ARVs
- Combination therapy
- How long will an HIV positive child live for without ARVs?
- Caring for children with HIV
- Social grants



**Welcome to Chapter 16** of the Health Literacy Series. In this chapter we will be talking about children and HIV. We will learn about how to give children ARVs and also how to care for children living with HIV. Children are often not the focus of treatment programmes and so there is a need to campaign for better access to ARVs that are for children.

## Children with HIV and AIDS

(Episode 16, Chapter 1)



Every year in South Africa 38,000 babies are infected with HIV at birth. Another 26,000 are infected through breast milk. That makes a total of 64,000 newly infected babies every year. A quarter of HIV positive children will develop AIDS related illnesses in their first year. Without access to ARVs, a child born with HIV will live on average for only 2 years. Over 90% of children born with HIV die before they are 5 years old. Only 30,000 children in South Africa are on ARVs.

A South African study conducted in 2010 by the Medical Research Council has shown the PMTCT programme to be highly effective in reducing HIV infection. This is good news as it shows that if we are able to get all pregnant HIV positive women on PMTCT then we can significantly reduce HIV in South Africa.

Currently there are very few children on ARVs. There are lots of children living with HIV that need treatment, but at the moment they cannot access ARVs. Children are not always the first priority for ARV programmes. ARVs for children are different to ARVs for adults. Their treatment can be complicated, because children need medication in syrups or in a powder, because pills are difficult to swallow. Syrups also make it easier for the caregiver to make sure that the child is receiving the right amount of ARVs. The amount of medicine given to children is calculated according to their weight. We must campaign for children to have access to the ARVs they need.

An important part of caring for children with HIV is to find out as soon as possible if they are HIV positive. We have spoken about PMTCT in Chapter 14. We know that it is very important for mothers to know their status and if they are HIV positive to access PMTCT so that they can prevent the transmission of HIV to their child.

You will remember that if you test a newborn baby for HIV using the normal antibody test that is used for adults, the test will probably show positive. This is because a new baby shares antibodies with the mother up until about 12 months. This means that if a baby is tested before 12 months, an antibody test may show a false positive result. A false positive means that the baby is HIV negative, but tests positive because of the mother’s antibodies. Only after 18 months can an antibody test be reliable and we can be completely sure about the test results. This is a long time to wait.

In children younger than 18 months, the best way to test for HIV is using a test that looks for the HIV virus itself and not the HIV antibodies. These tests are called PCR tests. A PCR test should be done when the baby is 6 weeks old.

If a child is breast fed, there is the risk that they can be infected with HIV through the breast milk. This means that once the mother has stopped breast feeding, the child should get a PCR test. The PCR test should be done 6 weeks after the baby has stopped breast feeding altogether. Ask your health worker about having a PCR test. At 18 months all children exposed to HIV, including those who tested HIV negative in the PCR test, should be tested again using an antibody test. This is to make sure that if the child is HIV positive, they get ARVs as soon as possible.



*Here we can see a care-giver measuring ARV medication in syrup form to give to a young child using a syringe.*



*It is best to find out as soon as possible if your child is HIV positive.*



## WORKBOOK NOTES

Four sets of horizontal dashed lines for writing notes, each set consisting of three lines.



## DISCUSSION POINTS

In a group talk about the following questions and see if you can answer them.

**1. Can children with HIV be treated?**

Yes, children with HIV can take ARVs, along with other medication.

**2. How soon will most children die if they are untreated?**

Without ARVs, most children will die before they are 5 years old.

**3. How are most children infected with HIV?**

Most children are infected during childbirth without access to PMTCT programmes.

**4. What test can be done at 6 weeks that can test if a child is HIV positive?**

A test that looks for HIV can be done at 6 weeks. It is called a PCR test.

**5. If a PCR test is not available, what is the other testing option for children?**

An antibody test is also an option for testing children, although the child must be at least 18 months old to be sure that an HIV antibody test result is accurate.

## Starting children on ARVs

We have talked about the immune system and how HIV disease progresses in Chapters 2 and 3. You might want to remind yourself and re-read these chapters.

The most important thing to remember is that our immune system has many different cells that defend us from infections and germs. One of these cells is the CD4 cell. HIV is a virus that attacks the CD4 cells. With the loss of CD4 cells our immune system cannot work properly. When our immune system is weakened, many diseases (such as TB, PCP pneumonia, oral thrush) take advantage and attack the body.

We have already talked about how HIV affects the immune system. We know that as HIV disease progresses the viral load goes up and the CD4 count goes down. With adults we measure the number of CD4 cells with a CD4 cell count (called absolute CD4).

Children are a bit different, because **we measure the percentage of CD4 cells in their blood.**

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(Episode 16, Chapter 2)



Here we can see d4Tin syrup on the left and in capsules on the right.

**Without ARVs,  
90% of HIV positive children  
will die before they are  
5 years old**



**Examples of children's stage 3 illnesses include:**

- Diarrhoea (for 14 days or more)
- Unexplained persistent fever (intermittent or constant, for longer than one month)
- Oral thrush
- TB of the lungs
- Severe bacterial infections that keep coming back

**Examples of children's stage 4 illnesses include:**

- PCP pneumonia
- Severe infections that keep coming back and are presumed to be bacterial
- Chronic herpes simplex infection
- TB outside the lungs
- Oesophageal thrush of the trachea, bronchi or lungs



*The child's health, as well as their home circumstances, helps decide when to start ARVs.*

When health care workers are deciding to put a child on ARVs, they will need to meet the caregiver who will be taking care of the child and administering their ARVs. The purpose of the screening visits before starting a child's treatment is to make sure that the parent or guardian is reliable, caring and prepared and able to support the child taking their ARVs properly. A child's adherence depends on their caregiver.

If the child experiences side-effects when starting on ARVs, go back to the health care worker at the clinic. Most side-effects are things like skin rashes, nausea and diarrhoea. As soon as you see something that isn't normal or the child is not well, go straight to the clinic as soon as possible. Illnesses with children get serious very quickly so don't wait. Don't just stop the treatment yourself. If your child is experiencing side-effects, the health care workers can either treat the side-effects or change the regimen. If the regimen is changed, the drug that is causing the side-effect will be replaced with another ARV (usually from the same family). You must never make the decision to stop the child from taking ARVs without first consulting the healthcare worker.



## DISCUSSION POINTS

In a group talk about the following questions and see if you can answer them.

**1. When should infants under 1 year start ARVs?**

Infants under 1 year should start ARVs straight away, regardless of their CD4 percentage.

**2. At what CD4 percentage should children aged 1 -5 years start ARVs?**

Children aged 1- 5 years should start ARVs if their CD4 percentage is 25% or less.

**3. What other things mean a child should start ARVs?**

A child who has been hospitalised more than twice in a year for HIV related illnesses, or who has any stage 3 or 4 opportunistic infections should start taking ARVs.

**4. What must a caregiver do if a child is experiencing side-effects?**

If a child is experiencing side-effects, a caregiver must bring the child to the clinic as soon as possible. Do not stop ARVs without speaking to a health care worker.

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# Preparing the caregiver to start ARVs

(Episode 16, Chapter 3)



Making sure that the caregiver is health literate is very important. It is vital that the caregiver understands how ARVs work and understands why adherence is so important. They should also be shown how to give ARVs to the child and know the correct dosage and time to give medication. As we already know, giving ARVs to children can be complicated because the amount of medicine needs to be increased as the child grows and their body weight increases.

Another challenge is that there is a need for ARVs to be developed specially for children. At the moment there are not many ARVs for children and so caregivers have to be shown how to break pills into the correct dose and how to crush the pills so that it is easier to give to the child. Some ARVs for children come in a syrup form, which is easier to give. For infants (children younger than 1 year), medication is often given in a syringe to make sure that the child swallows all the medication.

Making sure that the child gets the correct dose of ARVs every day is a big responsibility. If the caregiver does not ensure that the child takes the correct dose of ARVs every day, the child will suffer. Children cannot take ARVs on their own. They need their parent's or guardian's assistance. It's important that the guardian is a trustworthy person who is going to do exactly what the doctor says. This is why it is so important that the caregiver is health literate.

Before starting a child on ARVs, health care workers sometimes look at the child's Road to Health Booklet to see if the caregiver has made sure that the child has come to the necessary visits to the clinic. The health care worker will want to make sure that the caregiver takes the child to the clinic and that all the child's immunisations are recorded on the card. The health care worker will also look at the child's growth and weight to make sure that the caregiver is looking after the child properly and is able to feed him or her. A health care worker can also refer caregivers to Social Services for grants to make sure that there is enough food in the home. At the end of this chapter there is more information about Social Grants.

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*Children need a caregiver to help them take their ARVs.*

**ARVs in a syrup form are easier for children to swallow**



# Combination therapy

(Episode 16, Chapter 4)



We have already learnt that when we take ARVs, we take a combination of 3 different ARV drugs. Read the chapter on ARVs for Adults again if you want to remind yourself.

We have also learnt that ARVs are available in first-line and second-line regimens. What this means is that when people start taking ARVs for the first time, they will take first-line treatment. If they develop resistance or have side-effects from the first-line regimen, then they are able to move to second-line treatment. This is the same for children taking ARVs.

There is more than 1 combination of ARVs available for children in the public sector in South Africa. Not all children will start on the same regimen and some may need to change to a different regimen sooner than others. This is usually because of side-effects or because of resistance. Children's doses will change as they increase in weight.

Caregivers who give ARVs to children can experience some difficulties. You will have 3 bottles to give to a child at the same time. You will take a dose from each of the bottles to give to the child. The medicines do not taste very nice.

The WHO recommends Fixed Dose Combinations (FDC) be developed for children because it improves adherence to medication and helps make sure that the right dose is given. There is an urgent need for ARVs to be developed in syrup form so that young HIV positive children get the right amount of medicine.

The reason for using syrups for children is because their doses change as they grow and gain weight. Syrups make it easier to change the doses. Syrups are also easier to give to small children and infants because they can swallow them more easily and can't choke. But it means the caregiver has to be very responsible and ensure that the child is given the correct dose. The caregiver also has to learn how to mix the syrups with water to match the dosage with the weight of the child. It is a good idea for caregivers to practice mixing ARVs with their health care worker so that they can be sure they know how to do it correctly. The doses must be correctly given for the medication to work. Caregivers should also know the names, doses and times the doses need to be given.



## DISCUSSION POINTS

In a group talk about the following questions and see if you can answer them.

### 1. When does a child's dose change?

As a child grows, their dose needs to change because their body weight is increasing.

### 2. Why is it convenient that children's medicines are in liquid form?

It is convenient for a child's medicine to be in liquid form because it is easier to change the dose as they grow up. Syrups are also easier than pills for a child to swallow.



Here we can see a caregiver preparing ARV medicine to make it easier for a child to swallow.

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# Second line regimen

(Episode 16, Chapter 6)



Second-line regimen is used when children do not respond to the first-line regimen. This is called treatment failure. To find out if there is treatment failure doctors will look at the CD4 percentage when the child started ARVs and also the CD4 percentage after first starting ARVs.

Treatment failure is when the CD4 percentage (or count) drops to the level they should have started ARVs. For example, if a child over 1 year starts ARVs when their CD4 percentage reaches 25% and their CD4 percentage improves at first, but then later drops back to 25% or lower, this is treatment failure. Treatment failure can also mean that a child starts to have new or stage 3 illnesses that keep coming back. When a child needs to change regimen, there are a couple of options for second-line regimens. Health care workers will decide which regimen is the best depending on the child's age and history.

- If the child is under 3 years of age or the child's first line regimen included Kaletra or Aluvia, the child is referred to a specialist to decide the best treatment.
- If the child is over 3 years and their first line regimen contained ABC, 3TC and Efavirenz, the second-line regimen is AZT, (Zidovudine), ddl (Didanosine) and Kaletra or Aluvia (Lopinavir and Ritonavir).
- If the child has been on a regimen including AZT or ddl and provided no Lopinavir has been used, the second line regimen would be ABC, 3TC and Kaletra or Aluvia.



Here we can see an older child taking her ARV medication.



## DISCUSSION POINTS

In a group talk about the following questions and see if you can answer them.

### 1. When are second line regimens given?

Second line regimens are given when children do not respond to the first line or when they have bad side-effects from the first line drugs.

### 2. What are the second-line options for children under 3 years old?

Children under 3 years old and who has treatment failure for the first line regimen should be referred to a specialist.

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## WORKBOOK NOTES

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# How long will an HIV positive child live without ARVs?

(Episode 16, Chapter 7)



As we have learnt so far, most children will die before they reach 2 years old if they do not have ARVs. Children are very vulnerable to HIV, which means their bodies cannot fight it for a long time and they get sick quickly. Many adults can have HIV for 2-10 years without getting sick, but children get sick much quicker because their immune systems are weaker than adults.

## Caring for Children with HIV

(Episode 10, Chapter 1)



Regardless of whether or not a child is on ARVs, there are some important things we can do to take care of children who are HIV positive. You might want to re-read the chapter on Positive Living to remind yourself how adults live a healthy and longer life on ARVs. Many of the things we need to do to take care of children are similar to how we look after ourselves if we are adults. Most of these things are common sense, but it is good to remind ourselves.

### Early and effective treatment

Early diagnosis and treatment is one of the most important things when it comes to managing HIV infection. It makes a big difference to your health if you are treated for opportunistic infections before they get serious. Remember, if you are HIV positive your immune system is already weak. When your body has to fight infections, the immune system is weakened even further. This means that your CD4 count will drop and your viral load will go up. It is the same for children, but it is even harder for them to fight infections.

**If the child starts to get sick, make sure they get early and effective treatment for any infection.**

Effective treatment means that you get the right treatment for the infection and you complete the treatment. It also means you take the treatment like the doctor or health care worker explained. Do not share your medication. If you are the primary caregiver for a child, make sure that they finish the treatment and give it to them like the health care worker explained. Every opportunistic infection can weaken the child's immune system and make AIDS develop faster. This is why early and effective treatment is so important.

Using **Bactrim or Co-trimoxazole can protect the child against infections** like PCP pneumonia, diarrhoea and toxoplasmosis. All HIV positive children should be given Co-trimoxazole (Bactrim) to prevent infections. Bactrim can be stopped in children 18 months or older with a CD4 percentage of more than 20%. If the CD4 percentage is not available, Bactrim should only be stopped after 6 months of good adherence to ARVs. But Bactrim can also be continued even if the child is on ARVs. Ask your health care worker about Bactrim. Early and effective treatment needs a responsible caregiver.



*Take your child to the clinic for regular check-ups.*



*Bactrim (Co-trimoxazole) helps prevent infections.*

## Diet

We have already talked about the importance of nutrition for HIV positive people. Getting enough nutrients is very important for everyone, but especially if you are HIV positive. Having a balanced diet helps keep your body strong and gives your immune system a better chance at fighting infections. HIV positive children need to eat healthy food to get all the necessary vitamins to grow and also to keep them strong. If the health care worker thinks the child needs vitamin supplements, a multi-vitamin syrup will be provided by the clinic. Routine vitamin A injections are also done at the clinic until the child is 5 years old.

Infants (children younger than 1 year old) are fed milk until they can start to eat solids. We have already discussed infant feeding in detail in the chapters PMTCT and Maternal and Child Health. Read them again if you want to remind yourself.

Feeding choices are either **exclusive formula feeding** or **exclusive breast feeding**. Mixed feeding should be discouraged because it increases the chances of the child getting infected with HIV.

## Immunisation

Immunisation is when children are given a vaccine to prevent serious childhood diseases. Like all children, an HIV positive child needs to be immunised. This is free for all children and will be done at your local clinic. All children have a Road to Health Booklet where their immunisations are recorded. Since the introduction of immunisation, the number of children affected by diseases such as polio, measles, hepatitis B, rubella, diphtheria, pertussis (whooping cough), and meningitis caused by haemophilus influenzae type B (Hib) have declined by 90%. Read more about immunisations in chapter 15 on Maternal and Child Health.

A BCG immunisation (for TB) should not be given to children who have AIDS defining illnesses or a very low CD4 percentage.

## Monitor the child's growth

A child's weight is a good way of seeing if the child is healthy and doing well. All visits to the clinic with a young child include weighing to see if the child is growing and getting enough food. The weights are written down on the child's Road to Health Booklet. If an HIV positive child is not gaining weight or loses weight, it could mean they are not getting enough food or that they need to start ARVs.

## Listen to your child

Some children will tell you when they have a problem or are experiencing pain but others will not. It is important to ask your child how they are feeling. We must listen to our children. Take the child to the doctor or to the clinic and find out more about the pains they are experiencing. This is especially important when dealing with HIV positive children. Remember that early diagnosis and treatment can save your child's life.



*If you need vitamins, you can get them from the clinic.*



*It is better to choose either exclusive formula feeding or exclusive breast feeding.*



*It is important to measure and weigh your child to see if they are healthy and growing.*

**HIV positive children need to follow the guidelines for living positively**

# Oral hygiene

Good oral hygiene helps prevent the child developing oral thrush (thrush of the mouth) which is a fungal infection. Thrush makes eating very difficult, which will stunt the child's growth. If oral thrush becomes worse, it will spread down the food pipe, when it is called oesophageal thrush.

Thrush of the food pipe, or oesophagus, is very serious. It is a stage 4 illness, which means the child has AIDS and needs to start antiretrovirals immediately. If the child does develop oral thrush, it will be treated with Nystatin liquid. If the child develops thrush of the food pipe, or oesophagus, it should be treated with liquid fluconazole, which the child must swallow. Try and limit the amount of sweet things that you feed your child. Sweets and sweet drinks are bad for children's teeth. They also encourage oral thrush if the child is HIV positive.



*Nystatin liquid can be used to treat oral thrush.*

# Preventing other infections

(Episode 16, Chapter 8)



Many opportunistic infections are caused by bacteria. There are bacteria all around us and some of them can make us sick. With HIV positive children it is important to prevent bacterial infections. Diarrhoea is caused mostly by bacterial infections. Bacterial infections are reduced by washing our hands and making sure that food is prepared in a safe way. There are many simple things you can do in the home to prevent bacterial infections. We must:

- Always wash our hands when preparing food
- Make sure that fresh foods, such as fruit, are washed in clean/safe water
- Make sure that children's hands are clean when they eat
- Keep the child away from cats and pet birds which can spread disease
- Keep the child away from dirty and dusty environments
- Treat children for worms every 6 months
- Clean up vomit/diarrhoea/blood with bleach mixed in water

The fungus that causes cryptococcal meningitis is found in household dust. We must therefore keep the child's environment as clean as possible. Another dangerous opportunistic infection is called toxoplasmosis (tox). Toxo is spread in the faeces of cats and in bird droppings. So it is best to keep an HIV positive child away from cats and birds. Refer to the chapter on infection control for more information on preventing infections.



*Always wash your hands before and after eating food.*

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# Social grants

Many families in South Africa depend on social grants for food and other expenses. While the long term solution should be making sure South Africans can look after themselves through better education and more jobs, the short term solution is grants. In order to get a grant you will have to pass a means test which means that you will have to show that you have a low family income or are unemployed. There are local offices where you will need to fill in a form and apply for a grant. Social grants are paid every month either in cash payments, through banks or institutions. Child grants include:

- Foster Child Grant
- Care Dependency Grant
- Child Support Grant

## Foster Child Grant

The Foster Child Grant is given to people who are looking after children who are not their own and who have a court order/ legal responsibility to care for the children. The grant was first made to support families who were looking after children who were taken in from their families because of abuse or neglect. Nowadays it is mostly used to look after children who have lost parents because of HIV and AIDS. The person who is applying for the grant and the child must be resident (living) in South Africa at the time when they apply. The person who is applying will need a 13 digit barcoded ID document and a court order that shows their foster care status. Each child in foster care must have valid RSA or non RSA ID number. The foster child must pass the means test. In 2011, the Foster Care Grant was R740 per month.

## Care Dependency Grant

The Care Dependency Grant is for children with special care needs. This grant is given to caregivers of children who have severe disabilities and who need permanent care. It excludes those children who are cared for in state institutions. The child will need to have a medical examination and the parent must pass an income or means test. The person applying for the grant must be a South African citizen, except for foster parents who have foster children who also qualify for a care dependency grant. The person applying for the grant and the child must be resident in South Africa. The child must be between 1 and 18 years old. The applicant must have a barcoded ID document and the child must have a 13 digit birth certificate. In 2011, the Care Dependency grant was R1140 per month.

## Child Support Grant

The government is obliged to support children directly when their parents or caregivers are not able to support them adequately due to poverty. This means that the person who is applying for the grant and their partner must pass the means test. The child and primary caregiver must be South African citizens and resident in South Africa. The person who applies for the grant must be the primary caregiver of the child/ children and have an ID document. The child/children must be under the age of 18 years and must have a birth certificate. In 2011, the Child Support Grant was R260 per month.

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*Grants help make sure that children living in poverty have their basic needs met.*

## Where do you apply for a social grant?

You apply for a grant at your local Welfare Office or SASSA (South African Social Security Agency) office nearest to where you live. If you are too old or sick to travel to SASSA Offices to apply for a grant, then a family member or friend can apply on your behalf. You will need to fill in an application form in the presence of an officer from SASSA.

When your application is completed you will be given a receipt – keep this receipt because it is proof that you have applied for a grant. You do not have to pay any money to apply for a grant. If your application is not approved, you must be informed in writing to explain why your application was unsuccessful. You have the right to appeal to the Minister for Social Development in writing, explaining why you disagree with the decision. This appeal must be written within 90 days of being told that your application has been refused.

## Child-headed households

Many children have lost either 1 or both parents because of AIDS. Often these children are looked after by the extended family, such as grandparents. But sometimes, they have to look after themselves. A child-headed household is when all the people living in the household are under the age of 18 years old. Often the eldest child will drop out of school and take care of the younger children. It is very important that these children get support in the form of grants and also community help. If you know of such a family you should contact a social worker or Child Welfare so that they can visit the child-headed household and help them make sure they have food, are looked after and can continue to go to school. Another option is to look for foster parents to take in some of the children.

### Personal Story

**Thelile Dlame:** “My name is Thelile Dlame. My father was sick and he died in 1998. And my mother was always sick and she passed away in April 2003. I was at school, but I decided to leave since I’m the eldest. All the children are at school and I am looking after them. We are 5 children, including my child. We used to have everything, but the way we are living is very hard. The children I’m looking after are still very young, still at school. They want food, clothes, like other children. The way we have been living is not nice.”

**Nonhlanhla Magubane (Social Worker):** “We visited the family and we’ve discovered that there’s nothing. They don’t even have mielie meal. They have nothing to eat at all... We call her *intandane*, that’s the child without parents, but in terms of the act, she does no longer fall under the child-headed families, but the female-headed families, because she is 22 years old, so now she’s in the process of applying for the grant. So as a temporary measure we’re going to issue some social relief, which she will use to buy some food. Thereafter the social worker will have to compile a preliminary report that she used to take her to court and place the children to her as a place of safety. After 14 days, they’ll have to go back to court as well where the children will be put under her care as a foster care parent.”



### WORKBOOK NOTES

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## MULTIPLE CHOICE QUESTIONS

Name : .....

Circle the correct answer for each question. You can only choose 1 answer for each question.

**1. Which statement is correct?**

- a) HIV positive children die at birth.
- b) On average HIV positive children without ARVs will die within 2 years.
- c) On average HIV positive children without ARVs will live for 10 years.
- d) HIV positive children can't take ARVs.

**2. Which statement is correct?**

- a) Most HIV positive children in South Africa are taking ARVs.
- b) Children need ARVs in syrup form.
- c) It is easy to give children ARVs in pill form.
- d) It is easy for a child to swallow pills.

**3. If the mother is HIV positive, you should:**

- a) Test the baby for HIV at 6 weeks.
- b) Wait and see what happens.
- c) Mix feed the baby.
- d) Test the baby for HIV at 6 months.

**4. An HIV positive child should ideally start ARV treatment:**

- a) When they are 2 years old.
- b) When they get sick.
- c) As soon as you find out they are HIV positive.
- d) As soon as they are born.

**5. Caregivers who are looking after HIV positive children should be all but ONE of the following things:**

- a) Health literate
- b) Responsible
- c) Forgetful
- d) Reliable

**6. Which statement is true?**

- a) Children take the same dose of ARVs as adults.
- b) Children take only 2 different ARVs.
- c) Children take a combination of 3 ARVs.
- d) Children need to be in hospital to take ARVs.

**7. Which one is NOT important when caring for HIV positive children?**

- a) Early treatment
- b) Treating all infections
- c) Expensive nutritional shakes
- d) Regular clinic visits

**8. To prevent bacterial infections we should do all but ONE of these things:**

- a) Wash your hands before preparing food.
- b) Make sure children's hands are clean.
- c) Boil vegetables for an hour before eating.
- d) Boil water before drinking it.

**9. Social grants are:**

- a) So that you don't have to work.
- b) To help people living in poverty or who are too old to work.
- c) To give you extra spending money if you have a full-time job.
- d) So that children don't have to go to school.

**10. Which one of the following grants is not to help care for children?**

- a) Foster Child Grant
- b) Care Dependency Grant
- c) Child Support Grant
- d) Old Age Grant



## WORKBOOK NOTES

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