HOME VISITATION
FOR CHILDHOOD INJURY PREVENTION
A PREPARATION AND IMPLEMENTATION MANUAL

Editors

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Preface

The increased national focus on childhood deaths arising from unintentional injuries has drawn attention to the need for a strong and focused injury prevention and containment movement. In response to the need for prevention technologies and methodologies, the Crime, Violence and Injury Lead Programme (CVI LP), who is co-directed by the UNISA Institute for Social and Health Sciences (ISHS) and the Medical Research Council (MRC), in conjunction with its partner, the Child Accident Prevention Foundation of Southern Africa (CAPFSA), are promoting the development and implementation of home visitation programmes for childhood injury prevention. The home visitation programme is used as a way to control and prevent childhood injuries in low-income communities. In this home visitation programme we focus on unintentional injuries, especially those that are caused by burns, falls and poisoning.

This manual represents one comprehensive response to the need for controlling injuries among the most vulnerable in society, children. The home visitation programme that is proposed in this manual is one of the first such injury prevention programmes in South Africa. Home visitation programmes have been used for some time in providing health care and education to the home, and have been proven successful in assisting families to take care of children's health. The programme presented herein was developed through interventions in Cape Town and Johannesburg, from 2001 to 2005. Initial results from our study indicate that home visitations are effective in curbing injury risks in low-income contexts.

We present this manual to programme developers, managers and practitioners focused on preventing childhood injuries resulting from burns, poisoning and falls. The manual incorporates various sections, which detail the way in which a programme should be implemented, as well as the specific training sections aimed at the development of home visitors.

We hope that this manual will aid you in your child safety work. Should you have any constructive suggestions or comments kindly direct them to Ashley van Niekerk at ashleyvanniekerk@mrc.ac.za

Mohamed Seedat
Director: UNISA-MRC Crime, Violence and Injury Lead Programme &
UNISA Institute for Social and Health Sciences
Contributors

**Anabela Nascimento** holds a doctorate in psychology and works in private practice as a counseling psychologist. She acts as an external consultant to the UNISA Institute for Social Health Sciences and has been involved in different projects at UNISA since 2000. Anabela was responsible for developing the training materials for the module on Relationship-building and Interviewing skills, which lies at the heart of this programme.

Ashley van Niekerk is a specialist scientist with the Crime, Violence and Injury Lead Programme located at the Medical Research Council. He is a trained clinical psychologist and safety promotion researcher. His current research interests focus on childhood injuries in the home, especially burn injuries, and the identification, development and evaluation of home safety interventions. Ashley has written a number of articles on childhood home safety, has co-edited a number of books, including *Crime, Violence and Injury Prevention in South Africa: Developments and Challenges (2004)*, and is a member of the African Safety Promotion's editorial team. He coordinated the scientific development of the home visitation programme described in this manual.

**Loni Baadjies** was a psychology research intern student at UNISA's ISHS in 2004. She took a leading part in training the visitors for the current programme in the Johannesburg-site. She co-authored the module on “Child Development”

Lu-Anne Swart has been a researcher at UNISA's ISHS since 1994. She is a community intervention coordinator for the ISHS's volunteer safety promotion programme. Her contributions toward the current programme involved the development of procedures for the recruitment, training, assessment and supervision of home Visitors. She was also involved in the coordination of the programme in Johannesburg. She authored the chapter on “Recruitment and selection of home visitors.”
**Nelmarie du Toit** is deputy director and chief social worker at the Child Accident Prevention Foundation of Southern Africa (CAPFSA). As such she is responsible for the coordination of the Foundation in the Western Cape and has been involved in research, education and advocacy work on child injury prevention for a number of years. Her extensive practical experiences made her contributions to the programme invaluable. Nelmarie’s involvement with the current programme comprises the development of the training materials for the three safety topics, that is on burns, poisoning and falls.

**Noluthando Loleka** as employed by CAPFSA for three years as a trainer responsible for community safety education and training in various communities. She co-authored the module on Poison prevention and treatment.

**Royal Lekoba** has been employed by UNISA’s ISHS as a community intervention coordinator since 1995, and has extensive knowledge and experience working with community members in low-income communities. He has been involved with the programme since it’s inception in 2001, and has contributed extensively to refining the programme. Royal acted as the leading coordinator of programme activities in Johannesburg. He co-authored the chapter on “Preparing the community”.

**Salla Munro** holds an M.A. in Psychological Research from the University of Cape Town. She became involved in the development of the programme in 2002, while serving her internship at the UNISA ISHS. From 2002 to late 2004 she was responsible for developing components of the programme in Cape Town and Johannesburg. Salla’s contributions towards the current programme covered the full range of programme components, from developing instruments, training protocols, implementation schedules to conducting training and supervising the visitors in Cape Town. Her publication list and contributions in the manual reflects her extensive involvement and knowledge regarding home visitation programmes. Salla is the editor-in-chief of this manual.
**Samed Bubulia** has worked for the UNISA-ISHS as a public health researcher and community intervention coordinator since 1998. Over the past seven years he has been involved with community capacitation and development projects at the ISHS’s Cape Town site, and was actively involved in the initial injury survey that stimulated the conceptualisation of the programme. Samed has published a number of articles on volunteerism and co-authored the chapter on “Preparing the community.”

**Shehaam Hendricks** has been with CAPFSA for ten years as chief social worker. She has extensive experience in safety education and training in low-income communities. She co-authored the module on Falls prevention and treatment.

**Thoko Mdaka** is a research trainee at the MRC- CVI Lead Programme and is at present registered as a Masters student of the School of Public Health at the University of the Western Cape. Thoko has been involved in the programme since July 2003. She was responsible for certain components of the pilot of the programme including the recruitment and selection of visitors, their training and supervision, and the liaison with local community leaders. Thoko co-authored the chapter on “The training video.”

**Willem Odendaal** is a registered research psychologist. He became involved with the current programme in 2004 while conducting his internship at UNISA-ISHS. Apart from conducting the process evaluation on the pilot of the programme, Willem also took part in the training and supervision of the visitors at the Cape Town site. His involvement in the process evaluation brought insight into the multiple confounding issues that affect such programmes, as well as caregiver and visitor experiences of the HVP. Willem authored the chapter on Implementing the programme.
Acknowledgements

The research that underpinned this manual was developed over a period of five years. Since the project’s inception in 2001 we had the generous support of a number of research and funding organisations that made this enterprise possible. The authors of this manual wish to acknowledge the following institutions for their generous and kind support of this project.

- The Open Society Foundation (OSF);
- The South African National Research Foundation (NRF); and
- The Norwegian People’s Aid (NPA).

We would further like to extend our thanks and deep appreciation to the South African and international researchers who collaborated on this project. In particular, our international collaborator, Professor Lucie Laflamme at the Department of Public Health Sciences at the Karolinska Institute, Stockholm, for her contributions to the project. Also our sincere gratitude to Esme Jordaan, our colleague from the MRC Biostatistics Department for her excellent and steady guidance of the development and execution of the research basis to the final phase of this project, and Chrismara Gutierrez, MRC Biostatistics Department, for meticulously and timeously capturing the required data. Our thanks also to some of the other researchers who contributed significantly to the early development of this project, in particular, Susanne Bender, Athena Pedro and Luthando Ndayi.

We also wish to express our deep appreciation to the reviewers who carefully commented on the various research and programmatic dimensions to the Home Visitation Project, including Professors Arvin Bhana and Inge Petersen, from the Department of Psychology at the University of Natal, Professor Martin Terreblanche from the Department of Psychology, UNISA, Mr Rashid Ahmed of the Department of Psychology at the University of the Western Cape, Mr. Adlai Jacobs from the Human Sciences Research Council, Miss Shahraaz Suffla of the Student Counseling Services at the University of the Western Cape, and Mr. Garth Stevens from UNISAS Institute for Social and Health Sciences.

Lastly, but most importantly, we would like to thank the community members from the Nomzamo, Eldorado Park, Vlakfontein and Slovo Park communities who so generously participated in this project and allowed us into their homes and lives. By sharing their experiences and wisdom with us, these home visitors and caregivers played an invaluable part in the development of this programme. We also want to acknowledge the support and cooperation from the wards councilors and local SANCO committee members in the respective communities.

May this manual be a tribute to all who supported and participated in the project.

Salla Munro
Ashley van Niekerk
Willem Odendaal
Nelmarie du Toit
Lu-Anne Swart
**Glossary**

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<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Burn injuries</strong></td>
<td>These are injuries primarily caused by hot liquids or foods, open fire or flames, contact with hot solid material, defective electrical appliances or the careless use of paraffin.</td>
</tr>
<tr>
<td><strong>Caregiver</strong></td>
<td>The person in a household that looks after the child for the major part of the day. It may be the parents of that child, but can also be a family member, such as a grand-parent or even a neighbour.</td>
</tr>
<tr>
<td><strong>Checklist</strong></td>
<td>A list used by the home visitor to identify potential environmental and behavioral risks to unintentional injuries in a home.</td>
</tr>
<tr>
<td><strong>Child developmental</strong></td>
<td>Young children under the age of ten are more likely to sustain injuries because of developmental characteristics. These are the particular physical, intellectual and social characteristics that may expose the child to injury, such as the variable and sometimes limited of control of toddlers over their movement, or the curiosity of young children in their environment, often without a sense of the inherent risks that may be present in that environment.</td>
</tr>
<tr>
<td><strong>Fall injuries</strong></td>
<td>Children sustain a fall injury by falling on a level surface, or from heights, such as from playground equipment, and in the case of babies, if left unattended on a bed or a couch. This type of injury is a very common reason for children seeking medical attention.</td>
</tr>
<tr>
<td><strong>Handouts</strong></td>
<td>Training material given to the home visitor that serves as a summary of the information that will be shared with the caregiver.</td>
</tr>
<tr>
<td><strong>Home visitation</strong></td>
<td>An intervention strategy that aims to address the targeted needs of a household, through systematic and structured home visits to specific homes.</td>
</tr>
<tr>
<td><strong>Home visitor</strong></td>
<td>The person that conducts home visits with the purpose of facilitating specific behavioural and/or environmental changes in a home. Such a person can be a home visitor by profession or a para-professional that has been recruited and trained for a specific home visitation programme.</td>
</tr>
<tr>
<td><strong>Injury risks</strong></td>
<td>These are environmental, social or personal conditions or events that can lead to an injury. These risks are related to the environment, for example a crowded one-room house, the products we use, such as paraffin stoves, unsafe practices such as the placement of paraffin stoves on unstable surfaces, or a stressful familial situation, such as a single mother working while her children are left unattended in the home.</td>
</tr>
<tr>
<td>Intervention</td>
<td>Any activity that aims to address a specific problem.</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Levels of injury risks</td>
<td>When certain combinations of risks occur the possibility that an injury can happen increases. For example, when there are many environmental and product risks in a home accompanied by little supervision to children, there is a higher injury risk level for those children.</td>
</tr>
<tr>
<td>Low-income context/communities</td>
<td>An impoverished setting most often characterised by a lack of adequate infrastructure, unemployment and poverty with the possible accompanying social problems such as child neglect, woman abuse or alcohol abuse.</td>
</tr>
<tr>
<td>Poisoning injuries</td>
<td>Substances that are swallowed, tasted or even touched, such as paraffin, solvents, household detergents and pesticides can cause a person to be poisoned. Young children can also be poisoned by medicines or other pharmaceutical products.</td>
</tr>
<tr>
<td>Referral skills</td>
<td>The ability of a home visitor to correctly identify a social problem in a home, and respond to this by referring the person(s) to the appropriate organisation that can deal with the problem.</td>
</tr>
<tr>
<td>Relationship-building and interview skills</td>
<td>The success of home visitation programmes depends largely on the ability of the home visitor to establish a trusting relationship with the caregiver that will facilitate the caregiver’s responsiveness towards the programme. To achieve this the visitor also needs to be a competent interviewer.</td>
</tr>
<tr>
<td>Role-plays</td>
<td>These offer the home visitor the opportunity to simulate and practice the visits that she will conduct. This is extensively used during the training, and also serves as an assessment tool for the trainer.</td>
</tr>
<tr>
<td>Safety gift</td>
<td>This is a safety product given to the caregiver to enhance safety practices in the home. It is also an incentive for the caregiver’s participation.</td>
</tr>
<tr>
<td>Site coordinator</td>
<td>A site coordinator may be a home visitor that has the necessary leadership abilities, and who can assist and support the visitor team.</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>People often describe these types of injuries as the result of accidents. None of the events that lead to the injury are intended to cause physical harm either to oneself or to another person. The occurrence of unintentional injuries can be reduced if people are alerted to the environmental, social and personal causes of these injuries.</td>
</tr>
<tr>
<td>Use of photographs</td>
<td>Photographs that were taken in real life settings in low-income houses are introduced as a useful tool to stimulate discussion between the home visitor and caregiver. It is also a visual aid that the trainer can use.</td>
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INTRODUCTION
1 Orientation to the manual

Salla Munro

1.1 AUDIENCE

This manual is designed for use by agencies that are preparing to implement a childhood injury prevention programme in communities. The content of this manual is specifically designed for low-income settings in the South African context, but might also be appropriate elsewhere. This manual is applicable to those agencies that are experienced, or beginners, in community-based work. These agencies may wish to add an injury prevention component to their existing programme, or specifically start implementing an injury prevention programme in a community. The users of this manual may be programme directors, managers, trainers and other staff involved in the programme. This manual was written in English to reach the widest possible South African audience. It uses a hands-on approach and the language is kept informal to make the manual accessible to a wide audience.

1.2 PURPOSE OF THE MANUAL

The purpose of this manual is to equip programme staff to implement their childhood injury prevention programme. This manual is intended to give information on the following aspects:

- Community entrance and initial programme preparation
- Implementation planning
- Training home visitors to implement the programme
1.3 **USING THE MANUAL**

The programme presented in this manual serves as a generic model of an intervention strategy for low-income settings. However, local circumstances may require adjustments, and programme staff may modify components and the implementation schedule with their own ideas to meet such needs. The authors would welcome any comments from programme staff to further improve on this project. Please note that for the sake of consistency we refer to visitors and the caregivers of children as females. However, visitors and caregivers can be male or female. The flowchart below outlines the structure of the manual.

### 1.3.1 The structure

```
INTRODUCTION
  Orientation to the manual
  Unintentional childhood injuries

SECTION ONE
  Theoretical considerations

  Home visitation

  Evaluating your programme
  Ethical considerations

Preparing the community ────> Recruiting and selection of the visitors ────> Implementation

SECTION TWO
  The training
```

As can be seen from the above flowchart, the manual is separated into three parts. What follows is a synopsis of what you will find in each of these.

### 1.3.2 Synopsis of content

The *Introduction* not only covers general information on the purpose, audience and structure of the manual, but deals with the important issue of the injury...
problem, and more specifically the unintentional childhood injury phenomenon in South Africa.

In **Section One** we outline the components of the home visitation programme with which the programme manager will need to be familiar. This not only provides background information on home visitation, but also details the necessary steps in implementing the programme. The following topics are included in this section:

- **Introduction to unintentional childhood injuries**
  This section describes the injury problem and more specifically the childhood injury phenomenon in South Africa.

- **Home visitation programmes**
  Here we outline the public health model in which home visitation is theoretically located, and provides general information on home visitation programmes. This component concludes with a description of a home visitation programme for childhood injury prevention.

- **Preparing the community**
  We provide some information on entering a community and forming collaborations with stakeholders prior to the implementation of the programme.

- **Home visitors**
  Here the characteristics of an eligible home visitor are discussed. The recruitment and selection processes for home visitors are also included.

- **Implementing the programme**
  The logistics of the programme are discussed, as well as information on programme and visitor management. We also present possible solutions for difficulties that may arise during the programme.

- **Evaluating the programme**
  The use of process and outcome evaluations is discussed here.

- **Ethical considerations**
  This component presents important considerations that should be taken into account throughout the implementation of the programme.

In **Section Two** we describe the procedures, materials and content that you will need for training the home visitors in your programme. A full description of each training module is provided and structured as follows:

- **Aims and objectives of the module.**
- **A training schedule that provides an overview of the training sessions in the module.**
- **The detail of each training session, specifying teaching materials and methods, as well as the training content.**

In addition, a module is presented on the use of the training video that accompanies this manual. It is recommended that the video be used frequently during the training to improve the visitors' performance.

At the end of **Section Two** you will find a selective bibliography, which will point you to useful references if you wish to learn more about home visiting and intervention studies, and the various appendices referred to in this manual.
2 Unintentional childhood injuries

Ashley van Niekerk

2.1 UNINTENTIONAL CHILDHOOD INJURIES AND POVERTY

Unintentional injury is a leading cause of non-natural death to children, both globally but especially in low- to middle-income contexts, such as can be found in South Africa. In South Africa, concentrations of poverty and disadvantage are mostly located in black, working class communities living in townships and shack settlements within rural, peri-urban and inner-city settings. Township and shack settlements have historically been environmentally degraded, with inadequate infrastructure, limited recreational facilities, and widespread overcrowding, all of which compromise health and safety.

Despite concerted South African efforts to provide affordable housing, the number of informal settlements is reported to have increased from the 1980s through to the present. This is largely due to past segregation policies, ongoing migration to the metropolitan centres, and the vast housing problems faced by South African cities. In 2002 it was estimated that nearly 5 million, or 1 in 8, South Africans lived in approximately 1 010 informal settlements. Both international and South African research has indicated that children living in low-income settings such as these are more likely to be injured than children located in families and communities with greater financial resources. In addition, these children are not only at a greater risk to being injured, but are also more likely to suffer severe injuries and to die as a result of these.
2.2 THE EXTENT OF THE INJURY PROBLEM IN SOUTH AFRICA

It is estimated that approximately 1.5 to 3 million South Africans visit a doctor or a hospital because of injuries every year. Also, every year, between 65 000 and 80 000 people die because of injuries. These numbers are probably an underestimate, but this is still a large number of people to die every year from events, many of which could have been prevented. Every injury carries a significant cost to individuals, families, communities and the government. It is therefore important that we try to prevent these injuries before they happen, as this usually costs less, financially, but also in terms of suffering to people.

2.3 DEFINING INJURIES

Children are an age group that is especially vulnerable to unintentionally inflicted injuries. According to the World Health Organisation, an injury is the bodily damage that results from a transfer of energy to a body. Energy can come from a variety of sources. The first one is mechanical — here the injury is caused by movement or collision with an object, such as a motorcar. The second one is electrical — something that results from electricity, such as a child’s finger in a plug. The third one is thermal, heat related, so this would be for example anything that has to do with flames or hot liquid. It can also be chemical, such as in poisoning or chemical related burns — for example drinking paraffin or spilling paraffin on the skin. Energy can also be radiant. Radiant refers to anything that radiates something harmful, for example radiation sickness from nuclear radiation, and also sunburn.

Injury is a result of these forms of energy, if it exceeds the amount of energy, or threshold, that a body can take. For example, five minutes in the sun, a warm bath, aspirin, or a fall onto a mattress, or static electricity do little harm to a body. The injury occurs only when the body is exposed to more energy than it can handle. Children are more vulnerable than adults are, their skin is thinner and their physical structure is also more fragile, therefore children’s bodies cope with far less energy than adults’ bodies can.

In addition to the above, injury may also be caused by an insufficiency of vital elements. This is when injury is caused because there are not enough of the elements that people need to live, such as air or oxygen. For example, suffocation or choking would take away the oxygen from the lungs. A plastic bag over a child’s head would not give the child enough air, and without air the child cannot live. Now, here again we see that injury is caused by something that is excessive. For example, a child holding his or her breath for ten seconds would do little damage to them; whereas having their head under a plastic bag would cause very bad damage and could even kill a child. This is why it is important to keep plastic bags away from young children!

2.3.1 Types of injury

There are different types of injury, as can be seen from the above. The main difference between injuries that people usually talk about is whether the injury to a person was caused intentionally or unintentionally. If a child cuts his or her foot on
a piece of glass on the ground, that is unintentional. The child did not purposefully cut his or her foot on the glass. If another child stabs this child with a piece of glass, it is an intentional injury. The other child wanted to cause the child harm.

There are many different types of unintentional injuries, but we usually talk about the most frequent ones: traffic, falls, poisoning and burns. We also talk about drowning and choking.

Unintentional injuries are those that we also sometimes call “accidents”. However, we try to avoid talking about accidents because “accident” sounds like there is nothing we could have done to prevent the thing from happening, when often there is.

The South African National Injury Mortality Surveillance System (NIMSS) has indicated that the most common causes of injury deaths for children are burns and injuries by blunt objects for infants and toddlers, and pedestrian injuries due to motor vehicle accidents, drowning as well as burns, for children aged five to 14 years. Burn and traffic injuries are particularly strongly associated with poor socio-economic conditions.

2.3.2 Location of injuries

The place where an injury happens is especially important. The most dangerous places for childhood injuries are reported to be inside or around homes, or on close by roads. The recent NIMSS data, and similar accounts from international sources provide widespread evidence for the need for injury prevention interventions focused on the area where most of these injuries occur; namely at children’s homes.

PHOTO 4: Fire in settlement

(photo outstanding, please supply)
2.3.3 Categories of injury risks

When we walk into a house, there are different kinds of risks. They usually cluster in categories. Examples of these categories are:

- Environmental risk — those risks that are related to the structure of the house and the immediate environment, such as the building materials used; number of rooms; separations between the cooking and living areas; or even the materials that are lying around in the yard.
- Product risk — those risks that are product related, such as whether the household uses paraffin and whether it is accessible to children; whether the containers are childproof; or whether the household uses an old broken kettle or stove.
- Familial risk — those risks that are related to the family structure and abilities. These could be a single mother who is poor and working all day which means that the children are left alone in the house; these could be too many people in one household, which means that sometimes children cannot be looked after properly; the presence of physical abuse to children or between parents, or substance abuse, such as drinking too much alcohol.
- Social risk — this is related to the wider community and society where the children live; whether there is crime and violence in the society or neighbourhood.
- Child related risk — these are risks related to the child itself. These are not usually preventable, but have to do with the temperament, physical development and abilities of the child.

These risks may be related to each other and in combination may present a more dangerous home. For example, if there are many environmental and product risks, and there is little supervision to children, the children are more at risk from the environmental and product risks than if they were carefully supervised by an adult.
SECTION ONE
Theoretical considerations
3 Home visitation

*Salla Munro*

3.1 THE PUBLIC HEALTH MODEL

The programme was developed and is based on the public health model or approach to injury. The following serves as a brief description of this approach. The Public Health Model is aimed at maintaining and improving the health of all people, and has a logical way to the development of programmes that can meet this goal. The chart below depicts the four steps researchers follow in order to develop an intervention strategy such as home visitation.

![Chart showing the public health model phases]

The programme you will be implementing was developed according to these four phases. The first two phases focus on the identification of the problem and its causes, described in the section on unintentional childhood injuries and some of the causes underlying this problem. Phase 3 constituted a pilot study to test our intervention strategy, followed by a full implementation where we incorporated the lessons learned in the pilot study. Thus you are presented with an intervention programme that meets the scientific and development requirements that are recommended for public health interventions.
You may ask why we decided on home visits as an intervention strategy. In the following section we provide you with some background information on home visitation programmes and the rationale for choosing home visitation as a means to prevent unintentional childhood injuries.

3.2 HOME VISITATION AS AN INTERVENTION STRATEGY

The origin of home visitation dates back to the 19th century when hospitals began to send nurses to treat sick people in their homes. Today the practice of home visitation programmes is well established and may have become more sophisticated, but the principle is still the same: to deliver a service to the homes of people in need of help. It is used to address a multitude of psycho-social issues, ranging from child abuse and neglect, the promotion of maternal and child health, and childhood injury prevention. The common ground for most of these programmes is the focus on the early childhood years, recognising the important role parents play in shaping children's lives during that period.

These programmes differ in respect to their intended outcomes, vary in duration, frequency of visits, and who gets employed as a home visitor. An overview of published studies revealed that:

- Programmes usually comprise more than one visit (evidence in the literature suggests that at least four visits are needed to facilitate the desired outcome);
- These visits can be conducted weekly, bi-weekly or monthly, over a period of several months, and even over a number of years (it is generally said that longer interventions result in more successful programmes);
- Either professionals such as nurses, or para-professionals, such as community members trained to serve as visitors, can be used in the programme (each have
unique benefits and limitations, and the choice depends on issues such as funding and the complexity of the programme content;

- Activities focus on the parent-child relationship, and may include various components, e.g. parental education, counselling of family members and primary preventive strategies, amongst others. Programmes that include education and other activities such as safety product demonstrations, implicit enforcement using checklists, and the facilitation of referrals to other safety- and help-rendering organisations have proved to be more effective.

Most importantly home visitation is an intervention strategy that utilises systematic and structured home visits to effect changes in peoples' lives. The next section describes the programme you are about to use, which we believe to be a best-practices model of home visitation, appropriate and applicable for use in low-income communities in South Africa.

3.3 DESCRIPTION OF THIS HOME VISITATION PROGRAMME

3.3.1 The aim

The programme aims to reduce the risks to, and thereby occurrences of unintentional injuries to young children in and around the homes of people living in low-income communities in South Africa. In alerting caregivers to the risks in the homes, and fostering a positive attitude towards safety in the home, this programme will contribute to the prevention of childhood injuries and their associated pain and suffering.

3.3.2 Design and methodology

Community members are trained to conduct the visits. This is based on our understanding that they can relate to the living conditions of the recipients of the service, facilitating a good visitor-recipient relationship. In this programme we propose that six visits are conducted over a three-month period, scheduled on a bi-weekly basis. However, other variations are possible depending on the specific needs and circumstances of your community.

The visits included in this programme comprise the following:

Visit One: Recruitment of recipients and Orientation to the programme
Visit Two: Child Development
Visit Three: Burns
Visit Four: Poisoning
Visit Five: Falls
Visit Six: Closure

A possible implementation structure is proposed on the next page.

It is recommended that where possible the spacing between visits be negotiated with the participating families. The time of year in which the programme gets implemented will also affect programme processes. Take the following into consideration when planning the implementation schedule:
- The rain season in your area.
- During winter the living conditions in low-income settlements can be extremely harsh; it will impact on visitors’ attendance of the training.
- Be aware of the fact that many community members may start their preparations to leave for the December holidays at the beginning of November. If this applies to your community we recommend that the programme should come to a close at the end of October.

Table 1: Example of the implementation schedule

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<td>TRAINING Introduction</td>
<td>TRAINING Training video and Selection role-play</td>
<td>TRAINING Relationship building and interviewing skills</td>
<td>TRAINING Relationship building and interviewing skills</td>
<td>CONTACT VISIT (Start)</td>
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<td></td>
<td>SUPER-VISION Contact visit</td>
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<td>SUPER-VISION: Contact visit (Ends)</td>
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<td></td>
<td>TRAINING Child development</td>
<td>TRAINING Child development</td>
<td>VISITS Child development (Starts)</td>
<td>SUPER-VISION</td>
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The content and structure of each visit will be discussed in detail in Section Two. A multi-method strategy is used during each of the safety visits. This comprises an educational component on risk identification and prevention; the application of a safety checklist and ongoing risk monitoring; safety product demonstration and the provision of family counseling and referral as required. A child development
input is included in the programme as it provides the caregiver with much needed information on the developmental needs of young children and how this may influence the risks encountered by children at different ages.

3.3.3 **Caseload and approximate time per visit**

The following guidelines are based on our experiences in two particular communities, but your local circumstances may necessitate adjustments to these guidelines. The recommended caseload per visitor, participating on a part-time basis, is not more than five houses per week. It is very difficult to be exact on the amount of time the visitor needs per visit, but on average half an hour will be sufficient. A simple guide in this respect is that the visitor must not overstay her welcome but simultaneously be attentive to the needs of the caregiver.

3.3.4 **Payment of visitors**

Keeping in mind that unemployment and poverty are realities in low-income settings, we strongly recommend that you budget to pay the visitors. If payment is offered it is inevitable that some community members may want to become visitors for this reason, and it is not suggested that this be discouraged. However, paying visitors does not guarantee more motivated and competent visitors, and if this issue is not properly managed it may cause discontent amongst the visitors, and eventually undermine the aim of the programme.

The following is recommended to counter potential problems:

- When payment is introduced during the recruitment phase, be specific on the amount that will be paid, and what will be expected of them in return for being paid.
- The method and time of payment must be cleared beforehand and there must be minimal delays when the visitors are to receive their payment. Bureaucratic procedures can cause endless frustrations that may impact negatively on visitor-morale.
- Do not downplay the importance of payment, but constantly remind the visitors of the purpose of the programme. This may facilitate and encourage better performance from them.

You may consider other forms of compensating the visitors that may be a lesser demand on your budget. The occasional food parcel, a pair of shoes, additional skills training, sponsoring their attendance at conferences or seminars, and even touring opportunities, are ways to show appreciation for their work, and to ensure they are getting tangible benefits out of the programme. The purpose of the programme is not to alleviate the impoverished conditions of the visitors, but we all expect at some point to be rewarded for the work we do. Decide beforehand how you will go about this, and introduce this in the recruitment phase of the programme. We must reiterate that you should be specific about this and be able to keep your promises.

3.3.5 **Safety gifts**

One component of the programme involves the provision of participating homes
with appropriate safety appliances or products. This is an important means to improve the safety of homes that cannot afford safety products known to be very effective in reducing certain risks, e.g. paraffin safety caps, which are cheap but effective for the safe storage of paraffin. These safety products may be offered as gifts to the family, and simultaneously serve as incentives for households to maintain their participation in the programme. We will discuss this in more detail in Section Two.

With this synopsis of what you can expect to find in the programme, let us turn our attention to the preparatory and implementation activities.
4 Preparing the community

Samed Bulbulia and Royal Lekoba

4.1 CONSIDERATIONS BEFORE ENTERING THE COMMUNITY

Organisations that have prior experience of community work, or are involved with other projects in a community, will be familiar with what is presented in this section. For the benefit of first-timers, and as a refresher for experienced staff, let us review some of the basics of working in low-income communities.

- You will have to establish whether the particular community is in need of this programme. It is possible that your past involvement has already indicated such a need, but if this is not the case you will first have to conduct a needs analysis. This can be in the form of surveying the community by means of a questionnaire or having focus groups, and/or interviews with key people to determine what the most pressing needs are. By doing this you will also be able to tell whether there is an interest in this programme. Most often we may see that an intervention is needed in a community, but if the programme is not owned by the community members it is likely to fail.
- Always emphasise the importance of transparency, accountability and governance with all parties.
- Assess the level of infrastructure present in the community, such as the availability of office space, a venue for the training, and supportive agencies to assist with particular referrals.
- Another important issue is whether the distance and travel time to the community will be a problem. This programme relies on daily contact between staff and fieldworkers, therefore your organisation must be aware that travel can be costly as well as taxing for the staff.
- Transient communities may be problematic, especially because the programme hinges on the relationship that a visitor needs to establish with a household.
- Finally you may want to establish whether the programme will be sustained after you have left. The continuation of a project following the exit of an organisation may depend on the need, community interest, your liaisoning with other local organisations, and also whether the community feels that this project was theirs.

4.2 ENTERING THE COMMUNITY

This information applies to organisations that will commence with this programme as their first involvement in the community of their choice. In order to get the
consent from the appropriate local leaders and or organisations in that particular community, we propose the following:

- Make appointments with stakeholders in the community such as the ward councillor and his/her committee, leaders of the civic, e.g. the South African National Civic Organisation (SANCO), community organisations, non-governmental organisations, leaders and members of street committees, policing and safety forums, local clinics, businesses, religious leaders, traditional healers, school principals and local government officials, or any other groups or service agencies to inform them about your programme. Some of these organisations may become your partners, and others may be people whose approval is important to the community.
- Explain to them what your organisation does, and that you would like to invite them all to a presentation of your proposed project in the community. In this way, the community knows that their leaders and other members are aware of the programme, and may be better disposed toward the programme. This initial contact with community leaders and the community may be the most important contact you will have with the community, and may determine community acceptance of the project. The more time and effort you spend on this preliminary part of the programme the more likely the acceptance of the programme.
- Send invitation letters and ask stakeholders to confirm their attendance. Make sure that you invite them well in advance because they may be busy. You may follow up your invitation with phone calls or faxes encouraging their attendance. If people are not able to attend the meeting, send the presentation to them. It may also be a good idea to distribute leaflets in the community. Make sure the presentation is kept short, focused, easily understandable, discusses possible benefits of the project, and disseminates information to the community.
- Once you have gained consent and support from these organisations and leaders, you are set to announce and explain the programme to the community at large. This is discussed in further detail in the section on recruiting the home visitors (p. x-x).

We must emphasise the importance of the following:

- Do not impose the project on a community.
- Always encourage collective participation in the project, and make sure that you have the support of all, or the majority of, community representatives. At some point you may encounter groups and individuals who may accuse you of bias because they were not consulted — thus remember that this community consultative meeting is very important for your project.
- Make sure that you as an organisation maintain and nurture the trust from the stakeholders and maintain constant contact with all those who have agreed to participate in this project.
- The organisations that you consulted should be kept informed on the progress, successes and difficulties encountered during the programme. The format in which this is done may vary be it written reports, telephonic contact or personal visits, but by keeping them informed you may ensure their continual support for the programme.
4.3 HAVING A PLACE TO MEET

At this point, before you proceed with recruiting home visitors, we suggest that you procure an office in the community. Make sure that it has enough space and furniture for your group. Keep in mind that you also need a venue for the training, and it will be convenient if the office space can be used for this. If it is possible, get an office that is more or less central to all the visitors. Having such a place also increases your visibility and may facilitate acceptance of the programme in the community. Once you are known and you have a service that you deliver to the community, this can be a central point from which you can help people.

4.4 THE SUSTAINABILITY OF THE SERVICE PROVIDED BY THE PROGRAMME

One of the benefits of the programme that you may want to pursue once the programme has come to a close, is that the community will have a visitor team trained on the prevention of unintentional childhood injuries. This group can be turned into a consultancy center that community people can call upon not only for advice, but also for assistance in cases of emergency. Many people have died in the past because of lack of knowledge about what to do in an emergency resulting from an injury, e.g. on how to stabilise a patient. So if you have this resource at the doorstep of the community, the programme can have a sustainable impact on the burden of injuries in the community.
5 Recruitment and selection of the visitors

Lu-Anne Swart

5.1 RECRUITING HOME VISITORS

When recruiting community members to become part of a project there are various options:

- Approach community leaders and/or organisations with a list of the type of people that you require and ask them to recruit on your behalf. Be very clear in your community recruitment drive about the project's requirements and the benefits for those participating. By involving community leaders you are likely to minimise problems that may arise.

- Use a loudhailer inviting community residents to a general meeting or advertise using flyers in the local language in clinics, spaza shops, supermarkets, community hall and taxi ranks or in any other highly visible place. You may also approach the local priest and request a platform to address the congregation or visit the local clinic and ask to address people. If there are community-based organisations (CBO’s) or non-governmental organisations (NGO’s) working in the community, they may also be useful partners in your recruitment drive.

Allow some time for the leaders and or community residents to respond to your requests. Set up a meeting and explain what the organisation does, and how you envision the community having a visitor team with safety and health in mind, that would benefit the community. Ask people present who are interested to come forward and give their names. Choose people from the community as they are familiar with the dynamics of the community.

5.2 SELECTION

5.2.1 The interview

When you have a sufficient number of people keen to join, it is time to have the recruitment interviews (see Appendix 1: Recruitment interview). Be very clear about your objectives during the interview and don't raise unrealistic expectations. Often people will join a programme to get employment — make it clear if there are going to be financial benefits or not from the onset. When you say that eventually people will be paid for their work done, it is important to specify how this will be done, e.g. by cheque or cash. Don't promise if you cannot deliver.
5.2.2 Criteria for selection

Based on the interview you should select those individuals who appear to have the following abilities and qualities:

- Have basic reading and writing skills.
- Minimum Grade 10 education.
- Are able to work independently (i.e. visit homes on their own).
- Basic interpersonal and communication skills (i.e. talk clearly and confidently, come across as friendly and respectful).
- Commitment. For the initial selection this is the most important criteria. Is the person committed to attending all the training sessions or scheduled meetings? Will they be punctual? Are they available for the entire duration of the programme?

In addition to these, we also recommend that you look for candidates that have experience in working with people, e.g. via volunteerism, and who are able to work as part of a team.

5.2.3 Issues to consider during selection

- It may be advisable to have visitors who match your target group — if you are visiting mothers, try to have women of a similar age group.
- Keep an eye out for those who may be able to lead the group in the activities as site coordinators (see the chapter Implementing the programme, p. x-x for more detail on the site coordinator).

5.3 AFTER THE INITIAL SELECTION

At this stage you will have a pool of potential home visitors and your organisation should decide when it is most appropriate to formalise a performance contract with them. You may wish to do it immediately after the selection, or only once the programme staff had more time to assess the selected people.
Another option would be to inform the selected candidates that before a contract is signed, their final selection will be based on the following.

- Selection of safety visitors (30–10 August): Attendance and performance during the training of Module One and Two of the training.
- Successful role play of a visit at the end of Module Two (see Module Two, Appendix 11-A: Script for Selection role-play). During this role-play they must demonstrate the following:
  - good knowledge of the purpose and procedures of the programme.
  - good interpersonal skills i.e. be friendly and respectful.
  - good communication skills i.e. talk confidently and clearly.
6 Implementing the programme

Willem Odendaal

Once you have your visitor team selected and trained you are ready to start with the actual intervention. From the emphasis in the earlier sections, it should be clear that the key to a successful programme is the home visitor. Just as a good relationship between visitor and caregiver is crucial for the visit to be effective, your relationship with the visitor ensures that the visitors are motivated throughout the programme.

This section introduces guidelines that should be kept in mind when interacting with the visitor team, and when managing the programme during implementation. We also discuss some practical issues and contingency measures for situations that can cause problems during the implementation.

6.1 MANAGING THE VISITORS

6.1.1 Identifying clothing

It may seem to you as if issuing the visitors with clothing is a luxury, but this will address two important issues. Firstly, when the visitors are wearing identifying clothing, it will help to counter the suspicion they may encounter, especially during the contact visit. Secondly, it may boost their confidence. What you will be giving them to wear as identifying clothing will obviously be determined by the budget, but it needn't be very elaborate: a cap and/or T-shirt with your organisation's logo will be sufficient. Something that will cost the minimum but is definitely worth the while, is an ID tag that has an ID photo of the visitor on a laminated cardboard with the organisation's logo.

6.1.2 Stationery

Apart from what will normally be issued, it is necessary to provide the visitors with:

- a diary for making notes of appointments.
- a file in which to keep the paperwork for each visit.
- a bag in which to carry the material for the visit.

If it is at all possible, emboss your organisation's logo on the programme's stationery that they will be using.

6.1.3 Teambuilding

The arrangement of a teambuilding day once the training, final selection, as well as the training of Module One and Two have been done, is a useful way of fostering
team spirit amongst your visitors. Remember, for some this may be a first experience of working in a formally structured environment, and the teambuilding may help to orientate them towards this. The day should be structured around the following:

- A presentation around what it means to be member of a team.
- Activities that will promote the practical experience of being part of a team. We included some suggestions (Appendix 2: Team building day). The importance of such activities is that whilst the visitors are having fun, they also become aware of the value of being part of a team. End the day by treating them to a braai or a meal that they normally wouldn't have bought for themselves.

6.1.4 The role of site coordinators

Appointing two site coordinators, that is visitors that you have identified as being natural leaders, will help you to manage the visitors and their concerns more effectively and thus enhance the quality of the programme. These visitors should act as your representatives in the team when you are not present. Make sure that you can contact each other, which may entail paying them an allowance to buy airtime for a cellular phone. Together with the staff, they are designated to take responsibility for the well being of the visitors, and it is advised that you consult with them in decision-making. This will give weight to whatever needs to be conveyed to the group. It is useful to have one of the coordinators take responsibility for keeping the attendance register of the visitors during all of the meetings. A performance contract needs to be negotiated with the site coordinators.

6.1.5 Meeting with the visitors

Earlier we advised that you should have procured office space, even if you rent a container or share space with another agency or facility such as the local church or mosque. Not only will this provide your visitors with a place for meetings, but it will contribute to stability and a sense of belonging amongst them, and increase the visibility of the programme. If you have difficulty in securing office space the second best option would be to meet at one of the visitor's houses, or asking the use of an existing organisation's offices on designated days.

During your first meeting with the visitors, once the selection has been completed, you need to supply the visitors with a programme that will specify the dates of the meetings and the detail of activities during the rollout. Remember that the visitors are your collaborators, hence, before you finalise the dates and activities, discuss this with them. We also suggest that you prepare an agenda for each of the meetings that are to follow, to ensure that the meetings will not become a waste of anybody's time. A performance contract (see next page) that is negotiated with the team will help you to formalise expectations of the visitors and ensure appropriate conduct.

In the two weeks prior to the roll-out, a weekly supervision meeting will be sufficient. During these meetings you will ensure that the allocation of houses to visitors and a final practice of the first visit are done. Having the customary list of contact details for each visitor doesn't guarantee that you will have easy access to the individuals; the lack of telephones and airtime for cell phones are often a limitation. In
these cases, arrange a roster by which each person gets in contact with another member that stays close by.

Finally, be clear which of the expenses that they may incur with their own money will be reimbursed by your organisation. Ensure that the reimbursement is done efficiently so that there are no squabbles over money.

Table 2: Example of a performance contract with the visitors

I, .............................................. (name) hereby declare that I will keep to the following rules during my participation in the programme:

- I promise that I will attend all of the training sessions and understand that not doing so can terminate my services.
- That I will be punctual in attending all other scheduled meetings. If I do have a reason for being absent I will ensure that the programme manager and/or site coordinator receive notice of this prior to the meeting.
- I understand that if my conduct during visits does not promote the well being of the caregiver, the programme management has the right to terminate my services.
- I promise to uphold the rules of conduct for our meetings that were agreed by the visitor team.

Date: ..............................................

________________________________________  ________________________________
Visitor  Programme manager

6.2 MANAGING THE VISITS

6.2.1 Monitoring visitor morale and giving support: Supervision meetings

At the onset of the programme, you and the visitors will be looking forward to the programme, and their morale will be high. Both of you will soon realise that home visitation involves hard work often with few immediately tangible benefits. Visitors may become disillusioned when they experience stressful situations or rude caregivers during the visits, and keeping their spirits high may become increasingly taxing. It is strongly advised that you co-opt as many supervising staff members as needed (a maximum of four visitors is suggested per staff member) for the duration of the implementation to assist with supervision duties. Ask the site coordinators to assist you in the supervision of the visitors. Schedule a weekly meeting with them to discuss issues raised by the visitors and the best ways to solve it.
During the first week of roll-out, it is good practice to be available to deal with queries each day. This will enable you to respond immediately to problems encountered during the first visit, which can be quite a stressful encounter for some visitors. The staff should schedule individual meetings with each of the visitors and talk them through their first visits. Make sure that you are informed about all the visitors’ first visits and that any problems are addressed. Once you are satisfied that each visitor will be able to get along with the caregivers allocated to them, let them proceed with the next visit.

From there on it will be sufficient if you meet the visitors three times a week. Two of these supervision sessions could be individual meetings and the last one for the week a meeting with the entire team. Having a joint meeting can be an empowering experience for visitors when they share their experiences with each other and give advice to one another on problems raised. Remember that some visitors will inevitably be exposed to social problems in some homes. When this occurs, be sure that you are sensitive as to how the visitor coped with this and that you are able to give support; dealing with issues such as child abuse or substance abuse may become overwhelming for some. Remind them that they are there to help reduce the risks to unintentional childhood injuries and will not be able to solve all the other issues in the homes. (A training session, see Module Three, covers the referral skills needed by visitors for these situations).

To enable you to keep track of visitor-morale and their experiences during the visits we provide you with a diary (see Appendix 3: Visitor’s diary) that the visitors should complete on each visit. These diaries serve a twofold purpose. It can serve as a basis for the individual supervision session and help give you an indication of how the visitor experienced the visit. The other purpose is to help keep a record of how many visits are completed.

To keep your home visitors motivated remind them of the personal benefits that their work offers them. These can be:

- Personal achievements such as retaining caregivers in the programme.
- Continually acquiring new skills such as problem solving and other interpersonal skills, and
- Contributing to the well being of their community.

Giving the home visitors access to certain of your agency’s resources when needed, as well as the occasional cup of coffee, can maintain their morale in little ways.

Finally, just as the visitors need supervision and a space where they can get support and even counselling, you will need the same. Arrange with a colleague that will listen to your stresses in managing the programme, in the end it will strengthen the implementation of the programme.

6.2.2 Accompanying visitors on their visits

This may seem like an extra burden that you can do without, but it is the best way to ascertain the quality of the visits and the caregivers’ satisfaction with the visitor and programme. Provided that a good relationship prevails between you and the visi-
tors, they should be supportive of your attending occasional visits. If it is impractical for you to do this, for example because of a language barrier, be sure that a site coordinator is available. A proposal of how to arrange and structure this visit can be found in Appendix 4: Assessment of a visit by a staff member or site coordinator.

6.3 CONTINGENCY PLANNING

Based on our experience, the following scenarios may occur during the programme:

- **“A visitor leaves the programme.”**
  - The worst-case scenario is when a visitor leaves without giving notice. A site coordinator could take over her houses. If not, divide her houses amongst the visitors that you have identified as the most competent ones. It is important that you inform and get feedback from the concerned caregivers about these arrangements.
  - If a visitor must leave but gives notice, the same arrangements can be made. In this case get the departing visitor to accompany the 'new' visitor to the houses so that the latter can be introduced.
  - If the visitors are receiving a stipend per completed visit, it is important that you inform the visitor team why you selected a specific visitor(s) as replacement. This may help to contain rivalry between them.
  - Do make an effort to establish the reasons that visitors leave the programme. If these include valid complaints that have caused dissatisfaction amongst the group, you will be able to act proactively in future.

- **“A visitor reports problems with caregivers.”**
  - You and the site coordinator should pay a visit to those houses to establish whether the problem can be solved. Keep in mind that programme participation by caregivers is voluntary, and if the matter cannot be resolved to the satisfaction of the caregiver, count your losses and leave. It will be useful to discuss this with the whole group, as it can serve as a learning experience for all the visitors.
  - On the other hand you may assess that the situation in the house is in some way a threat to the visitor's safety, in which case you should withdraw the house from the programme.

- **“There is rivalry amongst the visitors.”**
  - A Code of Conduct (see Module One, Handout 10-2: Code of Conduct) should specify the way in which grievances must be solved. The site coordinators should be the first line of defence to handle this.
  - Be sensitive to the cultural customs in which conflict is normally resolved in that community.
  - Be proactive as disgruntlement can be a serious threat to the programme. An example of such a measure is to have a training session with the visitors in conflict resolution, which they may also apply during their visits.
  - Use your interpersonal skills to lay the rivalry at rest, but if the conflict is too serious for settling it internally, an outsider can be called upon to assist you.
· “You suspect that a visitor is deceiving you about conducting the visits.”
  — Either you or a site coordinator could pay courtesy visits to that visitor’s houses and enquire how many visits they have received.
  — You should make this process transparent from the beginning — the visitors should know that check-up visits will be conducted as a normal mode of maintaining programme accountability.

· “You notice that a visitor’s performance during the training is not satisfactory.”
  — It is important that such a visitor should be assigned to a ‘mentor’ in the group, who will be one of the competent visitors.
  — Arrange for the mentor to accompany this visitor as part of in-service training.
  — You may also wish to pay courtesy visits to those houses. Do not be too surprised if the caregivers report favourably on the visitor, because the ‘examination setting’ implied by your presence can be unsettling to some visitors and they may perform better during actual visits than in the training or when observed for other purposes.
  — Give constant feedback to the visitors based on your assessment of their performance.

· “The services of a visitor must be terminated.”
  — The golden rule is that the well being of the caregivers must be upheld under all circumstances. If a visitor’s misconduct is threatening this, you should terminate that visitor’s contract.
  — Follow the procedure as specified in the contract.

· “Something happens that has not been mentioned in the manual.”
  — Be assured that this will happen, as each community is as unique as your visitor-team. Discuss any such issues with a colleague or your immediate supervisor about how best to resolve the issue.
7 Evaluating your programme

Salla Munro and Willem Odendaal

There are three reasons why this is an important and integral part of the programme. Firstly you will want to know how successful the programme is; is the programme indeed reducing the risks to unintentional injuries? Secondly you want to know how you can improve on what you are doing. The third reason is that this will assist you when the expected reports on the programme need to be submitted either to your immediate supervisors or stakeholders in the programme.

You should also be alerted to the fact that funding agencies, if applicable, will want to know whether their time and money is well spent. If such an agency employs, or asks you to employ an individual or organisation to conduct the evaluation, then giving your full cooperation will be to the benefit of those served by the programme. When such an arrangement is not made, do proceed with this on your own.

We suggest that you conduct a process evaluation as well as an outcome-based evaluation.

7.1 PROCESS EVALUATION

7.1.1 Orientation

In very simple terms process evaluation means that you systematically monitor the implementation of the programme. This may sound obvious to you, but if this is not done in a structured way, important issues that may influence the success of the programme will be left unnoticed. The implementation often differs from what was planned, and knowing the reasons for these deviations will help you to act proactively. Let's illustrate this:

The visitors had agreed to three supervision meetings per week, but you find that their attendance is unsatisfactory. Now you are left with two options: either you enforce the arrangement, or you try and establish the reasons for the low attendance. You may find that the time of the meetings, the format or that some simply don't see the need for this, are the reasons why they don't turn up. Once you have established this, it is possible to act accordingly.

Similar situations may arise when it is necessary that you be also informed about the experiences of the caregivers and the rest of the programme staff. It is important that you should convince the visitors and the rest of your staff on the value of eval-
uating the programme, as they will serve as your sources of information. The caregivers will only be asked once the visits have started.

### 7.1.2 The instruments

A filing system in which you keep all the programme documentation such as minutes of meetings and implementation schedules, will assist you in referring back to important issues. You may also want to supplement these with notes on specific incidents, be it positive or negative that impacted on the programme. We also recommend that you keep a file with the visitors’ diaries.

Finally, you need to ascertain the caregivers’ experiences of the programme, and their assessment of the caregivers. This is fundamental to your ethical obligations towards the caregivers. You should randomly select 10% of the participating homes that is evenly distributed amongst the visitors, and pay visits to those homes. Complete **Appendix 5: Caregiver’s assessment of the visitor and programme**. It is suggested that this is done after the first visit (Child development) and again after the third visit (Poisoning).

### 7.2 OUTCOME EVALUATION

There are three main steps to any programme outcome evaluation. They are:

- Assess for risks and injuries in the home.
- Try to improve the risk situation in the home with your programme.
- Assess for risks and injuries after the intervention, with the same instrument, to find out whether your programme had a positive impact.

In short, outcome evaluation aims to check whether anything has changed after the programme. This is usually done with the help of a very detailed questionnaire that measures your outcome. Your outcome is directly related to the goal of your programme. Your goal in this programme would be to reduce injury risks and injuries in the households. Therefore if your programme works well, your outcome would be a reduction in the risks in the households.

Researchers often design complicated ways of finding out whether their intervention works, which require specialised knowledge about questionnaire development, random selection, statistical analysis and training a team of data collectors. Your organisation may have the resources and funding to pursue such a comprehensive process. For organisations that do not have the inclination or capacity for this, we can give the assurance that our programme was subjected to such a comprehensive outcome evaluation, which has shown a significant reduction in risks and increase in safe practices in homes as a result of this programme. What we propose below is a less complicated way to assess the outcomes of the programme.

### 7.2.1 The use of a safety checklist

For you to evaluate whether your programme is working, you need to know something about the risk levels in the households before the intervention. All household risks relate to each other and combined may present a more dangerous home. For
example, if there are many environmental and product risks, and there is little supervision to children, the children are more at risk from the environmental and product risks than if they were carefully supervised by an adult.

Each of the training modules on Burns, Poisoning and Falls (see Section Two), has a checklist where product and environmental risks are listed. Your duty is to train the visitors on how to use these checklists. Each of the checklists lists a specific risk, and the home visitor has to mark whether it is present in the home or not.

Example: A question in the checklist reads: “Are paraffin stoves and lamps placed on a flat solid surface away from curtains?” The visitor then asks the caregiver to show her where the stove is when in use, and will mark this on the checklist. “Yes” would mean less of an injury risk, “No” means a risk to injury (the caregiver will be trained about this) and “Not applicable” would mean that there is no paraffin stove in that home.

(For a detailed discussion on the checklists see Section Two, Module Five, Six and Seven.)

During the next visit, the visitor may observe or make enquiries about environmental and behavioural changes that were implemented since the previous visit, and this will give an indication of the effectiveness of the programme. Remember, your goal is to reduce the risks to unintentional injuries in homes, and if changes to this effect are made, you are achieving your goal.

Some of the items in the checklist are not be observable, for instance: “Do you put your child out of harm’s way when cooking?” Be aware that people are prone to answer such questions so that their answer will be socially acceptable. You should not be too concerned about this, because the choice to modify bad safety practices ultimately lies with the caregiver.

In conclusion, we want to emphasise that although conducting a comprehensive outcome and/or process evaluation may lie outside your interest when implementing the programme, it would strengthen the programme. Further details on the development of such evaluations can be sourced from the authors of this manual.
8 Ethical considerations

Ashley van Niekerk

All home visitation service providers are bound by a number of important ethical principles. Ethical principles provide us with a guide to the proper and respectful conduct required of all service providers. These principles serve to protect the interests, well-being and privacy of the people that participate in any projects or programmes that provide people with health, social or other services. Below are essential guidelines that you should follow while preparing for your home visitation programme.

- Respect for human rights and others
  Home visitors shall respect and strive to protect the dignity and worth of all individuals and families participating in the programme.

- Informed consent
  The programme staff will conduct a home visit or related activities only after they have obtained the informed consent of the individual, using language that is understandable to that individual. The individuals participating in the programme must be provided with (1) the necessary information about the services, (2) be informed of the voluntary nature of their participation, and (3) have the opportunity to ask questions and receive answers regarding the questions.

- Rights to confidentiality
  The visitor shall protect the information obtained in the course of the home visits. All notes and written material obtained from participating households shall be safely stored by designated staff, who will take the responsibility for ensuring that the identities of caregivers are protected. Programme staff shall only disclose information identifying caregivers after written and informed permission has been granted from those caregivers.

- Quality and provision of service
  The host organisation shall develop, maintain and encourage high standards when conducting home visits to ensure that the public is protected from service activities that fall short of accepted international and national standards. Programme staff shall accept that they are accountable for all actions relating to their service duties.
SECTION TWO

The home visitor training
9 Training structure

Salla Munro and Ashley van Niekerk

9.1 OVERVIEW

This section details the information you will be providing to the home visitors. The training comprises seven modules that cover all the training needed for turning the recruited community members into confident and competent visitors. Listed below is the approximate time needed for each module:

Module 1: Introduction to unintentional childhood injuries and home visitation
Session length: 4 hours

Module 2: The training video
Session length: 2½ hours

Module 3: Interviewing skills
Session length: Day One — 4½ hours
               Day Two — 2½ hours (excluding the role play assessments)

Module 4: Child development
Session length: Day One — 3½ hours
               Day Two — 2 hours (excluding the role play assessments)

Module 5: Burns prevention and treatment
Session length: Day One — 4½ hours
               Day Two — 3½ hours (excluding the role play assessments)

Module 6: Poison prevention
Session length: Day One — 4 hours
               Day Two — 3½ hours (excluding the role play assessments)

Module 7: Falls prevention
Session length: Day One — 2½ hours
               Day Two — 3½ hours (excluding the role play assessments)
9.2 MODULE STRUCTURE

You will notice that from Module Three onwards, each Module extends over two days: Day One comprises the training on the specific topic, while Day Two is spent on assessing the visitors' level of knowledge, practising the visit via role-plays, and the final preparations for the visit. Based on our experience you may even budget an extra day to help those visitors who need more practice. The need for an extra day will also depend on the number of visitors you have because of the time consuming nature of role-plays.

Within each module you will find the following:

- Aims
- Objectives
- Training schedule
- Teaching materials
- Content

9.3 GENERAL

9.3.1 Teaching materials

The basic materials (henceforth referred to as “Basic”) required for each session are as follows.

For the trainee

- Pen and paper for taking notes.

For the trainer

- For presenting your notes you can either use a flipchart or overheads. We recommend preparing overheads: it may be visually more attractive and it is easy to refer back to what was said earlier in the lecture. You may also consider putting your notes onto powerpoint.
- Flipchart for use by the visitors during group work.
- Presstic for putting up flipcharts.
- Felt pens in different colours.

Where other materials are required, they will be specified.

Furthermore you will find a number of Handouts in each module. These are summaries of the training content and materials for group discussions. You may wish to develop your own handouts, and we strongly recommend that you leave the visitors with something in hand, should they wish to refer back to the main points of the day’s training.

In Module Five to Seven you will find handouts that the visitors will need during the visits e.g. Burns visit material — 2: Burns Safety checklist. These are the information that the visitors will need to share with the caregivers. **Please note that the content of these handouts should not be changed.**
9.3.2 Teaching methods

We did not specify the different methods, such as lectures, group work, small group discussions or role-plays, as these are self-evident from the content and materials. We encourage you to be creative in the ways you will conduct the training, and reiterate the importance of getting the visitors to actively participate in the training.

9.3.3 Photographs

A unique feature of this programme is the use of photos that depict real-life situations in homes. These serve as useful tools for engaging the caregivers during the visit. You may want to substitute these with examples that are more appropriate for your community.
10 Module one
Introduction to unintentional childhood injuries and home visitation

Ashley van Niekerk and Salla Munro

10.1 AIMS

This module aims to:

- Provide a rationale for a programme that focuses on the prevention of unintentional childhood injuries.
- Introduce the mechanisms of home visitation and the role of the home visitor.
- Orientate the home visitors to programme implementation.
- Provide the visitors with an opportunity to raise initial concerns and expectations about the programme.

10.2 OBJECTIVES

At the end of this module you should have:

- An indication of the visitors’ understanding of:
  — Unintentional childhood injuries
  — Why home visitation is an appropriate intervention strategy for preventing unintentional childhood injuries
  — What is expected of the home visitor
- Agreement on the training dates and implementation schedule for the programme.
- Addressed the visitors’ expectations and concerns.
- A Code of Conduct.

10.3 TRAINING SCHEDULE

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Materials</th>
</tr>
</thead>
</table>
| 30 min | Ice breaker  | Handout 10.1
          |              | Attendance register                             |
|        |              | Appendix 10-A
<pre><code>      |              | Examples of activities for Ice breaker          |
</code></pre>
<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Code of Conduct for training and meetings</td>
<td>Handout 10.2 Code of Conduct</td>
</tr>
<tr>
<td>30 min</td>
<td>Injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Theory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Unintentional childhood injuries</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Home visitation</td>
<td>Handout 10.3 Characteristics of a good home visitor</td>
</tr>
<tr>
<td></td>
<td>— Theory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— The home visitor</td>
<td></td>
</tr>
<tr>
<td>20 min</td>
<td>This programme: Discussion and finalisation of the implementation schedule</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>40 min</td>
<td>Visitors’ expectations and concerns</td>
<td></td>
</tr>
</tbody>
</table>

**Total:** 4 hours

### 10.4 SESSION ONE: ICE BREAKER AND CODE OF CONDUCT

**Teaching materials:**

- Basic
- Name tags
- As for the Ice breaker activities you will introduce
- **Handout 10.1:** Attendance register
- **Handout 10.2:** Code of Conduct

#### 10.4.1 Ice-breaker

On arrival, hand out name-tags to each person. You should at this stage have a contact list available with the names and contact details of the group members. Ask them to check whether the information is correct. It is important that you also keep an attendance register. For the first two meetings before a site-coordinator has been selected, you may have to keep the register yourself. Since attendance of the training and other meetings are compulsory, keeping such a register will help you to keep a record of their attendance.
Handout 10.1: Attendance register

<table>
<thead>
<tr>
<th>Name</th>
<th>Session 1 Date:</th>
<th>Session 2 Date:</th>
<th>Session 3 Date:</th>
<th>Session 4 Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visitor A</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Visitor B</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Visitor C</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Visitor D</td>
<td>/</td>
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</tr>
</tbody>
</table>

The Ice-breaker introduces the group to each other and contributes to the building of team-spirit. In this way the group members learn things about each other, and will be more comfortable in each other’s company. You can use any fun activity that will help to release the tension normally found between strangers. Keep in mind that the activities should be age-appropriate, and ensure that the visitors are comfortable in doing these activities. The last activity described in Appendix 10-A: Examples of activities for Ice-breaker must be regarded as compulsory, as this introduces the group to the fundamentals of home visitation, i.e. interviewing, listening to others, and sharing information.

10.4.2 Code of Conduct

The Code of Conduct is to be distinguished from the performance contract (See Section One, Example of a performance contract with the visitors, p. x) that is to be signed between your organisation and each of the selected visitors. The Code of Conduct will serve as the rules to be maintained during the meetings.

Divide the visitors into small groups and ask them to brainstorm the values that they would like to uphold during meetings. For example, the group could suggest things such as punctuality in attendance, treating each other with respect, and honesty amongst the group. Write these on an overhead, and let the group at large discuss whether something should be added or omitted. When the group is happy with the result, each home visitor should write these down on the Code of Conduct. To give weight to the Code of Conduct, each visitor should sign it. Keep a copy of each signed agreement, and the original copy is to be kept by each visitor. You may wish to write these values on flipchart and paste it on the wall. Without pre-empting the values that will be decided upon, make sure that the following issues are addressed and included in the code:

- Punctuality.
- The procedures for non-attendance of meetings.
- The resolution of grievances between the visitors themselves and the visitors and the organisation.
- Behaviour during meetings.
**Handout 10.2: Code of Conduct**

I, ........................................, (name of home visitor) agree to the values on which the training group decided on the first meeting on the ........................................ (date).

The values that we agreed on were:

Table: Values

<table>
<thead>
<tr>
<th>Name of home visitor</th>
<th>Signature</th>
</tr>
</thead>
</table>

I will keep to the above values during my involvement with this programme and during my visits to homes.

Date: ..........................

---

**10.5 SESSION TWO: INJURIES AND UNINTENTIONAL CHILDHOOD INJURIES**

**Teaching materials**

- Basic

---

**10.5.1 The injury problem**

The content for this session is drawn from the chapter *unintentional childhood injuries*, p.x-x. In your input please include and elaborate on the following information:

- Injuries are a large concern to people all over the world.
- In South Africa it is estimated that 13% of all deaths are the result of injuries, that results in approximately 65 000 to 80 000 deaths per year.
- In addition, between 1.5 and three million people were estimated to go to doctors and hospitals every year because of injuries (the estimate was made in 1998 so it could be higher by now).
- Of these figures, children account for about 10% of the total.
- There are different types of injury but the main difference between injuries is whether the injury to a person was caused intentionally or unintentionally. See the earlier definitions of these terms and also the many causes of unintentional injury.
10.5.2 Unintentional childhood injuries

Let the group discuss the following three questions. Summarise their discussions by using the answers given below.

**Question to the group**

*There are many different types of unintentional injuries that can happen. Can you mention some of the injuries that happen to young children?*

*Answer:* The most important ones are: traffic, burns, falls, poisoning, drowning and choking. The recently implemented National Injury Mortality Surveillance System (NIMSS) in South Africa indicated that unintentional injuries are a leading cause of childhood deaths. Approximately 85% of the 7 300 children aged 14 years and younger that die because of injuries, die as a result of unintentional injuries. The most prevalent causes of deaths are burns and injuries by blunt objects for infants and toddlers, and pedestrian injuries due to motor vehicle accidents, as well as burns, for children aged 5 to 14. The other main categories are drowning, poisoning and falls.

**Question to the group**

*What are the most dangerous places for young children in terms of unintentional injuries?*

*Answer:* The place where an injury happens is especially important, because if we know where it occurs, we might be able to prevent it. The most dangerous places for childhood injuries are reported to be inside or around homes, and in adjacent public places such as roads. The recent NIMSS data, and similar accounts from international sources, provide widespread evidence for the need for injury prevention interventions focussed on the area where these injuries occur most; namely the children’s homes. This may be because children spend a lot of time in the home, and also because sometimes the home is a busy place where everything happens at once and it is difficult to keep an eye on a child all the time. It may also be because some parents are not knowledgeable about the many risks there are in any normal house.

In informal settlements and other low-income contexts, children are at a significantly greater risk to being injured than children located in families and communities with greater financial resources. In addition, these children are not only at a greater risk to being injured, but are also more likely to suffer severe injuries and to die as a result of these injuries. Burn and traffic injuries are particularly strongly associated with poor socio-economic conditions.

**Question to the group**

*Why do you think that children in low-income communities are more at risk to getting injured?*

*Answer:* These shack settlements are often environmentally degraded, have an inadequate infrastructure, limited recreational facilities, and widespread overcrowding, all of which compromise health and safety. Added to these factors, there is usually limited space in shacks; often a family lives in a one-room shack with very little storage space. These living conditions increase injury risks.
So you see, injuries are a big problem in our country. Not only does it cause pain and discomfort, but also costs a lot of money in health care to the government, money that could be used somewhere else. This programme will teach you to help parents and caregivers to reduce the occurrence of unintentional childhood injuries.

10.6 SESSION THREE: HOME VISITATION

Teaching materials

- Basic
- Handout 10.3: Characteristics of a good home visitor

10.6.1 Understanding home visitation

The content for this session is drawn from the chapter HOME VISITATION, from p.X to Y. In your input please include and elaborate on the following information:

- Home visitation has been used across the world to address a variety of problems; it is useful because it reaches parents and children in the place where they are most often - in the home.
- The programmes may differ with respect to its intended outcomes, duration, frequency of visits and who gets employed as a home visitor, but have the following in common:
  - Usually it comprises more than one visit (with indications that at least four visits are needed to facilitate the desired outcome);
  - Visits can be conducted weekly, bi-weekly or monthly, over a period of several months up to programmes that are running over a number of years (in general it is thought that the more of the intervention the client receives, the more likely that the programme will be successful);
  - Either professionals such as nurses, or para-professionals, such as community members, are trained to serve as visitors.

- Activities may include parent education, counselling of family members, primary preventive strategies, safety product demonstrations, implicit enforcement using checklists and facilitation of referrals to other safety- and help- rendering organisations.
- In general supplementing education with demonstrations, encouragement of environmental changes, and checklists that enforce behavioural changes, are more effective than visits that only focus on education.
- It is important to remember that home visitation is an intervention strategy that utilises systematic and structured home visits to effect positive changes in peoples' lives.
- Home visitation gives an opportunity for a relationship to develop between the visitors and the family. This relationship may help the family, if they are feeling isolated from the rest of the community.

After your input let the group discuss the following question. Summarise their discussions by using the answer given below.
Question to the group

Why home visitation to prevent unintentional childhood injuries?

Answer: As discussed in the previous session, one of the most common places where unintentional childhood injuries happen is in the home. Often families that are struggling to make ends meet may be socially isolated, and are unlikely to seek help from others outside their homes. This is why it makes sense to conduct home visits that will equip parents and caregivers to prevent these injuries from happening.

10.6.2 Characteristics of a good home visitor

Because the relationship between the family and the visitor is important to the programme's success, the home visitor should be alerted to those characteristics that may help them in establishing a good relationship.

Ask the group to separate into smaller groups and brainstorm characteristics that may be necessary for a home visitor. The visitors are to write this on a flipchart and present it to the group. Proceed then with the lecture.

- Be punctual and reliable
  The visitor should not only be on time, but also remembers to keep agreed appointments with the caregiver. It is important to let the family know if a visit cannot happen. If the visitor is on time and keeps the appointments, it means that respect is being paid to the family. When the visitor fails to keep the appointments it may upset the caregiver and this will have an adverse affect on the visitor-caregiver relationship.

- Be trustworthy
  The home visitor should make sure that when something is promised to the caregiver, that it happens. It is important to show to the family that the home visitor is willing and capable of helping the family. Unfulfilled promises can disappoint the family and ruin a good relationship.

- Be willing to learn and listen
  The visitor should not present herself as the 'expert' that always knows best. Be willing to learn from the caregiver, and help them to come up with their own solutions. Listen to the caregiver's point of view, and understand that there are reasons for them acting in a certain way. Don't feel embarrassed if you do not have the answers to all the caregiver's questions, but be sure to ask the supervisor, so that you will be able to have a fuller response on the next visit. By listening to the caregiver, the visitor will win her trust that is essential for the visit to be successful.

- Do not judge others
  The visitor should not judge others by her standards. She would need to understand that people have different ways of behaving and living, and their own reasons for doing so. The visitor must have an open mind when going into a home and not be judgemental about the way that each family lives their lives.
• **Be respectful**
  This relates to all of the above points. The visitors should reserve the same respect for the family they are visiting as expected for themselves or their own family and friends. The visitor’s respect for the people she visits should be shown in everything she does during the visit.

• **Be honest**
  It is not only when interacting with the caregiver that the visitor must act in an honest way, but also with the supervisor of the visitor team. For example, if the visitor is unable to keep an appointment with a caregiver she should be upfront about the reason for this. Concealing or omitting information from the supervisor may lead to an inaccurate depiction of the home, which in turn may affect the effectiveness of the programme.

• **Be observant**
  When the visitor is in the family’s home, she should observe the environment, without giving the impression that she is prying on the caregiver. Keep in mind that the point of the visit is to make sure children do not get hurt in the home, therefore be alert to see what are possible risks to the children. The visitor should also observe the person with whom she interacts; if the person is uncomfortable, the visitor can change her approach. Should the visitor see problems in the family, enquire about that in a non-intrusive way. However, the visitor should never interfere in the family’s personal business if not asked for help.

• **Keep things confidential**
  It is very important to tell the caregivers that their participation in the programme is confidential. Ask the caregiver’s permission if you learn something that you think is necessary to report to the supervisor. If a caregiver is to find out that you discuss her with other people in the community, it is likely that you will not be welcome in that house any longer. The home visitor should make sure that when discussing their work they never mention the families by name, by house number or by anything that may make the other person guess who they are talking about.

• **Be willing to help with issues not related to injuries**
  Sometimes the home visitors will come across situations in a home that do not have a bearing on childhood injuries. In these cases, and if the family asks for help, refer these to other support mechanisms within the community. Whenever the home visitor is not sure what to do, she should turn to the supervisor to make the best possible decision.

• **Look after their own safety**
  It is good to care for a family, but a home visitor should remember that their own safety is most important. If a visit is due, this should be made only when it is safe to do so. If a home visitor makes visits at night, she may put herself in danger. Dangerous situations may arise even in the homes, and in these cases the visitor should try and step away and not get involved in any arguments or fights that happen in the home. If a visitor feels threatened in any way, leave the home immediately and consult with the supervisor on the matter.
**Handout 10.3: Characteristics of a good home visitor**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
</tr>
</thead>
</table>
| Be punctual and reliable            | - Keep appointments made.  
                                    |  - Be on time.  
                                    |  - Let the caregiver know if appointment will be cancelled. |
| Be trustworthy                      | - Keep the promises you make.                                              |
| Be willing to learn and listen      | - Listen to what the caregiver has to say.  
                                    |  - Be willing to learn from them.                                          |
| Do not judge others                 | - Have an open mind for others.                                            |
|                                     |  - Don’t judge others by your standards.                                   |
| Be respectful                       | - Treat others with the respect you want for yourself.  
                                    |  - Show your respect to the caregiver in everything you do.                |
|                                     |  - Be willing to help, but only if the caregiver asks you.                 |
| **Be honest** | • Have the courage to admit if you have problems.  
• Be honest with the caregiver.  
• Treat your supervisor in an honest way as you expect her to treat you. |
| **Be observant** | • Observe but don’t embarrass the caregiver.  
• Be on the lookout for the risks to childhood injuries in the home.  
• Be aware of how the caregiver responds to you. |
| **Keep things confidential** | • You win a person’s trust if you don’t gossip.  
• Ask the caregiver for permission to discuss personal issues with the supervisor.  
• When you discuss a caregiver with the supervisor, don’t reveal that person’s name unless the circumstances prescribes it.  
• The only time you may reveal information without asking permission is when that person’s life is threatened or if that person is a threat to others. However, gaining permission should always be a first priority. |
| **Be willing to help with issues not related to injuries** | • When a caregiver asks for help that is not part of the programme, your role is to refer that person to the appropriate agencies that can deal with the problem.  
• Offer your help, but let the caregiver decide if she wants your help.  
• Have available the contact information of organisations that can offer help. |
| **Look after their own safety** | • Look after your own safety.  
• If you feel unsafe at any stage, withdraw from the situation and discuss this immediately with the supervisor. |
10.6.3 This programme

The aim

The aim is to reduce the risks to, and eventually the occurrence, of unintentional injuries to young children in and around the homes of people living in low-income communities in South Africa. By alerting caregivers to the risks in the homes, and fostering a positive attitude towards safety in the home, this programme will combat the alarming rate of childhood injury and mortality in South Africa.

Allocation of caregivers to home visitors

For this programme we are focusing on households where young children (aged about ten years and younger) are living. The caregivers you will be visiting indicated an interest in participating in the programme. However, on your first visit to the houses you will have to confirm whether there are young children that stay in that house, and if so, if the caregiver is still interested in participating in the programme. Each of you will have a certain number of houses to visit, and we will try to ensure that these houses are in close proximity to each other as well as to where you are living. The allocation of houses to each visitor will only be done after the training is completed.

Implementation schedule

We will conduct six visits to each participating home over a three-month period, scheduled on a bi-weekly basis or as otherwise arranged. Each of these visits will be preceded by two days of training. The six visits are as follows:

Visit One: Orientation to the programme
Visit Two: Child Development
Visit Three: Burns
Visit Four: Poisoning
Visit Five: Falls
Visit Six: Closure

The activities during a visit

The content and structure of each of the first five visits is discussed in detail in the training that follows. A visit can be anything between 20 and 40 minutes, but will depend on how responsive the caregiver is. In general, on each of the visits the visitor will engage with the caregiver around the following activities:

- Use a safety checklist to help the caregiver identify the risks in the home.
- Share information on risk identification and injury prevention.
- Supply and demonstrate the use of a safety product that the caregiver receives as a gift.
- If the family asks for help with problems that are not related to unintentional injuries, refer them to the appropriate assistance.

Visit 6: Closure is different to the rest as it is a courtesy visit that brings the programme to an end. No training will be presented on this visit; the visitor only needs to thank the caregivers for their participation and wrap up any outstanding issues.
At this point you should have an overhead that specifies the coming dates of the training and visits. Consult with the group on these dates and adjust if necessary. Only once the group has finalised this should you make copies and hand it to them at your next meeting. (For an example of the implementation schedule see the chapter 3 HOME VISITATION, p.)

10.7 SESSION FOUR: VISITORS’ EXPECTATIONS AND CONCERNS

This is an open-ended session with the aim to elicit the visitors’ expectations and concerns. Use small-group discussions for this and let them write their ideas on flip chart. Each group should then proceed with presenting this.

Keep the following in mind:

- Use the group to come up with solutions to possible problem scenarios, such as having to deal with a rude caregiver, or caregivers that refuse to participate after receiving some of the visits.
- Where there are issues that you cannot resolve, refer that to the programme management.
- Do not neglect even the most trivial of their concerns; it is often those seemingly unimportant issues that can become disruptive to the programme.
11 Module two
The training video

Salla Munro and Thoko Mdaka

11.1 AIM

The training video is an example of a typical home visit. The aim of this training video is to introduce the home visiting approach to people who want to help caregivers keep their homes safer.

11.2 OBJECTIVES

The specific objectives of this module are to:

- Develop effective interviewing and communication skills.
- Train home visitors to correctly conduct a home visit.
- Provide clear information on how the visitor is to introduce herself and the programme to the caregiver.
- Train home visitors to convey safety information to the caregivers.

11.3 TRAINING SCHEDULE

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Teaching method</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Introduction to the video</td>
<td>Lecture/discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Incorrect method: introduction</td>
<td>Viewing video</td>
</tr>
<tr>
<td>10 min</td>
<td>Correcting the wrongs</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Correct method: introduction</td>
<td>Viewing video</td>
</tr>
<tr>
<td>5 min</td>
<td>What could be improved</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Incorrect method: getting to know the caregiver</td>
<td>Viewing video</td>
</tr>
<tr>
<td>10 min</td>
<td>Correcting the wrongs</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Correct method: getting to know the caregiver</td>
<td>Viewing video</td>
</tr>
<tr>
<td>5 min</td>
<td>What could be improved</td>
<td>Group discussion</td>
</tr>
<tr>
<td>30 min</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Content</td>
<td>Teaching method</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>5 min</td>
<td>Incorrect method: safety checklist</td>
<td>Viewing video</td>
</tr>
<tr>
<td>10 min</td>
<td>Correcting the wrongs</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Correct method: safety checklist</td>
<td>Viewing video</td>
</tr>
<tr>
<td>5 min</td>
<td>What could be improved</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Incorrect method: sharing information</td>
<td>Viewing video</td>
</tr>
<tr>
<td>10 min</td>
<td>Correcting the wrongs</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Correct method: sharing information</td>
<td>Viewing video</td>
</tr>
<tr>
<td>5 min</td>
<td>What could be improved</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Incorrect method: closure</td>
<td>Viewing video</td>
</tr>
<tr>
<td>10 min</td>
<td>Correcting the wrongs</td>
<td>Group discussion</td>
</tr>
<tr>
<td>5 min</td>
<td>Correct method: closure</td>
<td>Viewing video</td>
</tr>
<tr>
<td>5 min</td>
<td>What could be improved</td>
<td>Group discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Session closure — discussion of home visiting</td>
<td>Group discussion</td>
</tr>
</tbody>
</table>

**Total:** 2 ½ hours

### 11.4 INSTRUCTIONS TO THE TRAINER

#### 11.4.1 Introduction to the training video

Introduce the training video to the group. Tell them what the aims of the video are and introduce the way the session will run. The visitors will see incorrect ways of conducting the visit, followed by the correct way of doing so. Encourage the visitors to take notes during the video so that they can have points to discuss after each section. *It is advisable that you watch the video on your own prior to showing it to the home visitors.*

#### 11.4.2 Showing the video

Show the video in the segments in which it is separated. After each incorrect session, stop the video and encourage the group to discuss what went wrong and what could be improved. The questions that you present to the group could include:

- *What was good about the way the visitor conducted this section?*
- *What was not good about the way the visitor conducted this section?*
- *How could this section be improved?*

After the discussion is finished, show them the correct way. Stop the tape again and discuss with the group what was done well and what could be improved. You can present the above questions to the group again.
### 11.4.3 Guidelines for the discussion

**Legend**  
😊 Appropriate actions and communications.  
😢 Actions and communications that should be avoided.

<table>
<thead>
<tr>
<th>The phases of a visit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>😊 Wear your name badge.</td>
</tr>
<tr>
<td></td>
<td>😢 Avoid saying to the caregiver: “You HAVE to participate...”; You HAVE to complete...”</td>
</tr>
<tr>
<td></td>
<td>😊 Explain the whole study if necessary.</td>
</tr>
<tr>
<td></td>
<td>😢 Not allowing the caregiver to say much e.g. if she wants to talk about her children.</td>
</tr>
<tr>
<td></td>
<td>😊 Confidentiality.</td>
</tr>
<tr>
<td></td>
<td>😊 Explain what your organisation does.</td>
</tr>
<tr>
<td><strong>Getting to know your client</strong></td>
<td>😊 Comment on the positive aspects of the house and make general conversation.</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t pry e.g.: “Where is your husband?”</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t assume things, e.g.: “Parents take things for granted.”</td>
</tr>
<tr>
<td><strong>Safety checklist</strong></td>
<td>😢 Don’t take over the interaction, instead allow the caregiver to have a say.</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t interrupt the caregiver.</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t laugh at the caregiver.</td>
</tr>
<tr>
<td></td>
<td>😊 Be prepared, e.g. know the content of the checklist.</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t say “I’ll do that now” — it should be done together!</td>
</tr>
<tr>
<td></td>
<td>😊 Be observant.</td>
</tr>
<tr>
<td><strong>Sharing information</strong></td>
<td>😢 Don’t say “You HAVE to remember the caregiver always has a choice!”</td>
</tr>
<tr>
<td></td>
<td>😊 Let the caregiver do things.</td>
</tr>
<tr>
<td></td>
<td>😢 Don’t take over the home.</td>
</tr>
</tbody>
</table>
### The phases of a visit

- 😞 Don't order the caregiver to do things.
- 😊 Remember to note and say when something is good.
- 😊 Give practical examples when you explain things to the caregiver.

#### Closing the visit

- 😞 Don't say: "You're not supposed to do that."
- 😊 Write down the date and time of your next visit.
- 😞 Don't leave abruptly.

### 11.4.4 Closure

Make your final comments about the video and invite comments from the group. Encourage home visitors to practice home visiting with their friends and family. Remind them that practice makes perfect.

There may be many more things that your group will not agree with, or that your group thinks is good about what they learned in the video. The important part is to familiarise the home visitors to the method of home visiting, and to get them thinking about the best ways to conduct the home visit.

### 11.5 SELECTION ROLE-PLAY

At this stage you should have a good sense who of the initial group of recruits will be your home visitors. However, you may want to have this confirmed by assessing their natural skills in conducting a home visit. Before you proceed with the rest of their training, and also in preparation of finalising the performance contract with them, a short role-play by each of the visitors will help in this regards. Follow the instructions in Appendix 11-A: Script for Selection role-play.
12 Module three
Relationship-building and interviewing skills

Anabela Nascimento

12.1 AIMS
This module is structured into two parts that coincide with Day One and Two. The module aims at:
- Improving the visitors’ ability to connect with the caregivers and teach them the skills needed for establishing good relationships with the caregivers.
- Improving the visitor’s communication skills as well as their ability to interview.
- Conveying the importance of the ethical values of the programme.
- Promoting the personal growth of each visitor.
- Preparing the visitor for the contact, or first visit.

12.2 OBJECTIVES
The module should ensure that the visitors:
- Realise that without a good relationship with the caregivers, the programme may fail.
- Acquire an understanding of the underlying principles for building a relationship.
- Understand and be able to apply concepts such as respect, trust, empathy, verbal and non-verbal communications, and effective listening.
- Are familiar with the principles that foster effective communication, are aware of barriers to effective communication, and can exercise effective communication.
- Understand the importance of upholding the ethical values the programme.
- Distinguish between problems she can solve and those that need professional help, and be able to refer caregivers to appropriate agencies for help.
- Have successfully role-played the contact visit.
### 12.3 TRAINING SCHEDULE

#### DAY ONE

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Materials</th>
</tr>
</thead>
</table>
| 40 min | Introduction  
  — The importance of a good relationship | Handout 12.1  
  *Ubuntu* |
| 45 min | Five principles for building a relationship  
  The importance of *Trust* in a relationship | Handout 12.2  
  *Five principles for a relationship*  
  Handout 12.3  
  *Hints for building relationships* |
| 30 min | Tea break                                    |                                               |
| 60 min | The counseling approach to relationship-building  
  — Attitude towards the caregiver  
  — Listening skills  
  — Difference between giving information or advice | Handout 12.4  
  *Good and bad listening*  
  Handout 12.5  
  *Information vs Advice* |
| 30 min | Tea break                                    |                                               |
| 60 min | Communication skills  
  — Basic skills  
  — Nonverbal communications  
  — Barriers to good communications | Handout 12.6  
  *Effective communication*  
  Handout 12.7  
  *Barriers to effective communication*  
  Handout 12.8  
  *Nonverbal communication* |

**Total: 3½ hours**

### 12.4 SESSION ONE: INTRODUCTION TO RELATIONSHIP BUILDING

**Teaching materials**

- Basic
  - **Handout 12.1:** *Ubuntu*
    - **Handout 12.2:** *Five principles for a relationship*
    - **Handout 12.3:** *Hints for building a relationship*

**12.4.1 Building group cohesion**

A useful way to introduce this module is repeating the interview exercise in Module One (see p.), as this will not only promote group cohesion (the visitors are coming to know each other better), but also expose them to interviewing people.
Activity 1

Make sure that the visitors are paired with someone different, and that they do not know one another already. Afterwards they are to introduce each other to the group. Here are some questions they can use:

- What does your name mean?
- Tell me what you enjoyed most of the previous training session
- What is the most important thing in life to you?
- What was the proudest moment in your life?

12.4.2 The importance of establishing good relationships with the caregiver

The home visitors live in a community; they are acquainted with the needs of this community and they need to work together with their community in a spirit of “Ubuntu”, which is a basic respect and compassion for others. The visitor needs to understand that this programme relies on winning the hearts of the people they will visit. Having a good and mutually rewarding relationship between the visitor and caregiver will lay the foundation for the programme to achieve its aim, that is, to prevent unintentional injuries to children in the home. Start this lecture by discussing the definition of “Ubuntu” with them.

Handout 12.1: Ubuntu

The South African Government White paper on Welfare officially recognises Ubuntu as:

“The principle of caring for each other’s well-being... and a spirit of mutual support... each individual’s humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual’s humanity. Ubuntu means that people are people through other people. It also acknowledges both the rights and responsibilities of every citizen in promoting individual and societal well-being.”

(Government gazette, 02/02/1996, no. 16943, p.18. paragraph 18)

A relationship is a person’s sense of emotional bonding with another person. The best relationships are collaborative, long-term, mutually reinforcing and mutually rewarding. The ability to develop good and satisfying interpersonal relationships is seen as an important precondition for learning to take place. For relationships to grow they need co-operation and trust, and in the following two days the visitor will learn skills to develop such relationships with the people to be visited.

Although the relationship with the caregiver is one of equality, the visitor will be acting as the helping person, and the caregiver as the receiver of your help. The caregiver does not merely have to co-operate, but must be encouraged to take the initiative in making her home a safer place. Neither the programme nor advice can be forced upon the caregiver. By establishing a good relationship with the caregiver the visitor will be able to achieve the aims of the programme.

For the visitor it is important to know that once you start visiting the household it is
necessary that you immediately start building relationships with the family. Get to know everyone’s name as soon as possible. Talk to them and treat them with respect and dignity. As you work on building a relationship, consistency is essential: if you say you are going to do something or find out something, then do it. Do not make any promises if you can’t deliver. This also means that you must be honest with the caregiver, your fellow visitors, and the supervisor. Don’t hide your shortcomings.

Good relationships are promoted when people:
- Are able to talk to each other and are willing to listen to each other.
- Respect each other and know how to show respect in ways the other person wants (be sensitive to what is culturally acceptable).
- Know each other well enough to understand and respect the other person’s opinions.

It is possible that once people come to trust you, they may talk to you about personal problems that are not related to your work in the programme. These difficulties need to be respectfully acknowledged without leaving the caregiver with a sense of being pushed to disclose more than they may be ready to do. Keep in mind that in this programme you will not be trained to act as a social worker, but by listening to the caregiver and making appropriate referrals, you will help them to solve their problems.

12.4.3 Five principles as the basis for a relationship

We as a group have agreed to a Code of Conduct. This is not only to help us become a group or to have rules that apply to our conduct during the meetings, but it also lays the foundation for the relationships between us. These rules will help ensure that people feel that it is safe for them to open up and discuss their concerns without being judged negatively by others. The principles underlying a good relationship may be applied to the visitor group but also to the visitor and the caregiver relationship. The principles are as follows.

Handout 12.2: Five principles for a relationship

<table>
<thead>
<tr>
<th>1. Confidentiality</th>
<th>Everything that gets discussed for example in the group does not get discussed outside the group. This includes discussing what is said with other group members, with friends, family members or partners.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Clear communication</td>
<td>Say what you need to say clearly and concretely. Avoid using vague language or making generalisations. It’s okay to disagree and express differences, as long as it is done respectfully.</td>
</tr>
</tbody>
</table>
3. Be yourself

This means that you have to take responsibility for yourself and have to be open and honest with yourself and the group. Don’t hide behind a mask, i.e. don’t withdraw from the group when you’re upset. Verbalise your feelings in a clear open manner. Note however that as visitor you should make sure that your feelings do not intrude with the visit. Remember that the visit is not for you, but for the benefit of the caregiver.

4. Allow others to be themselves

Avoid speaking for others, i.e. we are all angry and do not force others to talk when they might not be ready to do so. This allows people to take responsibility for themselves.

5. Respect

Learn to respect all the members of your group and learn to accept them as they are. It’s never acceptable to be disrespectful of each other.

Here are some useful hints for establishing a good relationship.

**Handout 12.3: Hints for building relationships**

<table>
<thead>
<tr>
<th>Developing and maintaining good relationships</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish formal working relationships</td>
<td>Establish informal relationships</td>
</tr>
<tr>
<td>Be on time for your appointment.</td>
<td>If you meet the people on the street, greet them and be friendly.</td>
</tr>
<tr>
<td>Deliver on your promises.</td>
<td>Do not discuss any issues the caregiver may have raised in confidence with you.</td>
</tr>
<tr>
<td>Be professional during the visit.</td>
<td>Show an interest in the caregiver’s activities.</td>
</tr>
<tr>
<td>Keep notes of things people want you to follow up on and get back to them.</td>
<td>Practice effective listening.</td>
</tr>
<tr>
<td></td>
<td>Look for areas that you both agree on.</td>
</tr>
<tr>
<td></td>
<td>Foster an environment of openness and trust.</td>
</tr>
<tr>
<td></td>
<td>Never embarrass anyone.</td>
</tr>
</tbody>
</table>
12.4.4 The importance of Trust in a relationship

Trust is very important for a mutually beneficial and lasting relationship. If you have a good relationship and mutual trust between yourself and the people that you’re visiting, they will be more receptive to the new ways of thinking and safety improvements you want to introduce. Remember that you have to earn the trust of the household and this does not happen automatically. For people to begin to trust you, you have to show them that you are competent and caring. If people feel that you are competent in your work but you don’t care about them or the things that are important to them, they might respect you but they won’t trust you. In the same way, if they think that you care about them, but do not feel that you are competent or capable of delivering what you promised, they will like you but will not trust you or the message you are delivering. There are a number of techniques that can facilitate a trusting relationship:

- Your greeting is very important. Be warm and clear about who you are and the purpose of your visit.
- Be confident, informative and relaxed. You want the household to feel relaxed and comfortable with you and the programme process. Remember that people might be anxious, unsure, suspicious or even aggressive. Explain what your task is and allow them to ask any questions they may have. Ensure that they understand that you do not have any hidden agendas.
- Understand what matters to people. People trust those whom they believe understand them, and are looking out for their best interests.

12.5 SESSION TWO: THE COUNSELLING APPROACH IN RELATIONSHIP-BUILDING

Teaching materials

- Basic
- Handout 12.4: Good and bad listening
- Handout 12.5: Information vs Advice

12.5.1 Attitude towards the caregiver

- Respect

One of the deepest human needs is that for respect. Respect means honouring someone just because they are human. In your work as a home visitor this means the following:

- Respect recognises the caregiver’s basic humanity and their potential to be more than they are right now.
- Respectful visitors acknowledge that working with the households is worthy of their time and energy. They must be committed to deliver their skills as outlined in the performance contract.
- The caregivers’ uniqueness needs to be respected. This means making the effort to “meet” the caregivers where they may be in terms of their needs, capabilities and resources. It also implies a regard for the persons’ resources.
- Respect each caregiver’s right to self-determination. Your work is to share your
skills with the caregiver, but do understand that she has the right to make her own choices, according to her own values. Effective home visitors do not manipulate anyone.

Respect may be expressed in a number of ways:

- By paying close attention to what the caregiver is saying. Listen with your whole body. Look at the person who is speaking. Try to make eye contact (if it is culturally acceptable) and do not look at your notes all the time. Do not look away or bow your head, listen attentively to what is being said to you. If your manner is one of complete attention, you are saying: ‘I am with you and I am committed to your needs and it’s worth my time and effort to help you.’ If you are distracted, it may be interpreted as: ‘You are not worth my time. What you are saying is not important’.

- Respect also means not making any judgments. Work hard at understanding the experiences, behaviours and feelings of the household. People generally believe that people respect them if they spend time and effort in trying to understand them.

- Show respectful warmth. Warmth may be expressed by non-verbal cues such as gestures, tone of voice, and facial expression. It’s important to be sensitive to cultural and religious values and expectations.

- **Genuineness**
  - Genuineness implies knowing who you are and having the ability to accept yourself, the good and bad, without defenses or excuses.
  - For the home visitor, being genuine with the caregiver is also a way of being respectful. Home visitors can be themselves without putting on airs and graces. They are willing to commit themselves to helping others.

- **Empathy**
  - Empathy is not sympathy. Being empathic means that you try and understand the persons’ world through that person’s eyes and feelings.
  - Empathy means entering the caregiver’s world but also communicating this understanding to her. This means identifying the core messages from the caregiver that are expressed not only in the words being said, but also in the feelings, experiences as well as the behaviours underlying them.

### 12.5.2 Listening skills

Listening is how you will gain an understanding of what is happening in the household and in the community. The caregiver must feel that you are listening to her. To help you listen effectively you need a good understanding of non-verbal behaviour and the importance of:

- eye contact
- tone of voice
- facial expression
- posture and body language
Activity 2

Divide the visitors in small groups and share experiences of not being listened to (10 minutes). In the large group, drawing from their experiences just discussed, brainstorm "what makes a good listener" (30 minutes).

Listening is the key to good communication. It means listening to verbal and non-verbal messages. The non-verbal messages that are carried in the client's tone of voice, silences, pauses, gestures, facial expression, and posture. Silence may reflect boredom, confusion, anger, pain, that the person is thinking or that the person does not know how to express what she is feeling. Effective listening is to be able to understand the content and the feelings of the message.

Keep the following in mind when you listen to somebody:

- Always listen without judging — suspend your own values, thoughts, opinions and feelings as far as possible.
- Listen to the facts.
- Listen to the feelings.
- In all cases the non-verbal message is as important, if not more important than the verbal message.
- Show acceptance of the other person's perceptions and attitudes.
- Allow freedom of expression of feelings and attitudes.
- Central to the listening process is checking out that you understand the message being sent to you.
- Don't make assumptions or jump to conclusions.

Effective listening requires a basic set of attitudes:

- Tolerance for others.
- Ability to accept others' feelings and a belief that they can handle the situation in which they find themselves in.
- It means saying the following:
  "I want to listen and have time to hear."
  "I want to learn from you."
  "I am willing to help if asked to."
  "I see the other person as an individual in his or her own right."

To end the discussion on listening skills, you may want to read the following handout with the visitors.
Handout 12.4: Good and bad listening

Blocks to good listening
Let the visitors give personalised examples of these blocks

| 'On-off' | When the listener “switches off” at times. |
| 'Red flag' | Certain words trigger a response that causes us to stop listening. |
| 'Open-ears, closed mind' | You quickly decide that you know what is going to be said. |
| 'Glassy-eyed' | You appear to listen while daydreaming. |
| 'Too-deep-for-me' | When you stop listening because you don't understand what is being said. |
| 'Don't rock the boat' | You don't listen to something that may challenge your opinions. |

Hints for good listening

- Show interest.
- Be understanding of the other person.
- Express sympathy.
- Single out the problem if there is one.
- Listen for causes of the problem.
- Help the speaker associate the problem with the cause.
- Encourage the speaker to develop competence and motivation to solve his or her own problems.
- Learn the ability to be silent when silence is needed.

In good listening, don't

- Argue.
- Interrupt.
- Pass judgement too quickly or in advance.
- Give advice unless the other requests it.
- Jump to conclusions.

(Source: The Oxfam Gender Training manual, 1995)

12.5.3 The difference between sharing information and giving advice

Be very careful about giving advice. Advice-giving may be appropriate in a crisis situation where some action must be taken and the household is unable to think clearly enough to make responsible choices, but it is inappropriate if people have time to make those decisions themselves. Be careful not to confuse advice with information. When the household requests information and you have the information that is needed, then it makes good sense to share it.
Activity 3

Use small groups (maximum 5 people). Cards (below in the handout) with a case history are given out to each group. They have to discuss this and decide whether this calls for giving advice or sharing information. End the exercise with a discussion in the large group.

Handout 12.5: Information vs Advice

1. The mother tells you that her husband comes home drunk and sometimes hits her. She asks you whether she should run away to her sister who lives in another city.
   Should you give advice or information?

2. A child tells you that her mother gives her hideings and she has heard that she can report this to the Police. Should she do it?
   Should you give advice or information?

3. A parent tells you that she suspects the neighbour is growing and selling dagga. Should she go to the Police?
   Should you give advice or information?

4. The father tells you that his son takes drugs and wants your help in helping his child.
   Should you give advice or information?

5. A young mother tells you that she has three children and now has found out that she is pregnant again. She is unemployed and so is the husband. She has heard that she can have an abortion. She wants you to tell her what she should do.
   Should you give advice or information?

6. A Grandmother tells you that her grandson has got himself involved with a gang and she wants to help him get away from them. She asks you to help.
   Should you give advice or information?

We included these examples to generate discussion amongst the visitors. The point to emphasise is that the visitors should refrain from giving advice without carefully weighing the consequences of their advice and rather consult with their supervisor when in doubt.

12.6 SESSION THREE: COMMUNICATION SKILLS

Teaching materials

- Basic
- Handout 12.6: Effective communication
  Handout 12.7: Barriers to effective communication
  Handout 12.8: Nonverbal communication
12.6.1 Basic communication skills

Communication is the interchange of messages between people. When your communication is good it helps to change the attitudes, feelings and actions of the people with whom we communicate. The following are important issues to promote good communications.

- **Attending**

By your very posture and body language you should let the caregiver know that you are with her, i.e. you are completely available to her during the time that you are together. This means engaging in such behaviour with good eye contact, concerned tone as well as facial expressions that will leave the caregiver with a sense of being appreciated. Distracting behaviours such as nervous tapping, backwards leaning, yawns, sighs, lack of eye contact, shrugs, finger movements, smoking, chewing, etc. all contribute to disrupt the communication and become a barrier to a good relationship. Here are some useful hints to apply:

- Sit squarely.
- If culturally appropriate, make eye contact when you speak.
- Have an open posture.
- Lean slightly forward.
- Be relaxed.

Remember: Your appearance, tone of voice and choice of language conveys something of your own attitude.

- **Responding**

Effective attending and listening will help the visitor respond in the right way. Home visitors need to respond in a way that shows that they have listened carefully and that they understand how the caregiver feels and what she is saying about herself. It is not enough to understand, the home visitors must communicate their understanding in a way that helps the caregiver explore and clarify problems.

- Always respond with warmth and in a way that makes the other person feel that you care about her.
- Do not interrupt unnecessarily.
- When you communicate it is helpful to be honest and open, and to speak clearly using easily understood sentences. Successful communication means that you avoid misunderstanding, confusion and unnecessary hurt. It also means that you are not leaving the conversation unfinished.

Differences in personal experience and culture are important and need to be respected. Always address people in the most respectful manner possible.

- **Reflective Listening**

This refers back to what we discussed when you are showing empathy towards someone. When you listen with your heart, you recognise the feelings behind the words people speak, and also hear what they are not saying. Reflective listening is almost like holding up a mirror in front of the person, telling her in your own words what the meaning and feelings are that she is expressing. In doing this, a person
feels understood and accepted. We “mirror” the message so the person can see herself more clearly. Use open responses, for example, when a caregiver tells you with anxiety about her children that often play outside, you may respond by saying: “I can hear that you were very frightened when your children ran into the street”, which reflects the feelings and meaning of the caregiver’s message to you. It’s very important to respond non-judgmentally to strengthen empathy and communication. Remember that the caregiver also looks at your nonverbal responses.

- **Example:**
You were saying to the caregiver that you heard that she is frightened, but you look bored when you say it. In doing this you will lose the trust of the caregiver.

Responding to non-verbal messages is important. Sometimes you need to respond to the sullen look, sulk, smile, tearful face etc. Catch the meaning of this behaviour and mirror it back to the person. This will tell the person that you are really listening to her whole person.

- **Probing**
Probing means using statements, which are gentler than questions (“You are concerned about this”), and prompts (“Tell me more”), to encourage the person to talk about specific experiences, behaviours and feelings related to specific situations. Avoid asking “Why” questions.

You may conclude this section with the summary provided below.

**Handout 12.6: Effective communication**

The following are important for effective communication:

1. The choice of words
   - be specific
   - give direct messages
   - say what you mean
2. Congruent body language, which means that your body and your mind say the same thing.
3. Listen to your tone of voice and make sure that it is calm and audible.
4. Effective listening.
5. Probing.

---

**Activity 4**

This activity should make the visitors aware of the many ways in which effective communications are often prevented from happening.

In the large group, the visitors are encouraged to brainstorm barriers to good communication. The trainer should start off by giving a few words and attitudes that serve as barriers (see **Handout 12.7: Barriers to effective communication** below).
Write the responses of the visitors on a flipchart. Select a few words and ask two visitors to role-play a situation where these barriers may prevent good communication between a visitor and caregiver.

Example: If you use “Interrupting” as an example of a barrier, then the visitor will keep interrupting the caregiver when she tries to tell the visitor about an incident. The group must then be asked if there are any barriers written down on the board on which they need clarification. If there are any, a further explanation should be given.

**Handout 12.7: Barriers to effective communication**

These are attitudes and words that can cause bad communications between people. Think of situations where you were treated in this way and how you felt afterwards.

<table>
<thead>
<tr>
<th>Criticising</th>
<th>Name calling</th>
<th>Ordering</th>
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</thead>
<tbody>
<tr>
<td>Threatening</td>
<td>Advising</td>
<td>Diverting</td>
</tr>
<tr>
<td>Interrogating</td>
<td>Closed questions</td>
<td>Preaching</td>
</tr>
<tr>
<td>Lecturing</td>
<td>Constantly correcting</td>
<td>Stereotyping</td>
</tr>
<tr>
<td>False reassurance</td>
<td>Interrupting</td>
<td>Jump to conclusions</td>
</tr>
<tr>
<td>“Why” questions</td>
<td>Being domineering</td>
<td></td>
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</table>

**12.6.2 Verbal and nonverbal communications**

Our messages are carried in the words we speak (verbal) but also in our body language (nonverbal). The expression on our faces, our body posture, and the tone of our voice are examples of nonverbal communications. As a demonstration of non-verbal communications, proceed with the following activity.

**Activity 5**

Get three people from the group to role-play three different situations. Two of them will act as home visitors and one as a caregiver. Call them outside and give each one a different card (see Handout 12.8: Non-verbal communication below). For the two acting as visitors, ask two other members to act as ‘neutral’ caregivers respectively without letting them know what to expect. Then select a ‘visitor’ with a neutral message for the person that will act as caregiver. Once all three scenarios have been acted, ask the two ‘caregivers’ and ‘home visitor’ how they experienced the other person’s nonverbal messages. In the larger group discuss the actors’ verbal and nonverbal messages.
Handout 12.8: Non-verbal communication

<table>
<thead>
<tr>
<th>INSTRUCTIONS ON CARDS</th>
</tr>
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<tbody>
<tr>
<td><strong>CARD 1</strong></td>
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<tr>
<td><strong>CARD 2</strong></td>
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<td><strong>CARD 3</strong></td>
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12.7 TRAINING SCHEDULE

DAY TWO

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Materials</th>
</tr>
</thead>
</table>
| 60 min | Refresher: Relationship building and interview skills | Appendix 12-A  
Key issues in building a relationship |
| | | Handout 12.9  
Golden rules for referral skills |
| | | Handout 12.10  
Contact list of agencies |
| 30 min | Tea break | Appendix 12-B  
Letter of informed consent |
| 30 min | Structuring the contact visit  
Preparations for role playing the contact visit  
Appreciation activity | |
| 30 min | Tea break | Appendix 12-C to 12-E  
Material for role-play assessment |
| 30 min per visitor | Role plays | |

Total: 2 ½ hours (excluding the individual assessment of role plays).
12.8 SESSION FOUR: REFERAL SKILLS

Teaching materials

- Basic
- Appendix 12-A: Key issues in building a relationship
- Handout 12.9: Golden rules for referral skills
- Handout 12.10: Contact list of agencies

12.8.1 Refreshing relationship-building skills

Because of the importance of relationship-building and interviewing skills we recommend that you provide a refresher on the training provided on Day One. At the end of this refresher give Appendix 12 — A: Key issues in building a relationship to the visitors.

- **Listening skills**
  
  Listen to what is said and also the manner in which the message is conveyed. It is important to hear very carefully what is being said. Asking the caregiver to repeat what she said too many times, could influence the interview negatively. Remember that you should listen more than you should speak.

- **Speaking skills**
  
  - Don't speak either too softly or too loudly.
  - Speak clearly and not too fast.
  - Your language should be clear.

- **Patience**
  
  The caregiver may fumble or hesitate to answer certain questions. Be patient and respectful and do not answer on behalf of the caregiver.

- **Probing**
  
  Encourage the caregiver to expand on her answers and to give more information. Do this in a way that will not create anxiety for the caregiver. E.g.: "Would you like to tell me more about this?"

- **Encouragement**
  
  This can be given non-verbally, with minimal language, or by longer expressions of empathy and understanding. The following are examples:

  - Minimal verbal expressions e.g. : "Mh ...."
  - Simple phrases e.g. : "I see..." or "Go on."

- **Immediate clarification**
  
  Ask for more information to explain an answer more clearly. For example you can say: "Earlier on you mentioned something about B and C, would like to elaborate on that?" Then you are most likely to get a positive response.
• **Establishing rapport**
  
  This refers to a comfortable, cooperative relationship between you and the caregiver. Respect for individual differences and dignity are key factors for effective relationships to flourish. A friendly approach is always desirable, but do not ask questions that may seem intrusive or too personal.

• **Empathy**
  
  It is important to feel what the other person is feeling, and understand these feelings. However, it is important not to leave the caregiver with the impression that she is pitiable; people rarely want this.

### 12.8.2 Referral skills

Since the visitor is living in the community, she may be well aware of the prevailing social problems in the community such as child abuse and neglect, alcohol abuse, woman abuse, drug use, poverty and unemployment. However this programme has not been developed to address these issues, and it is not expected of the home visitor to resolve all of the community’s social ills. At the same time we assume that the visitor is a caring person, and therefore we would not expect her to turn a blind eye when becoming aware of personal problems in a home. Visitors should use the following as guidelines with regards to social problems in homes. We recommend that you revisit the chapter 8 **ETHICAL CONSIDERATIONS** here to ensure that the visitors understand the ethics values that should be upheld during their visits.

• **At the closure of the visit**
  
  It is expected that at the closure of each visit, you will ask the caregiver if there are any other issues that she would like to discuss. At this point the caregiver may disclose a problem. Now is the time to use your relationship-building skills, such as showing empathy, effective listening, observing non-verbal messages as the caregiver is talking and gentle probing for more information. You should know the names of the different organisations and what services they offer, and may refer the caregiver to the appropriate organisation (see **Handout 12.10: Contact list of agencies**).

• **Becoming aware of a problem by observing what is happening in a house**
  
  An issue such as physical abuse or a drinking problem is difficult to miss. Depending on the relationship you have built with the caregiver, you may ask the person if she wants to talk about it. If you do not have that kind of relationship, it is best to consult with the supervisor on what you should do. If this is the case, remember that you should not reveal the identity of the caregiver without her consent, unless you are convinced that someone’s life might be in danger.

• **Learning from a neighbour about a problem**
  
  This situation should be handled very carefully, because when the caregiver finds out that her problems are discussed without her consent, it may not only terminate your visits to that house, but also damage the reputation of the programme. Do not start your own investigation on this, because sooner or later the caregiver may
become aware that you are trying to pry into her personal life. It is best to raise the issue with the supervisor. In your following visits you may be alert to signs that will tell you if there is truth in what you heard, but do not become prejudiced towards the caregiver. Do not let the information you received from a third party influence your genuineness and honesty in your visits to that house.

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**Activity 6**

Read **Handout 12.9: Golden rules for referral skills** with the visitors. This is to alert them to potential pitfalls when dealing with social or other personal issues they may encounter in homes.

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**Handout 12.9: Golden rules for referral skills**

**Golden rules for doing referrals**

1. Never do anything without the consent of the caregiver, unless the situation is life threatening.
2. Any social problems encountered in homes should be discussed with the supervisor without breaching the promise of anonymity to the caregiver.
3. When people experience problems, they very often are only in need of someone that is prepared to listen to them. By being willing to listen to a problem, you may already help a person.
4. When a situation in a house becomes too stressful for you, discuss this with the supervisor.
5. Do not pressure the caregiver to trust you with personal issues, but be available if you are needed.
6. When you do act on a problem, make sure that your information is sound; often our good intentions may lead to causing bigger problems for others.
7. Make sure that when asked for help that you do help. If it is not possible for you to do so be honest to the caregiver and supervisor about this.

Conclude the issue of doing referrals by discussing **Handout 12.10: Contact list of agencies**. This details the contact information of agencies that can be approached for help. Ask the group to add to the list, some of them may even know persons in such agencies that will be helpful in getting the cooperation of these agencies.

**Note:** We supplied national phone numbers of agencies where possible. Contact them to find out if they have offices close to your community. If some of these agencies do not have an office close by, you should explore whether alternative agencies are available in that area.
Handout 12.10:  Contact list of agencies

Contact details of organizations

Alcoholics Anonymous:  (011) 436-0116
Ambulance:  10177
Child line:  080 005 555
Children Accident Prevention Foundation of Southern Africa:  (021) 685-5208
* Clinic:
* Drug counseling agency:
Fire department:  1022
* Hospital:
HIV/AIDS Help line:  080 001 2322
Life line:
Paraffin Safety Association of South Africa:
People opposing women abuse (POWA):  (011) 642-4345
Poison control centre (Cape Town):  (021) 658-5428
SA Police Services:  10111
SA Police Services (Crime Stop):  086 001 011
Rape crisis:  (021) 447-9762 / 083 484 9409
Poison advice centre:  080 033 3444
Poison information (Redcross Children's Hospital):  (021) 689-5227
Poison information (Tygerberg hospital):  (021) 931-6129
Safe Schools project:  080 045 4647
* Shelter for abused women:
* Social worker:
Tough Love: (parental support group):  083 286 7270
Women abuse — Help line:  080 015 0150

* Get the contact numbers of the local agency.

12.9  SESSION FIVE: STRUCTURING THE CONTACT VISIT

Teaching materials

- Basic
- Appendix 12-B: Letter of informed consent
- Training Video

12.9.1 The sequence of activities

- Inform the caregiver about:

The purpose of your visit

The very first thing you need to do after introducing yourself and your organisation is to tell the caregiver about the programme in very general terms (helping people to
prevent unintentional childhood injuries in the home and the number of visits), and the reason for your visit (asking them if they are willing to participate). Only once the caregiver has agreed to participate, will you discuss the programme process in more detail.

What will happen with the information they share with you
They need to be told that the information obtained is confidential and also how that confidentiality is going to be guaranteed.

What they can expect from you and what you will be asking from them
Having a clear understanding of roles will help to create a good relationship. You will help them to understand the many risks in the home and share information on making things safer. Their role is to allow you to share this with them and also be willing to answer your questions.

- **Once the caregiver has indicated interest:**
  Now you can proceed with telling the caregiver about the programme in more detail. Remember what you have learned about honesty and not making empty promises. Advise the caregiver of the amount of time you will be spending during a visit and also get an indication of what days and times will suit her best. This information will help to plan and schedule the visits.

- **Getting informed consent to participate:**
  The letter of informed consent explains the nature of and format of the programme, as well as the issue of keeping information confidential. (Each letter has to have official address and telephone numbers for the organisation’s contact person.) This letter is essential to verify the home visitor’s authenticity. The visitors should be in possession of a copy of the letter at all times, indicating their identity, role and liability to the community.

  The final step is then to get the caregiver to sign the letter that is needed to prove that she fully understands the programme and will participate out of free will.

  At this stage hand out the letter (Appendix 12-B: *Letter of informed consent*) and read this with the visitors to ensure that they understand how to get informed consent. Be open to suggestions to improve the wording that may reflect cultural practices.

12.9.2 **General comments about the contact visit**
Ask the group to identify things they need to do before and during the contact visit. Ensure that they cover the following in their discussion.

- Dress appropriately and arrive on time. Despite the saying “Never judge a book by its cover” most people still believe that what they see from outside is what they will get from inside. So it would be wise for the interviewer to conform to the acceptable standards of the targeted group.
- Be prepared, stay on track, but allow for spontaneous discussion.
Before leaving remember to make an appointment for the next visit.
Don't forget to thank the caregiver for her time and participation.
Encourage the participation of the caregiver by stressing the importance of the work.

12.9.3 The training video
We recommend that you show the training video again, to refresh the visitors' memory of what is expected of them during the home visit. After having gone through the previous sessions on interviewing skills, they may have new insights into what should be done and what should not be done during the visit. We refer you back to Module Two where the way in which the video is to be used is discussed in detail.

12.9.4 Appreciation exercise
To end this session on a high note, we include an exercise to teach the visitors to appreciate one another. In the context of this work, the visitor will have to cope with many stresses caused by difficult caregivers, demands from the programme staff, and balancing their work in the programme with their daily chores at home. When their esteem is high, and they know that they have the support of their fellow visitors, they will be able to handle these stresses better. Expressing and receiving appreciation usually enhances our self-esteem. This exercise aids the process of noticing and valuing each other and each other’s differences.

Activity 7

Instruct the visitors to look around the room at the other visitors and notice one thing they like or appreciate about each other. They are to write the names of the other visitors and what they like of each one of them, on a piece of paper. They must not write their own names on the notes; each note is to be anonymous.

Example: "I like Patricia's strength in very difficult circumstances." or "I like Nomubulelo's smile" or "I like Nomazibulo's laughter"

Do this as quickly as you can for everyone and then hand the notes to the trainer who will distribute each person's notes to them. Everyone receives the comments that her fellow visitors made. Now let each visitor share one or two of the comments they really liked. Encourage everyone to share with the group. It's important to just share the information and say: "Thank you'. No editorialising or talking about the appreciation. Move the process along, keeping the group focused.

Discuss what it feels like to give and receive appreciations and compliments. End by thanking all those present for their participation.
12.10 SESSION SIX: INDIVIDUAL ASSESSMENT AND FEEDBACK OF THE CONTACT VISIT ROLE-PLAY

Teaching materials

- Appendix 12-C: Script and setting — Contact visit role-play
- Appendix 12-D: Scoring guide — Contact visit role-play
- Appendix 12-E: Scoring sheet — Contact visit role-play

Instructions

- Follow the role script and setting.
- It is important that feedback is given immediately after the role-play. Allow the visitor to talk you through her concerns about her performance.
- If the visitor performed badly then schedule a re-assessment once all the role plays are done or for the following day. DO NOT ALLOW THE VISITOR TO PROCEED WHEN YOU ARE IN DOUBT ABOUT HER COMPETENCIES FOR THE VISIT.

12.11 SESSION SEVEN: CLOSURE — VISITORS' CONCERNS

End the day's training by giving them the opportunity to address any outstanding issues. End on a positive and encouraging note: this will be the first visit with the expected anxiety in their minds. If you are confident about their competency, tell them.
13  Module four
Child development

Salla Munro and Loni Baadjies

13.1 AIMS

This module aims at:

- Providing the visitor with a basic knowledge and understanding of some of the key facets of child development.
- Identifying some of the important risks children may be exposed to due to their developmental characteristics.
- Preparing the visitors for the Child development visit.

13.2 OBJECTIVES

At the end of this module, the visitor should understand:

- The relationship between child development and unintentional injuries.
- The specific risks facing children at different ages.
- How different parenting skills can help to prevent injuries.

13.3 TRAINING SCHEDULE

**DAY ONE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 min</td>
<td>Understanding childhood injuries</td>
<td>Handout 13.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Injury triangle</em></td>
</tr>
<tr>
<td>30 min</td>
<td>Developmental stage 0-3 years</td>
<td>Handout 13.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Developmental stages: birth to 3 years</em></td>
</tr>
<tr>
<td>30 min</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Developmental stages (Cont.) 3-6 years</td>
<td>Handout 13.3</td>
</tr>
<tr>
<td></td>
<td>6-12 years</td>
<td><em>Developmental stages: 3 to 6 years</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handout 13.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Developmental stages: 6 to 12 years</em></td>
</tr>
<tr>
<td>Time</td>
<td>Content</td>
<td>Materials</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>30 min</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>40 min</td>
<td>Preparation for Day Two</td>
<td>Child visit material-1: Introductory information to share with the caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child visit material-2: Poster: “Milestones of Childhood”</td>
</tr>
</tbody>
</table>

**Total:** 3 ½ hours

### 13.4 SESSION ONE: UNDERSTANDING CHILDHOOD INJURIES

**Teaching materials**
- Basic
- Handout 13.1: *Injury triangle*

#### 13.4.1 Introduction

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**Activity 1**

Tell the group that the environment is usually designed for adults. Get the group to go on their knees on the floor. Ask each person to report how the environment changes for them. Would they have to reach high to get something off the table? Can they see anything on the floor that could cause an injury to a small child, something that would normally not be noticed by adults from their high perspective? (The trainer should have some objects on the floor) Do they think that for an inexperienced child, things close to the floor such as plugs, would seem interesting?

Remind the group that the point of the exercise is to remember that children are very different from adults; and that they see things from a different perspective than adults do. Not only are they physically smaller and have difficulty in functioning in an adult environment, but they are also not fully developed mentally and emotionally. Children are learning all the time and are very curious — sometimes it may be difficult for adults to keep up with children and to guess what they will do next!

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#### 13.4.2 Childhood injuries and child development

Children develop differently at each age. This development differs in terms of certain characteristics, i.e. the physical, emotional, mental and social skills and abilities that children have or don’t have at different ages. These developmental characteristics
cause the child to typically act in different ways at different ages. Their actions may then cause them to be more at risk for different injuries at different ages.

In general, injuries result from the interaction of three factors; namely the developmental characteristics of a child, a cause (or agent) such as an open flame, and the environment, e.g. the kitchen in a home. The following explains this. Give Handout 13.1: Injury triangle to the group.

**Handout 13.1: Injury triangle**

**INJURY TRIANGLE**

![Diagram of the Injury Triangle]

**CHILD**
- physical abilities e.g. a baby has little control over body movement
- developmental characteristics e.g. exploring the environment through touch and taste

**CAUSES OF INJURY**
- adult equipment that should be out of reach of children: knives, matches, stoves, medicines, paraffin
- child items that should be out of reach of very young children: climbing structures, toys, foods
- surfaces that should be inaccessible to children to fall onto or into: pavement, water

**ENVIRONMENTAL FACTORS**
- places and facilities: home, kitchen, water
- activities and time of day: late morning, evening when children are tired and hungry, and while adults are busy with other activities (e.g. cooking dinner, socialising, attending to another child)
- inadequate adult supervision: insufficient adult-child ratio, lack of knowledge of child development and safety, fatigue, alcohol and other drug use, stress

Ask the group to separate into smaller groups and think of examples where they know that the actions of the child, the environment in which they are and the injury cause may interact. Ask a representative of the group to report back to the team. The following examples may help to illustrate this relationship.
- A five year old child is playing in the kitchen, where the paraffin stove is placed on an unstable table while the mother is preparing a meal.
- A one year old child is being changed on a high table.
- An eight year old child is cycling to meet a friend.

13.4.3 Preventing childhood injuries

To prevent injuries from happening to children, we need to be aware of the kind of development a child is going through at different ages, and based on that and our knowledge of injuries, to turn the "injury triangle" into a safe situation.

In the *Injury Triangle*, two major factors, an unsafe environment and unsafe behaviours, bring the child and injury causes into unsafe contact, resulting in an injury. The *Injury Triangle* can be turned into a safe situation by making sure that children can have a safe environment and in trying to teach them safe behaviour. It is not always possible to teach a child safe behaviour — for example a small child of one year old cannot understand instructions. Therefore it is often up to the caregiver to make sure that the child cannot come into contact with dangerous things, and to give close supervision in unsafe places the caregiver can either prevent the child from coming into contact with the cause or allow the contact to happen in a safe manner.

Ask the group to think of the examples above and how a caregiver could ensure that no injuries happen to children in the examples they gave.

From the above we can see that the key steps to preventing childhood injuries include:
- Modifying and maintaining a developmentally-appropriate safe environment.
- Setting an example of the safe behaviours that children can follow.
- Teaching children and adults about safe behaviour.

Of these, modifying the environment to make it safer is usually the most effective way to prevent injury.

Children's risks to injury and the prevention measures needed, differ according to age. By understanding the developmental stages of a child, we can tailor injury prevention strategies to a child's particular age -and developmental stage. The sessions to follow are a discussion of the developmental stages of childhood that will be divided into three stages:
- The beginning years (birth to 3 years).
- Pre-school years (3 to 6 years).
- Primary school years (6 to 12 years).

Four areas of interest in the development of children will be used to discuss the changes taking place during the above-mentioned stages. These areas include:

- Physical development.
- Mental development.
- Emotional development.
- Social development.
Activity 2

Ask the group to remember the kind of injuries they had when they were children. What age did they happen? What was involved? How do they think that those injuries could have been prevented?

13.5 SESSION TWO: CHILD DEVELOPMENT STAGES: BIRTH TO 3 YEARS

Teaching materials

- Basic
- Handout 13.2: Developmental stages: birth to 3 years

13.5.1 The beginning years: birth to 3 years

- Physical development

This is extremely rapid during the first three years and especially during the first few months. For example, at four months, the average infant’s birth weight has nearly doubled (from between 2.7kg at birth, to between 5.4 and 6.8kg at four months). By the time babies are one year old, they weigh on average three times their birth weight. By the child’s second birthday, he or she will weigh about four times his or her birth weight. During the third year, the weight gain is still substantial, but less dramatic than in the first two years.
The child’s growth in terms of height follows a similar pattern, i.e. a very rapid increase in height during the first two years, followed by a slight slowdown during the third year. Obviously, the child’s physical development is largely dependent on whether or not he or she receives adequate nutrition. This change in physical ability, however allows the child to increasingly interact with his or her environment. At three months, infants can turn their heads and lift their chins as they lie on their backs. A four or six month old infant can grasp and hold things between their fingers or palms. Infants at nine months can stand on their own, and at about 13 months they may take their first steps. By the age of 3 years, the child can walk, jump and even run.

- **Mental development**

  Children in this stage may learn about the qualities of a small toy by looking at it, touching it, smelling it, and possibly by putting it into his or her mouth to taste it. Although this exploration of his or her environment is a valuable way for children to develop mentally, it may expose them to various risks, such as taking medicine that are within their reach, or trying to put their fingers in a open plug.

- **Emotional development**

  Over this period the child forms part of a bonding relationship with its parents or caregivers. The child smiles when recognising them. At this age children are concerned with satisfying their physical and emerging emotional needs. Children depend on their caregiver to provide for these needs and when caregivers fail to meet their needs, they develop a sense of mistrust towards their caregivers. They can comfort themselves by sucking on their thumb or pacifier.

- **Social development**

  Play is also an important aspect of learning for children and during the beginning years, they tend to play on their own with toys or objects in the environment such as small containers and empty plastic bottles. They will increasingly develop a greater sense of independence by free movement and the development of body control. This may be important, but simultaneously expose the child to risks when his or her caregiver is not attentive.

  The injuries that are common at this age are:

  - **Poisoning:** Small children like to put objects into their mouths, and are attracted to bright colours such as those used often on bottles of detergents and insecticides. They also like to imitate their caregivers’ actions, such as cleaning floors, but may not be able to do so — however they may still want to access the detergents caregivers use.
  - **Falls:** Children learning to walk are likely to fall when trying. Also, babies being changed may roll before caregivers expect them to, and fall off surfaces.
  - **Bums:** Children close to the caregiver when cooking may want to reach up to hot liquids, or to explore stoves and heaters. Also they may want to explore plug points and stick their fingers or other objects into them.
  - **Choking:** Inserting objects into the mouth can result in choking.
  - **Cuts:** Exploring things with their hands may result in cuts.
  - **Drowning:** Children left alone in the bath may drown.
### Activity 3

Questions for small groups

What other injuries can happen at this age? What could cause them? How could they be prevented?

Give each group a copy of the table (Handout 13.2: Developmental stages: birth to 3 years) and ask them to identify the possible injury risks and also explain why this is a possible injury risk.

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### Handout 13.2: Developmental stages: birth to 3 years

<table>
<thead>
<tr>
<th>Age</th>
<th>Physical development</th>
<th>Mental development</th>
<th>Emotional development</th>
<th>Social development</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td>- Has sucking and grasping reflexes</td>
<td>- Discovers that s/he has impact on environment (e.g. is s/he cries, caregiver will come)</td>
<td>- Recognizes caregiver</td>
<td>- Initiates social contact (e.g. smiles when caregiver appears)</td>
</tr>
<tr>
<td></td>
<td>- Reaches toward objects and grasps them</td>
<td></td>
<td>- Establish bonding with caregiver</td>
<td>- Develops a sense of independence through free movement</td>
</tr>
<tr>
<td></td>
<td>- Large muscle movement (arms and legs)</td>
<td></td>
<td>- Smiling and crying</td>
<td>- Play mostly on their own to familiarise self with environment</td>
</tr>
<tr>
<td></td>
<td>- Is able to follow objects and focus</td>
<td></td>
<td>- Very dependent on caregiver for fulfilment of needs</td>
<td>- Plays with own toys, or any object in their environment</td>
</tr>
<tr>
<td></td>
<td>- Rolls over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Rapid physical growth and change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6mths to 1½ years</td>
<td>- Sits by him/herself</td>
<td>- Curious about everything (explore his/her world)</td>
<td>- Does not like to be separated from caregiver</td>
<td>- Extends attachment to people other than caregiver</td>
</tr>
<tr>
<td></td>
<td>- Feeds self with spoon</td>
<td>- Realises an object can exist when out of sight and will look for it (e.g. drops things from chair and looks for it)</td>
<td>- Expresses several emotions clearly</td>
<td>- Developing some independence from caregiver (can meet some of his/her own needs, e.g. can feed him/her self and reach for objects)</td>
</tr>
<tr>
<td></td>
<td>- Has precise thumbs and finger grasp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Stands and walks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1½ years to 3 years</td>
<td>- Walks up and down stairs one step at a time</td>
<td>- Talks in sentences</td>
<td>- Can express feelings verbally</td>
<td>- Plays with other children</td>
</tr>
<tr>
<td></td>
<td>- Rides a tricycle</td>
<td>- Speech is understandable</td>
<td>- Can be separated from caregiver</td>
<td>- Washes and dries own hands</td>
</tr>
<tr>
<td></td>
<td>- Throws and kicks a ball</td>
<td></td>
<td>- Role of caregiver is crucial as child imitates adults' behaviour</td>
<td>- World expands beyond home to the outside world.</td>
</tr>
<tr>
<td></td>
<td>- Hold crayon with fingers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.5.2 Preventing injuries

There are many ways to prevent injuries to small children. One of the most important is supervision. However, it is not always possible to watch children all the time; therefore there should also be a safe area where children could be left for a short period of time. Also, the general environment should be made safer to make the task of supervising the child easier. In later sessions, more specific information will be given about the specific prevention measures for different injuries. Here a few are mentioned:

- **Poisoning**: Ensure that the bright and colourful objects available to children are safe; that all pesticides, paraffin, cleaning agents, medications and other poisonous substances are kept out of reach of small children.
- **Falls**: Ensure that children who are learning to walk have a safe surface to fall on, children will inevitably fall, but it is important to ensure that they do not hit their heads on something sharp or hard, such as sharp table corners. Also ensure that children are never on high surfaces such as a chair or table unsupervised. When changing a child, do not leave them unattended.
- **Bums**: Ensure that if the child is in the kitchen they cannot access anything hot. Keep heaters away from children. Teach the child that things are hot and should not be touched, if they are old enough to understand. Cover all plug points. Preferably do not have the child in the kitchen while cooking, but if it is necessary, have the child in a safe place. Do not drink or eat anything hot while the child is in your lap.
- **Choking**: Make sure that the toys you have for young children do not have small pieces that the children could remove. Buy age-appropriate toys. Keep small objects away from children's reach.
- **Cuts**: Try to reduce the sharp objects in your home. Clear away broken glass carefully and immediately. Supervise the child while they are exploring their environment.
- **Drowning**: Children at this age cannot bath unattended.

13.6 SESSION THREE: CHILD DEVELOPMENT STAGES
(3 TO 6 YEARS) AND (6 TO 12 YEARS)

Teaching materials

- Basic
- **Handout 13.3**: Developmental stages: 3 to 6 years
- **Handout 13.4**: Developmental stages: 6 — 12 years

13.6.1 The pre-school years: 3 to 6 years

- **Physical development**

The rate of growth is slower during the pre-school years than during infancy. However, changes in the proportions of the body are particularly noticeable during the pre-school years. At this stage of development, children show a variety of individual and sex-related differences, with boys developing more muscle per kilogram of body weight than girls. During this stage, children become significantly stronger because of rapid muscle and bone development.
• **Mental development**
  Children are very curious during this stage. They tend to want to know how things work, why they are done in certain ways. Their curiosity is their way of learning, but this can place them at risk of injuries because their appreciation of risks is limited.

• **Emotional development**
  Children can identify happy and sad faces. They are able to imitate their caregivers and they can be physically further away from their caregiver. The child in this stage can be overwhelmed by feelings; he or she can experience feelings of doubt and shame.

• **Social development**
  During this stage, the child is more concerned about gaining greater control over his environment. Certain gender differences also start showing after the third year. Boys are rougher at play and tend to be more aggressive, competitive and taking risks. Girls on the other hand tend to cooperate more with their parents and avoid rough play and fights. Children also start playing more with other children and take their play outside the home, e.g. in the garden.

The injuries that are common at this age are:

• **Falls**: Children can be clumsy as their body is developing fast. They are also extending their exploration of the environment to outside the home; therefore, they may climb trees, or other elevated structures; they may find it fun to jump off a cupboard onto the bed, and so on. Some children are learning to ride bicycles and fall off those.

• **Drowning**: Children may not have learned to swim yet. In their exploration of the environment, they may play near rivers, fall into open drains and so on. They also cannot bathe unattended, and may fall in the bath and drown.