Visual motor integration delay in preschool children infected with HIV

Ramona Odejayi, BSc OT (Wits); MSc OT (Wits) http://orcid.org/0000-0002-3353-766X
Occupational therapist, Northcott, Sydney, Australia
Postgraduate student, Department of Occupational Therapy, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand

Denise Franzsen, BSc OT (Wits), MSc OT (Wits), DHT (Pret) PhD (Wits) http://orcid.org/0000-0001-8295-6329
Sessional Senior Lecturer, Department of Occupational Therapy, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand

Patricia De Witt, Nat. Dip. OT (Pretoria); MSc OT (Wits); PhD (Wits) http://orcid.org/0000-0003-3612-0920
Sessional Adj Professor, Department of Occupational Therapy, School of Therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand

ABSTRACT

Introduction: It is estimated that more than 200 000 children under the age of 14 years are living with human immunodeficiency virus (HIV) in South Africa. These children - including those on antiretroviral therapy - may present with neurocognitive delay and may find it difficult to participate in educational activities. This study aimed to determine the extent of the delay of visual motor integration (VMI) which correlates significantly with academic achievement in preschool children with vertically transmitted HIV.

Method: This was a descriptive quantitative study in which 71 children infected with HIV aged between 5 - 6 years, attending a HIV clinic in South Africa, were assessed using the Beery Developmental Test of Visual Motor Integration (DTVMI). The results were compared to the normative DTVMI scores, and correlated with health factors related to HIV such as CD4 count and socioeconomic factors such as attendance at crèche or preschool and mother’s level of education.

Results: Results confirm that a delay exists in VMI and visual perception (VP) in the at risk category. Mean scores on the motor coordination (MC) fell in the average range. Visual perception was the most affected in this sample with an average delay of between 11 and 17 months found. Visual perception also showed a moderate positive correlation with CD4 count, while VMI had a moderate relationship to attendance at crèche or preschool and mother’s level of education.

Conclusion: This study confirms children with HIV are at risk for neurodevelopmental delay related to visual motor integration and visual perception, particularly in children with a low CD4 count. These aspects need to be assessed as part of routine neurodevelopmental monitoring.

Key words: Neurodevelopmental delay, HIV, preschool children, visual motor integration delay, visual perception delay, motor coordination

INTRODUCTION

Human Immunodeficiency Virus (HIV) causes a chronic condition that impacts the immune system resulting in infections and lifelong dependence on medication for survival. The growth and health as well as the economic and food security, psychosocial care, education and family composition of children with the virus are also affected. The estimated number of children living with HIV globally in 2018 was 2.1 million and at the time, it was estimated that 260 000 of these children (aged 0 to 14) were living in South Africa, with only 58% on treatment. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) new infections in South African children declined from 25,000 in 2010 to 13,000 in 2017. This could largely be due to the increase in the prevention of mother to child transmission (PMTCT) which reduced vertical HIV infections at birth from 3.6% in 2011 to 1.3% in 2017. The National Strategic Plan for HIV, TB and STIs 2017-2022, aims to renew the focus on children with HIV and their families to reduce this rate even further.

Although not yet optimal, the increase in the number of children in South Africa receiving antiretroviral therapy (ART) is due to the revision of the ART guidelines in 2013 and 2015 by the South African National Department of Health. These revised guidelines specified that for children between the ages of 5-10 years, ART should commence either when symptomatic or when CD4 < 500 cells/μl regardless if the child was at WHO stage 1 (asymptomatic) WHO stage 2 (infections), WHO stage 3 (malnutrition and persistent infections) or WHO stage 4 (severe wasting and severe infections). Children younger than 5 years should receive ART regardless of their CD4 cell count or clinical staging and infants exposed at birth should be started on ART at 4-6 weeks of age.

Ongoing care for children on ART should include monitoring their treatment response and adherence to ART as well as their developmental milestones. Children whose viral load suppression is insufficient within the first 3 years of life including those on ART who are considered clinically stable, may present with neurocognitive decline. This is due to HIV encephalopathy, associated with permanent neurocognitive deficits consistent with diffuse atrophy and bifrontal white matter abnormalities.

In view of the deficits which may occur in relation to the degree of encephalopathy, children infected with HIV, even those on ART, often have difficulties in participating in school activities. Occupational therapists need to monitor developmental milestones and address developmental delay in children with HIV, including visual motor integration (VMI), fine motor development and visual perceptual abilities required for formal education. The relationship between VMI and academic achievement is not clear but VMI has been correlated significantly with academic ability, in relation to perceptual abilities needed for reading, writing, spelling and...
In South Africa the development of children with HIV must also be considered in view of the multiple vulnerabilities these children may be exposed to, including low socioeconomic status, poor nutrition, limited access to services and neglect. The impact of poor VMI development on the education occupational performance area must therefore be considered and emphasised in children with HIV. A significant relationship exists between visual analysis, fine motor, visual motor integration with handwriting, reading and mathematical performance in the early school years. Visual-motor skills, or VMI is required for the integration of visual images of letters or shapes with a motor output and is an important pre-writing skill. These skills are multifaceted and are influenced by a number of factors such as pencil grip, fine motor skills, eye hand coordination, kinaesthetics, motor planning and visual perceptual skills. A good VMI performance is also a strong predictor of executive function related to self-regulation in the classroom.

Since the extent of the delay in visual motor integration in HIV-infected children, particularly within the South African context, is largely unknown the objectives of the study were to determine:

- the extent of the delay of VMI in pre-school children who have vertically transmitted HIV,
- the association between VMI, visual perception and motor coordination scores and medical factors related to HIV,
- the association between VMI, as the demographic and socioeconomic factors for children with HIV.

**METHOD**

A cross-sectional quantitative descriptive study in which no variables were manipulated, was undertaken to explore the visual motor integration, visual perception and motor coordination of 5 to 6 year old children infected with HIV who were receiving ART. Ideally a randomised clinical control study was desirable, but ethically this was not possible as the children who could potentially form the control group could not be tested to confirm if they were HIV positive. Socioeconomic status has been shown to be a factor related to Beery Developmental Test of Visual Motor Integration (DTVMI) scores but this is controversial as some authors found no delay related to low and middle socioeconomic status in preschool children. However, in view of the absence of a control group, the socioeconomic background of the children living with HIV was assessed to ensure that the sample was homogeneous for this variable and the possible effect on the results could be discussed. Results on the DTVMI were also compared to normative results from other South African studies of children from different socioeconomic groups.

Data were collected at one point in time from a sample attending a paediatric outpatient clinic at an academic Hospital in Johannesburg that provides services to infants, children and adolescents with HIV from the greater Johannesburg region in South Africa. Patients attending the clinic are mostly from middle to lower socioeconomic background. A sample of participants was selected using the following inclusion criteria:

- ambulant children who were HIV positive through vertical transmission,
- children who were between the ages of 5 years 0 months and 5 years 11 months,
- children who had been receiving ART > 1 year.

The children were excluded from the study if they

- were born prematurely with a gestation period of < 37 weeks,
- had neurodevelopmental delay due to other causative factors such as neonatal hypoxic-ischaemia,
- had physical manifestations of encephalopathy such as seizures,
- had visual deficits.
The estimated number participants required to be representative of the 1600 children attending the clinic according to Cochran’s sample size formula with a margin of error of 5% or alpha of 0.05 for the study was 794.

Ethical clearance was obtained from the University of the Witwatersrand (M160876) and prior to commencing the assessment, the caregivers of the participants gave signed informed consent, with the assistance of a translator if needed. Verbal assent was also obtained from the child participants.

Data Collection tools

Demographic and Medical Information was collected using a questionnaire developed by the researcher for this study. The caregivers were also asked whether the participant had undergone an eye test and the outcome of the eye test to determine the possible functional impact of visual deficits on visual motor integration. Children with known visual deficits that could not be corrected with glasses were excluded from the study. However, a limitation of the study was that no further assessment of the children’s visual function was completed so the presence of visual deficits may have affected the results. Medical information was obtained from the medical file and included details of ART, CD4 count, CD4%, viral load and height/weight of the participant.

The Beery-Buktenica Developmental Test of Visual-Motor Integration (Beery DTVMI) 6th edition39

The Beery DTVMI-6 is a standardised test and was used to assess the participants’ VMI, with supplemental tests for visual perception (VP) and motor coordination (MC). This test has been widely used as a research tool. The Beery DTVMI -6 has good predictive validity40. The test’s validity and reliability has been well-researched and is considered an effective measuring tool. The VMI, VP and MC tests have an overall average reliability score (inter-scorer, content and time sampling) of 0.92, 0.91 and 0.90 respectively. The VMI, in particular, has high reliability and validity when compared with other assessment measures of perceptual-motor skills40. Content validity was established through rigorous levels of item analyses and selection procedures over the years since its initial formulation in 1967. The results of the VMI test have been reported to show a statistically significant relationship with math-ematical achievement test scores40. Therefore, apart from being used to determine the level of VMI, VP and MC skills, inferences on academic performance can be made, although this is to be done with caution. The Beery DTVMI-6 has been found to be culture free40 and is a commonly used research tool to determine the VMI, VP and MC of children internationally41. The Beery DTVMI-6 was normed on a population of American children and has been shown to be valid for the assessment of children in South Africa42,43 with significant differences between the scores for preschool children in high to middle and low socioeconomic groups. Although children in middle and lower socioeconomic groups had scaled scores that reflected the normative score in the test manual44.

The data were collected for a period of eight months and assessments coincided with the participants’ clinic appointment. The testing took place in a private room at the clinic and lasted approximately 30 minutes. The caregiver was asked to complete the demographics form and HESSI II with the help of a translator if necessary while the child was assessed by the researcher. The researcher collected the medical information from the participants’ clinic records. The Beery DTVMI was administered according to the standard procedure with a research assistant, familiar with the test completing a direct translation of the written instructions in the manual.

Data Analysis

Demographic data, medical data and the data from the HESSI II were analysed using descriptive statistics including frequencies and ranges. The data from the Beery DTVMI were analysed using descriptive statistics including percentile and z scores using the mean, standard deviation and confidence intervals. A chi-squared test was used to determine the significance of the results from the Beery DTVMI in comparison to the norms established by other authors in South Africa.

Correlations were also established between the medical factors and socioeconomic factors related to HIV and the VMI, VP and MC z scores41.

RESULTS

A sample of 80 participants was initially selected for this study. During the screening process, 9 participants were found to be ineligible to participate as 3 clients received ART < 6 months, 1 client was born prematurely, 1 client had a history of medical illnesses and 2 clients were above the age of 6 years and two participants were too ill to complete the assessment. This resulted in a final sample of 71 participants.

The demographic information revealed that 40.85% of the child participants were male and 59.15% were female with ages ranging from 5 years 0 months to 5 years 11 months. The home language of nearly half (46%) of the participants was Zulu while between 3% and 11% of participants spoke Tswana, Xhosa, Ndebele, Setswana followed by Northern Sotho and Shangaan at home. Other languages spoken included English, Afrikaans and French. Only 14% of participants had not attended crèche, day care or a nursery/pre-primary school.

Socioeconomic data from the HESSI indicated all the participants came from a middle or low socioeconomic background. On average two adults and one child were reported living in each household. Thirty-six (51%) of the caregivers, who were all the child’s mother, reported living with a partner while 35(48%) were single parents. Thirty-one (43%) of the caregivers reported having completed three or five years of high school, with 32(45%) having post school training at technical college.

The caregivers’ housing was located in the areas around the hospital, which mostly consisted of low-cost housing. While 23 (32.39%) of the caregivers reported living in a house, 8% reported to sharing their home with other families. Fifteen (21.13%) of the participants lived in a flat, while the remaining 27 (38%) caregivers reported the family lived in a shack or single room/garage, which indicated a low socioeconomic status as 81% of these dwellings did not have indoor plumbing and some did not have electricity.

Medical factors impacting on VMI

The average length of time a participant had received ART was 3.5 years resulting in an average CD4% of 31.41% and CD4 absolute count of 1237.96X10^6/L. (Table 1).

<table>
<thead>
<tr>
<th>Table 1: Medical Information of participants (n=71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years on ART</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>3.53 (1.58)</td>
</tr>
<tr>
<td>CD4 absolute (x10^-6/L)</td>
</tr>
<tr>
<td>CD4 (%)</td>
</tr>
</tbody>
</table>

The length of time on ART showed a positive moderate correlation with CD4% (r=0.51) indicating a positive association between ART and CD4%. Interestingly a weak positive correla-
tion ($r=0.38$) existed between the length of time on ART with the CD4 count.

**Visual motor integration**

The results of the Beery DTVMI reveals that when compared to the USA norms the scores for VMI and VP fell in the "at risk" category below average with a mean z score of -1.13 and -1.43 respectively. Motor coordination mean z scores fell in the average range at -0.86. Visual perception achieved the lowest in this sample on the mean raw score and 20.5% of the z scores falling -2SD below the mean (Figure 1 on the left).

The Beery DTVMI scores were compared to the USA normative data since South African norms in means were not available for this age group. A significant difference existed between the z scores of VMI ($p=0.00$), VP ($p=0.00$) and MC ($p=0.00$) and the normal distribution of scores. These scores indicated that 13.6% of the sample presented with visual motor integration deficits with z scores below -2 SD, while 20.5% of the sample presented with deficits for visual perception in this range (Figure 2 on the left).

**Table II** (below) indicates that a delay exists in VMI, VP and MC in the sample in this study when compared to the normal distribution of scores for the United States with a scaled score of 10 (SD 3)$^{34}$. When compared to scores reported for studies in South Africa$^{35,36}$, the scores for the study sample are not significantly lower ($p=0.223$) than the norms reported for South African pre-schoolers, but confirmed developmental delay. The mean scores are equivalent to the average scores for children of 4 years 6 months for VMI, children of 4 years for visual perception and children of 4 years 7 months for motor coordination. This indicates a deficit of 11 months on the mean VMI raw scores and a deficit of 17 months for visual perception. The mean motor coordination scores show a deficit of 10 months.

The relationship between medical factors and the Beery Developmental test of Visual Motor Integration

Visual perception had a moderate positive significant correlation with the CD4 count and CD4 (%) with weak correlation between these variables and the VMI and MC scores.

There were weak non-significant correlations between the other medical factors and all the Beery DTVMI scores. (see **Table III** on page 28)

The relationship between demographic and socioeconomic factors and the Beery Developmental test of Visual Motor Integration

Only one demographic factor (attendance at crèche, day care or nursery/pre-primary school) and one socioeconomic factor (mother’s level of education) assessed in this study, correlated moderately with the VMI z scores. All correlations for the VP and MC z scores were weak. (see **Table IV** on page 28)

**Table II:** Comparison of Beery Developmental Test of Visual Motor Integration score to United States and South African norms

<table>
<thead>
<tr>
<th></th>
<th>VMI-6 Study sample scaled scores (n= 71)</th>
<th>VMI-4 South African sample middle to low SES (Dunn et al.$^{34}$ (n=83))</th>
<th>VMI 6 South African preschool norms (Visser and Nel$^{42}$) (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Median-(range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Visual motor integration</td>
<td>6.64(2.37)</td>
<td>6 (2-12)</td>
<td>10.5(3.80)</td>
</tr>
<tr>
<td>Visual perception</td>
<td>6.04(2.91)</td>
<td>6 (1-14)</td>
<td></td>
</tr>
<tr>
<td>Motor co-ordination</td>
<td>7.62(3.06)</td>
<td>7 (1-13)</td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION

The participants in this study came from a variety of cultural backgrounds and had received ART for between one and five years. None of the participants started ART before the age of 1 year but there was only a weak correlation between the length of time on ART and their CD4 scores evidenced by the relatively high CD4 count and CD4% scores found. These scores determine the extent of the spread of the virus systemically and the degree of cognitive impairment. A stronger CD4 count will also decrease the likelihood of opportunistic infections that can negatively impact the visual motor area.

Even with the initiation of ART, some neurocognitive delay occurred in this sample with a low average score on at least one of the Beery DTVMI tests. However, this was in line with South African studies linking lower and middle economic status and that HIV is a major determinant of neurodevelopmental delay with children infected with HIV and receiving ART.

The results from this study supported the conclusion that HIV is a major determinant of neurodevelopmental status was less of a mediating variable than the impact of HIV even when other factors such as poverty were considered. This supports research studies that neurocognitive deficits, particularly visual perceptual deficits exist in children infected with HIV and receiving ART and that HIV is a major determinant of neurodevelopmental delay.

HIV causes a delay in visual perception and visual motor integration. Both the VMI and VP scores in this study were below average, indicating the presences of neurological deficits in the LOC and parietal lobes as reported by Wang et al. The parietal cortex, responsible for integrating and processing somatosensory visual, information, plays a role in producing planned movements required for VMI. Motor coordination scoring was a low average. The findings for MC in this study reflect those reported by Fraga-Sousa et al. that fine motor function in 5 year old children with HIV is relatively intact and not significantly different from that of typical children. It must be noted that the scores obtained for VMI, VP and MC in this study reflect the findings of other studies in South Africa using the Beery DTVMI. In all the studies the participants obtained the lowest scores for VP and the highest scores for MC when compared to normative data from the test manual. Therefore, delay in VMI, VP and MC must be interpreted accordingly when determining the real delay for this South African sample of HIV positive children.

It is important therefore that the delays in visual perception in children with HIV are addressed as it is necessary for visual information analysis to explore the environment and gain mastery in educational activities. Visual perception and visual motor integration are integral to the development of prewriting and handwriting skills, as well as behaviour reflecting self-regulation which are necessary for achievement in the classroom.

Limitations of the study

A possible limitation is the small sample size which was only representative of the population with a 10% margin of error. When analysing the socioeconomic levels of the study participants, a composite score of the HESS II could not be obtained as not all participants completed all sections however, from the information completed a socioeconomic level could be concluded in all cases. The visual function of the children was not assessed and only based on a report from the caregivers.

CONCLUSION

The results from this study supported the conclusion that HIV is a major determinant of neurodevelopmental delay with children at risk for delay on the Beery VMI test. There was an association the prevalence of visual perception delay and the level of the CD4 count and CD4% which has clinical and research implications on the extent of the delay. The middle to lower socioeconomic status of the participants was a mediating factor even when compared to other standardisation studies of the Beery DTVMI on a South African population, with participants in this study had lower scores confirming that HIV is a major determinant of dysfunction in neurodevelopment.

It is recommended that a combination of ART and neurodevelopmental occupational therapy intervention is necessary, particularly at a preschool and the early school level for children with HIV and that VMI, VC and VP should be assessed as part of routine neurodevelopmental monitoring in these children.

| Table III: Correlations between demographic and socioeconomic factors and z scores on the Beery Developmental test of Visual Motor Integration (n=71) |
|---------------------------------|---------------------------------|
| **CD4 count**                   | **CD4 (%)**                     |
| **r**                           | **r**                           |
| VMI z score                     | 0.00                            | 0.12                            |
| VP z score                      | 0.56*                           | 0.46*                           |
| MC z score                      | 0.27                            | 0.27                            |
| Significance p ≤ 0.05*          |                                 |                                 |

<p>| Table IV: Correlations between demographic and socioeconomic factors and z scores on the Beery Developmental test of Visual Motor Integration (n=71) |
|---------------------------------|---------------------------------|</p>
<table>
<thead>
<tr>
<th><strong>Attendance at crèche, day care or nursery/pre-primary school</strong></th>
<th><strong>Mothers level of education</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>r</strong></td>
<td><strong>r</strong></td>
</tr>
<tr>
<td>VMI z score</td>
<td>0.56*</td>
</tr>
<tr>
<td>VP z score</td>
<td>0.32</td>
</tr>
<tr>
<td>MC z score</td>
<td>0.11</td>
</tr>
<tr>
<td>Significance p ≤ 0.05*</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


49. Rens Z. The standardization of the Beery-Buktenica developmental test of visual-motor integration with supplemental developmental tests of visual perception and motor coordination (revised, 1997) on an Eastern Cape population aged 7 years 0 months to 7 years 3 months. University of the Witwatersrand, Johannesburg, 2009.


AUTHOR’S ROLES
• Ramona Odejayi - Postgraduate MSC OT study
• Denise Franzsen - Supervisor of study
• Patricia de Witt – conceptualisation and editing of article

Corresponding Author
Ramona Odejayi
Email: ramona.odejayi@gmail.com