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Original Research Article

Health Psychology Perspective of Child Counselling

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ABSTRACT

This article was developed based on the qualitative literature search with the intention of delineating childhood disease conditions in under-five children and how this can inform psychosocial counselling practice. In developing countries, several millions of children die before they reach their fifth birthday every year; and eight in ten of these deaths are due to neonatal conditions, pneumonia, measles, diarrhoea, malaria and severe malnutrition, or a combination of these diseases. This implies that a single diagnosis may not be possible or appropriate, and treatment may be complicated by the need to combine medications for several different diseases at the same time. It is plausible to infer that some sick children at health facility level are not properly examined and treated, and their parents are not adequately advised and guided, especially in rural communities where staffing and capacity of trained health personnel poses a gigantic challenge. It is in the context of these gaps that psychosocial counselling in health becomes an imperative desirability, particularly for purposes of improving the continuum of management and care. Providing quality care to children suffering from various disease conditions can be quite overwhelming. Therefore, there is need to promote and strengthen the management and care of childhood illness with aspects of nutrition, immunization, personal hygiene, environmental sanitation, prevention, health education, promotional advice, supportive care, and psychosocial counselling.

KEYWORDS: Health psychology, childhood illness, disease conditions, child counselling

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INTRODUCTION

This article explores disease conditions that adversely affect children below the age of five years that would require formal psychosocial counselling with regard to aspects of prevention, information, education, adherence to treatment and supportive care. Emphasis is placed on highlighting some disease conditions in under-five children from a health psychology perspective. In 1946 the World Health Organization (WHO) defined health as: 'the state of complete physical, social and spiritual wellbeing, not simply the absence of disease or infirmity'. While it is difficult to understand how a person can achieve 'complete physical, social and spiritual wellbeing', it is plausible to postulate that health is synonymous to disease. The traditional perspective suggests that health is not the opposite of disease, but it is a correlate to illness. The modern understanding of health is that it integrates more factors than those advanced by the WHO. Health is a state of wellbeing with biological, physical, psychological, sociocultural, economical, educational, spiritual and environmental aspects, not merely the absence of illness (Marks *et al*., 2010). This is a broader definition which suggests that a 'health status' is better measured on a continuum of wellness and illness. Viewed from a wellness-illness continuum, on one end is optimal wellness and on the other is death, with the middle point being neutral health status. Although all human beings live and eventually die, child deaths are particularly very shocking and devastating.

Optimal wellness is dependent upon very healthful signs and lifestyle, that is, optimal balance in biological, physical, psychological, sociocultural, economical, educational, spiritual and environmental needs. Death is a terminal state which occurs after a chronic illness, sudden injury, accident or physiological malfunctioning (such as coronary thrombosis, heart attack or asthmatic attack). The mid-point neutral health status integrates both parameters of wellness and illness that are contextually manageable and tolerable by degree of association, either at individual, family or group level. In this context, a person is regarded as enjoying 'good-enough health' even if he experiences occasional stress such as a traffic jam or mild headache due to a family discord. Equally, a person is not regarded as being in 'good-enough health' if his economic or nutritional needs are not satisfactorily met for the daily living. Between the neutral health status and terminal illness, there are average signs and symptoms that cause illness but are manageable to restore the neutral health status. This is the basic principle for treatment of illnesses, physical exercise, nutritional balance, health promotion, and prevention of diseases.

When the treatment or healing fails, then a person advances to major disability from illness and eventually dies. Sedentary life precipitates physiological malfunctioning that may lead to illness or sudden death. Obese people are not fundamentally healthy because their status renders them vulnerable to lifestyle diseases and psychological distress that could be fatal (Braisby and Gellatly, 2012; Schneiderman, Antoni, Saab and Ironson, 2001). Children between the ages of 0-5 years are very prone to illness because their immune systems are not yet fully mature and their nutritional needs can easily be compromised. Because infants have a habit of exploring the world around them with their hands (as they craw) and mouths (eat anything they pick), this means that they easily come into contact with harmful elements in the environment that can cause illness or accidental injury. Depending on the nature of illness and its prognosis however, most older-children (i.e. above six years of age) have an inclination and resilience to quick recovery than adults; and most of them die from accidental injury than chronic diseases characteristic in adults (Costello, Mustillo, Erkanli, Keeler and Angold, 2003; Sarafino and Smith, 2011).

A person's optimum state of health is equivalent to the set of conditions which fulfill or enable the person to achieve his realistic chosen and biological potentials. Some of these conditions are of the highest importance to all people, while others are variable and dependent upon individual abilities and potential. In other words, in addition to universal conditions (for all people) there are also specific conditions for different individual situations and circumstances (Berns, 2010). For instance, a person with a mental disorder or physical disability or terminal disease or an expectant mother will have each specific requirements, priorities, needs and environments. A healthy environment provides safety, opportunities for social integration, and the ability to predict or control aspects of that environment; whereas an unhealthy environment threatens safety, undermines the creation of social ties, and is perpetually detrimental to optimal wellness (Taylor, Repetti and Seeman, 1997). It is plausible to infer that support and care are critical factors primarily because children are dependent upon their parents, guardians or older siblings for survival in their daily life as well as when they are ill. Physical health and illness are inextricably interwoven with the psychological and social environments (Walker, 2002). From this viewpoint, health becomes the thing that a person achieves through adequate attention to biological, physical, psychological, sociocultural, economical, educational, spiritual and environmental needs rather than something that is taken for granted. The equation of wellness-illness is partly dependent upon variable factors as well as the people's perceptions and reactions to such factors (Taylor, 2008). This has serious implications for child health.

Human beings are complex systems and illness can be caused by a multitude of factors, not just a single factor

such as a virus or bacterium. A multiple combination of factors involved in illness are biological (virus, bacterium, fungus, lesion), psychological (behaviours, beliefs, attitudes, perception) and social (environment, illiteracy, poverty, unemployment), hence the ***biopsychosocial*** model of defining wellness and illness (Hewstone, Fincham and Foster, 2005). This broader view allows analyses, diagnosis and treatments of illnesses and injuries to incorporate multiple factors that might influence patients and their recovery, including improving the healing process to attain the neutral health status (Snooks, 2009). The biopsychosocial model is integrative in orientation and looks at treating the person as a whole, that is, biologically, physically, psychologically, socioculturally, economically, educationally and spiritually within his environmental context. In addition to treatment of any presenting physical illness, other measures include behaviour change, changes in erroneous beliefs and attitudes, adaptive coping strategies, nutrition care, and adherence counselling for appropriate medical recommendations. The model emphasized on proactive interventions directed towards disease prevention, promotion of healthy behaviours and beliefs, prevention of accidental injury or death, and environmental improvements (Cummings and Kropf, 2013; Sarafino and Smith, 2011); and improved social relationships and support from family members and friends through enhanced psychosocial counselling (Brown and Lent, 2008; Woodward, 2015).

The other interventions include changing people's lifestyles to prevent the onset of illness and rehabilitation facilities; supportive resources provided by other people or an exchange of resources intended to enhance the well-being of children; and maintaining close personal relationships with others which acts as a social resource factor that protects against illness and premature death (Baron *et al*., 1990; Pawlik and Rosenzweig, 2000). The psychosocial aspect of this model describes the way in which human behaviour and experiencing help to mold wellness and illness (Marks *et al.*, 2010; Ogden, 2004). The role of a counsellor is to address the behavioural and social factors that impair the children's normal functioning in society through systematic preventive counselling, health education, and promotional advice or advocacy. In chronic disease and related adverse conditions, the counsellor should provide supportive care and adherence counselling, including social guidance to the affected children through their parents or guardians or older siblings (Jordans, 2003; Sharf, 2012).

Selected disease conditions

Developmental psychologists have studied children's growth and development focusing on the effect of childhood experiences in adulthood, child psychiatrists have focused on mentally disturbed children, and counselling psychologists have a special interest in children with learning, psychosocial, behavioural and health problems (Alloy, Riskind and Manos, 2005; Chiboola, 2018; Hurlock, 2011). In developing countries, several millions of children die before they reach their fifth birthday every year; and eight in ten of these deaths are due to neonatal conditions, pneumonia, measles, diarrhoea, malaria and severe malnutrition, or a combination of these diseases (WHO, 2012). The WHO indicate that these disease conditions will continue to be major contributors to child suffering (morbidity) and deaths (mortality) beyond the year 2030 unless significantly greater efforts are taken to prevent and control them. In some developing countries, three in four episodes of childhood illness are caused by one of the instanced disease conditions; and most sick children present with these signs and symptoms are related to more than one disease (WHO and UNICEF, 2005). This overlap implies that a single diagnosis may not be possible or appropriate, and that treatment may be complicated by the need to combine medications for several different diseases at the same time. It is plausible to infer that some sick children at health facility level are not properly examined and treated, and their parents or guardians are not adequately advised and guided, especially in rural communities where staffing and capacity of trained health personnel poses a gigantic challenge.

Effective case management is only possible in situations where parents access early medical intervention for their sick children and counsellors provide proactive preventive counselling, supportive counselling and adherence counselling to the parents, caregivers and communities as a comprehensive continuum of care. The role of counsellors is to advise and guide parents on the importance of seeking early medical intervention, teaching and informing parents on how to care for a sick child at home, guidance to parents on how to solve feeding problems for sick children, advising parents when to return to the heath facility for review visits, and informing parents and communities on the importance of prevention and health promotion as conduits to optimal wellness, among other factors. From a health psychology perspective of child counselling, the selected disease conditions in under-five children are: neonatal conditions, pneumonia, diarrhoea, malaria, paediatric retroviral disease (AIDS in children), malnutrition, immunizable childhood diseases, and cholera. These disease conditions have been selected because of the high morbidity and mortality they cause in the under-five children not only in Zambia, but in many other developing countries worldwide as well.

Neonatal conditions

Neonatal conditions refer to health problems that affect infant children during their first month of life after birth; and they include premature birth, neonatal infections and

birth asphyxia (UNICEF, 2012). The first month of the infant's life is very critical because it accounts for a remarkable number of all deaths in children below the age of five years. Premature birth is defined as all births before 37 weeks of pregnancy or fewer than 259 days since the first day of a woman's last menstrual period. Complications of premature birth are the single largest contributor to neonatal deaths; and premature babies lack the necessary physical development which often requires special care and support. Survivors of premature birth may face greater risks of non-communicable diseases, and they may suffer lifelong effects such as impaired neurodevelopmental functioning, physical impairments in visual, hearing, lung and cardiovascular functioning (Setiawan, 2013).

Neonatal infections include disease conditions such as tetanus, sepsis, pneumonia, diarrhoea, and meningitis. Neonatal sepsis and meningitis are caused largely by bacterial germs that are transmitted to the infant baby by the mother during delivery. Having a catheter in a blood vessel or staying in the hospital for an extended period increases an infant's risk of sepsis after delivery. The chances of survival are reduced for infants with a serious infection regardless of whether or not they are hospitalized; and the complications of neonatal sepsis and meningitis may lead to lifelong disability or death. Birth asphyxia is the failure to establish breathing or perfusion at birth; and it accounts for the complication of low oxygen intake that may include damage to the brain tissues which causes seizures and other neurological problems, lifelong disability or premature neonatal death (Setiawan, 2013).

The primary agenda for psychosocial counselling related to childhood neonatal conditions should be social guidance, educational and promotional advice, based on the following key messages:

- Risk factors for premature birth include age, multiple pregnancy, infection, maternal illness, psychological health and preparedness, nutritional, lifestyle and genetics. Mothers and fathers must be advised to dissuade or discourage their teenage children from early marriage and accidental pregnancy.
- Expectant mothers and fathers must be advised on the importance of maternal health and antenatal clinics, as well as the need to seek early medical intervention when delivery is due, including promotion of delivery at the nearest health facility.
- Mothers and fathers must be advised on the importance of seeking early medical intervention for treatment of maternal illness to avoid mother-to-child transmission during delivery.
- Mothers and fathers must be advised on the importance of family planning as an integral component of wellness at family level.
- Communities must be sensitized on the adverse effects of child marriage and the promotion of traditional values and morals on human sexuality.

Pneumonia

Pneumonia is a form of acute respiratory tract infection (ARTI) that affects the lungs and presents with severe chest pain, difficulty breathing, and dry cough, amongst many other symptoms. Pneumonia is the single leading cause of child deaths in every region of the world, with most deaths occurring in sub-Saharan Africa and South Asia (Tong, 2013). Pneumonia is mainly caused by bacteria and viruses, and it is preventable through immunization with *Haemophilus influenzae type b* vaccine (UNICEF, 2012). Pneumonia can affect all age groups in a community, but children up to the age of five years and adults above 65 years are more susceptible to infection. Additionally, people suffering from chronic heart and lung disease, sickle cell anaemia, and retroviral disease (AIDS) are also at increased risk for pneumonia. Whereas healthy children have strong natural defenses that protect them, undernourished children are at a higher risk of developing pneumonia because of their compromised natural defenses due to illness.

The primary agenda for psychosocial counselling related to childhood pneumonia should be educational and informational, based on the following key messages:

- Childhood pneumonia is preventable. Mothers and fathers must be advised on the importance of immunization for pneumonia.
- Mothers and fathers must be advised on the need to seek early medical intervention when their children are sick with pneumonia.
- Mothers and fathers must be advised on the need to avoid overcrowding children in sleeping rooms.
- Mothers and fathers must be guided on the importance of adherence to the care and treatment plan for their sick children.
- Mothers and fathers must be advised on best practices related to feeding options for their sick children.

Diarrhoea

Diarrhoea is defined as having loose or watery stool at least four times per day, or more frequently than normal for an individual child. Although most episodes of childhood diarrhoea are mild, acute cases can lead to significant fluid loss and dehydration which may result in other complications if fluids are not replaced systematically. Acute diarrhoea and severe dehydration can cause death if not treated promptly. Diarrhoea is a common symptom of gastrointestinal infections caused by

many germs such as bacteria, protozoa and viruses. Rotavirus is the leading cause of acute diarrhoea, and it is responsible for almost 40 percent of all hospital admissions diarrhoea amongst children under-five years of age worldwide (UNICEF and WHO, 2009). Most diarrhoeal germs are spread from the stool of one person to the mouth of another through contaminated water, food, or objects.

There are three main types of acute childhood diarrhoea, all of which are potentially life-threatening and require different treatment regimens: acute watery diarrhoea is associated with significant fluid loss and rapid dehydration in an infected child; dysentery which is marked by visible blood in the stool; and persistent diarrhoea that lasts at least 14 days or more (UNICEF, 2012). Undernourished children and those with paediatric retroviral disease are more likely to develop persistent diarrhoea, which worsens their already compromised condition. Diarrhoea is a common manifestation of human immunodeficiency virus (HIV) infection in both children and adults due to deteriorating immune system and frequent attacks by opportunistic infections. Children with poor nutritional and health status as well as those living in poor environmental conditions are susceptible to severe diarrhoea and dehydration than healthy children. Diarrhoea can have a detrimental impact on childhood growth and psychosocial development.

The primary agenda for psychosocial counselling related to childhood diarrhoea should be educational, informational and promotional advice, based on the following key messages:

- Exposure to diarrhoea-causing germs is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of faecal matter (excreta). Mothers and fathers must be advised on the importance of drinking safe water, eating properly prepared food, and living in clean environments.
- Mothers and fathers must be advised on the need to promote healthy behaviours and practices such as washing hands with soap or detergent before eating food and after toilet, avoiding raw foods during diarrhoeal outbreaks, and avoiding open defecation. Disposal of children's faeces is equally very important.
- Diarrhoeal episodes are frequently accompanied by vomiting which may adversely affect the child's appetite for food. Mothers and fathers must be advised on helpful feeding practices in childhood diarrhoea.
- Mothers and fathers must be encouraged to seek early medical intervention every time their children develop diarrhoea.
- Communities must be sensitized and motivated to utilize available child health and care services, including the promotion of sustainable personal hygiene, food hygiene, and environmental sanitation.

Malaria

Malaria is caused by parasites transmitted by female anopheles mosquitoes, which bite usually between dusk (early evening) and dawn (just before day break). The malaria-causing mosquitoes become active and troublesome during the night, and there are also other types of mosquito that bite even during day time. In Zambia for instance, there are plenty of mosquitoes in almost all districts, and malaria is an endemic disease in most villages and communities countrywide. Consequently, it is manifest that both children and adults suffer from malaria occasionally. The initial symptoms of malaria are nonspecific and may be related to other infections such as headache, fatigue, abdominal pain, muscle and joint aches. Progressively they comprise of fever, chills, perspiration, vomiting and worsening malaise; and in young children, malaria may also present with poor feeding and coughing.

Malaria is easily preventable and treatable. However, if ineffective or poor-quality medicines are given or treatment delayed, the parasite burden continues to increase and the patient may develop severe malaria (UNICEF and WHO, 2009). Young children, expectant women and people who are immunosuppressed are particularly at high risk of severe malaria. Expectant women with severe malaria are at increased risk of miscarriage, stillbirth and maternal death. Severe malaria is usually present with one or more of the following conditions: cerebral malaria, severe anaemia, acute renal failure or acute pulmonary oedema. In Zambia for instance, malaria accounts for up to 40 percent of all infant mortality and 20 percent of all maternal mortality (MOH, 2008); and it poses a severe social and economic burden on people living in endemic communities (CSO *et al.*, 2009). In many developing countries where malaria is both endemic and an important contributory cause of death in infancy specifically and childhood generally, presumptive treatment of fever with antimalarial medication is advocated because it is cost-effective and efficacious (WHO, 2015).

The primary agenda for psychosocial counselling related to childhood malaria should be educational, informational and promotional advice, based on the following key messages:

- Encourage mothers and fathers to seek early medical intervention every time they notice signs and symptoms of sickness in their children.
- Encourage and advise mothers and fathers on the importance of feeding options for sick children.

- Encourage individuals and families to be proactive in undertaking preventive activities such as cutting tall grass and emptying water in unusable containers within the surroundings of their homes, particularly during the rainy season.
- Encourage all individuals, especially young children and expectant women, to acquire and regularly use insecticide-treated mosquito nets during bedtime every day throughout the year.

Paediatric retroviral disease

Paediatric retroviral disease is more aggressive, with a significant proportion of children presenting with symptoms in early infancy and a small proportion presenting after infancy (Lachman, 1991). Children with retroviral disease usually present with recurrent clinical episodes of common conditions such as pneumonia, persistent diarrhoea, and failure to thrive. They die in early childhood, most of them are undiagnosed, particularly in rural communities with health provision challenges. Almost 95 percent of HIV infections in children are acquired through mother-to-child transmission during pregnancy, delivery or breastfeeding; and approximately slightly over one third of HIV-infected children die by the age of one year, and over half die by the age of two years (USAID and BASICS, 2007). Estimations of child morbidity and mortality due to paediatric retroviral disease keep increasing annually, suggesting that this problem will continue to erode many of the hard-worn gains in lowering rates of childhood illness and death thereby posing a public health threat.

HIV infection in children is preventable through interventions of prevention of mother-to-child transmission (PMTCT) and antiretroviral treatment (ART). Efforts to expand care and treatment for children ought to go hand-in-hand with efforts to rapidly improve the uptake of PMTCT services. High rates of maternal HIV infection, high birth rates, lack of access to recommended best practices, and the widespread practice of prolonged breast-feeding translate into a high burden of paediatric retroviral disease not only in Zambia, but many other countries in Africa as well (Tindyebwa *et al.*, 2006). The fast rate of HIV progression and the high morbidity and mortality in infected children aged below five years means that identifying these children and enrolling them in care and treatment programmes should be considered as an emergency and of extreme importance as a public health requirement.

The primary agenda for psychosocial counselling related to paediatric retroviral disease should be educational and informational, promotional advice and adherence counselling, based on the following key messages:

- Mothers and fathers must be encouraged to proactively seek and fully utilize PMTCT services at the right time (when they decide to have a baby) and for the duration of pregnancy (without defaulting).
- Mothers and fathers must be adequately informed on the significance of adherence to the care and treatment plan in the context of PMTCT and ART. Non-adherence affects drug efficacy and resistance.
- Prolonged breast feeding increases the infant's risk of acquiring HIV infection. Mothers and fathers must be encouraged to exclusively breast feed their infants for short periods or provide alternative feeding options when financial resources are available.
- Paediatric retroviral disease is manageable through treatment. Mothers and fathers must be encouraged to access ART for their infected children and themselves, as well as adhere to the prescribed care and treatment plan without defaulting.
- Communities must be sensitized on the importance of universal preventive measures for HIV infection and care services for children.
- Communities must advocate for the protection and support of children with or affected by paediatric retroviral disease.

Malnutrition

The term malnutrition refers to a deficiency of nutrition, that is, both to under nutrition (inadequate nutrition) and over nutrition (excessive nutrition) that result into illness. Many factors can cause malnutrition and among these relate to poor diet or severe and repeated infections, prolonged illness, and inadequate food particularly in under privileged population groups globally (Blossner and de Onis, 2005). Inadequate food and endemic disease are closely associated and linked to the general standard of living, environmental conditions, and capacity of individuals, families, communities and nationalities to meet their basic needs for livelihood and survival. Although it is rarely the direct cause of death (except in extreme famine situations), childhood malnutrition is associated with increased prevalence of child mortality in most developing countries presently, which is further compounded by worsening poverty and food inadequacy at family and community levels (UNICEF, WHO and WORLD BANK, 2012). It is plausible to deduce that malnutrition is both a health outcome and a risk factor for disease, more so in children under five years of age. Although malnutrition commonly affects all age groups, infants and younger children are the most vulnerable because of their high nutritional requirements for growth and psychosocial development as well as dependence on parents or guardians for provision of the needed food to enhance their survival, livelihood and nurturance.

The nutritional status of women and children is very important because it is through them that the adverse

effects of malnutrition are propagated to future generations. The malnourished expectant mother is likely to give birth to a low-birth-weight baby that would be susceptible to growth failure, impaired mental development, disease and premature death (Felitti and Anda, 2009). This compounds the economic development of the family and society, and perpetuates the intergenerational circle of poverty and malnutrition (Hernandez, 2003). Adequate nutrition is essential in early childhood to ensure healthy growth, proper organ formation and function, a strong immune system, and cognitive development (UNICEF, WHO and WORLD BANK, 2012). Child malnutrition adversely impacts cognitive functioning, contributes to poverty through impending individual's inability to lead a productive life, and contributes to a remarkable number of under-five deaths attributable to under nutrition and other compounding factors. This has psychological implications for child health.

Growth monitoring measures the growth level of a child on a monthly basis from birth until five years of age. The purpose of growth monitoring is to check whether or not the child is growing normally and healthily as well as to detect stuntedness (growth retardation) and underweight (failure to thrive). Underweight signifies that the child is either malnourished or diseased. When the child is not growing well or losing weight, there is urgent need to redress this development because it could lead to fatality. It is common knowledge that access to good nutrition is a major and cross-cutting determinant of good health. Presently, malnutrition underlies more than half of all under-five deaths, stunting rate in under-five children is close to half of all reported cases, and micronutrient deficiency rate is equally high (CSO *et al.*, 2009). Micronutrient deficiency contributes to functional anaemia and iodine deficiency disorders.

The primary agenda for psychosocial counselling related to childhood malnutrition should be educational, informational and promotional advice, based on the following key messages:

- Malnutrition is closely linked to and has an effect on many other childhood diseases. Mothers and fathers must be encouraged to learn better ways of improving their children's diet specifically and that of the family generally. Sharing information and experiences is a useful avenue in this regard.
- Malnutrition is preventable. Mothers and fathers must be advised to give balanced foods in enough quantities and at the right times to their children every day. It is essentially necessary to promote and sustain the utilization of locally available foods through nutrition counselling.
- Mothers and fathers must be advised on the importance of growth monitoring as a barometer for detection of underweight or stunted growth. These have a symbiotic link with malnutrition.
- Improving the child's diet might lead to appreciable weight gain and improved wellness. Mothers and fathers must be encouraged to seek early medical intervention when their children are losing weight, stunting, or sick.
- Mothers and fathers must be encouraged to attend health education and promotional talks, including cooking demonstrations at health facility level when advised to do so by health professionals or providers.

Immunizable childhood diseases

The WHO guidelines for vaccinating children through the expanded programme on immunization have been largely successful in ensuring that all children gain access to this service at country level (CSO *et al.*, 2009). The service is offered routinely at under-five clinics and regularly through outreach programmes; whereas infant babies start accessing the service soon after birth at maternity clinics with the initial tuberculosis and poliomyelitis vaccinations. Immunization is the process of giving preventive medicine or vaccines by injection or orally to children aged 0-5 years. The vaccines make the body produce antibodies that protect children (and adults) from getting a particular disease. Table 1 shows the common immunizable childhood diseases: tuberculosis (BCG), diphtheria, pertussis and tetanus (DPT), hepatitis B/haemophilus influenzae type b (HepB-Hib), poliomyelitis (polio), measles and rubella. Since the year 2006 in Zambia for instance, DPT is given as combination vaccine with HepB-Hib (DPT-HepB-Hib); and in 2016 the Ministry of Health introduced a combination vaccine for measles and rubella. Neonatal tetanus is prevented by immunizing all expectant women with tetanus toxoid (TT). At least two dosages are recommended during the first pregnancy and three more each year or during each subsequent pregnancy. It might be of public health value to routinely vaccinate girl-children aged nine years and above with human papilloma virus (HPV) to prevent against cervical cancer in adulthood.

Table 1: **Immunization schedule**

When Started	Vaccine	Dosage	Disease	Remarks
At birth	BCG+	1	Tuberculosis	Revaccination at 5-7 years.
At 6 weeks	DPT-HepB-Hib++	4	DPT-HepB-Hib	-2nd and 3rd dosage given at 4-6 week intervals. -Revaccination at 18 months.
At birth	Polio*	4	Poliomyelitis	-2nd and 3rd dosage given at 4-8 week intervals. -Revaccination at 18 months.
At 9 months	Measles-Rubella**	1	Measles & Rubella	-Presumed life long -Revaccination as directed or during epidemic

\+ Revaccination advisable if there is no scar
++ Four vaccines combined in one. Revaccination advisable during disease outbreak
* Four dosages are sometimes recommended with first dosage at birth
**Two vaccines combined in one. Revaccination advisable during disease outbreak.

Immunizations should be started as soon as the child is born and be continued as scheduled until all the required dosages are given at the right time by the age of five years. Equally, repeat dosages must be given as indicated and, when desirable, children must be revaccinated without fail especially during disease outbreak. Immunizable childhood diseases are fatal: they cause suffering, disability and death if acquired and remain untreated. In Africa generally and Zambia in particular, many children suffer from preventable and immunizable childhood diseases and, out of these, some usually die. The livelihood of under-five children is anchored upon their parents, guardians or older siblings depending on varying situational and environmental circumstances.

The primary agenda for psychosocial counselling related to immunizable childhood diseases should be educational, informational and promotional advice, based on the following key messages:

- Under-five childhood diseases are preventable. All childbearing mothers and fathers must ensure that their children get fully protected against the listed immunizable diseases.
- Incomplete dosage of any vaccine does not guarantee full protection of the child. Mothers and fathers must be encouraged to complete the immunizations as scheduled.
- Each vaccination only works for a particular disease as reflected in the immunization schedule. Mothers and fathers must be encouraged to check with their health professionals or providers to ensure that all vaccinations are given to their children at the right time.
- Children should receive booster dosages for polio and DPT-HepB-Hib at eighteen months or whenever necessary as indicated by the relevant authorities such as during immunization week, disease outbreak, or school health day. Mothers and fathers must be advised on the need to abide by such directives in order to promote and sustain good health for their children.
- Delayed and irregular vaccinations may adversely affect the uptake of vaccines according to approved timeframes. Mothers and fathers must be encouraged to cooperate with health professionals or providers and develop positive attitudes that foster promotion of a common good for the children's health.
- Mothers and fathers must be informed and encouraged to be vaccinated with tetanus toxoid to prevent neonatal tetanus during pregnancy.
- Communities must be sensitized and provided with information on the importance of prevention of immunizable childhood diseases.
- The expanded programme on immunization must be adequately supported and promoted as a viable intervention to fostering child health.

Cholera

Cholera is caused by a germ called ***Vibrio cholerae*** and it is characterized by vomiting, profuse diarrhoea with rice-water stools, severe dehydration, toxaemia, muscular cramps, and suppression of urine. It spreads very rapidly and it is fatal. Cholera is a notifiable and internationally quarantinable disease; and it is highly contagious such that for every typical case there could

be several-dozens, other symptomless carriers excrete cholera germs within the locality (Lucas and Gilles, 1980). The reservoir of infection is a sick person, convalescent patient or human carrier (i.e. a person carrying the cholera germ but not suffering) through the faeces or vomit. Cholera also spreads by close contact, contaminated food, flies, and inanimate objects such as utensils and beddings. In order to flourish, cholera requires a combination of four factors: dense population, unsafe water, poor environmental sanitation, and human carriers.

Although cholera usually spreads during the rainy season due to poor environmental conditions, in Zambia for instance, the most recent epidemic occurred in October 2017 at the peak of the dry season. This development suggests that cholera is slowly transforming into an endemic disease for reasons yet to be explored and reported through epidemiological research. This is a source of great concern, especially in the context of child counselling. According to the Zambian Ministry of Health briefings, between early October 2017 and end of February 2018 a total of slightly over 4,000 cases of cholera were reported countrywide, of whom close to 1,400 (35%) were children. This state of affairs is tragic. Cholera is a disease of special concern because of its virulence and adverse effects on under-five children.

The primary agenda for psychosocial counselling related to childhood cholera should be educational, informational and promotional advice, based on the following key messages:

- Mothers and fathers must be encouraged to seek prompt medical intervention every time their children develop signs and symptoms of cholera.
- Since exposure to cholera is frequently related to contaminated water and unhygienic practices in food preparation and disposal of faecal matter, mothers and fathers must be advised on the importance of drinking safe water, eating properly prepared food, using toilets for faecal disposal, and ensuring hygienic disposal of their children's faeces.
- Mothers and fathers must promote healthy behaviours and practices for themselves and their children such as washing hands with soap or detergent before eating food and after toilet, avoiding raw foods during cholera outbreaks, and avoiding open defecation. Living in clean environments is equally very important.
- Individuals, families and communities must be encouraged to seek prompt medical intervention when cholera infection is suspected or confirmed; and to abide by all directives and guidelines issued by the relevant authorities.
- During cholera outbreak, parents and their children must be encouraged to observe personal hygiene with sustained washing of hands to avoid contamination; and during large gatherings, all individuals should be dissuaded or discouraged from unnecessary handshakes.
- During cholera outbreak, communities must be encouraged to follow the prescribed preventive and curative measures advocated by the relevant authorities in order to reduce anticipated high morbidity and mortality rates at all levels of contact.
- Communities must be sensitized on the promotion of sustainable personal hygiene, food hygiene, toilet hygiene, and environmental sanitation.

CONCLUSION

This article has delineated some disease conditions in under-five children that have an interface with psychosocial counselling practice. It is manifest that illness impairs the normal functioning of the body, soul and mind; and for most children below the age of five years, illness is an alien anathema. In a majority of cases children don't know what is wrong, what is happening, why they cannot eat, why they cannot play, why they are taking medicines, and why they are distressed or miserable or irritable. Most children become distressed when they are sick and this heightens their anxiety, despondence and discomfort. The longer they remain ill, the greater they become psychologically distressed and emotionally disturbed. Childhood illness evokes many psychosocial issues in the sick children and their parents or guardians, including other family members. It is in the context of this understanding that psychosocial counselling in health becomes an imperative desirability and practically relevant, particularly for purposes of improving the continuum of management and care. Providing quality care to children suffering from various disease conditions elucidated herein can be a gigantic challenge and quite overwhelming. In response to this challenge, and in recognition of the valuable role of curative care, there is need to promote and strengthen the management of childhood illness with aspects of nutrition, immunization, personal hygiene, environmental sanitation, prevention, health education, promotional advice, supportive care, and psychosocial counselling. The continuum of management and care should integrate the various aspects to enhance the children's wellness and livelihood as a public health requirement and for a common good of the society.

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