MINISTRY OF GENDER, LABOUR
AND SOCIAL DEVELOPMENT

A HOLISTIC APPROACH TO PSYCHOSOCIAL SUPPORT

A national training manual for caregivers of orphans
and other vulnerable children in Uganda

Table of Contents

Foreword

The Government of Uganda faces an increasing population of children who are deprived of parental care, live outside of family care, lack access to basic needs, need psychosocial support, or neither fully enjoy their rights nor exercise their responsibilities. These circumstances deny children the opportunity to grow up in a supportive, loving family environment and develop into responsible young adults. This has adverse effects on children's social functioning, their ability to make and maintain meaningful relationships, and their ability to thrive and attain their life aspirations.

Deprivation and vulnerability of children in Uganda is largely attributed to HIV and AIDS, poverty, and conflict. The absence of social safety nets, especially at community level, coupled with poor household economic status, further exacerbates the problem of child neglect, abuse, and exploitation. The loss of a guardian to HIV and AIDs or other causes can leave a lasting effect on a child's psychological and emotional well-being. Yet the living conditions described above inhibit the ability of the family and community to respond to the psychosocial and emotional needs of children.

Oftentimes, caregivers of orphans lack basic psychosocial support skills and are therefore unable to support orphans to cope with adversity, develop meaningful relationships, and overcome emotional difficulties. As a result, orphans and vulnerable children are at a high risk of sliding further into delinquency, becoming despondent, and indulging in high-risk behaviours. Psychosocial support is a core programme area in our National Strategic Programme Plan of Implementation of services for OVC. This manual is also part of the OVC toolkit for service providers. The revision of this manual therefore comes at the right time, as the Ministry—through its OVC National Implementation Unit—has stepped up efforts to strengthen the social service workforce for effective delivery of quality OVC services by caregivers.

We are therefore grateful to our partners, TPO Uganda and REPSSI, which came together to work with the Ministry and other stakeholders to revise the first edition of this manual. This version is more user-friendly, has a better layout, and contains content that is up to date and in line with present discourse.

Let hope never run dry for the children of Uganda.

Hon. Muruli Mukasa

Minister of Gender, Labour and Social Development

Acknowledgements

The Ministry of Gender, Labor and Social Development (MOGLSD) is proud to have joined hands with TPO Uganda and the Regional Psychosocial Support Initiatives REPSSI to produce this revised edition of *A Holistic Approach to Psychosocial Support – A national training manual for caregivers of orphans and other vulnerable children in Uganda.* The process of revising this manual was highly participatory and consultative, and drew on the experiences of several local and international NGOs and civil society organisations involved in delivering care and support services to orphans and vulnerable children.

Acronyms

ART/ARV	Antiretroviral Therapy / Antiretroviral Treatment
AVSI	Association of Volunteers in International Service
CBT	Cognitive Behavioural Therapy
DLG	District Local Government
EMDR	Eye Movement Desensitisation and Reprocessing
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IASC	Interagency Standing Committee
IPT	Interpersonal Therapy
LRA	Lord's Resistance Army
MGLSD	Ministry of Gender, Labour and Social Development
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological, and Substance use disorders
NOP	National OVC Policy
NOSC	National Orphans and Vulnerable Children Steering Committee
NSPPI II	National Strategic Program Plan of Implementation II
OVC	Orphans and other Vulnerable Children
PMHCW	Primary Mental Health Care Workers
PSS	Psychosocial Support
PTSD	Posttraumatic Stress Disorder
REPSSI	Regional Psychosocial Support Initiative
STI	Sexually Transmitted Infection
TPO	Transcultural Psychosocial Organisation
UDHS	Uganda Demographic and Household Survey
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

About the Manual

This is the second edition of the manual, *A Holistic Approach to Psychosocial Support – A national training manual for caregivers of orphans and other vulnerable children in Uganda.* The first version of this manual was published by the Ministry of Gender, Labour and Social Development (MGLSD) in 2004. This manual takes into consideration the changing context and dynamics of OVC programming since the first edition.

Who is this manual for?
This manual targets both primary and secondary caregivers of OVC.

Primary caregivers are people who are in daily and direct contact with the children in the family and community. They can be parents, teachers, or relatives who care for the child, including grandparents, aunts, uncles, and siblings.

Secondary caregivers are those whose role is usually to support the primary caregivers. These can be volunteers or professionals working with children, such as social workers, child protection officers, probation and social welfare officers, community volunteers, and health workers.

In this manual we refer to both groups simply as "caregivers". The information in this manual is intended for both groups, as they share many of the same challenges and concerns in trying to provide psychosocial support to OVC.

Structure of the manual
This manual consists of five modules. Each of these has clearly outlined learning objectives. Each module consists of different sessions and includes session objectives, activities (divided into purpose, time required, instructions to the facilitator, and facilitator notes) and further resources for additional reading.

Methodology
The manual utilises various participatory learning methods, including group work, pictures, brainstorming, storytelling, lectures, debates, and case studies.

Development of this manual
This manual was developed by the Ministry of Gender, Labour and Social Development with support from TPO and REPSSI. The development process was consultative, involving other government line ministries, development agencies, civil society organisations at both national and regional levels, and district local governments. An interactive process involving feedback, revision, and validation was undertaken, resulting in this final version.

Guiding principles of this manual
This manual is based on the guiding principles of the National Orphans and Other Vulnerable Children Policy (NOP, 2004) as well as on the NSPPI II (2011-2016). It provides those who are unfamiliar with these policies an opportunity to learn more about them. The focus is on translating theoretical knowledge about the policies into practical actions to provide psychosocial support to orphans and vulnerable children.

What is psychosocial support?

The NSPP II defines psychosocial support as all actions and processes that enable OVC and their households or communities to cope with stress in their own environment, develop resilience, and reach their full potential. Psychosocial support enables children and their caregivers to experience love, feel protected, build meaningful relationships, and have a sense of self-worth and belonging.

The NSPPI II specifies the outcomes that all people involved in providing care to OVC should aim for:

1. Improved physical, social, and emotional well-being of OVC through provision of quality psychosocial support services

2. Increased access and utilisation of basic care services by OVC and their caregivers.

The current OVC situation

Vulnerability in Uganda remains persistent and pervasive, with many children frequently categorised as vulnerable to a range of risks because of a number of factors. The drivers of vulnerability include poverty, armed conflict, natural disasters, community conflicts, HIV/AIDS, and other diseases. There are also other family-related factors, including domestic violence, alcoholism and drug abuse, abandonment of the traditional family setting, and cultural beliefs and customs (such as child sacrifice).

Although HIV infection rates have substantially decreased since the early 1990s to a current rate of 7.3%, complacency, unabated population growth, and life-sustaining treatment in the form of antiretroviral (ARV) therapy have led to a substantial number of individuals still becoming infected; recent surveys indicate that Uganda's HIV/AIDS rate is on an upward trend.

Vulnerable children in Uganda are also susceptible to violence in multiple forms, including through neglect and abandonment, hazardous labour, child trafficking, sexual abuse, and emotional and physical abuse in homes, communities, schools, and the justice system. According to the Uganda Demographic and Health Survey (UDHS, 2012), 25% of Ugandan women report that their first sexual encounter was coerced, and more than half have experienced physical violence. Women and children who suffer from sexual abuse or who are subjected to early marriages and other forms of violence are at a higher risk of HIV infection.

The long history of civil unrest has left some parts of the country fractured and impoverished. Depression is widespread, and the country faces growing exposure to instances of child abuse. Many children and their caregivers continue to suffer from the psychological effects of the conflict.

Although national poverty rates have dropped over the last few years, Uganda's Child Poverty Report 2014 estimates that over six million children live in extreme poverty, comprising 62% of the estimated 9.6 million Ugandans experiencing absolute poverty.

The Government of Uganda's 2009/2010 OVC Situation Analysis estimated that 14% (approximately 2.43 million) of the then 17.1 million Ugandan children below the age of 18 years had been orphaned, with nearly half (48%) of these children orphaned by HIV/AIDS. Up to 96% of Ugandan children were considered to be vulnerable, of which 43% (7.3 million) suffered from moderate vulnerability and 8% (1.3 million) from critical vulnerability. Orphanhood in Uganda remains a big challenge, with the proportion of children who are orphaned increasing from 11.5% in 1999/2000 to 13.4% in 2002/2003 and 14.8% in 2005/2006. (However, in 2009/2010, the magnitude reduced slightly, to 14%.)

This manual seeks to address some of the psychosocial effects children experience from living with poverty, conflict, abuse, and parental death. The first module provides a general introduction to psychosocial well-being. Modules 2 through 4 provide information and suggestions on how to practically promote psychosocial well-being. The manual concludes with Module 5, which gives an overview of care for caregivers.
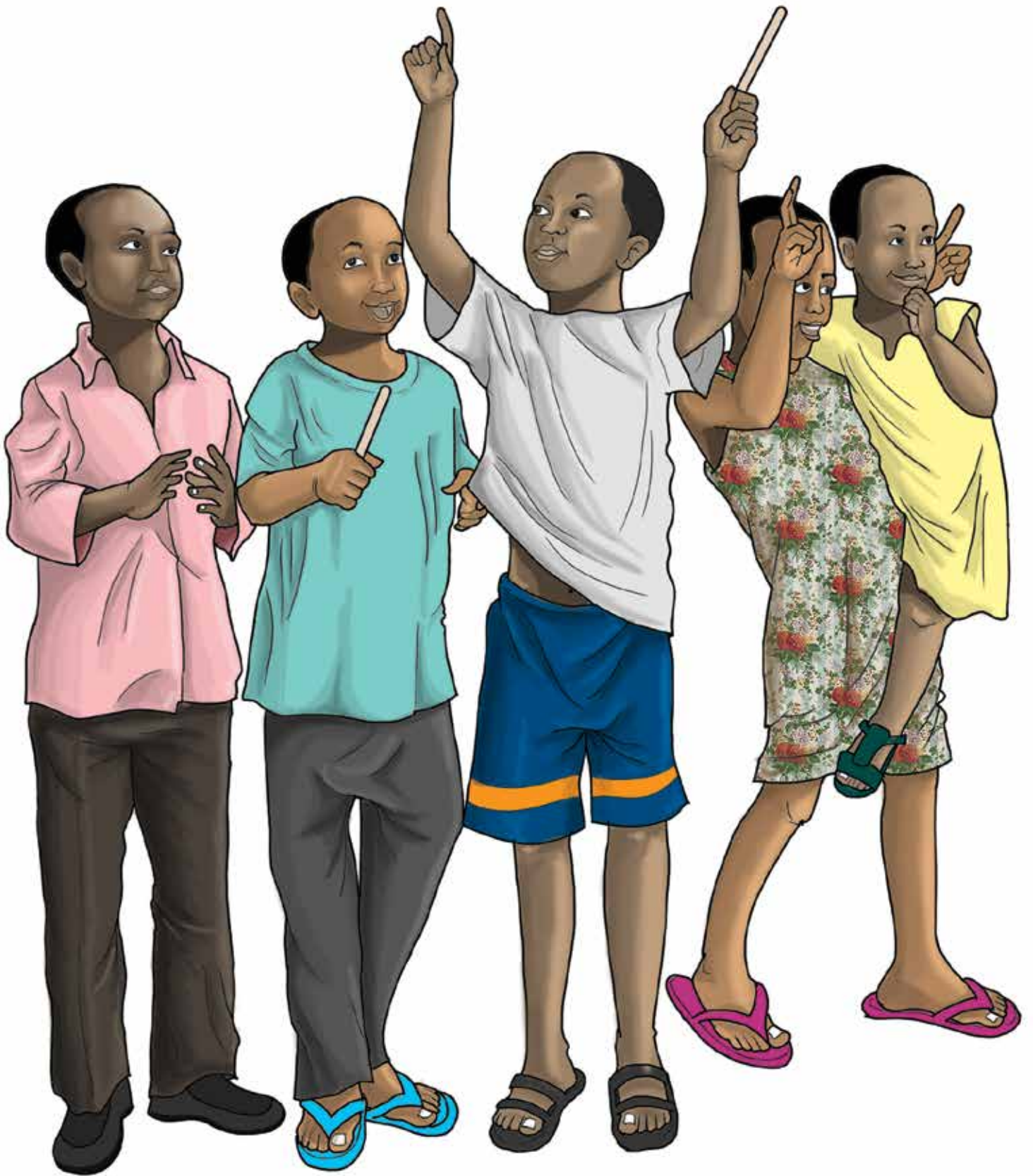
Module 1

Psychosocial well-being, care, and support

Introduction

This module introduces the main ideas that help us understand what psychosocial well-being and psychosocial care and support are. It starts with a discussion of vulnerability and what makes orphans and vulnerable children (OVC) in Uganda vulnerable. It explains why psychosocial support is important for children as well as adults and how psychosocial well-being can be promoted. The psychosocial pyramid is introduced. This pyramid groups together different types of psychosocial interventions based on the magnitude of the problem that children and caregivers experience. The last section looks at coping and resilience and how to help caregivers respond to children's psychosocial problems. The four sessions of the module are:

1 The vulnerability context: understanding what makes children in Uganda vulnerable, as well as the effects of vulnerability

2 Psychosocial well-being, care, and support

3 Psychosocial interventions pyramid

4 Coping and resilience

Module objective
By the end of this module, participants should be able to explain the concepts of vulnerability, psychosocial well-being, coping, and resilience

Resources
- Flip charts
- VIP/sticker cards
- Markers
- Masking tape
- Rubber bands

Session 1 ▸ The vulnerability context: understanding what makes children in Uganda vulnerable

Session objectives

By the end of this session participants should be able to:

- Identify the underlying causes of vulnerability and corresponding solutions
- Articulate the various categories of vulnerability and how they affect growth and development

Time frame
45 minutes

Facilitator tips

Group participants into buzz groups to brainstorm the definition of vulnerability before sharing in plenary. You might like to ask them to brain storm the following issues:

- Brainstorm the causes of vulnerability and write responses on a flip chart
- "Not all orphans are vulnerable."
- Difficulties that children in your area are facing that we have not listed here?
- What makes some children more vulnerable than others?

Summarise discussions and draw key conclusions.

Facilitator notes

Definition of vulnerability

Sometimes there is confusion about how we use the word "vulnerable". Vulnerable can describe:

1. An emotional state (e.g., "He is feeling vulnerable because something bad happened to him.")
2. A set of negative circumstances that may occur (e.g., "She is vulnerable to sexual exploitation.")
3. Categories of children (e.g., "vulnerable children")

This manual defines vulnerability and a vulnerable child based on the NOP and NSPPI-2 for OVC:

Vulnerability is a state of being or the likelihood of being in a risky situation, where a person is likely to suffer significant physical, emotional or mental harm that may result in their human rights not being fulfilled.

A **vulnerable child** is a child who is suffering and/or is likely to suffer any form of abuse or deprivation and is therefore in need of care and protection. An **orphan** is a child whose parents are dead. **OVC** stands for "orphans and other vulnerable children".

Generally, at a community level, children are regarded as vulnerable when they are separated from caregivers, malnourished, abused, emotionally, physically and economically neglected, out of school, disabled, ill, required to do excessive work, or when they lack access to services. By this definition, very large numbers of children are vulnerable (Richter et al, 2006: 21). It is important to note, however, that not all children automatically fall into the category of "vulnerable children" if they experience some of the circumstances described above. For instance, just because a child is poor or has become displaced, does not mean that she is vulnerable.

Many factors affect whether or not a child becomes vulnerable:

- A combination of difficulties can make the child feel overwhelmed by the adversity they are facing. For instance, if a household is already poor, the death of a parent can further impoverish the family. A child in this household may feel that the combination of negative factors and events is too much to cope with.

- If the child does not have the care, love, or support of a primary caregiver, this can make them vulnerable. The child can feel abandoned in a difficult situation they are unable to change. Children are made vulnerable by the absence of stable, affectionate adult care and protection coupled with stressful factors or risks (Richter et al, 2006: 46).

- The length and severity of the stress the child is experiencing affects vulnerability. If stress and risk continue for time periods, it makes the child vulnerable, especially if the child cannot see a solution to her situation or does not feel that s/he can do anything about this situation.

- Specific individual factors of the child, such as a physical or mental disability, together with an adverse situation, such as the loss of a caregiver, might make the stressful situation worse for the child.

Drivers of vulnerability at different levels:

- **Factors in society:** Many children live in communities that are affected by poverty, conflict, violence, and displacement. These factors have a negative impact on community, family, and individuals. Natural disasters, such as floods and mudslides, are increasing and can devastate communities and families.

- **Factors in the community:** In their communities, children may witness and experience violence, discrimination, and abuse. Early marriages, lack of access to services such as schooling or vocational training, and a lack of opportunity to contribute to communities may all be issues facing children.

- **Factors in their home environment:** In their family environment, children may experience domestic violence, sexual abuse, and neglect. The illnesses and deaths of parents, siblings, and other family members cause bereavement and grief. Other children may be prevented from attending school or may be forced to do hard labour.

- **Factors that affect individual children:** On an individual level, children may also experience difficulties, such as being HIV-positive or suffering from other illnesses, becoming pregnant at an early age, or having a disability.

When children experience any of the difficulties discussed above, their well-being may be affected in many different ways and they may be exposed to further harmful consequences. This is what we refer to as "vulnerability".

Additional information for the facilitator:

Vulnerable children are groups of children that experience negative outcomes, such as the loss of their education, morbidity, and malnutrition, at higher rates than their peers. The loss of a parent through death or desertion is an important aspect of vulnerability. Additional factors leading to vulnerability include:

- Severe chronic illness of a parent or caregiver

- Poverty, hunger, and inadequate clothing or shelter

- Institutions such as orphanages

- Lack of access to services

- Deficient caretakers

- Factors specific to the child, including disability, direct experience of physical or sexual violence, or severe chronic illness.

This means that although certain categories of children like orphans may constitute many vulnerable children, not all vulnerable children are orphans[1] .

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1 Ministry of Gender, Labour and Social Development (2012).

Vulnerability affects the well-being of children negatively

How children are affected by the adversity they face vary, but vulnerability can affects their ability to grow, develop and learn; their health and physical development; and their happiness, self-esteem, confidence and relationship with others. In this manual we will focus on the psychosocial well-being of children and how it is negatively affected by these situations. We will also be looking at how resilience in children can be fostered by improving their psychosocial well-being.

Before we can do that, we need to first look at the following concepts: What is psychosocial well-being and what do we mean by psychosocial care and support, interventions and programmes?

Session 2 > Understanding psychosocial well-being, care, and support

Session objectives

By the end of this session, participants should be able to:

- Explain the terms well-being, psychosocial care, and support
- Understand psychosocial and social needs
- Define and describe psychosocial well-being

Time frame
1 hour 30 minutes

Facilitator tips

- Group participants and ask them to share their understanding of well-being and psychosocial well-being.
- Ask participants to list and explain the different terms used in their local languages that relate to psychosocial well-being.
- Present the case study about Martha, and ask participants to role-play the case. Then facilitate participant discussions through key questions on psychosocial problems, effects, and responses.
- Summarise discussions and draw key conclusions.

Facilitator notes

Well-being can be referred to as the state in which an individual is well in all or most of life's domains; namely, physical wellness (in our biological composition), social wellness (reflecting the quality of our relationships with respect to values, traditions, culture, people, and our environment), and cognitive wellness (experiencing healthy thinking, feelings, emotions, and spirituality).

Psychosocial well-being has been defined as the ability to make sense of one's world, and to have a degree of control over it and a sense of hope for the future (Antonovsky, 1979).

Psychosocial well-being with regard to children concerns the connections between the child and the people in the community and society ("social") around him/her. It involves the ways in which the child feels and thinks about him/herself and about life ("psycho"). It is often linked to the African concept of *ubuntu*: **"I am because we are, and we are because I am"**. Psychosocial well-being includes many different aspects of the child's life: physical, material, psychological, social, cultural, and spiritual. The focus of psychosocial well-being is not solely on the individual; it includes households, families, and communities.

What do you mean by **"psychosocial"?**

The dynamic relationship between psychological and social effects of experiences, each continually influencing the other.

PSYCHOLOGY
- Mind
- Thoughts
- Emotions
- Feelings
- Behaviours

SOCIAL WORLD
- Family, community, society
- Enviroment
- Culture
- Traditions
- Relationships
- Roles and tasks

Emotional (psychological & spiritual)

Cognitive (skills & knowledge)

Biological (physical body)

Material (possessions)

Social (relationships)
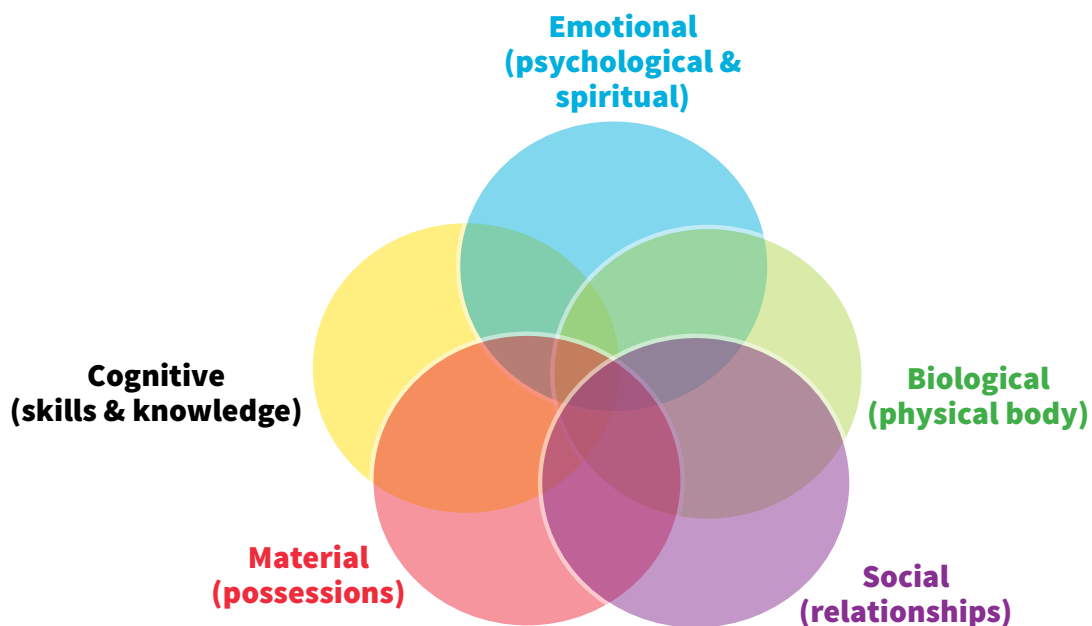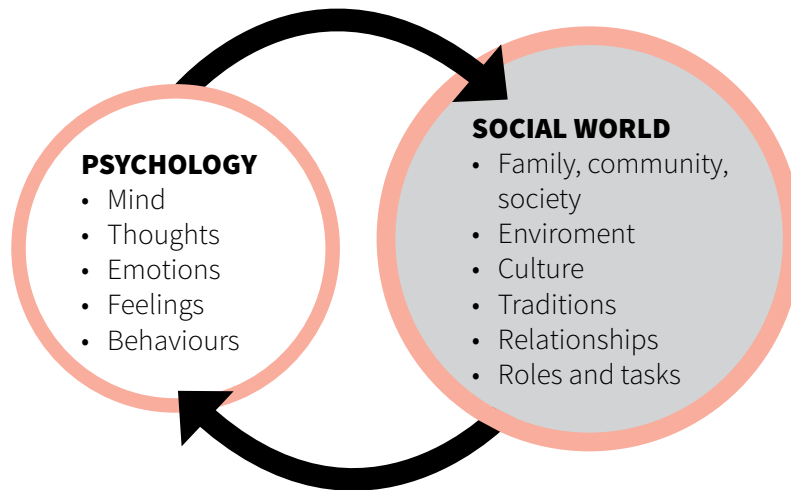
Psychosocial care and support is provided through interactions that occur in caring relationships in everyday life, at home, at school, and in the community. These include:

- The love and protection that children experience in family environments
- Support provided by the community that assist children and families in coping.

Care and support help children to have a sense of self-worth and belonging and are important for children to learn, develop life skills, participate in society, and have faith for the future. Care and support also help to strengthen children and their caregivers in dealing with the challenges they face and ensure their active participation in coping with the difficulties.

Psychosocial interventions and programmes

Psychosocial interventions and psychosocial support programming are activities, programmes and services that someone has planned and organised. Psychosocial interventions include activities like:

- Counselling
- Support groups, such as kids' clubs
- Different types of therapy
- Memory work
- Play groups

Psychosocial interventions and programmes are activities by individuals and groups outside of the child's everyday life or social circles. These are different from psychosocial care and support in that they are provided in order to strengthen the everyday care and support provided by caregivers of the children.

Case study: Martha

Martha, who is 14 years old, was walking from school through a lonely walking path when she met a 64-year-old man who was riding a bicycle. Unconscious of her surroundings, Martha continued on her way with her school bag on her back. As she got closer the man, she noticed that the man's bag was falling off the seat. The man asked her to help him pick it up and hand it back to him. Martha quickly bent over to pick up the bag from the ground and the man pushed her over from behind, held her mouth with his hands, and quickly tore off her clothes and defiled her. He then left her there and jumped back on his bicycle and rode off. Martha, in tears, quickly ran home and reported to her aunt. Her aunt immediately started yelling and snapping at her about walking alone. She told her that everything was her fault. Martha felt very sad and stopped playing with her peers. She often sat alone and in tears, reflecting on how it was her fault. She often had bad dreams in which she would see someone trying to kill her. Over the next three months, Martha lost a lot of weight and complained of headaches and general body aches. She looked pale and shabby. She dropped out of school because she thought everyone seemed to be laughing at her. Even though she spoke about this to her aunt, she never received any support.

Discussion questions

- How was Martha's physical health affected?
- How was Martha's mental/emotional health affected?
- How was Martha's social life affected?
- If Martha had come to you, what would you have done?

Possible physiological, social, and emotional reactions

Physiological reactions

- Contracting of sexually transmitted infections
- Unwanted pregnancy
- Headaches
- Loss of energy
- Loss of appetite, which may lead to ulcers
- Irregular menstrual cycles
- General body pain
- Experiencing of psychosomatic complaints (physical complaints that cannot be medically explained), such as body pains, headaches, appetite problems, and weight loss or weight gains
- Sleep problems, such as difficulty falling asleep or staying asleep

Social reactions

- Rejected by family and peers (social stigma)
- Inability to relate well to men
- Dropping out of school because of low self-esteem caused by stigma
- Becoming involved in risk-taking behaviours, such as prostitution or drug abuse
- Disturbed relationships with others
- Blame of other people
- Feeling of isolation
- Decreased productivity
- In some cases, inability to marry
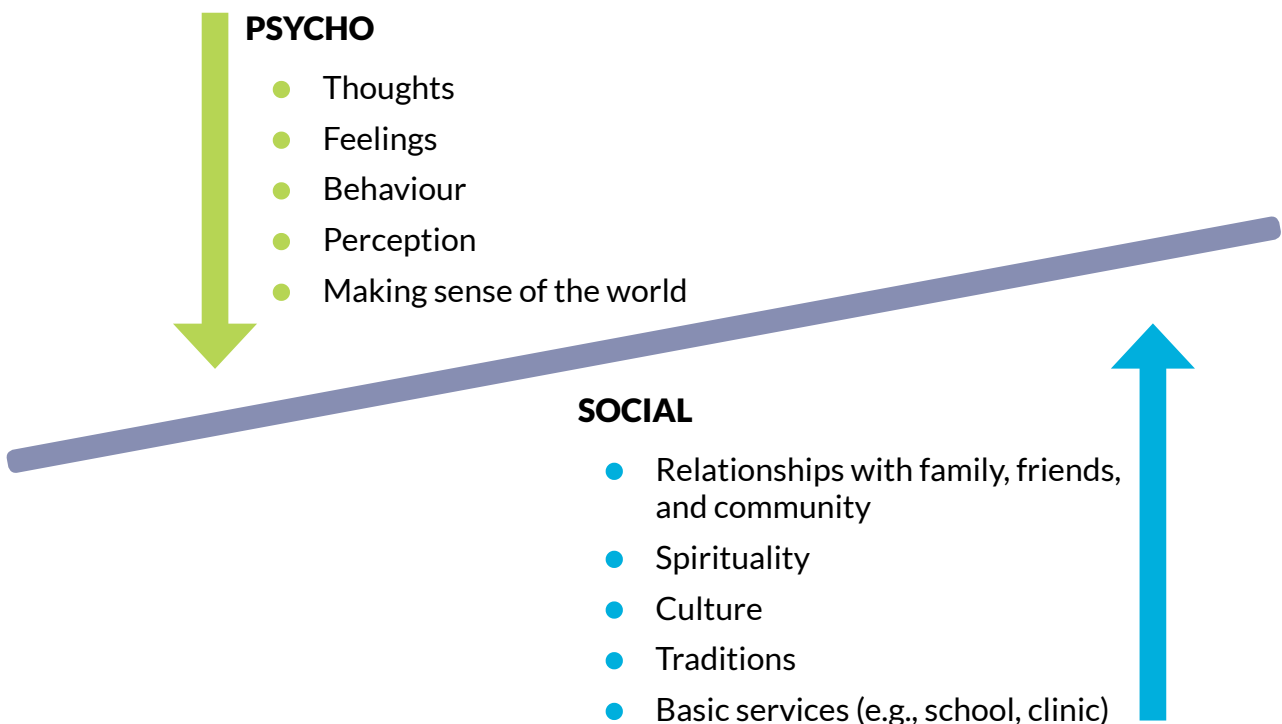- Social withdrawal (difficulty socialising)

Emotional/Mental

- Crying most of the time
- Sadness
- Too many worries
- Nightmares about the incident
- Irritability or outbursts of anger
- Frustration
- Low self-esteem
- Feeling jumpy and easily startled
- Feelings of shame and guilt
- Suicidal thoughts and feelings
- Difficulty concentrating
- Fear, hopelessness, and helplessness

Implications of psychosocial problems

The case of defilement/rape above is just one example of how a problem that occurs in everyday life can affect the well-being of children. There are both short- and long-term consequences. The social and psychological consequences are sometimes neglected and not addressed by many humanitarian workers. The physical consequences are always easy to identify and address. For example, the physical injuries during defilement/rape can be tended to; the STIs can be screened and managed, and legal services can be arranged to address injustice. The social, psychological, and emotional problems are difficult to address. Even if they are identified, they are given low or no priority. Yet their effects negatively influence the well-being of the survivor, thus depriving the survivor of his/her right to enjoy life for a potentially long time.

Who needs psychosocial support?

Everyone needs psychosocial support because we all have social, emotional, and psychological needs. However, we need to pay extra attention to people who have experienced grief, the death of a loved one, physical and sexual violence, displacement, or any of the other difficult situations we mentioned earlier. Others who need special attention are people who live in difficult circumstances, such as poverty; those who have a lot of stress; adolescents who are going through a challenging time; and people who may be involved in alcohol and substance abuse. Anyone who experiences the psychological, social, and physical reactions mentioned above will need psychosocial support.

PSYCHO

- Thoughts
- Feelings
- Behaviour
- Perception
- Making sense of the world

SOCIAL

- Relationships with family, friends, and community
- Spirituality
- Culture
- Traditions
- Basic services (e.g., school, clinic)

A change in our social world or environment produces an emotional and behavioural response in us. This influences how others experience us as well as how we relate to our environment and those in it.

Session 3 ▷ Psychosocial interventions

Facilitator notes

Psychosocial interventions are activities that focus on facilitating the provision of psychosocial care and support. These include counselling, support groups (e.g., clubs), different types of therapy, memory work, and play groups.

Understanding psychosocial support: The Wheel Model

Instructions to facilitator:

1. Draw a copy of the Wheel Model on a flip chart (see next page). Invite participants to write things children require for optimum growth and development. Each of them should be written on a separate piece of paper. (Post-its are useful for this.)

2. Each participant takes a turn to stick his/her pieces of paper on the diagram of the Wheel Model in the appropriate sector. Education, for example, would go in the mental sector. As they do so, the participants should call out the elements they have identified.

3. After all the participants have completed their turn, point out that children have diverse requirements for optimum development and overall well-being.

4. Refer participants to the Wheel Model Information Sheet.

Session objectives

By the end of this session participants should be able to:

- Define and describe different kinds of psychosocial interventions and programmes
- Examine the different psychosocial support interventions around their communities
- Discuss the different psychosocial interventions available at different levels of the pyramid

Time frame
45 minutes

Information sheet: The Wheel Model
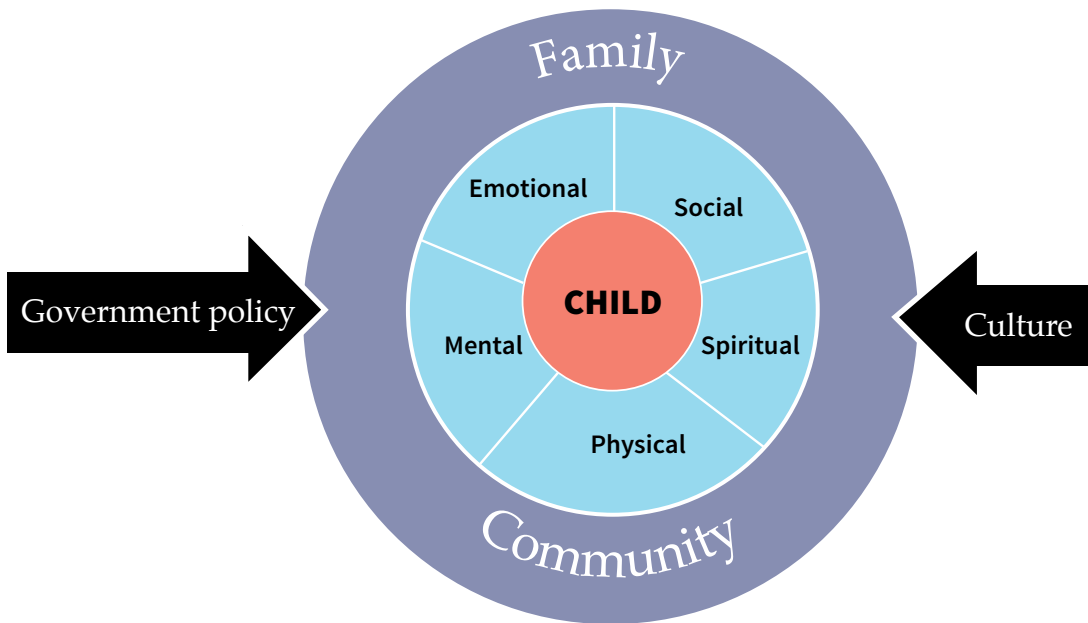
The Wheel Model draws on the analogy of a bicycle wheel. At the centre is the axle, which represents an individual with a range of requirements for protection and participation. These requirements may be categorised as emotional, social, mental, spiritual, and physical. They are represented by the wheel's spokes. The aspects of life that are represented by the parts of the wheel will constantly change position in relation to their urgency for an individual and the impact that they have on his/her psychosocial well-being at different periods of his/her life.

The family and community are represented by the rim and tyre. They provide the structure, support and context within which the individual's survival and development needs are met. They are the main custodians of care and support. The model implies that the bonds and interactions that link an individual (child) with a particular family and a community require an enabling political, socio-economic and cultural environment to ensure that they protect and nurture the development of the individual (child).

Social:
- Refers to the need to belong to a family, peer group, culture and other relevant social institutions
- Includes healthy relationships with family, friends, and community members
- Also involves participation and age-appropriate inclusion in social and cultural activities, both of which are essential

Emotional:
- Refers to the ability to identify and communicate a range of emotions
- Requires safe opportunities to express thoughts and feelings related to personal experiences
- Includes the need to feel accepted, appreciated, understood, loved, and supported

Spiritual:
- Refers to the need to feel connected to the greater universe
- Includes connections to a "higher power" (God), humanity, life in the world and the universe, and ancestors
- Is often expressed through religion and culture
- Has a great influence on values and norms

Physical:
- A range of environmental, biological, and material requirements for optimum growth
- Includes clean water, nutrition, sleep, exercise, shelter, and health care
- Access to physical requirements influences psychosocial well-being

Mental/intellectual:
- Refers to the need for challenging thoughts, reading, learning, and the stimulation of the mind
- Includes formal and informal education

Principles of the Wheel Model

1. **Holistic programming**
   - Developmental needs are varied and must be met.
   - All of these needs are important for the healthy development and survival of children—and ultimately for their psychosocial well-being.
   - Needs are equally important and interdependent.

2. **Child centeredness**
   - Ensuring that children themselves meaningfully participate in addressing their own needs and concerns is consistent with meeting their fundamental rights.
   - Children are not passive recipients of services, but can be active participants in the solutions.

3. **Family and community involvement**
   - It is the responsibility of parents, the extended family, communities and, ultimately, the government to ensure the satisfaction of children's needs.
   - Positive local cultural practices, norms, values, and beliefs need to be respected and upheld when meeting these needs.
   - Support and care services targeted at children need to be child-centred as well as family- and community-focused.
   - The local cultural context and value system plays an important role in determining how these needs can be met.

IASC Pyramid (emergency settings)

- Severe psychological disorders
- Professional treatment for individuals or families
→ **Specialised services**

- Mild to moderate mental health disorders
- Individual, family or group interventions
→ **Focused, non-specialised services**

- Mild psychological distress (natural reactions to crisis event)
- Psychosocial support activities
→ **Community and family supports**

- General population affected by crisis
- Fulfilling basic needs, providing security
→ **Basic services and security**

Although the IASC pyramid above relates to emergency settings, we can use some aspects of it to understand where psychosocial services to OVC should be targeted. We have adapted the pyramid here to show how we believe psychosocial services for OVC should be distributed:

Adapted Pyramid for OVC

4. Specialised services
Referrals to mental health workers for therapy, medication, and specialised treatment

3. Focused, non-specialised services
Support groups, counselling, Children's Clubs, memory work, etc.

2. Community and family supports
Positive interactions with teachers, neighbours, friends, and community (e.g., being able to participate in activities that other children are able to do, such as go to school, attend training, and be part of religious groups and peer groups)

1. Basic services and security
Everyday love and support given to children by their caregivers and family members (e.g., good communication, an accepting attitude, and respect of children's rights)

Psychosocial support can therefore be offered at these four levels:

Level 1 ▶ **Caregiver and family psychosocial care and support**

Caregivers and family are the most important providers of psychosocial support because they offer children stability, safety, and a sense of belonging. Most OVC can overcome the difficulties they face in time if caregivers provide them with support. However, caregivers may need assistance in knowing how to provide psychosocial support for these children, which is why the MLGSD has developed this manual. In addition, caregivers also need to look after their own psychosocial needs.

Module 2 of this manual focuses on this level.

Level 2 ▶ **Community and services support**

Positive daily interactions with community members, teachers, neighbours, health care providers, and other service providers can help OVC improve their well-being. Feeling accepted, being part of the community's social sphere, and feeling like they can contribute to the community are all very important aspects of building self-esteem and confidence. Adults who interact with the children may need information and guidance on how to respond positively and supportively to the OVC. Examples of this information are:

- Creating programmes aimed at reducing stigma and discrimination against children affected by HIV or armed conflict
- Mainstreaming psychosocial support into teaching, nutrition and early child development provision
- Raising awareness in the community of how to advocate for rights
- Developing psycho-education programmes for teachers and community members
- Using parenting skills programmes

Module 2 of this manual provides information on this level.

Level 3 ▶ **Focused non-specialised support**

A small number of OVC have problems that are not met through the natural systems of care provided by caregivers, families, and community members. They require additional support that is more directly focused on improving psychosocial well-being and helping them overcome their problems. This additional support is typically provided through psychosocial interventions and programmes that concentrate on specific issues affecting the children. Examples of this are:

- Individual or group interventions, typically carried out by trained and supervised workers
- Counselling
- Children's Clubs
- Memory work
- Support groups and life skills training for adolescents

These programmes are called "non-specialised" because anyone can deliver them; you do not need to be a professional to run these programmes. They are called "focused" because they focus on specific groups of children with special problems.

Module 3 of this manual focuses on this level.

Level 4 ▸ **Specialised services**

At the top of the pyramid is specialised support for the small percentage of children whose problems are not solved at the first three levels and who have great difficulty functioning due to depression or posttraumatic stress disorder. Examples of assistance at this level are:

- Psychotherapy
- Medication if a child is very anxious or very depressed

Children who experience such serious problems need to be referred to specially trained mental health workers. This manual cannot provide such training but does provide information on these conditions and on when caregivers may need to refer a child to these services.

Module 3 of this manual focuses on this level.

Facilitator tips
- Ask participants to brainstorm the different psychosocial interventions within the community.
- Summarise discussions and make key conclusions.

Summary
So far we have talked about the vulnerability context of OVC in Uganda and the different factors that can make children vulnerable. We have defined psychosocial well-being, psychosocial care and support, and psychosocial programmes and interventions. We have looked at a way of categorising the different levels at which psychosocial well-being can be improved. Now we will look at one of the main things that we aim to achieve: building resilience. To do that, we first need to look at what resilience is. We will do this by discussing a case study.

Session 4 ▶ Coping and resilience

Facilitator tips
- Ask participants to brainstorm on the concepts of coping and resilience.
- Present the case study ("Brenda's Story") and discuss the questions and answers.
- Ask participants to share similar stories from their community.
- Summarise discussions and make key conclusions.

Session objectives
By the end of this session, participants should be able to:
- Define coping and resilience
- Explain factors affecting coping and resilience
- Examine the link between coping and resilience

Time frame
1 hour 30 minutes

Facilitator notes

Coping refers to dealing with a new situation, for instance, a behaviour that people develop to deal with a new and challenging experience. Coping can be both negative and positive. Negative coping involves people promoting an unpleasant experience or creating new problems, while positive coping involves adjusting positively to the situation or trying to eliminate it.

Resilience refers to the process of adapting well while experiencing difficult circumstances. It can be described as "bouncing back" from difficult experiences. Research has shown that resilience is normal or ordinary and not extraordinary. All people can demonstrate resilience.

Distinction between resilience and coping

Coping and resilience are often used to mean the same thing. Though they are similar, the two need to be treated distinctly. As explained above, coping refers to the different strategies that a person will try in order to deal with the difficult experience. These can be positive or negative. Resilience is the ability to recover and return to normal functioning after a difficult experience.

Case study: Brenda's Story [2]

Brenda comes from a family of four children, three girls and one boy. Her parents, Mr and Mrs Lubega died when she was thirteen years old. As the youngest child, Brenda used to spend a lot of time with her mother, who taught her much about life. Her mother always spoke about how she believed in her heart that Brenda would grow up to be a successful. She also always encouraged her to have a relationship with God, who would always be there for her. Brenda treasured her relationship with her mother dearly and told herself that she would live to be the success that her mother wished for.

When Mr and Mrs Lubega died, they left behind three houses, two of which had always been rented out. However, soon after their death, relatives came and took two of the houses away from them. Brenda and her siblings were left with one very small house to live in and no money for food and other basic necessities. Life for Brenda, who was the youngest of the four children, was very tough. Her eldest sister soon got married and left home; her other sister looked to boyfriends for affection and soon had a child of her own to care for. The relatives decided that Brenda and her brother should go and stay with an uncle in another town. The uncle mistreated them, and her brother soon left to live on the street. Brenda explained her situation to one of the church elders, who encouraged her to join the church's youth club. This provided her with the opportunity to share her problems with other children, many of whom had also had difficult life experiences.

Through the youth club, she befriended a girl, Mavis, who told Brenda's story to her parents. Mavis's parents, who were both moved and troubled by Brenda's situation, decided to offer Brenda a new home. Their offer came at a very good time because Brenda's uncle had thrown her out of his home. Mavis's parents gave Brenda a caring and supportive home and also provided Brenda with the opportunity to attend school. Brenda now takes part in all aspects of their family life and aims to study social science at university so that she can become a social worker and reach out to children and families facing difficulties in life.

2 Adapted from REPSSI (2011c): "Upile's story".

Questions

1. What made Brenda respond in a different way from her siblings following the death of their parents?

2. What actions did Brenda take that demonstrated her resilient qualities?

3. What role did the community play in encouraging or enhancing Brenda's resilience?

4. Do you have similar stories from your families and communities about children like Brenda who show the ability to stand, survive, and fight on despite difficulties?

Answers

Possible answers:

1. Her close relationship with her mother; her relationship with God

2. She talked about her problem; she joined a youth group; she built new relationships; she got involved with her new family; she maintained her focus

3. Ensuring that her schooling continued; having a family adopt her; taking part in a church youth club; having someone to talk to

Brenda's story presents a good example of a child who copes with the challenges she faces and develops resilience. We will now look more closely at what we mean by coping and resilience.

Facilitator tips

- Ask participants to discuss the following question: What are the positive and negative things that OVC do to deal with their difficult experiences?

- Summarise the responses and supplement missing answers from the notes below.

Possible responses:

Positive	Negative
Talking to other children	Blaming people
Attending a ritual	Exhibiting denial
Seeking advice from adults	Doing nothing about the problem
Keeping busy	Isolating themselves
Praying	Abusing substances
Getting involved in recreation activities	Demonstrating suicidal behaviour
Seeking counselling	Running away to live on the street

Factors affecting coping

Two people who have experienced the same traumatic event may not necessarily cope in a similar way. One may cope positively while the other copes negatively. One may take a shorter period to recover while the other takes longer. People have different coping styles because each individual is unique, with a different personality, experiences, and resources, all of which influence their coping abilities. Therefore, caregivers need to understand the factors that influence coping so that they are able to help children rebuild their lives. These factors include an individual's level of self-esteem, as well as the availability of community protective factors, such as social services and supporting institutions.

Most of the factors that influence resilience are the same as those that influence coping. Other factors that influence coping include:

- Availability of resources like land, property, income, and community support structures

- Meaning of the experience to the victim (For instance, how the individual perceives an event will affect both the level of stress she experiences and her coping effectiveness. An individual who believes she was at fault at the time of the event may suffer severe guilt feelings and depression.)

- Past experiences in dealing with problems

- Magnitude and context in which the experience occurred

- State of the person's health (For instance, he may have pre-existing stress.)

- Ethnic and cultural differences, which may endanger individuals as well as interfere with their ability to obtain or use services and supplies during a traumatic event.

Facilitator tips

- Use the rubber band example to explain the concept of resilience.

Resources

Rubber band

Facilitator notes

Rubber band exercise[3]:

Take a rubber band and stretch it as far as possible, then bring it back to its original size. Repeat the exercise several times and then relate it to a person's experience by asking:

- What happens when we stretch the rubber band?

- What happens when we let go?

- What happens when we stretch it too far?

- How does this relate to resilience?

Possible answers:

The rubber band changes shape when it is stretched. It adapts to being pulled. When I let go, it snaps back but it may not look exactly the same as before. (It can be longer or have a slightly changed colour.) When I pull it too much, it can break. This is similar to resilience in that people can recover from stress and difficulties (being "stretched") and "bounce back" to their original shape. However, this does not mean that they are just like they were before the experiences. The difficulties can leave their mark on their emotions, behaviour, and abilities. And just like the rubber, if people are "stretched" too far, they may not be able to cope. No one is infinitely resilient. This means that they need support to become more resilient[4].

Additional notes

When we use the term resilience in psychology:

- Resilience means the ability to recover quickly from severe events, especially if there is a supportive environment.

- This does not mean that after being "stretched" by an adverse event, there are no effects. Individuals experience all the reactions to stress that we spoke about, but they are able to quickly adapt and solve the problem or adapt to the new situation.

- Just as the elastic band snaps when it is stretched too far, it is important to remember that nobody is infinitely resilient. Without proper support and with prolonged exposure to adverse situations, even the most resilient person can "snap".

- Good news about resilience: Almost anybody can build and cultivate it.

Factors affecting resilience

Facilitator tips

- Discuss why some people are able to more quickly return to functioning normally than others.

- Brainstorm on the role of caregivers in enhancing resilience and positive coping. How can they promote resilience in children?

Facilitator notes

Resilience involves behaviour, thoughts, and actions that can be learnt and developed in anyone. A combination of factors contributes to resilience. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models, and offer encouragement and reassurance help strengthen a person's resilience. Factors that influence resilience can be categorised as either external or internal.

4 Adapted from ANCHOR & HOPE Worldwide (2006).

External	Internal
Support of caregivers	Intellectual maturity
Quality of family life	Self-esteem
Positive role models in the community	Coping style
Degree of community social support	Capacity to manage strong feeling
	Sense of purpose and optimism

The most important of these is the support of caregivers. As Richter et al (2006: 9) state:

"*Children are able to be resilient, that is, to bear and recover from significant suffering, when they are surrounded by people who love and care for them. The sense of belonging and hope that is nurtured in these relationships enables children to cope with hardship, including hunger, illness, discomfort, and other deprivations of poverty and loss.*"

Being resilient does not mean that a person does not experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major painful experiences in their lives. The road to resilience often involves considerable emotional distress. Here is a story that illustrates this:

The Wedding Feast/Tortoise's Journey

One day there was a great wedding feast in the sky. All the birds were invited, and they talked excitedly about going. Tortoise heard them and longed to go. He begged his bird friends to take him with them. They agreed and carried Tortoise to the party. At the party, Tortoise ate too much. On the way back, he was so heavy that the birds could not carry him and he fell. Tortoise's shell cracked into many pieces. Tortoise was miserable and very exposed. Tortoise could not move about and stayed away from others.

One day, Tortoise realised he could not stay alone feeling depressed for the rest of his life. He decided to start looking for the pieces of his shell. His friends also began to miss him and came to find him. They helped him to pick up the pieces and put them together.

Tortoise felt better about himself and rejoined the other animals. To this day, Tortoise has scars on his shell, but he moves around as he did before the wedding feast.

Through this simple story, we can see the meaning of resilience. We can also see that resilience does not mean forgetting adversity. We see that tortoise remains with the scars on his shell, but he still moves about as he did before the feast. The story also illustrates coping because we see that tortoise is initially depressed and in hiding (negative coping) before he comes out of this. Here we see the importance of his friends and even his inner capacity (the factors that help us become resilient) as he realises that he cannot live like this anymore.

Resilience can be compared to taking a journey on a boat down a river. On the river you may encounter rapids, windings, slow water, and shallow spots. When travelling on a river, it helps to have knowledge about it and past experience in dealing with it. Your journey should be guided by a plan—a strategy that you consider likely to work well for you.

Perseverance and trust in your ability to work your way around boulders and other obstacles are important. You can gain courage and insight by successfully navigating your way through difficult parts of the river. Trusted companions who accompany you on the journey can be especially helpful when dealing with rapids, upstream currents, and other difficult stretches of the river. You can climb out to rest alongside the river, but to get to the end of your journey, you need to get back in the boat and continue.

A caregiver needs to not only make the OVC understand the nature of this journey, but also mobilise friends (social support) to accompany the OVC through this journey. The caregiver is part of the social support.

I have, I am, I can[5]

The "I have, I am, I can" model is one way in which resilience in children can be built. There are three important ingredients needed for resilience to emerge. Caregivers and those working with OVC can ask children to think about these:

I HAVE

The **I HAVE** factors are the external supports and resources that promote resilience. Before the child is aware of who she is ("**I AM**") or what she can do ("**I CAN**"), she needs external supports and resources to develop the feelings of safety and security that lay the foundation (or the core) for developing resilience. This support continue to be important throughout childhood. The resilient child says:

I HAVE...

...trusting relationships

It is important that parents, other family members, teachers, and friends love and accept the child. Children of all ages need unconditional love from their parents and primary caregivers, but they need love and emotional support from other adults as well. Love and support from others can sometimes compensate for a lack of unconditional love from parents and caregivers.

...structure and rules at home

Parents who provide clear rules and responsibilities expect the child to follow them and can rely on the child to do so. Rules and routines include tasks the child is expected to perform. The limits and consequences of behaviour are clearly stated and understood. When a child breaks a rule, the child is helped to understand what she did wrong, encouraged to tell her side of what happened, punished when needed, and then forgiven and reconciled with the adult. When the child follows the rules and routines, he or she is praised and thanked. The parents do not harm the child during punishment, and no one else is allowed to harm the child.

...role models

Role models are parents, other adults, older siblings, and peers who act in ways that display desired and acceptable ways of behaving both within and outside the family. These people demonstrate how to do things, such as dress or ask for information, and encourage the child to imitate them. They are also models of morality and may introduce the child to the customs of their religion.

...encouragement to be autonomous

Adults, especially parents, who encourage the child to do things on her own and to seek help as needed, help the child to be autonomous. They praise the child when he or she shows initiative and autonomy, and help the child, perhaps through practice or conversation, to do things independently. Adults are aware of the child's temperament, as well as their own, so they can adjust the speed and degree to which they encourage autonomy in their child.

...access to health, education, welfare, and security services

The child has access to resources and services that can meet the needs the family cannot fulfil — hospitals and doctors, schools and teachers, social services, and police and fire protection.

I AM

The **I AM** factors are the child's internal, personal strengths. These are feelings, attitudes, and beliefs within the child. The resilient child says ...

I AM...

...lovable and my temperament is appealing

The child is aware that people like and love him or her. The child does endearing things for others that help make him or her lovable. The child is sensitive to the moods of others and knows what to expect from them. The child strikes an appropriate balance between excitement and quietness when responding to others.

...loving, understanding, and giving

The child loves other people and expresses that love in many ways. He or she cares about what happens to others and expresses that caring through actions and words. The child feels the discomfort and suffering of others and wants to do something to stop or share the suffering or to give comfort.

...proud of myself

The child knows what she/he can do to achieve her/his desired goals. The child does not let others belittle or degrade him or her. When the child has problems in life, confidence and self-esteem help sustain him or her.

...autonomous and responsible

The child can do things on his or her own and accept the consequences of the behaviour. There is the feeling that what he or she does makes a difference in how things develop and the child accepts that responsibility. The child understands the limits of his or her control over events and recognises when others are responsible.

...filled with hope, faith, and trust

The child believes that there is hope for him or her and that there are people and institutions that can be trusted. The child feels a sense of right and wrong, believes right will win, and wants to contribute to this. The child has confidence and faith in morality and trustworthiness, and may express this as a belief in God or higher spiritual being.

I CAN

The **I CAN** factors are the child's social and interpersonal skills. Children learn these skills by interacting with peers and from those who teach them. The resilient child says ...

I CAN...

...communicate

The child is able to express thoughts and feelings to others. He or she can listen to what others are saying and be aware of what they are feeling. The child can reconcile differences and is able to understand and act on the results of the communication.

...solve problems

The child can assess the nature and scope of a problem, what he or she needs to do to resolve it, and what help is needed from others. The child can negotiate solutions with others and may find creative or humorous solutions. He or she has the resilience to stay with a problem until it is indeed solved.

...manage my feelings and impulses

The child can recognise his or her feelings, give the emotions names, and express them in words and behaviour that do not violate the feelings and rights of others or themselves. The child can also manage the impulse to hit, run away, damage property, or behave in an otherwise harmful manner.

...gauge the temperament of myself and others

The child has insight into his or her own temperament (for example, how active, impulsive, and risk-taking or quiet, reflective, and cautious he or she is) and into the temperament of others. This helps the child know how fast to move into action, how much time is needed to communicate, and how much he or she can accomplish in various situations.

...seek trusting relationships

The child can find someone — a parent, teacher, other adult, or same-age friend — to ask for help or with whom to share feelings and concerns, explore ways to solve personal and interpersonal problems, or discuss family conflicts.

Each of the **I HAVE**, **I AM**, and **I CAN** factors suggests numerous actions children and their caregivers can take to promote resilience. No one child or parent will use the entire pool of resilience factors. Some use many; others use few. However, the larger the pool of possibilities before them, the more options children, parents, and caregivers have and the more flexible they can be in selecting appropriate responses to a given situation.

Activity[6]: Apply the "I HAVE, I AM, I CAN" model to the case study below

Case study: Rona

Rona is a 12-year-old girl in P6 who has just lost her parents and close relatives in a mudslide. She returns home from school to hear the tragic news. When Rona's parents were still alive, they taught her a lot of things about cookery. She would participate during the holiday in making little cakes (mandazi) to sell as a contribution for her school fees. Rona also once heard her father speak of a good family friend who lives in the nearby town. She remembers the address, but realises she has no transport to go there. It is quite far to walk. Rona feels sad, but still dreams of a bright future in school.

How can Rona move on? What advice would you give to Rona at this difficult moment in her life?
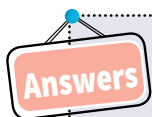
Answers

Possible answers could include:

Make some little cakes (mandazi) to sell, and use the proceeds to travel to town to get assistance.

(Through activities **I can** study, work, eat, dance, do any everyday activity = **competence, confidence, initiative**)

There must be someone in the village that could help her — a leader, another family friend, a teacher, etc.

(Through relationships **I have** parents, family, friends, teachers, a community = **trust, love, sense of belonging, identity**)

Rona should stick to her dream and hope and believe things will be well. This will keep her going as she plans the next move.

(Through beliefs about yourself: **I AM** values, beliefs, culture = **self esteem, purpose in life, identity and responsibility**)

Summary

In this module we have looked at vulnerability, psychosocial well-being, care and support, psychosocial interventions, coping and resilience.

6 From AVSI SCORE (2013).

Module 2

Caregiver and community support

Introduction

This module focuses on the two levels of caregiver and community support on the intervention pyramid. These two levels relate to providing children with everyday care and support to enable them to become resilient. These two levels are referred to as "natural systems" (or informal systems) of care for children. These levels include caregivers, families, friends, peers, religious groups, neighbours, community members, teachers, health care providers, and others in the immediate environment. While we know how to care for children, sometimes it is necessary to provide people with some information to help them understand and assist children better. This module covers the following seven sessions:

1. Child development
2. Needs of children and how to meet them
3. Rights and participation
4. Cultural and religious practices as a form of psychosocial support
5. Communicating with children
6. Working with groups
7. Adolescents and young people

Module objective
By the end of this module, participants should be able to explain the path of child growth and development and the role of natural/ informal systems and families in promoting children's psychosocial development

Resources
- Flip charts
- VIP/sticker cards
- Markers
- Masking tape

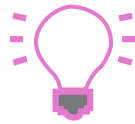# Session 1 > Child survival, growth, and development

Session objectives

By the end of this session, participants should be able to:

- Define child growth and development
- Describe the stages of child growth and development
- Discuss the challenges that children face during their growth and development

Time frame
45 minutes

Facilitator tips

- Group participants and ask them to brainstorm on the definition of child growth and development.
- Ask participants to discuss the stages of child growth and development by sharing their own local experiences.
- Ask participants to point out the different aspects of development that adults need to pay attention to in order to see if a child is developing well.
- Ask participants to reflect on the challenges that children face during their growth and development.
- Engage people to suggest how challenges to child growth and development can be overcome

Facilitator notes

The Uganda Constitution, 1995, defines children as anyone below the age of 18.

A child is a person who is below the age of 18 years (National OVC Policy 2004).

### Additional information for the facilitator on children in Uganda:

- The age of sexual consent is 18 for both girls and boys [Penal Code Act 120].
- The age for marital consent is 18.
- The age of consent for an HIV test without parental or guardian approval is 12.
- The age of criminal responsibility is 12. All children have the right to legal representation.

- Children up to the age of 11 should not be engaged in any type of work. Children between 12 and 14 can only be employed for light work under the supervision of an adult and not during school hours. A child under 18 cannot be employed in work that is harmful to their health, dangerous, or unsuitable. A child under 18 cannot be employed in work that takes place between 7:00 PM and 7:00 AM [Employment Act, 2006, s. 32].

- Children have the right to inherit 75% of the property and assets of a deceased parent who leaves no will. If a will has been made, but the children are not included, the court has the right to provide the child with a share of the property. A girl child has the right to stay in the house of a deceased head of household until she turns 21, and a boy child has the right to stay until he turns 18 [Succession Act Cap 162].

- There are also laws that outlaw domestic violence, child trafficking, female genital mutilation, and other practices that are harmful to children.

Child growth and development refers to the progression of life from birth to adulthood.

Generally, child growth and development progresses in more or less predictable stages from birth until the child reaches adulthood.
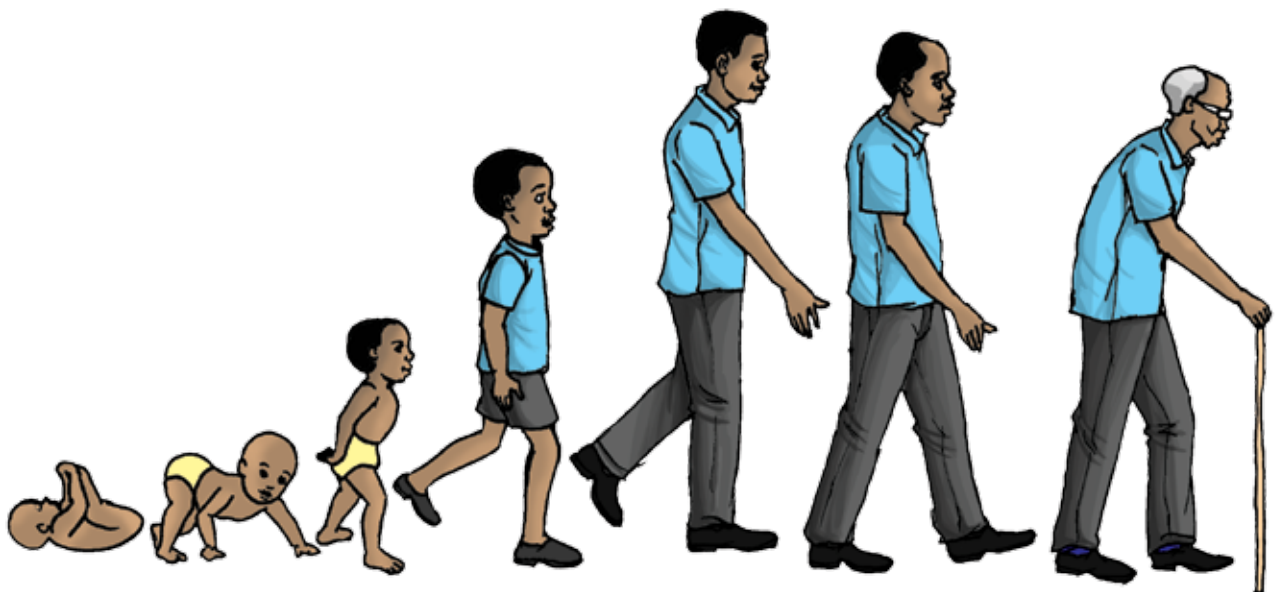
The stages of child growth may be culturally specific, but for learning purposes the following stages will be used:

1. Birth to infancy	0-2 years
2. Early childhood	2-6 years
3. Middle childhood	6-11 years
4. Adolescence or teenage	11-18 years

Differences between child growth and development

Child growth is different from child development in the following ways:

- Child growth is about the physical growing that a child's body goes through. It is based on biological events. Growth is usually measured in terms of height, size, and weight.

- Child development is about the cognitive, emotional, and social progress that a child undergoes. Development is influenced by the psychosocial environment in which a child lives; for example, the attention and encouragement she receives, the stimulation available to her, and the love and care she receives from caregivers. There are some general "milestones" that most children achieve at a certain levels of their life cycle. These milestones relate to skills, capacities, and abilities.

- Child growth and development are closely related. Growth is usually considered to be one part of development (i.e., the physical development).

The main areas of child development that occur are:

- Physical (gross and fine motor skills)
- Cognitive function
- Language
- Emotional (temperament)
- Social skills

Child Development [7]

Stages	Physical	Psychological	Concerns	Role of caregiver
Newborn to 2 years Children are physically helpless and totally dependent on others	- Move their bodies - Can hold up their head, sit by themselves, feed themselves, walk, and talk - Use their hands and eyes together to manipulate objects and throw things - Develop sense of vision, hearing, taste, smell and touch	- Bond with caregivers - Develop feelings of love and trust - Feel other emotions, such as fear and separation anxiety - Develop a sense of understanding - Understand how objects work - Learn that things are still there even if they cannot see them - Understand what is being said to them - Follow through with simple requests - Know the names of familiar objects, body parts, and concepts - Become independent as they begin to do things for themselves and play on their own	- Failure to meet the child's basic needs consistently may lead to the child not having trust and faith in others as he becomes an adult. - When a child does not get the needed support and encouragement — or is blamed — the child will experience shame and doubt their abilities.	- Be reliable and consistent about feeding times, bathing, and changing. Attending to the child's basic needs on time and responding appropriately helps to develop the child's trust. - Be friendly and accepting. Encourage the child to achieve tasks.

7 Adapted from ANHCHOR & HOPE Worldwide (2006).

Stages	Physical	Psychological	Concerns	Role of caregiver
Ages 3-5 years	- Develop self-care skills (dressing, feeding, and toileting) - Have a very high degree of energy	- Learn language and start thinking for themselves - Very self-focused, often thinking that they have a far greater effect on the world around them than they really do: "magical thinkers" - Learn social rules (culture) like the expectations within their family, schools, and communities. - Learn general routines - Understand what is real and what is fantasy (may use imaginary play or have more fears and nightmares) - Think in the "here and now" and not the future - Ask a lot of questions - Understand consequences/effects of their action/emotions and know right from wrong - May begin attending pre-school/creche/day care and learn new skills like counting - Begin developing new relationships outside the home (e.g., teachers and peers)	- Failure to learn these tasks (such as dressing, feeding, making friends) may lead to one feeling guilty or afraid to try new tasks. - A child could depend on adults and others too much. - A child could have problems relating with others later in life. - One may end up being unable to deal with life issues or concerns — or unable to make decisions.	- Allow the child to experiment, but still set limits. - Give honest responses to questions raised. - Give praise when the child achieves. - Do not shout at the child when they fail in certain tasks. - Help children learn how they could have done better or differently. - Encourage creativity. - Encourage talking about feelings (e.g., share your own feelings, observe the child, and try to interpret their feelings).

| Stages	Physical	Psychological	Concerns	Role of caregiver
Ages 6-11 years	- Continue to grow in height and weight - Able to do more with their hands and the rest of the body as they have more control of it	- Continue to work on their skills - Begin to understand that another person's point of view may be different from their own - Gain a greater understanding of emotions and how people are feeling (begin to be able to "empathise", or put themselves into another person's emotional shoes) - Begin to think logically about concrete things that they experience in their everyday life (e.g., "I have to go to school so that I can learn how to read and write") - Have increased understanding of social roles and norms (like a man can be a father, son, teacher, and friend) - Understand how objects relate to each other - Better able to solve problems as their memory skills greatly improve - Can understand most concepts (ideas/theories) that are explained to them - Can learn skills such as reading, writing, and mathematics - Can have increased responsibility around the house	- When the child does not accomplish the tasks, he may give up hope for the future. - The child might feel inferior (less than his/her peers). - The child may feel inadequate (not knowing, not being able).	- Praise the child's efforts. - Encourage the child to see himself/herself as equal to peers. - Encourage the child to have a sense of being able to achieve, even against all problems. - Teach them how to handle failure and solve problems. - Caregivers must give appropriate support.

Stages	Physical	Psychological	Concerns	Role of caregiver
Ages 12-18 years	- Experience intense physical changes in the body (puberty)	- Think primarily of themselves - Begin to think about the future - Focus most of their attention on social relationships and are preoccupied with appearances, beliefs, and values - Are developing a sense of themselves in relationship to the rest of the world to establish their own sense of identity, but at the same time are desperate to fit in and belong to a group - Often do not want to do what they are told to do - Want to be independent, but are still dependent - Experience a stronger division in the roles of males and females - Often begin serious relationships (with family, friends, and romantic partners) - Begin to think about abstract things like social class - Gain an increased understanding of moral issues and what is right or wrong - Have increased emotional needs and insecurities - Practice being an adult	- If a child does not successfully achieve this stage, there is confusion regarding identity, religion, sexuality, etc.	- Keep communication channels open. - Encourage the child to speak their mind or express their opinions. - Provide advice and guidance. - Allow the child to have some independence, but provide limits or boundaries. - Give the child the opportunity to express his/her anger and other difficult feelings.

Additional Information for the facilitator:

Even though children have different needs at different stages, children are still people and have common needs too! No matter what their age is, children learn and develop by feeling loved, valued, and wanted; through playing and exploring; from making mistakes and practicing things over and over again; by asking questions and watching role models; and through experience.

UNICEF (2011) suggests that:

Rather than thinking of children as "little people who are in the process of becoming fully grown" adults, many global child development experts suggest that we think of them as full human beings in their own right: we need to fully recognise children, in each stage of their development, as having unique needs and skills, as well as personal voices that deserve to be listened to with respect and empathy (p.4).
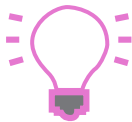
Facilitator tips

- Break into four groups and ask each group to take one of the previously discussed developmental stages. Each group should discuss the age group and create a role-play of a child in the developmental stage they were assigned.

- The role-play should be about a child facing a problem or misbehaving and how an adult should interact with them in an age-specific way. An example is a child who doesn't want to go to school or a child who does not want to go to sleep at night. Have all groups discuss how best to assist a child with such problems.

Facilitator notes

Importance of play

The facilitator explains that many children around the world are growing up with very limited opportunities to play. The day-to-day demands of life on children have resulted into a very significant reduction in playtime. This is particularly true in the context of HIV/AIDS, whereby children have to assume roles that were once seen as adult roles (e.g., nursing ill parents, taking care of siblings, and providing income to sustain the daily needs of families and the general management of households). Play is the work of childhood and is a cornerstone of healthy psychosocial development.

Why is play important?

Possible Answers: Learning, Healing, Fun

Learning:

- Play is significant in the development of children and contributes to social, emotional, physical, and mental development.

- It is one of the child's ways of finding out what effects s/he can have on her/his environment and what effects it is likely to have on her/him. It is an active learning method that provides manipulation and facilitates mastery, self-worth, and the development of basic competencies – including social competencies.

- Children are curious, and play provides a safe way to explore and learn about the environment. Individual and cooperative play facilitates neurological growth; fosters the development of physical strength and coordination; provides relaxation; encourages planning; facilitates processing of symbols; allows practice of life skills; unites body, mind, and spirit; and allows a child to enjoy learning.

Healing:

- Apart from its role in the development of a child, play has an equally powerful healing value for children coping with traumatic life experiences. Some psychologists say that to "play it out" is the most natural and self-healing process in childhood. Play allows for emotions to be expressed; compensation in fantasy for loss, hurts, and failures; and self-discovery.

Fun:

- Play is fun for children and young people (and adults too). It can be a good way to distract yourself from your problems, relax, and enjoy yourself, all of which can give you renewed energy for dealing with challenges you face in your life.

Session 2

Needs and how to meet them

Facilitator tips

Give participants VIP cards and ask them the following questions:

- What are your most important needs?
- What do you consider to be the most important needs for your child? List three.
- In groups arrange the needs in the five categories: emotional, physical, mental, spiritual, and social.
- Are these needs important? If so, how important are they to both the parent and the child?

Session objectives

By the end of this session, participants should be able to:

- Identify and understand needs
- Comprehensively respond to the needs of children

Time frame

45 minutes

Facilitator notes

Categories of needs

Note that each need reinforces the other. Addressing any one need is as important as another.

Psychological needs of child

- Parental love
- Parental care
- Values/beliefs
- Spiritual guidance
- Sense of belonging
- Recognition
- Respect
- Independence
- Love/companionship from partner
- Freedom

Material needs of child

- Food
- Shelter
- Clothing
- Medical care
- Security/protection
- Money/possessions

Social needs of child

- Family
- Friends
- School
- Religion
- Culture
- Community
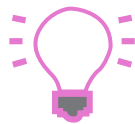
The above diagrams have been taken from the AVSI (2014) manual.

Facilitator tips
- Make an illustration of the Bronfenbrenner (1979) ecological systems model, and explain to participants how needs are met by different actors at different levels.

Facilitator notes

You can never think of a child in isolation, but must see the child as part of a larger social system that provides different aspects of care and support. According to the ecological systems model developed by Bronfenbrenner (1979), a child is influenced in their development and well-being by:

1. The microsystem (usually the immediate family)

2. The ecosystem (school environment, neighbourhood, community, etc.)

3. The macrosystem (socioeconomic conditions, political context and service provision).

Families, schools, and communities can be natural systems of care. Caring relationships within these three contexts can improve resilience and help them deal with stressful situations (Richter et al, 2006). The importance of everyday interactions in the form of love, support, and reassurance cannot be overestimated. It is here that a child can feel safe, secure, and normal. Children may often feel insecure about their future and their standing within their family, so reassurance through daily support is important.

All parts of the system are equally important; the system cannot function without other parts.

Macrosystem

Ecosystem

Laws

History

Microsystem

Extended family

Parent's work environment

Family

Individual child

Peers

School board

Mass media

Siblings

Social conditions

Culture

Neighbourhoods

Economic system
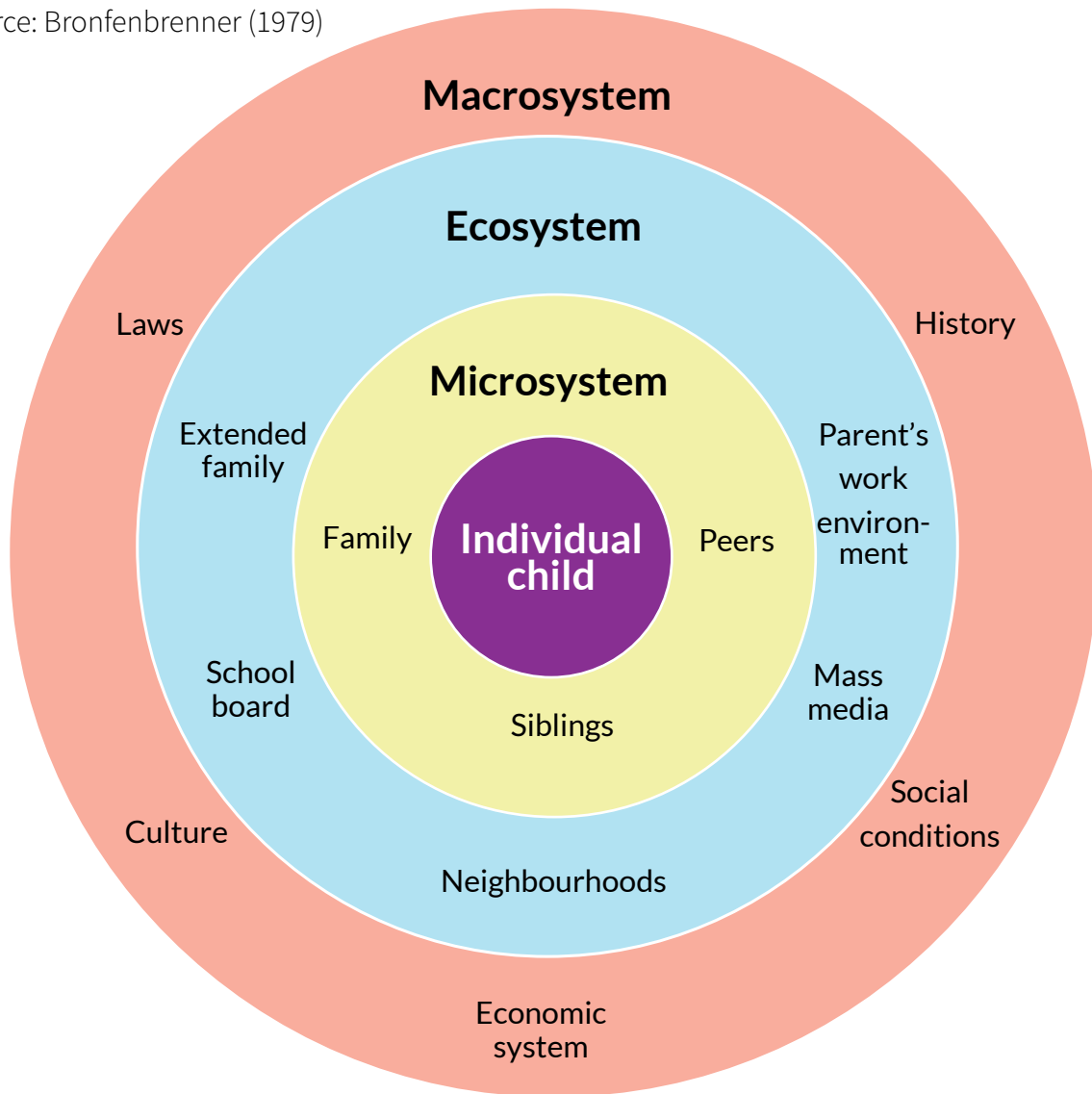
Additional notes for the facilitator

Meeting needs improves their psychosocial well-being

- Responsive parental care, which involves affection and reassurance, can help the child feel safe and loved.

- Improve ways of communicating with the child (see session 5 of this module).

- Return to normalcy by providing structure and routines in the child's life. Caregivers can give the child stability, which helps the child feel secure and safe. Doing the same things every day, such as waking up, washing, and going to school, creates daily patterns that the child will come to expect and find reassurance in.

- Provide opportunities for social participation for the child (Richter et al, 2006). These could be things such as joining a sports group or joining in communal activities.

- Think about the different aspects of the child's needs (emotional, spiritual, social, mental, and physical) and about how you could provide assistance in each area of their development.

- Think about how you can coordinate the social support system around the child to operate in a holistic manner. For instance, what can different agents, such as schools, NGOs, churches, and social services, provide that will improve the child's situation?

Session 3 ▷ Rights and participation

Facilitator tips

Group participants and ask them to discuss the following questions and report in plenary:

- What are the rights of children?
- What responsibilities do children have?
- Have you ever witnessed a clash between rights and responsibilities?
- If rights are violated, what are the likely psychosocial effects?
- Present the case example about young girls in a host community school. Discuss the rights violated.

Facilitator notes

Child rights are a set of universal entitlements for every child and young person below the age of 18, UNCRC (1989). Some of these are listed below:

Session objectives

By the end of this session, participants should be able to:

- Define and identify the rights of children
- Identify the responsibilities of children
- Identify the cost of violating children's rights

Time frame

45 minutes

Right	Household	Community	CSO	State
Food	• Provide a nutritious and balanced diet from locally available foods. Ask children to participate in the preparation and choice of food, while guiding them on what a balanced diet is. • Ask your local health unit workers which foods are nutritious in your community.	• Establish collective nutrition gardens in the community.	• Link communities with agricultural services. Link caregivers to grant facilities (e.g., food parcels). • Provide food distribution systems. Provide training on nutrition. Provide energy saving, appropriate technology. Monitor feeding schemes. • Mobilise communities for gardening.	• Provide grants for feeding schemes. Provide seed money for community gardens. Provide agricultural extension services. • Avail health and nutrition staff to communities.
Clothing	• Provide clothing (more than two pairs) appropriate for the child's age. • Provide school uniform. • Provide adequate bedding.	• Community members can mobilise themselves to donate clothing. If used, it should be cleaned and disinfected.	• Mobilise cloth donations. Establish a distribution mechanism. • Economically empower caregivers to buy clothing.	• Target households that have vulnerable children and improve their incomes. • Ensure that no child is denied education due to lack of uniform.
Home Environment/Security	• Provide shelter. • Make sure that the house is clean. • Provide privacy for older children.	• Traditional leaders/local councils to ensure that the community is mobilised to provide shelter for those children who have none. • Leader to monitor cleanliness and safety of homes. • Raise awareness on environmental issues.	• Create awareness, knowledge, and skills for caregivers and children about a safe home environment.	• Provide environmental-related services, such as drainage systems and subsidised basic household infrastructure. Provide shelter to homeless children. Monitor safety of home environment. • Provide education to caregivers on home environmental matters.

Right	Household	Community	CSO	State
Hygiene/ infection control	• Practise basic hygiene. Apply precaution guidelines.	• Promote community awareness.	• Provide basic hygiene materials. • Give knowledge and skills on hygiene and disease control.	• Provide materials for basic hygiene (e.g., gloves, bleach, and detergents).
Treatment and health care	• Take children for immunisation. • Acquire and apply basic first aid knowledge. • Be informed about illness symptoms. • Administer medication as directed.	• Community leaders and traditional healers to be involved in promotion and awareness activities for HIV/AIDS and STDs. • Community leaders and traditional healers to get involved in promotion of safe sex practices.	• Provide awareness and skills for caregivers on identifying and taking action against illness. • Give skills on basic first aid. • Provide basic homecare kits. • Provide medical care. • Monitor treatment and health care.	• Give grants for health care. • Build health units. • Provide medication and health care staff. • Monitor disease trends. Hold widespread education campaigns. • Provide basic home care kits. • Ensure that all children are immunised. • Provide food supplements.
Poverty alleviation/ social security	• Participate in income generation activities. • Be self-sufficient by being innovative. • Seek active support for self-reliance. • Seek knowledge about income generating activities.	• Mobilise communities for income generation. • Support community social support systems. • Organise communities into safety networks.	• Mobilise communities for income generation. • Link caregivers with microfinance and other service institutions.	• Promote and support income-generating activities. • Promote access to microfinance.

Right	Household	Community	CSO	State
Security: Protection against abuse and neglect	• Provide caring and reliable adult presence. • Respond to reports of abuse and neglect. • Apply discipline to children and guide them in behaving in a culturally and socially acceptable manner. • Parents should make a Will appointing a guardian to care for the children.	• Form child protection committees. • Report cases of abuse to probation officers and police. • Protect children with HIV/AIDS against stigma. • Protect orphans from having their homes vandalised and their property grabbed. • Ensure that children have property inheritance rights. • Construct houses for orphans.	• Advocate against negative cultural practices that disadvantage children. • Report cases of abuse to police and probation office. • Ensure that children have access to child-friendly courts. • Help OVC access legal redress in case of property grabbing. • Train the community on child rights. • Train caregivers in recognising signs and symptoms of abuse. • Advocate internally against child abductions. • Provide life skills to children to help them adjust positively to adverse conditions. • Provide alternative care in cases where children have no one to care for them. • Closely supervise standards at alternative care institutions. Set standards for rehabilitation and reintegration.	• Provide guidelines for care of children in communities and institutions. • Develop and implement legislation for child protection. • Advocate for support to OVC. • Provide a framework for referral, reporting, and communication. • Provide backup grants for NGOs and local governments.

Right	Household	Community	CSO	State
Affection	• Provide constant and unconditional love. • Give extra care to younger children whose parents are very sick. • Take time to listen and to communicate with children at their level.	• Provide forums in which children can interact with adults, such as through dance and drama clubs. • Provide ongoing support for caregivers. • Screen and provide caregivers and members of the child protection committees.	• Ensure that caregivers are being supported. • Provide skills, knowledge, and awareness for caregivers in child care. • Put screening and monitoring mechanisms for OVC caregivers.	• Facilitate activities geared toward creating awareness and providing skills and knowledge to caregivers. • Provide a supportive environment for caregivers.
Socialisation: Identity & schooling/ education	• Register children. • Make sure that the child's kinship, name, and identity are retained. • Before death, parents should ensure that they have identified a person who can provide children with a sense of family continuity. • Take time to provide a child with possible memory aids regarding family and cultural connections and linkages. • Aid the child to go school, supervise homework, and provide help in schoolwork.	• Promote community cohesion. • Inform orphaned children of their heritage and ensure its protection. • Identify and screen family members who can take care of children. • Advocate for children to go to school and monitor school attendance. • Promote love of education in communities. • Promote traditional social protection systems.	• Put in place programmes that ensure childcare within the community. • Build the capacity of family members to provide care for children. • Provide awareness on how to help children get a sense of belonging. • Put a mechanism in place to ensure that children do not lose memory of family, (for example, photos and directories of significance). • Provide awareness on creating an enabling environment for schooling. Monitor and advocate for the education of OVC.	• Provide free education to OVC. • Provide legal protection against loss of identity. • Ensure that the principle of caring for children in their community settings is followed. • Ensure that schools are functional and are monitored. • Ensure that OVC are not discriminated against. • Provide effective and accessible systems of childbirth registrations with special emphasis in rural settings. • Provide opportunities for learning for child heads of households.

Right	Household	Community	CSO	State
Child participation	• Caregivers to discuss with children about care plans. Apply decision-making mechanisms that are appropriate to the child's culture and are in the child's best interest.	• Promote and encourage community participation.	• Promote and encourage decision-making in the areas that affect their lives. • Provide training for caregivers on how to facilitate children to set their own priorities, make goals, and make choices. • Provide opportunities for child forums.	• Put in place decision-making mechanisms in the areas that affect their lives. • Ensure participatory mechanisms that allow children to evaluate services offered to them.
Access to information	• Caregivers to create an environment for interactive communication with children. • Provide training on basic survival skills. • Give children information about diseases and how to prevent them.	• Raise awareness on issues affecting OVC. • Give HIV/AIDS messages. Give messages that challenge discrimination and exploitation of children.	• Provide training in basic life skills. • Provide life skills training. Provide accurate information on HIV/AIDS and other risks to OVC. • Provide awareness, knowledge, and skills to OVC and caregivers (e.g., about death and dying, sex and relationships, STDs, early marriages, etc.) • Equip caregivers with basic helping skills.	• Provide skills training for children. • Provide accurate information to traditional leaders, healers, and political leaders. • Put in place programmes aimed at developing caregivers' knowledge around sex and related issues. • Provide knowledge about effects of armed conflict and other related issues.

Right	Household	Community	CSO	State
Supportive services/ counselling	• Provide continuity and security. • Communicate and be sensitive to needs. • Understand the psychosocial needs of children at different stages of development. • Accept and support HIV-positive children.	• Accept people living with HIV/AIDS. • Provide emotional and spiritual support to caregivers.	• Provide caregivers with awareness, knowledge, and skills to respond to emotional and social needs of OVC. • Provide networking systems to help children in need of supportive services. • Provide emotional and spiritual support for caregivers.	• Provide social workers who are not office-based to the community. • Provide social workers who can respond quickly to referrals. • Provide social workers who can help caregivers access resources. • Provide well-trained social workers who work proactively and insightfully. • Put in place a mechanism for referral, reporting, and networking for effective supportive services.
Recreation	• Give children an opportunity to play. • Give the child an opportunity to be a child.	• Ensure that children placed for care are not being used as cheap labour and that they have time to play. • Teach traditional songs, stories, and dance to children.	• Help caregivers learn to help children identify and utilise their talents.	• Provide awareness to caregivers on how to help children use their imagination, creativity, and intelligence through play.

Right	Household	Community	CSO	State
Palliative care	• Provide a caring presence and pain relief to terminally ill children. • Provide a child with emotional and spiritual support (bereavement support). • Provide sanitary material. • Discuss death with children, and when it occurs, put in place activities that bring about closure.	• Ensure that customary burial rituals are followed. • Provide emotional and spiritual support in all bereavement stages.	• Give caregivers knowledge and skills to provide basic bereavement and grief counselling for adults and children. • Ensure that there is a referral system between all institutions and individuals involved in palliative care.	• Provide all necessary medication.
Rehabilitation & reintegration	• Give emotional and social support to children in need of rehabilitation.	• Reduce stigma in the community. • Prepare communities to receive children.	• Provide rehabilitation services. • Follow-up on reintegrated children. • Provide counselling to affected families. • Advocate for better services for children in need of rehabilitation.	• Ensure that all rehabilitation has social reintegration as its goal. • Provide social workers who can move in communities to follow up on reintegrated children. • Ensure protection for children in the community. Provide grants for this purpose.

Child participation[8]

One of the rights we talked about above is children's participation in decisions that affect them. There are many reasons why participation can increase their psychosocial well-being:

- It enhances self-confidence and self-esteem. Participating gives children a sense of purpose and competence in their own lives and a belief that they can make a positive impact on their own lives and those of others.

- It can help to heal the past. Participation can be an important tool to counter silence, passiveness, and victimisation of children.

- It can ensure that adults make better decisions on how to help children. If children can influence the types of support and interventions available to them, the measures will become more appropriate, relevant, and sustainable.

- It can enhance child protection and thereby increase psychosocial well-being. If children are encouraged to speak about their experiences and to report abuses to adults, this makes it easier to protect children from abuse.

Violation of rights

What happens when child rights are violated and children are abused, for instance, physically and sexually? When family or community members become aware that a child's rights are being abused, there may be several strategies they can follow, depending on how serious the violation is. Below are some examples of possible strategies:

- Talk to the child to try and find out what has been happening to the child.

- Tell the child that he/she may have to tell someone else about what is happening in order to get help.

- Report the abuse to the police and/or social services authorities so that they can intervene.

- Make psychosocial support available to the child to help them deal with the effects of the abuse that has been happening. This also ensures that there is no "backlash" for the child, for example, other family members blaming the child for what has happened.

- Talk to others in the family about how to support the child.

8 Adapted from REPSSI (2009).

Responsibilities

Responsibilities are obligations/duties that are age appropriate.

Children's responsibilities include:

- Doing some work at home and institution in line with their capacity
- Going to school and doing their homework
- Taking medication as directed by the health worker
- Deliberately infecting other children with HIV
- Practising hygiene and preventing infections
- Improving themselves and the community through participation in such activities as sports, peer education programmes, clubs, drama groups, discussions, and conversations at community and family level
- Listening to advice and guidance from guardians
- Seeking advice and counsel from people they trust
- Reporting crime against them and the community

How caregivers can encourage children to adhere to their responsibilities
- Informing children in an appropriate way about their responsibilities in the home
- Establishing routines
- Encouraging children to express their opinions about their responsibilities

Session 4

Cultural and religious practices as a form of psychosocial support
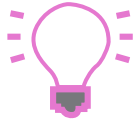
Facilitator tips

- In groups, ask participants to identify the religious and cultural institutions and practices in their communities.

- For each of the identified institutions and practices, identify how these can potentially promote psychosocial well-being of the children.

- Divide the participants into groups, and assign them roles of religious and traditional systems. Then, ask them to come up with a drama skit showing how these roles negatively impact psychosocial well-being.

Session objectives

By the end of this session, participants should be able to:

- Identify and explain the role of traditional and religious practices in promoting psychosocial well-being

- Outline and discuss negative religious and traditional practices

Time frame
1 hour

Facilitator notes

The role of religious groups and organisations in providing PSS

In many countries, religious groups and organisations provide people with spiritual, emotional, social, and material support in times of difficulty. Churches, mosques, temples, and other places of worship are stable sources of spiritual support when people experience challenges. They serve as positive resources that facilitate coping. The three main ways in which religious groups provide PS support are:

Spiritual: Religious leaders provide spiritual guidance and encouragement during difficult times, which allows people to try to find meaning in the experiences of loss and distress they have undergone. Religious leaders may also interpret religious texts in such a manner as to communicate to the distressed person that they are not alone with their problems, but that a higher power (God) is concerned about them.

Emotional: Many religious leaders and groups provide people with the opportunity to talk about their feelings, difficulties, and experiences, thereby providing informal counselling and advice to the person in need. Having someone to talk to (and being listened to) can comfort and strengthen a distressed person.

Social: Being part of a religious community provides people with an opportunity to experience social integration, and inclusion in religious activities provides structure and meaning and the chance to socialise. If people lead difficult, impoverished lives where there may be little opportunity to "take a break" from their daily hardships, participation in religious activities can provide such a "break". Through these social activities, new relationships can be formed, which will have a positive impact on well-being.

Material: Sometimes religious groups can also assist individuals by providing them with access to material resources that are needed and not available elsewhere. Often religious leaders may have social connections and access to people who can facilitate access even if they themselves cannot assist. These forms of assistance can represent a crucial way for people to survive in extremely difficult circumstances.

Children and young people may find participation in religious activities just as comforting as adults as they try to find meaning in the events that have happened to them. Religious groups specifically intended for children may provide them with social support, and youth group leaders may provide them with emotional and spiritual support.

Note, however, that sometimes religious groups can be misleading, especially if they hold fundamentalist views about, for instance, preventing children from going to school, seeking medical treatment, or abandoning government programmes such as immunisation and birth registration.

The role of traditional practices in providing PSS

Facilitator tips

- Group participants and ask them to brainstorm which traditional beliefs in their communities can promote a child's sense of belonging and identity.
- How do these beliefs help the child feel anchored in his/her community?

Facilitator notes

Traditions are beliefs and practices that are important in the day-to-day life of an individual, family, and the community in general.

Some of the roles tradition plays in a society include:
- **Instilling a sense of belonging and togetherness.** African tradition in general emphasises the clan as well as the extended family. In this way, it gives children a sense of identity.

- **Passing on values and norms from one generation to another** through instruction by elders and opinion leaders. Usually elders' opinions are respected not only in the community in general, but also in the clan and family settings.

- **Promoting the existence of a society through procreation.** Every adult member of the society is expected to marry, and bear and raise morally upright children.

- **Explaining the causes of different psychosocial problems**, for example, mental health problems (sometimes in negative ways that may not promote healing).

- **Providing coping mechanisms** for distressed community members to deal with the distress through ritual performance and support from clan members.

- **Mobilising community efforts to deal with new problems**, for example, by building a house for orphaned children.

- **Teaching society members what is right and what is wrong.** It also prescribes punishment for any deviant behaviour. For example, if a wife goes against the norms of behaviour toward her husband, her people may be requested to pay a fine in the form of beer or livestock.

- **Prescribing the role of members in the society**, for instance, men being responsible for providing food for a household and women taking care of children and other household members.

- **Promoting normative social interaction in society.** For example, tradition prescribes hierarchical roles and property ownership by family members.

- **Prescribing child-rearing practices** like feeding, instilling discipline, protecting, socialising, and providing general welfare.

- **Prescribing ways of interacting with external societies.**

- **Explaining the meaning of certain events in the community**, such as linking heavy floods to a curse for wrongdoing.

- **Setting guidelines for inheritance and protection of vulnerable children and orphans.** However, tradition can at times contradict formal laws.

Additional notes for the facilitator

When discussing traditional healing, we should not only point at witchcraft or magic. Caregivers need to consider all the traditional healing options in their communities. These could include herbalists, diviners, religious leaders, clan elders, and bonesetters, among others.

Traditional practices can also affect children negatively. Some of these include:

- Traditional practices typically promote ownership of the deceased's property by adult males ("property grabbing"). Often, orphans are cheated of their parent's property. The relative who takes care of the orphans also automatically becomes the owner of all the property. Female orphans are especially vulnerable because most patriarchal cultures consider females to be property themselves, and they have no voice over any property.

- Sometimes the traditional explanation for the cause of death places blame on the deceased or the orphans. For instance, tradition may explain that a person died because they sinned or someone has practiced witchcraft. This explanation stigmatises the child, but also leads people in the community to have less compassion for such orphaned children. It also promotes community violence.

- Some traditional beliefs and practices do not provide correct information. For example, in many communities, malnutrition and HIV/AIDS are linked to witchcraft, thereby increasing their prevalence.

- Some traditional beliefs prevent children from accessing and using health services such as immunisation.

- Some traditional beliefs and practices push children into early marriages.

- Some practices treat female members of society only as child-bearers, domestic servants, or sources of wealth, which promotes child labour and sexual abuse.

- Some traditional practices do not consider children to have feelings or give them the right to express their views. This prevents children from expressing their feelings while prolonging the recovery period. Such children are also vulnerable to poor physical health due to psychosomatic disorders.

- Some traditional practices call for the use of unsafe methods to administer treatment to children and other patients. Traditional healers use unsterilised instruments to administer medication in the skin. This puts children at risk of blood-borne infections. Additionally, traditional healers may give overdoses of their herbal concoctions that are toxic and dangerous to the lives of orphans and other vulnerable children.

- Healers who are quacks and are only out for financial gain — without really providing any healing — can be a problem because people place their trust in them, wasting time and resources that could be spent on other forms of health care.

Additional information for the facilitator

Harmful traditional practices can have a negative effect on psychosocial well-being. For instance, children who are accused of witchcraft may be stigmatised and excluded by family and community members. When psychological problems such as depression and symptoms of trauma are not recognised by family or community members, they may be interpreted as demon possession. Children may be subjected to exorcism or other forms of driving out evil spirits, which may leave them feeling very upset and distressed. They may also be subjected to physical abuse. Children accused of witchcraft may feel guilty about their parents' deaths and confused about the cause of death. This may also occur if a religious leader talks about sin as being the reason for illness and death because children may feel it is their fault — or their parents' fault — that the illness or death happened.

Working cooperatively with traditional and religious leaders:

Caregivers should discuss with all traditional helping institutions, including religious leaders, healers, elders, and community leaders and members, about the strengths and weaknesses of existing methods of helping. Cooperation and collaboration between caregivers and these institutions is essential in helping the people in need. Referrals back and forth between every one of the institutions should be encouraged. This means that integrative psychosocial support should be encouraged.

Session 5 ▸ Communicating with children

Session objectives

By the end of this session, participants should be able to:

- List the principles of communicating with children
- Demonstrate skills of communicating with children
- Identify potential barriers and the consequences of such barriers in communicating with children
- Utilise relevant skills and techniques to overcome communication barriers

Time frame

1 hour 30 minutes

Facilitator tips

Ask participants to think of a favourite song and game from their childhood.

- Divide participants into groups and ask them to prepare one favourite game and song from childhood for presentation in plenary.
- After the plenary, ask participants to share the importance of games and songs when communicating with children.

Ask participants to discuss the principles of communicating with children. Then ask them to:

- Discuss the barriers they have experienced in communicating with children
- Identify an event that happened in their lives that illustrates one of these communication barriers

Pick a pair and ask them to share in plenary.

Facilitator notes

Principles for communicating with children

Our words, actions, facial expressions, and body language convey many messages to children. The following principles are important when communicating with children:

- **Trust:** Trust is important. The child needs to be able to trust those who are caring for them. Similarly, the parent/guardian/caregiver needs to be able to trust the child.
- **Honesty:** Never lie to a child! Lying can destroy a child's trust in those who are caring for him, causing him to fear future care and increasing his anxiety!
- **Respect:** Respect children for who they are with a non-judgmental attitude. Do not ignore the child's viewpoint and feelings.
- **Attitude:** Speak with the child, not to the child.

- **Unconditional care:** Treat children equally regardless of gender, background, or socio-economic status. Treat each child as an individual.

- **Confidentiality:** Avoid disclosing private information about children and their caregivers.

- **Patience:** Communicating well with children takes time. Develop patience and make the time you have with the child count.

- **Our own feelings:** Be careful of your own feelings: Children are very perceptive to the attitudes of those around them. They pick up on the distress and anxiety of those around them.

- **Freedom to express:** Allow children to express their worries and anxieties through play, drawing, songs, or other activities.

- **Information needs:** These are often neglected, sometimes on the pretext that understanding is limited.

Facilitator tips

Group participants into five and allocate a case study to each group[9]. Then ask the group to discuss for 10 minutes and then report their responses in plenary.

- **Group 1:** You are taking care of a 3-year-old child. He/she is misbehaving and having an outburst. How do you communicate with the child to change his/her behaviour?

- **Group 2:** Your 9-year-old nephew has been telling you a lot of lies about many things, and you are beginning to feel that you cannot believe anything he says. How can you address this with him?

- **Group 3:** You are passing the school, and you notice that children are teasing another child and calling him/her names. You know the child is HIV-positive, and you perceive that this may be the reason for the teasing. How would you deal with this situation?

- **Group 4:** Three children, ages 3, 5, and 7, are playing a hide and seek game. The 3-year-old asks you, "Aunt, can you play with us?" You are very busy and tired after a long day at work. What do you do?

- **Group 5:** A 12-year-old child who used to tell you a lot of things has lately been very quiet and gives one-word answers to your questions. He seems to have become withdrawn in relation to adults, but you see him talking with his friends. What – if anything – do you do?

Communication with children is the use of age-appropriate language to facilitate both the passage of information to the child and the expression of their feelings. Communication is a two-way process and can be learnt.

The language of children:

To communicate with children, you must be able to speak and understand their language: Children speak 3 languages:

1. **The language of the body:** One has to be very observant to see and interpret this.
2. **The language of play:** Children love this language and use it most. It includes games, drawing, and singing.
3. **Spoken language:** This is usually the least used and the least expressive language (depending on the age).

In order to effectively communicate with children, we need to know the language that children speak and also note that children are different from adults.

- Children are unique: They are not just small adults, but human beings who are different from adults and therefore have their own communication styles.

- They have physical, psychosocial, and spiritual needs that are different, meaning our responses need to be different than those we would give to adults.

- Effective care requires us to understand these differences.
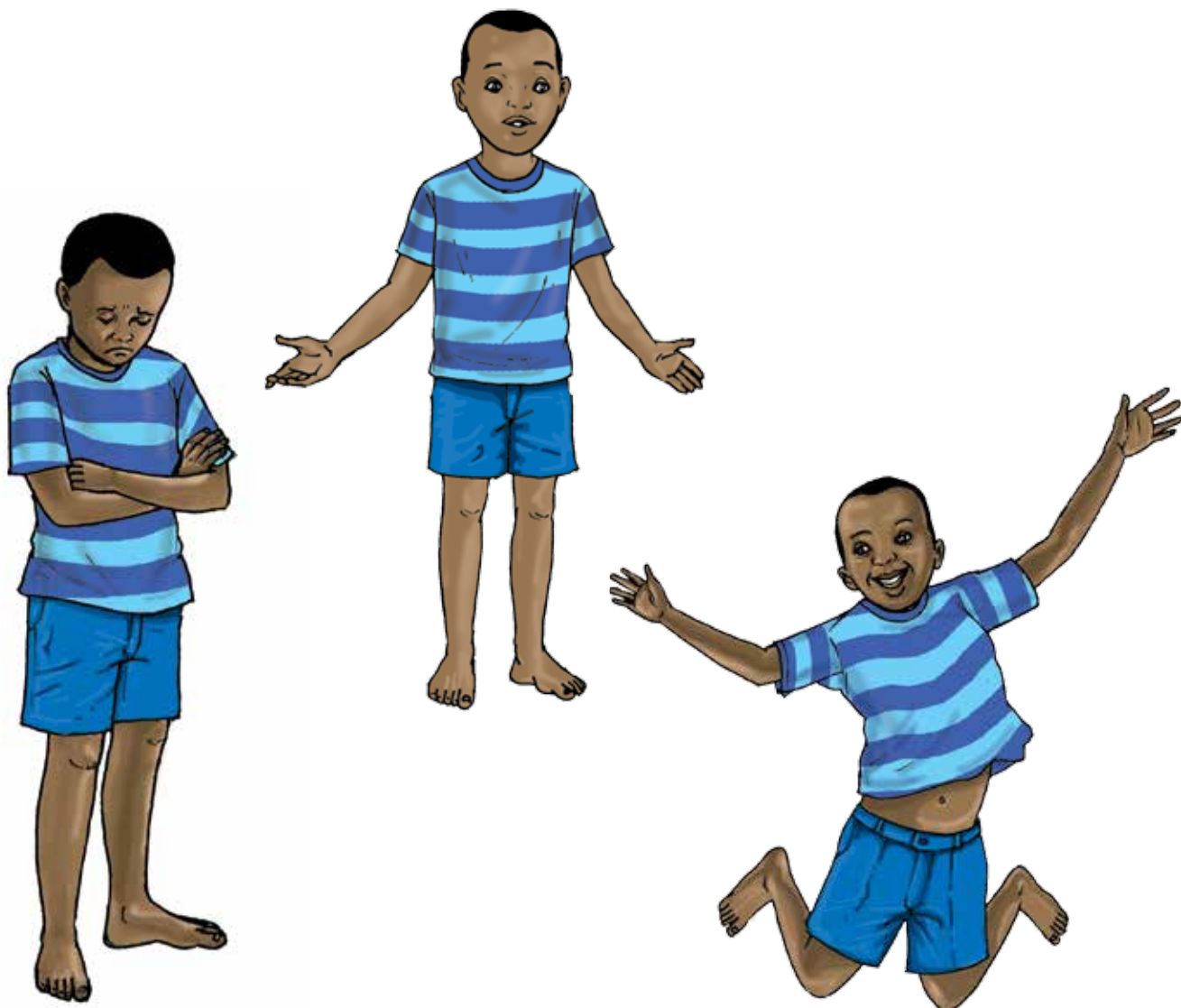
Skills and techniques of communicating with children

- Stop what you are doing, and pay attention to what the child is saying and doing.
- Use simple language: Think about the words you use. Long sentences will confuse children.
- Use a child's experience to explain things.
- Be friendly and approachable. Do not look bored, angry, or worried while a child is talking because this will stop him/her from talking.
- Actively listen and respond to the child. Try to answer his/her questions as honestly as possible.
- Provide adequate time and space.
- Provide an appropriate and conducive environment.
- Use a moderate dress code.
- Observe confidentiality.
- Be empathetic.
- Be polite and helpful.
- Maintain eye contact.
- Use minimal encouragers.
- Use silence.
- Comment on the process.
- Ask open-ended questions and answering questions.
- Summarise and clarify.
- Repeat things frequently.
- Seek to understand what the child understands about any given information or situation.
- Seek to understand what the child means.
- Be sensitive to cultural norms.
- Sit at the same level as children.
- Do not rush children. Be patient, go at their pace, and allow them to express their emotions.

Barriers to effective communication with children

- Language used
- Use of adult methods
- The size and height of an adult compared to a child
- Children identifying more with peers
- Attempting to handle everything yourself
- Getting emotionally involved
- Not listening effectively
- Blaming and judging the child or barking at the child
- Disability-related barriers (e.g., the child is dumb and deaf)
- Adult may symbolise another abusive adult that the child knows
- Use of formal roles, titles, and social standing
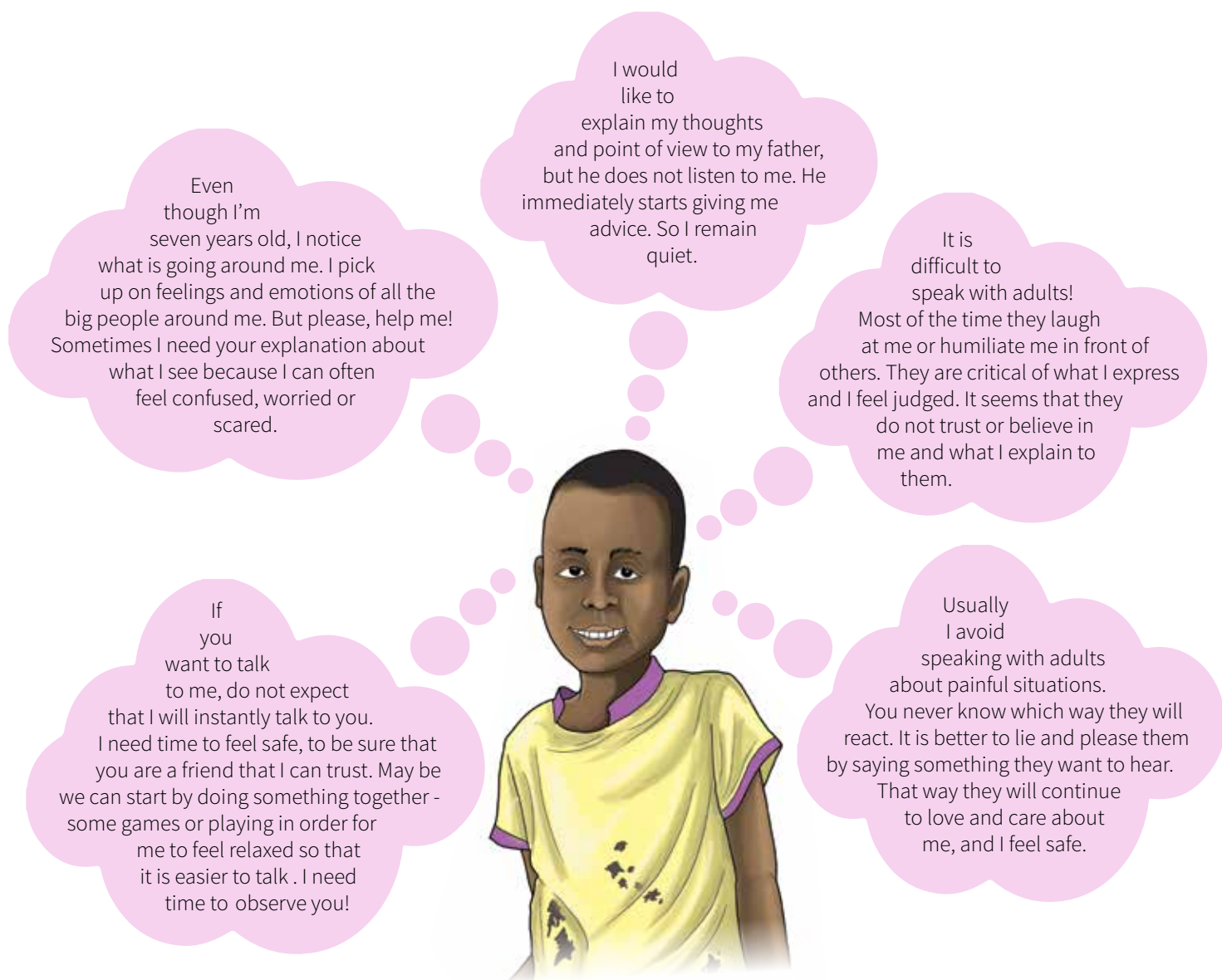
Even though I'm seven years old, I notice what is going around me. I pick up on feelings and emotions of all the big people around me. But please, help me! Sometimes I need your explanation about what I see because I can often feel confused, worried or scared.

I would like to explain my thoughts and point of view to my father, but he does not listen to me. He immediately starts giving me advice. So I remain quiet.

It is difficult to speak with adults! Most of the time they laugh at me or humiliate me in front of others. They are critical of what I express and I feel judged. It seems that they do not trust or believe in me and what I explain to them.

If you want to talk to me, do not expect that I will instantly talk to you. I need time to feel safe, to be sure that you are a friend that I can trust. May be we can start by doing something together - some games or playing in order for me to feel relaxed so that it is easier to talk . I need time to observe you!

Usually I avoid speaking with adults about painful situations. You never know which way they will react. It is better to lie and please them by saying something they want to hear. That way they will continue to love and care about me, and I feel safe.

Taken from AVSI (2004).

Consequences of communication barriers

- **Miscommunication:** The child cannot convey what he/she thinks and feels, and the adult cannot make the child understand what he/she is trying to say.
- **Mistrust:** The child feels that he/she cannot trust the adult.
- **Anger and frustration:** Both the child and the adult may feel these emotions.
- **Isolation and withdrawal:** The child feels that no one understands him/her and begins to withdraw from engaging socially with others.
- **Blame:** The child and the adult can blame one another for failed communication and behaviour that is not understood.

Other practical ways of communicating with children

Using drawings: Drawings enable children to communicate their emotional state without having to put it into words. Use open-ended questions to encourage them to talk more about what they have drawn and why; for example, "How do the people in the drawing feel about what is happening?"

Using stories: Telling stories can help children to resolve problems. When children are finding it difficult to talk about painful issues, listening to a story about someone in a similar situation can be very comforting. At the end of the story, encourage the child to talk about what happened. For example, ask about the message of the story to check that the child has understood it.

Using play: Playing is an important way that children explore their feelings about events and make sense of their world. When children play, they act out certain roles, which help us to understand what they are feeling. Follow and observe what the child is doing. Do not take over the play. Make comments if you want to check understanding. For example, say: "I see that the mama doll is so sick that she cannot get out of bed" and see if the child disagrees.

Session 6 ▶ Working with groups[10]

Session objectives

By the end of this session, participants should have:

- Learnt the different activities that can be implemented in clubs
- Learnt the roles of clubs in promoting psychosocial well-being
- Acquired relevant skills for creating and working with clubs

Time frame
45 minutes
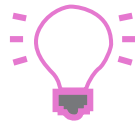
Facilitator tips

- Ask participants to share their understanding of clubs.
- Ask participants to think of any clubs they have heard of, the activities carried out, and the potential benefits the clubs have in promoting psychosocial well-being.

Facilitator notes

Children's Clubs are constituted groups of children that meet regularly in a safe environment for the purpose of creating an environment that allows children to receive and give support to each other while developing life skills. These groups can either be self- or externally facilitated. These clubs have been started in many countries by community members, religious groups, and CSOs to provide children with a positive environment in which they can participate in their own development and receive support for difficulties they may be experiencing. The main objectives of these clubs are:

- To facilitate community-based care and support for children
- To create an opportunity for young people to participate in their development and meet their needs
- To mobilise community members to assist in mitigating the impact of HIV/AIDs, poverty, and conflict on children
- To provide an opportunity for children to be children and have fun.

The guiding principles of working with children in Children's Clubs include:

- **Rights and responsibilities:** Children's Clubs programming is rights-based and puts into practice the promotion and protection of the fundamental rights of children.

10 This session is adapted from REPSSI & Olive Leaf Foundation (2009).

- **Child participation:** Children participate in the planning, implementation, monitoring, and evaluation of Children's Clubs. The methods used in the Children's Clubs take into consideration the different capacities children have to participate.

- **Building resilience in children:** Children's Clubs are based on the idea that the ability to cope with life challenges depends a lot on them having a good sense of who they are and having good knowledge of people and structures that can support them.

- **"Do no harm":** Children should be safe in the Children's Clubs at all times. This means that they are not therapy groups where children can open up about their experiences. Children are referred to specialised support if they need assistance with emotional and psychological problems. Club leaders accept cultural and religious beliefs the way they are and do not try to change them. Discipline problems are dealt with through positive discipline.

- **Making referrals and follow-up:** Children's Clubs need good referral systems in place.

Additional notes for the facilitator

How Children's Clubs meet the needs of children
- **Building resilience and life skills:** Children have an opportunity to develop skills such as conflict management, seeking help, self-expression, and taking care of others.
- **Social integration:** Children who may be marginalised in the community can form friendships, be part of a group, and have a sense of belonging.
- **Platform for having fun and playing:** Many OVC have a lot of responsibility at home, but at the Children's Club they can just be children, relax, and be taken care of for a few hours.
- **Opportunity to express themselves in a safe environment:** Children can share their problems in a non-threatening environment and feel supported and understood.
- **Platform for youth leadership:** Youths can develop skills and awareness that allow them to take initiative and try out new roles.
- **Awareness of rights:** At the Children's Clubs, rights are put into action, and children learn about their rights and what action they can take to protect themselves.
- **Resource mobilisation:** The Children's Clubs can serve as a means of collectively organising support for the most vulnerable children in the community.
- **Providing a continuum of care:** Children's Clubs can be used to follow-up on children who have received support from other organisations.
- **Cultivating a culture of care:** Children learn that it is important to try to understand each other and be supportive of one another. This builds a culture of empathy and compassion.

Factors to consider when setting up Children's Clubs:
- **Purpose:** It is important to have clear objectives and goals for the group.
- **Logistics:** Where and how will the group meet? What type of input will the group meeting need?
- **Group approach:** Will the group be open- or close-ended? Will it be for both genders?
- **Group homogeneity:** Will age be a criterion for joining? What other characteristics will group members share (or not)?

- **Ground rules:** These guide the behaviour of the group members.
- **Leadership approach:** Who can lead meetings? How will they be run?
- **Manage challenging behaviour:** Positive discipline must be used.
- **Cultural and religious beliefs:** Mutual ground must be found if children come from different religious and cultural backgrounds.

Steps to follow when setting up Children's Clubs

The steps taken to start a Children's Club vary according to context, location, purpose, and the organisation initiating the club. It is important to keep in mind guiding principles of using Children's Clubs to facilitate care and support. Ask for permission from relevant authorities and ensure that all responsible actors (caregivers, community leadership, and organisations working with children) are involved and informed. Children's Clubs can also be an extension of an already existing programme.

When starting a Children's Club as an extension of a programme, it is important to ensure that the children belonging to the club and the club leaders remain separate from the initiating organisation. The role of the initiating organisation in such a context is to identify Children's Club leaders and support them in starting the club.

Frequency and duration:
Children's Club meetings can be held daily, biweekly, weekly, or monthly. Some clubs follow a specific curriculum, after which those children graduate and a new "class" begins, while other clubs are ongoing year after year. It is recommended that Children's Clubs meet for a maximum of three hours per meeting. If the club meets for too long, children can get bored and caregivers may raise concerns about children not fulfilling some of their duties at home.

Age groups:
Some clubs cater to specific age groups (and may change names accordingly). Others cater to all ages, but may split up into smaller age groups for certain activities.

Venue:
Children's Clubs may meet at school, in a classroom, on the playing fields, at a church, in a community hall, or at another suitable venue. The clubs may or may not be linked to the institution providing the venue. It is important that the venue is safe and has clean water and shade/shelter for the rainy season. If a venue is offered, request for written permission to use it for at least two years.

Membership:
Some clubs cater for all children in a particular community whilst others target specific children (such as orphans or abused children). Membership can also be open (children attend when they wish) or closed (the club takes in a certain number of children and works with them until after a certain period, at which point they graduate and a new group comes in).

Leadership:
Children's Clubs are run by the youth (Children's Club leaders), who are supported by the adults in the community, civil society, and the children in the club.

Additional notes for the facilitator

Role of a patron:
- Acts as a spokesperson for the Children's Club and a liaison between the club and the community
- Oversees the general running of the Children's Club
- Supports the leaders in their work and personal growth
- Assists with all referrals from the leaders
- Meets periodically with Children's Club leaders to monitor and evaluate proceedings
- Assists in the planning of community Children's Club activities
- Offers counselling (when necessary and if capable) to Children's Club leaders
- Gives support on monitoring children's progress
- Helps in sustaining Children's Clubs (by troubleshooting and mobilising resources)
- Helps with report writing and meetings (especially high profile meetings).

The role of patron is voluntary and is supported by community members.

Do's and don'ts for running Children's Clubs

Setting up and running a Children's Club requires thought and planning. It is best that you read the REPSSI & Olive Leaf Foundation (2009) manual on this if you want to know how to do this. Here we just want to provide some guidelines for important factors to keep in mind. When you are running a Children's Club:

Do	Don't
Refer them to someone who is properly trained and can assist them if they talk about their problems and need specialised help.	Don't ask children to empty their feelings and emotions. Children's Clubs are not places where children can receive therapy, and this can do more harm than good.
Have a good understanding of the many different cultural and religious beliefs that children in your club have, and respect them.	Don't try to change the child to believe in what you believe in. That is not your job.
Try to strengthen relationships between the child and their family and community.	Don't criticise the child's family and friends unless there are serious concerns about the child's well-being.
Try to discipline children in a positive way instead of in a punitive way.	Don't just discipline a child and leave it at that. If a child is misbehaving, it usually means that something is wrong.

Activities for Children's Clubs

Children's Clubs offer a range of activities that are decided by the children themselves together with the club leaders. Some suggestions for topics include:

- Understanding my rights and responsibilities
- Relating with other people/children
- Taking care of my living space
- Understanding my body
- Protecting myself
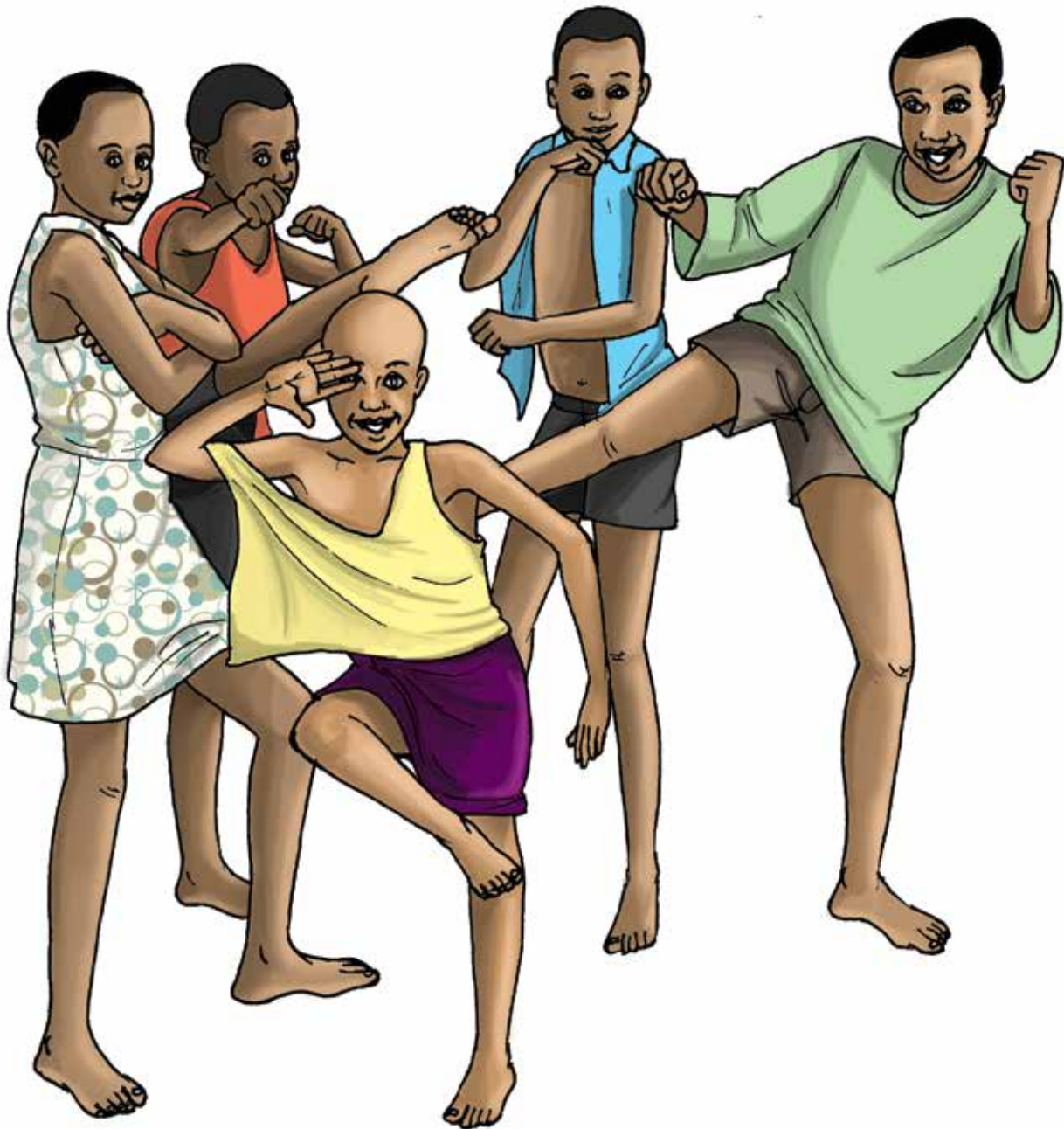
Session 7 ❯ Adolescents and young people

Facilitator tips

- Group participants into pairs for doing buzz groups, and ask them to share what feelings and thoughts the words "adolescence" and "adolescents" trigger in them. Then ask participants to share their discussion in plenary.
- Group participants and ask them to categorise stages of adolescence and discuss changes that occur in each of the stages. Then ask groups to report in plenary.
- Have participants brainstorm effects of uncontrolled psychosexual desires

Facilitator notes

Adolescence is the period between childhood and adulthood. An adolescent is an individual in the age category of 10 to 19 years (UNICEF, 2011). Adolescence is categorised into three stages: early adolescence (10-13 years), mid adolescence (14-16), and late adolescence (17-19).

In many societies, adolescents are often seen as a problem and sometimes even as a threat to social stability. This results in attempts to "control" them. However, it is important to remember that the adolescents of today are the adults of tomorrow and our future leaders. They need to be supported through this difficult stage of development.
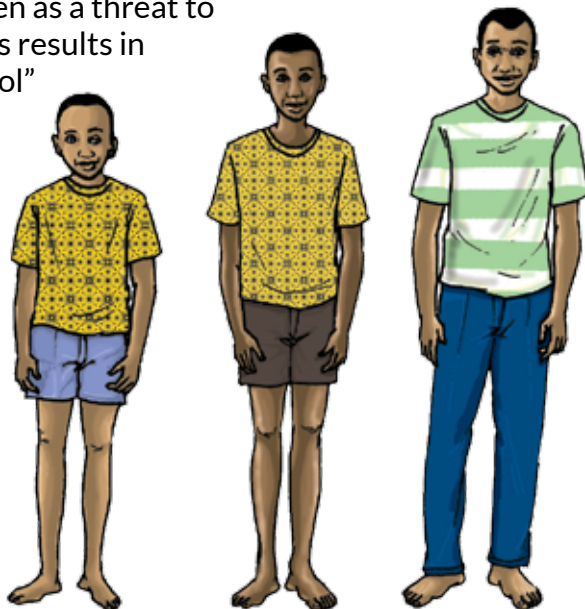
Session objectives

By the end of this session, participants should be able to:

- Discuss the changes that occur during adolescence
- Examine the psychosexual development of adolescents
- Highlight effects of uncontrolled psychosexual desires
- Discuss the sexual reproductive issues that arise during adolescence

Time frame
45 minutes

Changes in adolescence

Adolescents have the same human rights as children and adults, but they have different needs based on their particular developmental stage. Adolescence is a challenging stage because they are passing from being children to adulthood and undergoing new experiences:

Emotional changes	Social and behavioural changes	Physical changes
• Insecure and anxious • Need to establish identity • Difficulty communicating • Need to become more emotionally and economically independent • Self-conscious about their appearance; attach great importance to it • May have negative emotions, such as low self-esteem, depression, or suicidal thoughts • Adventurous • Seek recognition	• Peer group gains in importance • Establishing satisfying relationships are very important • Fitting in with peer groups (in relation to appearance, clothes, music, etc.) is important • Try out new things like smoking, drinking alcohol, or taking drugs • Behaviour changes (e.g., withdrawal, rebellion, criticism, disobedience, aggression)	• Physical maturation • Sexual attraction • Have sexual relationships • Engage in risky sexual behaviour, which can result in early pregnancy, STIs and HIV infection, abortion, or early marriage

How can adolescents be supported?

- Caregivers should talk to children with love and due consideration of their age.
- Give them information about emerging issues, for instance, the changes affecting their bodies and emotions, or behaviour associated with being a teenager.
- Encourage practices that boost their self-image, and be sure to point out when the adolescent has done tasks well.
- Encourage teenagers to involve themselves in recreational activities to avoid negative use of time.

Sexual and reproductive health for adolescents

Psychosexual development

During adolescence the psychosexual development of a child into an adult occurs. This brings with it a number of physical, emotional, behavioural, and social changes. Somewhere between the ages of 8 and 13, the body starts producing puberty hormones that drive the maturation of male and female genitalia and the full development of the sexual and reproductive system. With some children, the onset of puberty can be as early as 7 or 8 years, while for others this only occurs much later — at 13 or 14 years. Most children start experiencing puberty somewhere between these two ages. Girls tend to start their sexual development earlier than boys, but because of great variation, it is hard to predict.

Undergoing these changes can be challenging for girls and boys in different ways. Mood swings are common, as is sensitivity to how one looks and what others think about them. Coping with the onset of menstruation and breast development can be difficult if there is no one to talk to about this. And for boys, the deepening of the voice, having wet dreams (ejaculation) at night, and having erections are changes that they may want to talk to someone about. However, in many contexts it is difficult to talk about sexual issues, which often means that adolescents find themselves alone with the changes they are undergoing.

The possible negative outcomes of negotiating sexual and reproductive health on their own without any assistance may be severe for young people: High adolescent pregnancy rates, unwanted pregnancies, early initiation into sexual activity, sexually transmitted diseases (including HIV), sexual violence, and other reproductive health challenges have a profound impact on the well-being of adolescents and their families. In Uganda, most girls drop out of school at this age.

Additional information for the facilitator

Services and support must be available for adolescents in regard to SRH, which is what UNFPA recommends as part of its youth-friendly core health care package[11] . Some aspects of this package include:

- Open-minded adults to whom adolescents can talk to about sexual issues
- Accurate sexual reproductive health information
- Family planning services that are youth-friendly and offer a range of safe and affordable contraceptives
- Sensitive counselling and good quality antenatal care for all girls and women
- Prevention and management of sexually transmitted infections (STIs)

Discussing sexual issues with children and young people

Facilitator tips

Group participants and ask them to discuss the following questions:

- At what age should children be given sexual knowledge?
- What kind of issues would you discuss at what age?

11 UNFPA website (http://www.unfpa.org/public/home/adolescents/pid/6484)

Facilitator notes

Most caretakers of children shy away from discussing sexual matters with them. Yet this is very important as it may protect the children from reproductive health-related problems.

Mode of communication:
- An atmosphere of trust is very important in discussing with children.
- Start the subject in such a way that sexuality is not made synonymous with sin and suffering. The aim of the discussion should be to help the child feel good about their changing bodies.
- Respect the child's privacy; do not criticise his/her friends.
- Have a sound understanding of sexual health issues to transmit any skills and knowledge clearly and coherently.
- Communicate genuinely and effectively, verbally as well as non-verbally
- Respect and have concern for the child.
- Understand and appreciate the child's culture and religion, which may be different from yours.
- Appreciate the adolescent's limits and characteristics. For example, the fact that their attention span may be short. Do not try to give a lecture but be interactive and let the child ask questions.
- Listen and show interest. This provides a comfortable environment that encourages the adolescent to open up.
- Establish a relationship based on tolerance, trust and openness. If you are uncomfortable with your own sexuality, you are unlikely to discuss the subject.
- Evaluate your own values and reactions toward different sexual issues (for example be ready to discuss subjects such as masturbation and contraception)

Why we need to consider adolescents as an important category:
- Overlooking needs of adolescents denies their entitlement to good psychosocial health. Although they are neither children nor adults they have both the rights of children and adults.
- The potential that adolescents have to be productive social contributors is overlooked. Adolescents have energy, curiosity, creativity and much other strength that can be used in positive ways to improve their own and others' well-being.
- Sometimes adolescents are seen by adults as "big children" when it may be better to see them as "small adults". Adolescence is usually a time when young people can experiment with adult roles but do not need to commit to them completely.

Attitudes required in communicating sexual matters with children.

Positive perception of sexuality	Being comfortable, being honest	Availability and tolerance	Respecting intimacy.
• Present sexuality in a positive manner as a stimulating and interesting part of life. • Avoid judgments or lectures. • Avoid discussing sexuality solely in terms of disease. • Give adolescents a chance to have a healthy sex life that is not based on fear. • Speak of emotions and sensations rather than offering only technical guidelines. • Emphasise the ideas of pleasure and prevention rather than negatives.	• Be honest, direct and straightforward when raising the issues. • Use correct terms, while showing tolerance. • Avoid vulgarity. • Be aware of the influence and the power of your own values on the child's mind. • Be aware of your own limitations, and refer to other resources. • Ask the adolescent to get involved in the search for information or solutions. • Be aware that comfort with the issue comes over time and with practice.	• Set limits explaining when a question is considered too personal. • Accept adolescents as sexual beings, and do not assume that they do not have concerns or a sex life "at that age". • Be able to listen, show empathy and warmth, and remain authentic as well as objective. • Respect adolescents' values, and never trivialise their experiences. • Assist the adolescent with their own thought processes rather than just offering suggestions. • Allow the adolescent to express their concerns or emotional reactions and to share information. • Use humour to lighten difficult situations.	• Avoid talking about your personal sexual experiences. • Give value and importance to intimacy.

Additional Case Studies for Reference

These case studies provide an opportunity to apply your learning from the different sections of this module to the situations of children who are exposed to difficult circumstances.

Divide into groups and have each group take a different case study. Groups should discuss the following:
1. How is the child's well-being negatively affected in this case study?
2. What can be done to provide PSS to the child and caregiver?
3. Who needs to be involved in this?

Case study 1:

Keith is a 16-year-old boy whose mother was hit by a taxi when he was 5. The accident left her unable to walk, and she now uses a wheelchair to get around. His father works in another city, but never provides financial support to the family. Because of her injuries, Keith's mother is unable to work. Although she receives a disability grant, it is not enough to meet the needs of her family. Keith and his siblings have often been hungry. Their basic needs go unmet. Keith and his older brother, Jabu, are thinking of robbing houses to make some money.

Case study 2:

Sabiti was a 9-year-old boy when his mother died. A couple of months later, Sabiti's uncle came by the home and found Sabiti living alone. He invited Sabiti to come and live with his family. Sabiti was very happy to be part of a family again. He enjoyed playing with his cousins, and his uncle's wife was very kind to him. However, Sabiti's uncle had a friend who was staying with them while he looked for a job. He shared the little outdoor room where Sabiti slept. He came home late at night after he was drinking and would force Sabiti to touch him inappropriately. He raped him a couple of times. The man threatened Sabiti that if he told anyone, his uncle would hate Sabiti and throw him out of the house. He also threatened to kill Sabiti's cousins. Sabiti grew to feel very angry and ashamed. However, he never told anyone because he loved his aunt, uncle, and cousins and needed them to take care of him.

Case study 3:

Masiko's family came to Uganda from the DRC when the armed conflict there threatened their lives. Masiko was 13-years-old at the time and she thought that finally her family would be safe and have a home of their own. She looked forward to eating nice meals and thought she might be able to go to school now. When Masiko's family arrived in Uganda, she was very surprised

that things did not go as she had imagined. Although she started school, the children at school threatened her and called her names. After a couple of weeks, Masiko stopped attending school. Her father couldn't find work and her family ended up living on the streets. Eventually, Masiko's family became so desperate to survive that they forced her and her older sister into prostitution. Masiko felt ashamed and depressed, but she kept working as a prostitute because she knew her family needed to eat; since they were foreigners they couldn't access any government support.

Case study 4:

David was 16-years-old when he started working. His mother had died of HIV/AIDS three years earlier, after which he had gone to live with his granny. His granny was 86-years-old and couldn't work anymore, but when four of her children died, she ended up looking after nine of her grandchildren. The family was very poor, and granny was very overwhelmed. David, who was the oldest, decided to stop going to school so he could instead find work. He got a job at the mine, but it was very hard work for a child his age and his body often ached from the long, hard hours he worked. When David was 18-years-old, his granny died and he was left with the responsibility of the eight other children. David worked hard to provide for them, but money was tight, and he wondered every day if he could manage to feed all the children.

Case study 5:

Patience was 6-years-old when her mother died of HIV/AIDS. They lived in a small, remote village and had no access to medical care. Her mother had believed that her ancestors had caused her illness and went to a traditional healer to ask for guidance. Patience had been sickly since she was born and had often had diarrhoea and sweaty nights. When an NGO moved into Patience's village, she was able to participate in their Children's Clubs designed for orphaned children. Some of the other children in the neighbourhood were jealous of the support Patience was receiving and began teasing her and saying she was HIV-positive herself. Patience wasn't allowed to play soccer with the other children because they said she would give them her disease. Patience continued to grow very sick and became lonely and depressed as none of the children would play with her anymore. She became more and more confused and wondered if she had somehow gotten this AIDS thing she had heard about, even though she had never had sex, which the poster said was how someone got HIV/AIDS. By the time Patience was 8-years-old, she had started to look just like her mom had before she died.

Summary

In this module we have looked at the roles of the family, community, and organisations in helping families learn coping mechanisms so they can stabilise and build resilience.

Module 3

Psychosocial interventions for children who need additional support

Introduction

This module focuses on serious psychosocial problems that cannot be resolved through the "natural systems of care" by caregivers, families, peers, and community members. The module centres on the third level of the psychosocial interventions pyramid, which is about "focused, non-specialised psychosocial support". The word "focused" means that these interventions are usually designed and targeted at specific groups of children, for example, children who are HIV-positive, or children who have experienced sexual abuse. The word "non-specialised" refers to the fact that these PSS interventions are not highly specialised programmes that can only be delivered by experts in the field – instead, they are interventions that can be run by people who have received some additional training in psychosocial programming but are not necessarily professionals in that area. This module covers three sessions:

1 Reasons why children need additional psychosocial support interventions and programmes

2 Difficult circumstances that put children at risk

3 Problems associated with adversity

Module objective

By the end of this module, participants should be able to identify children who need additional psychosocial support interventions and refer them for focused non-specialised psychosocial support.

Resources

- Flip charts
- VIP/sticker cards
- Markers
- Masking tape

Session 1

Reasons why some children need additional PS interventions and programmes

Session objectives

By the end of this session, participants should be able to:

- List characteristics of a child who needs additional non-focused psychosocial interventions
- Identify the difficult circumstances that put children at risk
- Know the reasons why some children need additional psychosocial interventions

Time frame
45 minutes

Facilitator tips

- Draw the intervention pyramid with four layers on a flip chart starting from the bottom. Plot level three on it, and discuss why some children are unable to get help from the lower levels.

- Ask participants to think of reasons why children in their communities need additional psychosocial support interventions. What are their circumstances? And how do these circumstances affect the children?

Facilitator notes

There are two main reasons why some children need focused psychosocial support:

1. Because they experience very difficult circumstances

   These could be:

   - Children experiencing grief and emotional turmoil following the death of a loved one

   - Children who have been exposed to traumatic experiences like war, natural disasters, violent robberies, rape and other forms of child abuse

   - Children suffering from chronic illnesses like HIV, epilepsy, or nodding syndrome

2. Because their caregivers are absent or cannot provide the psychosocial care they need

Children may need additional PSS programmes because they do not have the support they need to become resilient and develop positive coping strategies. These are children who lack the "natural systems of care" that would help them become resilient; for instance, those who do not have a supportive caregiver, those who are orphans, those living in dysfunctional families, or those living in families that abuse drugs and alcohol.

There are several different categories here:

* Children who live **without an adult caregiver**: No caregiver is there to provide the children with psychosocial support

* Children whose **caregiver is too old or ill** to provide children with the care they need

* Children who live with a **caregiver who does not treat them well**, perhaps even exploiting or abusing them.

In all the three situations, children do not have the natural care and support we described in Module 2. This means their resilience and coping strategies may not be able to develop well enough to overcome the difficulties they face. We will now describe and discuss some of the difficult circumstances that children face.

Session 2 ▸ Difficult circumstances that put children at risk

Child Abuse and Neglect

Session objectives

By the end of this session, participants should be able to:

- Discuss how child abuse and neglect places children at risk
- Discuss the effects of child abuse and neglect, how to prevent it, and ways of supporting children experiencing abuse and neglect
- Discuss how HIV/AIDS places children at risk
- Identify ways in which children with HIV/AIDS can be helped to achieve psychosocial well-being
- Discuss how emergencies place children at risk
- Identify ways in which children in emergencies can be supported to achieve psychosocial well-being

Time frame
1 hour 30 minutes

Facilitator tips

Ask participants to brainstorm on the following questions:

- What is child abuse? How would you define it?
- What different types of child abuse are there?
- Which types are most common in your communities?

Facilitator notes

Child abuse can be defined as "intentionally causing or permitting any harmful or offensive contact on a child's body; and any communication or transaction of any kind that humiliates shames or frightens the child." Child abuse can be emotional or physical. Some physical abuse is sexual.

Facilitator tips

Ask participants to brainstorm on the following questions:

- What do you believe child abuse and neglect are according to your culture?
- Do you think it is right to discipline a child who is being naughty?

Facilitator notes

Child neglect refers to the failure to provide for the child's basic needs. This includes not providing supervision when a child needs it; for instance, not sending the child to school, or failing to give the child medical care when needed. Neglect can be physical, educational, or emotional.

The Child Status Index (2008) points out the following as indicators of child abuse or maltreatment:

- Lack of proper care
- Being provided less food than others in the household
- Young children being put to work or children of any age forced to do inappropriate work
- Being physically beaten by household members
- Being beaten by others and not protected by adults in the household
- Being sexually abused.

Types of child abuse and neglect

Facilitator tips

Ask participants to brainstorm on the following questions:

- What are the various forms of child abuse and neglect that exist in your community?
- Are orphans (vulnerable children) treated differently from other children in our communities? If yes, how?

Facilitator notes

The main types of child abuse are physical, emotional, and sexual abuse and neglect.

Emotional Abuse (also known as verbal abuse, mental abuse and psychological maltreatment) includes acts, or the failures to act, by parents or caretakers that have caused, or could cause, serious behavioural, cognitive, emotional, or mental disorders. This can include parents/caretakers using extreme and/or bizarre forms of punishment, such as confining a child in a closet or dark room, tying a child to a chair for long periods of time, or threatening and terrorising a child. Less severe acts that can be just as damaging include: belittling, using derogatory terms to describe the child, habitually scapegoating the child, or blaming and rejecting the child.

Physical Abuse is the infliction of physical injury upon a child. This may include, burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child. It may, however, have been the result of over-discipline or physical punishment that is inappropriate for the child's age. Physical abuse varies between cultures. In some societies, hitting a child to promote obedience and respect is not only acceptable but also encouraged, while in others it is disdained and prohibited.

Facilitator tips

Ask participants to brainstorm in groups on the following questions:

- What do you understand by sexual exploitation?
- What forms does it take in your community?
- What does rape, defilement, early/forced marriage, and transactional sex mean?

Facilitator tips

Ask participants to brainstorm in groups on the following questions:

- Who are the victims of these acts? Who are the perpetrators?
- What are the consequences of each of these forms of abuse for children? (Each group discusses one form of child abuse.)
- What do people in the community do to help the victims?

Child sexual exploitation is defined as a situation where a person takes advantage of some power imbalance between himself/herself and another person under the age of 18 in order to use them sexually.

Common forms of child sexual exploitation:
- Use of money or other material things to have sex with a child
- Use of fear and coercion to have sex with a child (for example, the abduction of children by LRA rebels in Uganda, who then used the girls as sex slaves)
- Use of young children for commercial sex purposes
- Child pornography

Risk factors that make children vulnerable to sexual exploitation:
- Loss of parents and adult protection
- Lack of caregiver supervision or guidance
- Wars and conflicts
- Poverty
- Child abuse at home
- Lack of education opportunities
- Poor enforcement of laws governing sex with minors
- Drug and alcohol abuse
- Placement of children in dangerous jobs; for example, selling alcohol, ground nuts, drugs, and cigarettes outside discothèques

Consequences and risks of sexual exploitation include:
- Sexually transmitted disease (STDs), including HIV
- Physical injury
- Fatigue
- Psychological disturbances
- Haemorrhoids and intestinal disorders among boys
- Abuse by clients (who do not pay)
- Blows and injuries
- Abduction followed by gang rape
- Unwanted pregnancies
- Risky abortions

Transactional sex is the occasional exchange of sex for gifts and money. This is not the same as commercial sex or prostitution. Many disadvantaged children are involved in this activity because they lack a livelihood.

Some of the consequences of transactional sex are:
- Unwanted pregnancies and single parenting
- STDs and HIV
- Social isolation
- Cross-generational sex
- Loss of education opportunities
- Abuse from people they have sex with
- Increased poverty
- Stress
- The possibility of going into the sex trade
- Abortion
- Death from pregnancy complications
- Stigma and rejection

Early marriages refer to a situation when a child below the age of 18 gets married either to an older person or to a young person of the same age bracket.

Effects of early marriage:
- School dropout
- Social isolation from peers
- Disability or death due to complications arising from early pregnancies
- HIV/STDs and other diseases
- Likelihood of bearing too many children
- Lack of decision-making when married to an older person
- Assumption of adult responsibilities
- Increased stress
- Vicious cycle of poverty

Defilement is forced, unwanted intercourse with a person younger than 18.

Causes of defilement:
- A cultural perception of girls as passive and submissive or cultural beliefs that young girls do not have HIV/AIDS
- Pornography
- Traditional and religious beliefs
- Belief that one is entitled to sex when they have spent some money on a girl
- Alcoholism and drug use
- Peer influence
- Some boys believe that if a girl is sexually active, she can readily have sex with them as well

Who is at risk of being defiled?
All children can be defiled. High-risk age groups are girls between 15 and 18.

Facilitator tips

Present the following case study to participants and ask the following questions:

Sarah, a 13-year-old girl, was left at home with a 20-year-old male relative. While the parents were away, the relative raped her. He told her not to tell her mother because she would be very angry with her. Sarah had only had her menstruation cycle once. After the rape, she did not get any other, which her mother thought was normal with young girls. She had actually become pregnant, but for a long time did not know she was. Months later, teachers at school noticed and told her parents. The parents did not do anything about it. Sarah was taken to the hospital when she was due for delivery. She had to be operated on to remove the baby, which weighed four and a half kilogrammes.

Questions for discussion:
- Why did Sarah not tell her mother?
- How could Sarah have avoided becoming pregnant?
- What are likely consequences of this pregnancy?

Child neglect

Child neglect refers to the failure of a parent or caregiver to provide for the child's basic needs. It can be categorised as physical, educational, or psychological.

- **Physical neglect** can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (against heat or cold). It may include abandonment.
- **Educational neglect** includes failure to provide appropriate schooling or special educational needs. It can also include allowing excessive truancies.
- **Psychological neglect** includes the lack of any emotional support and love, never attending to the child, spousal abuse, and drug and alcohol abuse, including allowing the child to participate in drug and alcohol use.

Facilitator tips
Questions for discussion:
- Who are the people likely to abuse or neglect children?
- What are the factors that lead to child abuse and neglect?

Facilitator notes

Any person who takes care of children could abuse or neglect children. Parents, guardians, domestic servants, neighbours, teachers, health workers, workers in children's day-care centres are all people who could abuse children.

Factors that contribute to child neglect

- Inability of parents or guardians to cope with the stresses involved in caring for their children
- Inability of parents to cope with life stresses, such as the loss of loved ones to HIV/AIDS
- Some guardians intend to harm orphaned children so they can inherit the property of the orphans' parents
- Poverty
- Children's ignorance
- Involvement of parents, guardians, and caretakers in substance abuse, e.g., drugs and alcohol

Effects of child neglect

- Shows signs of distress
- Shows signs of physical abuse, such as bruises, malnourishment, or generally ill health
- Has low self-esteem or low self-confidence
- Shows signs of regression; for instance, a child speaking like a younger child or failing to control bed wetting
- Has sexually transmitted disease, such as HIV/AIDS
- Has nightmares or other sleep disturbances
- Trembles or is frightened
- Cries or screams without justification
- Eats abnormally or loses appetite
- Is unusually physically aggressive or rough during play
- Is unusually withdrawn and quiet and never expresses feelings or desires
- Appears depressed and unresponsive
- Is restless and unable to complete any task
- Is unable to concentrate and has difficulties learning
- Is irritable toward others and unable to work with others or form relationships
- Shows obvious fear and mistrust of others and threatens to do harm
- Keeps thinking that bad things will happen in the future
- Is withdrawn
- Has psychosomatic complaints like headache or stomach ache
- Has suicidal thoughts and ideas

Preventing child neglect:

- Educate families and the community about the rights and responsibilities of children.
- Educate families and the community about the forms and consequences of child abuse and neglect.
- Provide psycho-education for families and communities about the dangers of alcohol and drug abuse.
- Educate families on alternative forms of instilling discipline in children.
- Educate individuals, families and community about positive ways of coping with stress.
- Encourage and enable vulnerable families to participate in socio-economic programmes to improve their standard of living.

- Encourage community members to participate in child protection committee activities.
- Promote Children's Clubs.
- Promote child participation in all aspects of life.
- Intervene when a child reports abuse.

Living with HIV/AIDS

A second difficult set of circumstances that children face is living with HIV/AIDS.

Facilitator tips

Ask participants to brainstorm on the following questions and prompts:

- What is HIV/AIDS?

- What is the difference between HIV and AIDS?

- What symptoms can you identify of a child living with HIV/AIDS?

- How can caregivers be helped to disclose their own HIV status or a child's HIV status?

- Identify ways of managing the process after disclosure as well as adherence to ART.

Facilitator notes

HIV/AIDS stands for Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome.

Often we think of HIV affecting children in two ways: through parents dying and/or when children themselves are infected with the virus. However, HIV/AIDS can affect lives in many different ways:

- **Emotionally:** Parents or family members can be HIV-positive. Children will worry about family members dying and feel sadness and grief when they die.
- **Socially:** The family can experience stigma and discrimination, and children may experience this at school or amongst friends and in the community.
- **Financially:** The household may lose income either because of increased medical bills or because adults are unable to work due to illness.
- **Increased workload for children:** Children may need to help with household and farming duties or take care of an ill family member.
- **Schoolwork:** Children may have to drop out of school because they have to work or because the family cannot afford to send them to school.

Some of the challenges faced by children in the face of HIV/AIDS include:

- **Fear of the unknown and the tendency to dehumanise the infected.** In some cases the immediate family members may isolate and blame one of the spouses for the infection. Such behaviour and attitudes increase both emotional and social distance. Children living in such a family may go through the same emotional processes as the sick parent.

- **Over-identification.** Children may spend an unreasonable amount of time and energy on the sick parent or on their younger infected siblings. In the long run, children may neglect their own needs and burn out.

- **Fear or even actual risk of infection.** With an increased awareness about the phenomenon of HIV and AIDS, children, just like other members of the general community, may believe myths about HIV, such as the idea that HIV can be transmitted through air and contact. On the other hand, lack of adequate knowledge may lead to erosion of fear, thus increasing the risk of infection.

- **Fear of death and dying.** Being around a dying person evokes many feelings. Depending on the child's age, these feelings may activate extreme anxiety and fear of the child's own mortality.

- **Helplessness and hopelessness.** People with AIDS can activate a sense of helplessness and hopelessness in those around them. In young people and even adults, this may be difficult to acknowledge.

- **Guilt and blame.** An increased feeling of helplessness may lead to guilt or blame directed toward the victim. This process may result in reduced contact with the patient, and some children may run away from home. Their running away from home exposes them to risky behaviour and also makes them vulnerable.

- **Increased economic stress on the family, which may also have an impact on children's feelings.** Chronic illness leads to depleted resources. Children may be very young, but they can notice changes in family status. Some children may react by engaging in antisocial behaviour, such as petty thieving.

Impact of HIV on children

Physical effects	• Abdominal pain • Headache • Chest pain • General malaise • Fatigue
Behavioural effects	• Restlessness • Hyperactivity • Withdrawal and self-neglect • Aggressiveness • Disturbed sleep • Acting out • Stealing • Drug abuse and sexual promiscuity
Emotional effects	• Emotional neglect in infants from sick, depressed mother • Irritability • Lack of interest in surroundings • Depression, sadness, and mood changes • Suicidal tendencies • Anxiety, fear, and anger • Outbursts
Cognitive effects	• Inability to concentrate • Regression of milestones • Forgetfulness or poor memory • Confusion • Poor academic performance
Effects on mental health	• Social withdrawal and isolation • Complications from treatment • Antisocial behaviour • Confusion • Forgetfulness • Disorientation • Memory loss • Personality changes • Anxiety **These all require referral to specialised support (see module 4).** • Seizures • Agitation • Aggression • Hallucinations • Delusions • Mood disorders

Helping caregivers disclose their own and/or their child's HIV status

Facilitator notes

Usually, the disease process is not explained to the children. Older children, who often become caretakers to their sick mother, are left to draw their own conclusions. Group counselling and empowerment of parents to disclose and discuss their status with the children should commence early in order to prepare the children for the eventual passing away of the parent(s). However, this is not easy. The following quotes from parents show how difficult this can be for parents[12]:

"If my husband doesn't know about my HIV status, how do I begin telling my son?"

38-year-old mother about disclosing her status to her 12-year-old son, who is living with his stepfather

"Telling my son about my infection and his HIV status is like stripping naked in front of him and discussing my sex life with him."

"There is no value added in disclosing her status to my daughter. Let her continue to have a normal childhood."

32-year-old mother on disclosing her daughter's HIV-positive status

36-year-old mother on disclosing her status to her 11-year-old son

"It's too painful to face my little girl and start discussing HIV with her."

26-year-old mother on disclosing to her 10-year-old daughter

Why should parents disclose their health conditions to their children?

- Protects children from getting infected

- Helps children to cope when the parents die

- Reduces levels of anxiety and unanswered questions in children

- Protects the children from being vulnerable to HIV/AIDS

- Reduces the possibility of long-term emotional problems

- Gives the child the opportunity to say goodbye and begin the process of healing in the event that parents die

- Gives the parents peace of mind that the child will be prepared to live without them if and when they die

12 Adapted from Catholic Relief Services (2009).

Discussing HIV/AIDS with children seems the best thing for parents to do. However, parents must overcome many barriers to do this. Individual and cultural barriers include:
- Parents' insecurity about their HIV-status and possible breaches of confidentiality
- The child's maturity level
- Fear that disclosure will make the child's life harder
- The parents' grief process
- Feelings of guilt and self-blame
- Concern about the child's reaction
- Stigma and discrimination
- Traditional belief that children are resilient

How disclosure should be done:
Caregivers often need help with the disclosure process. They can get this by talking to a health care provider who has training in disclosure counselling. The health care provider can advise on the following:
- What to say and how to say it
- What is important during the process; for example, making sure the child can understand what HIV is and does not receive conflicting messages

The health care provider may also offer to be present during the disclosure.

Age of consent:
- The appropriate age for disclosure and consent to test is 12 and above.
- For children below the age of 12, parents or guardians should sign the consent form.
- When a child requests a test, or is being disclosed to, a counsellor should assess the child's ability to understand and emotionally cope with the result.
- Children should be tested for their benefit and not simply because their guardians or parents want it done.
- Notification of schools or other facilities about the child's serostatus should only be for continued support and disclosure. The best interest of the child should be the guiding principle.
- Confidentiality must be observed. Health workers and caregivers should not disclose the child's status without her/his consent unless it is necessary for the child's well-being.

Post-disclosure support and adherence to ART [13]

Facilitator notes

Support for children:
- Encourage interaction with others.
- Refer/link the child to support groups.
- Support positive living.
- Share experiences/testimonies.
- Provide information and materials on disclosure.
- Network with spiritual leaders.
- Encourage adherence to treatment.
- Continue with supportive counselling.
- Encourage drama/music/dance.

Support for Parents and Caregivers
- Encourage sharing the burden with a close friend.
- Give hope and build self-esteem.
- Offer on-going counselling and support.
- Encourage parents and caregivers to join support groups.

Adherence

Facilitator notes

ARV adherence means taking the right drug, in the right doses, at the right time, with the right frequency, and in the right way. It also means that children attend clinic appointments, conduct routine lab tests and CD4 counts, and refill prescriptions monthly. Antiretroviral

therapy, or ART, refers to the combination of drugs people living with HIV must take to prevent the virus from growing. If they are not taken on schedule or in the right way, they cannot effectively fight the virus.

Why should we adhere?
- Decreased viral load
- Increased immunological status
- Improved quality of life
- Prolonged life into adulthood
- Ability to participate in normal activities

How to improve adherence to ART:
- Caregivers should be educated on how to administer medications to children.
- Health care providers should support the family, guardian, or caregivers as they help the child to adhere to medication.
- Health care providers should provide regular nutrition education and support to parents or caregivers.
- Involve children in peer education programmes on positive living, for instance, the Young Positives.
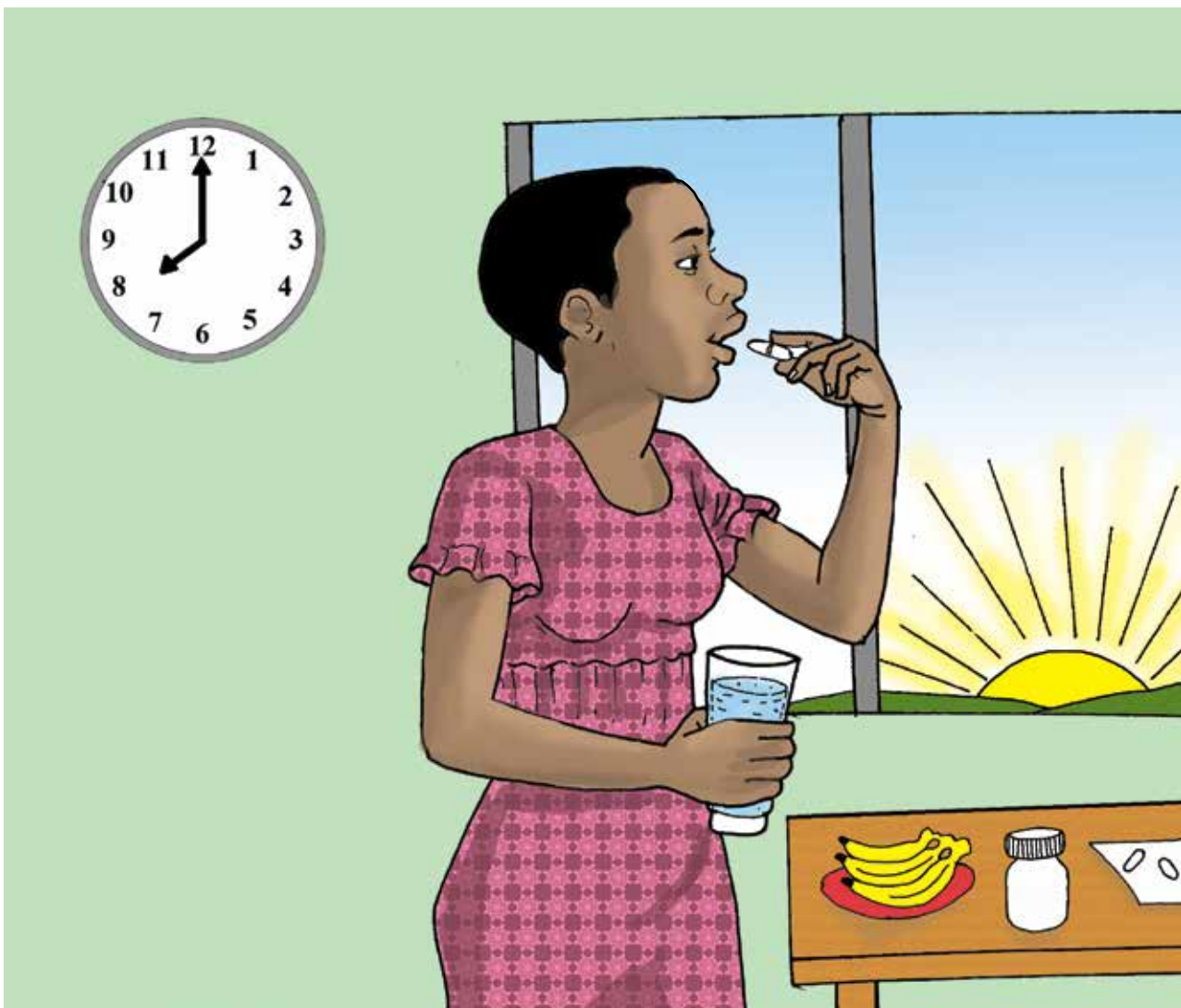
Children in emergencies

In this section we focus on a further set of difficult circumstances that can affect children: emergencies and displacement.

Facilitator notes

An **emergency** can be defined as a sudden, unforeseen happening that requires action to correct or protect lives or property.

In many parts of the world, communities are affected by complex emergencies, ranging from natural disasters such as mudslides and flooding to armed conflict, displacement, and family separation. Often, these emergencies, in combination with poverty, physical hardship, loss of life, and injury, affect the well-being of children and young people in a profoundly negative way. Natural disasters also increase the risk of diseases, including cholera and typhoid, due to disruption of the water supply.

Displacement and family separation

When natural disasters or armed conflicts occur, children may be lost or separated from caregivers during the flight to safety and the general commotion that occurs. The longer this separation occurs, the more likely it is that the child will be at risk of violence, abduction, sexual exploitation, or trafficking. It has also been found that children have enhanced resilience when they are with their caregivers during times of upheaval and displacement. Many organisations focus on reuniting separated children with their caregivers as soon as possible in order to minimise the negative impact separation has on them.

The Inter-agency Guiding Principles on Unaccompanied and Separated Children (2004) provide guidance on how separated children should be supported. Some of the main principles include:

- **Preserving family unity wherever possible.** This means keeping children and their families together wherever possible even during evacuations.

- **Tracing and reunification.** This should be based on an assessment of the context and situation that led to separation as well as on an analysis of policies, community practices, and resources, amongst other things. Reunification is considered a priority action when children have become separated.

- **Care arrangements.** Separated children must be give interim care until they are reunited with their families or until other long-term arrangements can be made. This may be community-based care, foster care, or institutional care, depending on contextual factors.

Armed conflict

Armed conflict affects communities, families, and children in a variety of different ways, and the consequences of armed conflicts are many and disastrous[14] . These might be:

- Loss of livelihoods
- Increase of HIV/AIDS (where rape might be used as a weapon)
- Destruction of health services and schools
- Breakdown of community structures
- Loss of sense of safety or security
- Deaths, injuries, and displacement
- Migration to cities (looking for jobs or for security)
- Encampment

Effects of armed conflicts
- Breakdown of cultural values or norms
- Breakdown of community systems
- Child-headed households
- Loss of sources of income
- Homelessness and/or having no access to land (to cultivate)
- Rural-urban migration
- Educational disruption and dropouts
- Stigma (due to being an orphan or ex-combatant, having a disability, or being displaced)
- Exclusion from society (being seen by others neither as a "child" nor an "adult")
- Increased violence
- Increased intake of alcohol or other harmful substances
- Changes in traditional gender roles

Facilitator tips
Present Okello's case study to participants and discuss the questions that follow.

Okello's story:

Okello, an 11-year-old from West Nile, Uganda, lost his mother and was living with his stepmother, who, he says, used to beat him and deny him food. Okello became very frustrated and angry. One day rebels told him that if he joined them he could get food and that once they took over power, he would become a rich man.

When Okello joined, he was first assigned to cook for the rebels. Then he was asked to man checkpoints around the rebel bases. Eventually he was trained and got involved in active combat. Okello says that the older soldiers told him that whenever he killed a person, he was to lick the person's blood and shoot two bullets in the air. Afterwards, they would give him and the other soldiers herbs, which they were told would prevent them from being attacked by their victims' ghosts.

14 This section is adapted from IFRC (2014).

Okello was demobilised from the rebel group after a peace deal with the government. Okello recounts that after discharge, life became very difficult for him. He was hungry all the time, and because he was considered very young, he was not given the same resettlement package as the older combatants. They were told they would be sent to school. Okello says that if there were another armed group, he would join.

Okello reports that he and other children stay together because they cannot associate with other children who go to school and look smarter than them. He also says that the community does not generally favour them because community members say that he and the other children looted, maimed, and killed. He also dreams of being at war and sometimes hears gunshots and dodges bullets that do not exist. He often gets flashbacks of an encounter with government forces in which one of his friends was shot dead at his side.

- What are Okello's needs?
- What assistance can Okello be given to overcome the difficulties he is facing?

Facilitator notes

Issues that may not have emerged from Okello's story:

- Child soldiers spent a significant part of their lives in a strictly hierarchical structure and underwent a socialisation process, which serves the purposes of the military but not civilian life. Such children may find it difficult to adjust and re-learn new codes of behaviour that are not based on fear and power.
- Children who have been involved in killings and all sorts of acts may have been told what this means only in military terms. This may mean that children have to learn new moral behaviour appropriate to civilian life.
- Girls may find it very difficult to adjust to how girls in society are expected to behave. They may also have limited marriage prospects, and the rape and sexual abuse they encountered may make it difficult for them to adjust.
- Some children, especially those who would have held positions of authority, may find it difficult to adjust to civilian life, where their authority is no longer relevant.
- Children experience a sense of low self-esteem and a confused sense of who they are and may need longer-term support from the family and their community.
- Reintegrated children need a lot of peer support and may have actually experienced it despite other brutalising experiences as soldiers. They may have developed a strong sense of community in the army.
- There is a need to initiate community reconciliation initiatives, taking note of how communities traditionally reconcile cases such as rape and murder.
- The integration of vulnerable children, such as child soldiers, into overall programming of war-affected children will need to be carefully considered and monitored. Strategies that mobilise communities around important issues — such as family poverty, education, skills training, health, disabilities, and reconciliation — are most likely to ease children's reintegration.

Children like Okello may need additional help in the form of:

- Assistance with family reintegration and mediation if family members feel ambivalent about their experiences and activities in armed groups
- Traditional healing ceremonies that allow children to reintegrate into the community again and that can symbolise a new start for them
- Practical assistance in the form of vocational and educational assistance that allows them to imagine a future for themselves
- Opportunities to socialise with their peers in ways that do not stigmatise them further.

Additional notes for the facilitator

What must be avoided are interventions where the children are singled out for special treatment because of their experiences, for example, having access to resources that other children do not have, as this can foster resentment and increase stigmatisation.

It is also important to remember that children react differently to situations of armed conflict. This is the statement of a Palestinian mother whose children have been affected by armed conflict:

Different responses

"Our children go through similar experiences but respond differently. Some of our children become anxious and fearful and cling to us. Others become withdrawn and depressed. Some of our children don't seem to be affected and carry right on with their play. I have six children ... two of them don't leave the house, two spend their time watching TV and observing events around them, and the other two are outside playing and enjoying themselves."

(USAID/Save the Children, 2003)

What can help children rebuild their lives?

- Establishing temporary schools and play activities for children
- Encouraging peer support
- Maintaining daily routines and structures, thereby establishing a sense of normalcy, for instance, through child-friendly spaces, adolescent and youth centres, and even integration into family life
- Establish regular social gatherings through various community structures
- Revive positive cultural beliefs, traditions, and practices
- Provide additional psychosocial support activities, including counselling, support groups, case management (through a social worker or mental health worker), hotlines, and memory boxes

Additional notes for the facilitator

One key intervention that is often used in emergency settings is that of Psychological First Aid. We will describe this in more detail now.

Psychological First Aid (PFA) [15]

This is an intervention recommended by the IASC Guidelines on Mental Health & Psychosocial Support and is used in the first few weeks after an emergency has taken place. It is not intended to be used for a long time period. The National Child Traumatic Stress Network and National Center for PTSD (2006) provide some guidelines for how PFA can be used. We have reproduced some of these here, but it is important to remember that people must be trained in how to use PFA before they can go out to use it. The following information is will enable you know what PFA is and how it can be used.

PFA principles

You can best help others if you are calm and focused. It is most important to remember that your safety comes first and to avoid putting yourself in a situation where you might get hurt, or might hurt others. Above all, it is important to do no harm! The "Three Do No Harm Principles":

- Respect the person
- Protect the person from harm
- Act only in the best interests of any person you encounter

A person using PFA helps by:

- Being present
- Listening to the affected person
- Providing the practical things and information a person may need right away
- Connecting affected people with the services and people that can assist them immediately and as they recover in the longer-term.

Key things to remember when providing PFA:

- It is **COMFORTING** to someone in distress.
- It is **PRACTICAL** support – helping people with basic needs.
- It is **TAILORED** to the needs, concerns, and culture of affected persons and their situation.
- It is **IMMEDIATE** and intended to help people who recently experienced a very distressing event.
- It is **CONNECTED** to other support (services and people) that can help in the longer-term.

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15 Adapted from the National Child Traumatic Stress Network and National Center for PTSD (2006) and REPSSI (2011b).

Basic Action Principles of PFA:

- Assess the situation so you will know what to do. Identify the people who are experiencing serious reactions. Consider questions about safety, obvious urgent physical needs, problems, and available resources.
- Be attentive and respectful.
- Provide comfort through your presence and good communication. Assist people to begin using their own coping resources.
- Act practically and efficiently to help people meet their basic needs, solve problems, and find their loved ones.

- End your assistance when the people who needed your assistance are connected to proper support systems. Make sure that you give yourself some care and attention after you have finished attending to the needs of others.

Steps of PFA:

- Assess the issues.
- Be attentive.
- Provide comfort.
- Act practically, e.g., identify coping strategies and resources, link them to services, and share information.
- End the interaction when you have referred the person.

Session 3 ▸ Problems associated with adversity

Bereavement and grief

Facilitator tips

Ask participants to discuss the following points…

On bereavement and grief:

- Definition of loss, bereavement, grief, and mourning
- Stages of bereavement
- How do children react to grief and bereavement?
- What are the factors that lead to complicated grief?
- What are the care and support options for grieving children?
- Definition of succession planning and its importance

On stigma and discrimination:

- Types of stigma and discrimination, their effects and how to overcome them

On substance abuse:

- Causes and effects of substance abuse and how to overcome it

Facilitator notes

Loss refers to deprivation of something valuable to an individual, group or community. It can involve moving to a new place, changing schools, ending a friendship, or watching parents separate or die. All of these can bring sadness and grief to a child's life.

Bereavement is a state of loss due to the death of a loved one. The death of a loved one is one of the greatest losses that can occur. Bereavement includes the period of adjustment in which the bereaved learns to live with the loss. The root word for "bereaved" means to be robbed or deprived of something valuable.

Session objectives

By the end of this session, participants should be able to:

- Explain grief and bereavement in children
- Recognise the signs of grief and bereavement
- Elaborate how to provide care and support to children experiencing grief and bereavement
- Explain succession planning and its importance and list all the necessary elements
- Define stigma and discrimination
- Establish the effects of stigma and discrimination and help children overcome it
- Explain the contribution of substance abuse toward adversity
- Discuss the importance of preventing substance use

Time frame

2 hours 30 minutes

Grief is a normal, dynamic response that takes place after any type of loss. The process involves physical, emotional, cognitive, and spiritual responses to a loss. It is highly individualised and depends on the individual's perception of loss.

Mourning is used interchangeably with grief and specifically refers to a public expression of grief. Mourning is usually related to cultural and religious values and encourages social support for the mourner.

Stages of bereavement

It is generally agreed that people go through five stages of grief when they experience loss or are diagnosed with a life-threatening illness. However, it is important to point out to participants that there can be "rebounds" where the bereaved person moves from one stage to another and back again before reaching the final stage of acceptance.

The five stages are:

Denial: In this stage, we basically refuse to believe that someone is terminally sick or has died.

Anger: Anger can be directed toward the sick or dead person or even at oneself. We can blame others for the sickness, or we can blame God, higher powers, or ourselves. We can also experience angry emotional outbursts.

Bargaining: We can bargain with ourselves or, if religious, with God. We may ask God to take away the reality of what has happened.

Depression: This is characterised by extreme sadness, lack of sleep, lack of concentration, lack of interest in life and in activities that have previously given us delight, feeling hopeless and worthless, and, in extreme cases, thoughts of suicide.

Acceptance: Here one realises that despite what has happened, one has to go on. Thoughts of loss may still come, but they are less intense and less disabling. There is energy to go on and what happened is taken as a fact of life.

Children and mourning

The process of grief among children can be different from that of adults. Young children who experience the death of a loved one often ask themselves three questions[16]:

1. Did I cause this to happen?
2. Will this happen to me?
3. Who will take care of me?

Depending on the child's developmental stage, the child may not accept the irreversibility of death, especially if death is not explained properly to the child.

The mourning process for children has been described as involving four tasks[17]:

1. Helping them to accept the reality of the loss
2. Assisting them to experience the pain or the emotional aspects of the loss
3. Aiding them to adjust to an environment where the deceased is missing
4. Supporting them to find ways of remembering the person and give them a "place" in their memory and life story.

16 Adapted from Balk (2010).
17 Adapted from Worden (1996) in Balk (2010).

Research suggests that children may initially appear to be coping with the bereavement and may continue with their daily tasks, but that grief may re-emerge at a later stage of their life.

Common Reactions to Grief (not age specific):

We can categorise common grief reactions into four main areas: how the death affects our thoughts, emotions, behaviour, and physical reactions.

Thoughts	Emotions	Physical reactions	Behaviour
• Preoccupation with the death • Disbelief • Confusion • Hallucinations • Absentmindedness	• Guilt • Shock • Anxiety • Irritability or anger • Numbness • Loneliness • Relief • Fatigue	• Dizziness • Tightness in throat/chest • Breathlessness • Loss of sexual drive • Hollowness in stomach	• Sleep disturbances • Lack of appetite • Social withdrawal • Crying • Restlessness

There are other common reactions to grief. It is important to note that these are normal reactions and almost everyone feels them following the death of a loved one. These reactions will pass after some time. How long this takes depends on the individual.

Complicated grief and bereavement

Grief is a reaction to loss, while bereavement is the process of dealing with the loss. Grief is complicated when the symptoms of grief (refer to the table on children developmental stages of grief on page 115) persist for at least six months and especially if it goes on for over two years, leading to notable functional impairment (psychological, physical, and social).

The grieving process can take time and should not be hurried. However, if it takes too long, usually more than two years, then it raises concern. Some people may be unable to move on from grief, making it impossible to rebuild their lives.

Factors leading to complicated bereavement:
- Several previous bereavements resulting from multiple losses
- A history of mental illness, such as depression, anxiety, or a previous suicide attempt
- A dependent relationship with someone who has died or a relationship where one had troubled or negative feelings about the deceased
- Low self-esteem, especially if a person's esteem depended on the dead person
- Lack of support from family and friends
- Sudden or unexpected death, for example, from suicide or an accident
- Death of a parent when one is a child or an adolescent
- Death of a cohabiting partner or a partner from an extramarital relationship, where the relationship may not be legally recognised or accepted by family and friends
- Death involving murder, legal proceedings, or media coverage
- Death where the bereaved may be responsible
- Death from a quarantine disease like Ebola or Marburg
- Death where a postmortem or an inquest is required

Other factors leading to complicated bereavement:

- The nature of cultural and religious beliefs: Some cultural and religious beliefs and practices may aid or complicate the process.
- Personality traits: Some people express emotions and look for support from similar individuals, while others may find this does not work for them.
- Substance abuse: In some communities, drugs and/or alcohol are used as coping mechanisms during bereavement. Such a method of coping often leads to complicated grief because it masks the actual grief response and limits opportunities for the bereaved to deal fully with their grief issues.

Additional information for the facilitator

Gender issues in complicated grief:

In many cultures, men and boys are not encouraged to grieve. For example, boys may grow up hearing adults say things like "men do not cry because they are supposed to be strong". This type of gender stereotyping[18] affects the way in which men are able to grieve because they are not allowed to show their emotions. Men may suffer a lot more than women because they do not receive psychosocial support. They are expected to "get over it", so instead of developing positive coping strategies, they may turn to alcohol or other substances to help them through the bereavement period. For some young boys and men, this type of experience could be the start of addiction and substance abuse problems.

Women often receive more empathy and support than men because they are freer to express how they feel. A bereaved woman is likely to receive support from family, friends, and neighbours, who allow her to grieve more openly than men are able to. However, cultural norms may also affect how women are allowed to behave following the death of a loved one, for example, determining if and when she can remarry and what clothes she has to wear. To facilitate the development of positive coping styles, it is important that both boys and girls be allowed to grieve openly and express their emotions. Suppressing emotions likely leads to negative coping styles, and these can lead to further difficulties and hardships, both for the grieving person and for family and friends.

How children react to grief and bereavement

Children have some responses to illness and death that are similar to adults'. But they also have some very specific issues based on their developmental capacity to understand what is happening to them and their loved ones. Caregivers need to appreciate and understand the various stages of development in children in order to appropriately respond and support them. Children are often neglected when it comes to dealing with grief because they are considered "too young" to understand what has happened. Children "act out" in a bid to get attention. Even if a child is too young to comprehend, he or she can respond to changes in the emotional status of the family. Children may be dealing with the death of family members — and they may also have HIV. The caregiver must be given a sense of where the child is on his/her developmental trajectory. Four streams of development are usually presented:

18 Gender stereotyping refers to fixed ideas that people have about how men and women should behave, and about their abilities, characteristics, and beliefs. "Women are better at looking after children" or "men are better drivers" are examples of such stereotyping.

- Physical growth and physiological maturation
- Motor skills development
- Cognitive maturation
- Social and emotional maturation.

Anticipatory grief in children during a parent's illness

It is important for caregivers to note that children begin grieving well before the death of their parents, so there are early opportunities to begin helping the children to avoid later complications. Children may experience various symptoms of grief as they watch their parents or siblings get very sick. Using stories about death and dying may be one way in which children can express their feeling and think about the death of a loved one. Below is a story of a sparrow that experiences loss. The story can be used to discuss feelings of grief with children and young people. It weaves a tale of nature, trees, and animals to discuss death, dying, and change.

The Story

Once upon a time, Chintu, a little sparrow, lived in a big banyan tree. Her mother and father had laid a nest there, and when she opened her eyes for the first time in her life, the tree was the first thing she saw. She loved to go up and down the branches and perch on the leaves. Many of her friends came to visit her in the tree — the butterflies, the bees, and other little birds like her. As she grew up, she went to spend some time with her grandparents, who lived in the neem tree across the field. Her mother and father were out for a whole day looking for food for the family, and they wanted Chintu to be safe. But every morning, she would fly to the banyan tree to say hello.

One day, she found the banyan tree drooping and the leaves looking brown. She flew from branch to branch, asking the tree what was wrong. The banyan tree said that he was feeling very weak and tired. Chintu ran to her grandfather. He knew a lot of things and would surely help the banyan tree. He took some herbs, but they did not help. Finally, he consulted his friends. They had a meeting, but nothing seemed to help. Chintu went to the deepest corner of the banyan tree and curled up. She did not know what to do now. She stayed there quiet and not moving.

Chintu went to her grandmother. She was feeling very sad. Her grandmother told her to be kind to the banyan tree and to call her friends to cheer him up. She called the butterflies, bees, and the little birds and every day they would go and play on the banyan tree to make him happy. Sometimes Chintu did not feel like playing, but would go to the tree and hold on to one branch and sleep. The banyan tree was feeling very sad and Chintu would talk to him and remind him of all the lovely times they had: when Chintu was born, the day she fell out of the nest and his branches

protected her from falling to the ground, how she had hid behind the roots and leaves while playing hide and seek. Chintu had grown into a confident little bird; she was no longer the little helpless newborn in the nest. One day the banyan tree did not respond. He was too tired and sick and one day the tree shed its leaves and drooped to the ground forever. Chintu and her friends felt very sad. The forest keeper came one day and chopped off the tree, but he left a stump. The rains came and all around the stump beautiful flowers and green grass began to grow. The butterflies came and sat on them, and Chintu felt that although the banyan tree had gone away, he was still there for her.

A few guideline questions have been provided below:

- What did Chintu do when she was happy? Sad? Helpless? Ask a volunteer to demonstrate it through their voice and body.
- Did they think Chintu would have an appetite? Sleep? Would her body feel tense? Tired? Achy? Would she have a headache? Body ache?
- If children are willing, the facilitator can ask if they have ever felt like Chintu. When? What did they feel?
- What did Chintu do to feel better (sing, play, talk)? Who did she go to for help?
- The facilitator should ask volunteers to share what they do when they feel like that. Who can help?
- How did Chintu feel later? Why?
- How do children suggest that their friends be comforted? What can young people do? What about adults?

The story is taken from the book Life Skills Education for Adolescents and Youth: Facilitator's Manual, which is part of the AVSI SCORE Project (2013). AVSI slightly modified it from the original version taken from the book Life Skills Education Toolkit for Orphans and Other Vulnerable Participants in India by Family Health International (FHI) India Country Office in collaboration with the National AIDS Control Organization (NACO).

Some examples of quotations from children who have experienced illness and death:

"For me, I just felt anguish because my mother's illness was going forward."

"Every time I was at home, tears would flow from my eyes. At night I would be crying. I did not cry when I was playing, but the moment I went home tears would begin to flow from my eyes. I used to feel sorry for him, and it hurt me seeing him suffer so much. I feel this pain when I am beaten at home or when I am not given food. I start feeling bad again and remember my father."

"I used to feel sad because I knew my mother was going to die. She was experiencing difficulty breathing. I used to feel so much pain in my heart thinking about what was going to happen when she dies. Whenever she cried of pain, I felt worse than before. I cried so much because I did not know that when you die you go to heaven if you used to pray. I did not know all this and used to cry all the time thinking that I will never see my mother again. The people at my church are the ones who used to encourage me."

Facilitator tips

Before presenting the table below, ask participants to consider how the following change as children become older: physical appearance and physiological maturity, motor skills, cognitive maturity, and social and emotional maturity. How might each of these factors affect how children grieve?

Developmental Stages of Grief (by age)[19]

Age	Thoughts	Feelings	Actions	Interventions
0-3 years			• Cries • Exhibits clinging behaviour • Exhibits regressive behaviour	• Hold the child. • Offer words of reassurance in a calm tone of voice.
3 – 5 years	• Believes loved one will return • Believes loved one is just away	• Confused • Anxious • Fearful of separation • Sad or angry	• Cries • Has temper tantrums • Has nightmares • Exhibits regressive behaviour • Exhibits clinging behaviour	• Provide attention. • Offer reassurance calmly; don't worry about the "right words".
6- 9 years	• Wonders if loved one will return • Believes deceased can still function • Believes their actions or words caused death	• Confused • Anxious • Fear of separation • Sad and angry • Fearful they might die too	• Cries • Has temper tantrums • Has nightmares • Exhibits regressive behaviour • Exhibits clinging behaviour • Has difficulty concentrating	• Provide extra attention. • Tell the truth; give appropriate information. • Reassure the child they were not responsible for the death. • Encourage physical or artistic expression.

Age	Thoughts	Feelings	Actions	Interventions
9 – 12 years	• Understands finality and irreversibility of death • Believes their actions or words caused the death	• Sad • Confused • Anxious • Withdrawn • Lonely • Guilty	• Exhibits and engages in risky or dangerous behaviour • Shows decline in grades • Has difficulty concentrating	• Provide extra attention. • Tell the truth; give appropriate information. • Reassure the child they were not responsible for the death. • Encourage physical or artistic expression of grief. • Maintain structure, limits, and rules.
12 – 18 years	• Understands finality, irreversibility, and non- functionality of death • Believes their actions or words caused death	• Sad • Confused • Anxious • Withdrawn • Lonely • Guilty	• Exhibits and engages in risky or dangerous behaviour • Shows decline in grades • Has difficulty concentrating	• Seek community and school support. • Maintain structure, limits, and rules. • Encourage physical or artistic expression of grief.

Care and support for grieving OVC

Support to children should begin with preparing them for the death of a loved one. Some practical ways include the following:

• Communicate openly, factually and honestly.
• Give information that is adjusted to the child's age.
• Do not give abstract explanations.
• Allow the child to express anger or fear, and help the child to do so without harming himself/herself or others.
• Beware that the natural reaction to death is denial.
• Gently and continually discuss with the child issues around death and dying, and allow the child to ask questions.
• Help children to know what death and dying mean in their culture and religion.
• Enable children to talk about how they would like their family members or themselves to be remembered; for instance, through drawings, poems, or visiting the grave. The memory book project in Uganda is an example of this practice.

- Give the child an opportunity to think about death and ask questions.
- Respect a child's silence as well.
- Ask children to bring photos of their loved ones and to discuss memories.
- Children may engage in searching behaviour such as physically looking for the deceased. Make this an opportunity to help the child and gently confirm the reality of death.
- Allow children to express emotions such as anger, sadness, and fear. Allow them do so without harm to themselves or others.
- Assist children to make the loss real by allowing them to participate in the burial ceremony and funeral rites.
- Never impose assurances on the child, such as: "You have to move on with life. You will be better after a few months."
- Ensure that the child's environment, such as family, school, and community, provide emotional coping and that the child uses them as a source of emotional support.
- As much as possible, avoid removing the child from loved ones such as siblings. Make sure that children do not get divided up among relatives if this is avoidable (although social and economic factors may dictate otherwise).
- Use available services and referral for children with complicated grief.

Additional information for the facilitator

When a child shows any of the symptoms discussed, refer to child organisations if there are any in your area. You may also refer the child to your local psychiatric unit in case of a suicide attempt or depression. Psychiatric services exist in every district in Uganda. If the child has a serious emotional or psychological problem, it is best to refer to a trained person. However, it is also important to encourage the caregivers to show love and support to the child throughout the mourning period.

Succession planning

One factor that makes parental death even more difficult for children is that the parent may not have made a will or plans for how the children will be looked after and the property distributed. In this section, we look at how succession planning can be done so that children are protected when a parent dies.

Succession planning may be defined as a process whereby a parent (or parents) prepares for the care of his/her children in the event of death. This includes the issue of property transfer, deciding who will be looking after the children after the death, and the general psychosocial care of children.

Importance of succession planning

Facilitator tips

Read these two quotes by OVCs from Zambia, and consider what has started going wrong for the vulnerable children at what stage of the illness.

Namoonga's story (14-year-old girl):

"Since my mother had a good job, she had acquired a lot of wealth. After she died, her relatives grabbed everything, starting from the household goods and money she had in the bank. You can imagine how depressed I am as a result of all these sad developments: It's like from riches to rags, yet my father is still alive, although his status has also betrayed me. Worse still, my father is still trying to sell the only house he has — and what would happen if he died? I told him that he was making a big mistake by trying to sell the house. I know he needs the money for his medication, and at the same time we need support. I feel he should not do that, just for the sake of his children."

Mwaya's story (17-year-old boy):

"Speaking of property grabbing — my family and I were stripped even before… my parents died. My uncle forced my sick father to give him the TV and VCR we had. We tried to stop him but failed. Other things that were grabbed were items that were not listed or mentioned in the will by my father. Livestock of up to 20 goats were taken by my grandmother, two cars were taken by my uncle, and many other items despite the will."

In your groups discuss the following questions:

- What is the importance of succession planning?
- In your community, what happens when a person dies without making succession plans?

Facilitator notes

The following are some of the problems that can emerge after the death of a primary caregiver of a child:

- Disputes over the division of property
- Fighting among the surviving relatives
- Concealment of part of the property
- Children and the surviving spouse cheated of their property by relatives
- Women chased from the homes and children scattered among relatives
- Contesting of the will of the deceased

Succession planning is important because it:

- Protects children from abuse

- Protects children against loss of property

- Prepares children to expect what is going to happen

Responsibility for succession planning

Facilitator tips

Ask participants to brainstorm on the following points:

- What is a will and who is responsible for succession planning?

- How and when is succession planning done?

Practice designing a will in groups. Groups can then present before discussing in plenary.

Facilitator notes

Men and women who have property that they would like to distribute in a specific manner after their death are responsible for succession planning. They may also decide who should act as a guardian if the children are still minors.

An instrument used in succession planning is called a will.

A **will** is an official statement on what an individual has decided should be done with their money and property after their death . Very few people make a will in their lifetime.

In will making, caregivers need to ask themselves these questions:

- What do I know about inheritance in my community?

- What do I know about a will and the will-making process?

- How is a valid will made?

- How can I obtain this knowledge and apply it in my work?

Who can make a will?

- A person who is 21 years and above

- Anyone mentally capable of understanding what they are doing during the process of making a will as long as the will is not made under duress, coercion, or deception

Questions to ask patients in the process of preparing them for a will:

- Employment details

- Trusted companions/relatives capable of helping to manage property issues

- Family relations (children, spouse, and other dependents)

- Debts and related issues

Types of Wills

There are basically two types of wills: written wills in the form of a written document or video and unprivileged wills, which may be made orally or in writing.

Unprivileged wills are made by armed forces in warfare or on an expedition or by mariners at sea; they are considered valid. When a person is no longer under these circumstances, the will ceases to be binding. This type of will is reserved for people who operate under imminent threat of death.

Who gets included in a will?

A person is free to give his/her property to anyone. However, it is important to explain to the patient that certain categories of people have to be catered for. Failure to do this would lead to contesting the will. The categories are:

- **A surviving spouse:** If the patient is legally married to one or more wives under customary law or Islamic law, the wives are entitled to a share of the deceased person's property. In cases where a spouse was separated from the deceased, there is no right to property, and this has to be stated in a will.

- **Children of the deceased:** Any child below the age of 21 born in or out of wedlock has a right to the deceased person's property.

- **Relatives:** Relatives who depend totally on the deceased for basic necessities of life such as food, clothing, medical care, and education should also be considered in a will.

Will Content:

- Illiterate or semi-literate patients should be assured that a person they trust can make them a will and that if they sign the document or make a thumbprint, it is considered valid.

- There is no legal style of making a will — it may be written in any language or format. However, there are some important aspects that must appear. These are:

  - The date of the will

  - The name of the will maker

  - Details of spouses, including those who are separated or divorced

  - Details of children and, in case children are too young to manage their property, a trustee, who is a person who should manage on their behalf

  - A full list of the beneficiaries

  - A full list of all the property of the will maker

  - The distribution scheme of the property

  - The name of the person who will oversee the distribution process, who is referred to as the executor

  - Signature of the will maker

  - Signatures of two witnesses

  - Instructions on when the will should be opened

Other details that may be included are:

- A person to act as a guardian if the children are too young to take care of themselves
- If the custom requires, and if the patient so wishes, the name of an heir or heiress
- Details of the place where the person chooses to be buried
- If the person is employed, full details of the salary and all other benefits and entitlements
- Details of all businesses that the person holds shares in
- Names of banks and account numbers where the person keeps money
- Any insurance policy that the person holds
- Details of debtors, creditors, and amounts involved

THE WILL

Date _____

Name (in full) of Testator _____

Born at (place) _____ Now living at _____

Working as _____ Employed by _____

I am making this as my last Will. It replaces any other Wills earlier made by me. I have made this Will voluntarily without any pressure while I am in sound mind.

My father is (name) _____ of (place) _____

My mother is (name) _____ of (place) _____

I belong to _____ clan, of _____ tribe

I was born on (date) _____ at (place) _____

My wife / wives / husband is / are (name)_____

Married on (date / dates)_____

Below are my children: (add more lines on back if more children)

Name	**Male / Female**	**Age**	**Name of other parent**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have chosen (name of child) _____ as my heir

The following will be the Executor of my will (the person entrusted to make sure all the wishes expressed in this Will are met):

Name_____

Address _____

THE WILL (continued)

The following Will be the Guardian(s) of my children (the person legally entrusted to be their caregiver):

Name   **Address**

_____   _____

_____   _____

I have distributed my property to the following people (Beneficiaries):

Name	Property	Relationship	Any conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I wish to be buried at (place) _____ in _____ District.

You may add anything else you wish (or do not wish) to be done at your burial or after your death.

_____

_____

Any other necessary information or message to your children:

_____

Made on this day _____ of (year) _____

Name   **Address**

_____   _____

Witnessed by (at least two people knowwn to you):

Name	Residence	Relationship	Signature or thumbprint
_____	_____	_____	_____
_____	_____	_____	_____

page 2 of 2

The role of the executor and witnesses

The executor must be well-known and trusted by the patient. He or she must be a person of integrity and must be willing to carry out this task. This could be a wife, husband, brother, sister, religious leader, or the administrator general (the government official charged with administration of estates). The role of the witnesses is to attest that the patient wrote the will voluntarily and in his or her right senses — it is not to read the will. Witnesses should not demand to be informed of the contents. Alternatively, wills can be made in video format, so that there is no need for witnesses.

Things that invalidate a will:

- When the language used is vague, confusing, or ambiguous
- When it excludes categories of people who are legally entitled
- When the will-maker made a will when he or she was mentally unstable, or under duress or coercion
- When it omits naming an executor or omits signature of two witnesses

Sometimes, people may be worried that once a will is made, it cannot be changed. Patients can be informed about the circumstances under which a will can be changed. These are:

- If the person acquires more property or children or marries more wives under Islamic or customary law
- If a person makes a will when still single and then marries later
- If the will-maker divorces and remarries

Where a will can be kept

Patients should be asked with whom they wish to keep their will to avoid its being tampered with. This will depend on the person's circumstances. The following are possible people who can keep a will:

- A trusted person, such as a parent or spouse
- Religious leader
- Local leader
- Administrator general

Procedure to take after the will-maker has died:

- The people in possession of the will read the will according to the funeral procedures.
- The executor applies to a court of law to be granted permission to manage the affairs of the deceased.
- The court asks the executor to produce the will and to advertise to the public the fact that the executor wants to manage the affairs. At this stage, anyone who wishes to contest the will comes forward. The court helps to ensure orderly execution of the will.
- Fourteen days after the public announcement, the executor is allowed by the court to manage the affairs. He or she must, however, report to the court within six months on the extent to which he or she has complied with the instructions in the will.

The Land Act of Uganda is an important legal framework for protecting the land rights of women, children, and persons with disabilities. Caregivers should know some basic information about the Land Act of Uganda in order to protect the land rights of women and children. The following are excerpts from the Land Act that might guide caregivers in giving information:

Chapter 227 Article 27 Rights of women, children, and persons with a disability regarding customary land

Any decision taken in respect of land held under customary tenure, whether in respect of land held individually or communally, shall be in accordance with the customs, traditions, and practices of the community concerned, except that a decision which denies women or children or persons with a disability access to ownership, occupation, or use of any land or imposes conditions which violate articles 33, 34, and 35 of the Constitution on any ownership, occupation or use of any land shall be null and void.

Article 33 of the Constitution of Uganda

- Women shall be accorded full and equal dignity of the person with men.
- The state shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential advancement.
- The state shall protect women and their rights, taking into account their unique status and natural maternal functions in society.
- Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.
- Without prejudice to article 32 of this constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition, or custom.
- Laws cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status are prohibited by this constitution.

Article 34

- Subject to laws enacted in their best interests, children shall have the right to know and be cared for by their parents or those entitled by the law to bring them up.
- A child is entitled to basic education which shall be the responsibility of the state and the parents of the child.
- No child shall be deprived by any person of medical treatment, education or any other social or economic benefit by reason of religious or other beliefs.
- Children are entitled to be protected from social or economic exploitation and shall be not be employed in or required to perform work that is likely to be hazardous or interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development.
- A child offender who is kept in lawful custody or detention shall be kept separately from adult offenders.
- The law shall accord special protection to orphans and other vulnerable children.

Article 35
- Person with disabilities have a right to respect and human dignity and the State and society shall take appropriate measures to ensure that the person with disabilities realise their full mental and physical potential.
- Parliament shall enact laws appropriate for the protection of persons with disabilities.

Laws protecting persons who have lived on a piece of land for many years:

Because of their ignorance of the law, some children have been thrown off land (by others claiming the land) that their parents occupied for many years. The 1995 Constitution provides protection for such children. Article 29, paragraph 2, provides a legal framework for protection:

(2) "Bona fide occupant" means a person who before the coming into force of the constitution-

(a) Had occupied and utilised or developed any land unchallenged by the registered owner or agent of the registered owner for twelve years or more.

Stigma and discrimination

Reducing stigma and discrimination against vulnerable children is one of the guiding principles of the National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI 2) and a crucial aspect of trying to improve the well-being of these groups of children and young people. Not all vulnerable children will necessarily experience stigma. However, from experience we know that children affected by HIV/AIDS and disability are specifically at risk of being discriminated against. This makes Vulnerable Children "double vulnerable", as they have to cope not only with the difficulties affecting them but also with the negative attitudes and behaviour of others around them.

Stigma can be defined as:

An unfavourable attitude and belief toward someone or something, which can be directed toward others or toward oneself.

Examples of states that can cause self-stigma:
- Something about a person that causes that person to have deeply compromised social standing, like stigma toward disabled people
- Attributes that are deeply discrediting and reduce that person from a whole and normal person to a tainted and discounted individual
- The attributes of stigmatisation can vary from context to context, but can include issues such as illnesses (HIV/AIDS, cancers, skin diseases, etc.), gender, sexual orientation, disability, age, and poverty

We distinguish between internal and external stigma:

Internal stigma or self-stigmatisation is a person's own negative feelings and beliefs about one self. The person may have diseases or predisposing factors, including HIV/AIDS, disability, cancer, and hydrocephalus.

Examples of internal stigma:

- Self-isolation, for instance, refusing to go to school, staying home, and refusing to play with others
- Depression
- Self-pity and low self-esteem
- Feeling bitter
- Aggressiveness toward others
- Suicidal feelings
- Condemning self and God
- Irresponsible sexual behaviour

External stigma is stigma that is expressed by the community against someone.

Examples of external stigma:

- Isolating individuals
- Gossiping
- Religious leaders using persons living with AIDS as examples of bad behaviour in their talks and sermons
- Making individuals use separate eating utensils
- Composing negative songs about a person, tribe, or group
- Refusing to share things with some people, for instance, those with HIV/AIDS

The results of stigma are disapproval, rejection, exclusion and discrimination.

Discrimination is a product of stigma. It may be defined as denial of the person's rights on the grounds of their social or health status. For example, certain people — orphans, children from broken families, children with HIV/AIDS, children of poor single mothers, children of refugees or displaced persons, former child soldiers, and abductees — already carry some stigma from their birth status or family situation, which may become a reason for discrimination. These are some of the adverse situations that can lead to discrimination of children and their families.

Types of discrimination

- Gender discrimination
- Social discrimination (e.g., due to health or social status)
- Discrimination based on ethnicity
- Discrimination based on ability
- Discrimination based on age (against the very old and the very young)

Causes of stigma and discrimination:
- Desire by certain groups to control others
- Religious and cultural beliefs surrounding certain conditions and diseases (e.g., if a behaviour or disease is associated with perversion, shame, crime, or horror, the individual is demonised)
- Ignorance about causes of diseases and effects of adverse conditions on individuals, for example, the effects of abduction on children
- May be a means of blaming people about their status so as not to take the responsibility for caring for them
- Fear of life-threatening diseases
- Association of behaviour diseases with that is already stigmatised in society
- Lack of protective legislation to protect individuals against discrimination in social and health sectors
- Lack of treatment and support

Effects of discrimination
- Low self-esteem and self-stigma
- Depression
- Suicide
- Keeps the community in denial and prevents it from taking positive steps to solve or prevent the problems
- Causes certain diseases to be kept underground, thereby affecting large sections of the community
- Leads to lack of care and support
- Extension of stigma attached to certain diseases and behaviour to the next generation, placing an emotional burden on those left behind
- Popular ignorance
- Discrimination and stigma being felt by children in their hearts, even if they are unable to articulate and define this concept (the child's mental, physical and social life may be adversely affected)
- People denying that they are personally vulnerable to the same problems
- Dropout from school

How stigma affects children[20]

Stigma faced by children takes many forms. Some examples are:
- Children may be blamed for their parent's death or for being a burden; in some countries, orphans are seen as unlucky children, as though they "killed their parents".
- Children may be excluded from school, families, and communities because of fear of infection if their families are HIV positive.
- Orphans are often treated differently from other children in families, such as being given extra work or being accused of promoting their parents' "bad behaviour".
- Very poor children may be seen as "dirty" and street children as being out of control.

[20] Adapted from International HIV/AIDS Alliance & PACT Tanzania (2007).

- Some adults see children who are HIV-positive as a "waste of resources" because they will die soon.

> **Additional information for the facilitator**
>
> Quotes from children who are HIV-positive:
>
> "My teacher chased me from school because I had sores on my body. I didn't have problems with my friends." Girl, 10-years-old
>
> "At home, friends never used to like me. They said I have TB and measles. They used to run away from me."
>
> "Other children like to tease me since I don't have a mom and dad like them."
>
> "My friends like to mock me. One friend of mine, a boy, dragged me into the restroom and hit me."
>
> "[I'm] worried about many things … When will I get a new pair of shoes? I have to wear the torn ones, and I feel ashamed about it."[21]

Reducing stigma

Several activities can be carried out to prevent stigma and discrimination. These can include:
- Stimulating community dialogue on underlying factors that contribute to a certain stigmatised state
- Ensuring that people are given basic facts about diseases and other problems
- Challenging fear-based messages and biased social attitudes
- Carrying out activities that elicit the support of community leaders
- Carrying out activities that motivate individuals and communities to demand information, so that they play the role of advocates
- Increasing awareness about the real causes of stigma and discrimination
- Carrying out support activities that increase self-confidence and self-esteem among affected individuals
- Carrying out activities that encourage more people to go for voluntary testing and counselling
- Advocating for protective legislation
- Increasing care and support for affected children
- Carrying out activities that trigger compassion, solidarity, and support, for example, joint drama, sports, and music
- Empowering a person who is being stigmatised to become more resilient
- Avoiding labelling as this can have a negative effect on the children and reinforce stigma against them

21 The first two quotes are taken from International HIV/AIDS Alliance & PACT Tanzania (2007) and the last three quotes from Punpanich et al (2008).

Substance abuse

Substance abuse refers to use of any chemical substance, natural or manmade, that by its chemical nature alters someone's biological structure or functions when administered and absorbed. Drugs can affect feelings, perceptions, thought processes, or behaviour. Drugs affect vulnerable children by altering the functioning of their nervous system. There are many types of drugs that are available that are legal (recognised as a medication prescribed by a professional doctor). There are also others that are illegal/illicit.

Facilitator tips

- What types of drugs do you know?
- What are the local names for such drugs?
- What are some of the reasons for using drugs?
- How did this alter your moods, judgment/decision-making, perceptions, and behaviour?

Facilitator notes

There are four main classes, or types, of psychoactive substances:

- Stimulants

- Opioids (sometimes called narcotics)

- Depressants

- Hallucinogens

Others do not fit neatly in the above categories:

- Cannabis (marijuana)

- Khat/miraa (mairunji)

- Inhalants (aviation fuel, paint thinner)

Effects of drugs

Drugs can affect the following:

- **Mood** (feeling more alert, relaxed, angry, sociable, fearful, depressed, etc.)

- **Thinking** (poor judgment, distorted perceptions, inability to plan or make a decision, racing thoughts)

- **Perceptions** (changes in temperature perception, pain perception)

- **Behaviour** (decreased or increased activity, increased risk taking, undertaking of dangerous activities, aggression, violence, passivity, or increased or decreased sexual behaviour)

Drugs can have a positive effect (often lasting a short time) or can have negative effects. The effects vary depending on the type of drug, the person who uses it, its action and chemical structure, and its potential for abuse.

The method of administering a drug to oneself affects how quickly it gets into the brain. Some drugs reach the brain faster and are more dangerous. There are several methods for substance intake:

- Swallowing

- Inhaling through the nose

- Smoking

- Injecting (into a muscle, vein, or skin)

- Placing under the tongue

- Placing in the anus or vagina

Why children use substances

- Experimentation
- Relief of emotional pain
- Homelessness
- Absence of responsible caregivers (or have parents with poor parenting skills)
- Peer pressure and age-related factors
- Low self-esteem
- Influence from the media
- Being born into a family where substance abuse is prevalent
- Genetic predisposition
- Culture (for instance, in West Nile when a child is born, alcohol is put on its tongue)
- Inadequate implementation of government policies on alcohol and drugs
- Lack of regulation and poor enforcement mechanisms
- A country's heavy reliance on revenue/taxes from alcohol and drugs
- Occasional/circumstantial use
- Regular users who want to achieve the desired effects
- Gender
- Poor mental health state
- Unstructured life (for instance, joblessness may increase time available for engaging in substance abuse)
- Child abuse
- Easy availability of drugs and substances (for instance, the packaging of alcohol in small and cheap packages and unregulated alcohol production)
- Lack of information

Drug influence, signs and symptoms

	Substance	Behaviour
Alcohol	Beer, wine, distilled spirits	Slurred speech, staggering, slow reactions, odour of alcohol, confusion, nausea, vomiting, sluggishness/slowness, and fumbling
Other depressants	Barbiturates, Quaaludes, Valium, Xanax	Slurred speech, staggering, odour of alcohol, confusion, nausea, vomiting, sluggishness/slowness, fumbling
Inhalants	Gasoline, propane, solvents, aerosols, anaesthetic gases	Confusion, slurred speech, bloodshot or watery eyes, non-communicativeness, residue around the mouth and nose, lack of muscle control, flushed face
Cannabis	Marijuana, hashish	Bloodshot eyes, body or eyelid tremors, increased appetite, odour of marijuana, impaired perception of time and place, lowered inhibitions, confusion, possible paranoia
Stimulants	Amphetamines	Body tremors, excitement, loss of appetite, runny nose, dry mouth, red nasal area, eyelid and leg tremors, euphoria, talkativeness, exaggerated reflexes, insomnia, increased alertness, irritability
Hallucinogens	Peyote, mushrooms, LSD, MDMA	Body tremors, disorientation, paranoia, hallucinations, lack of coordination, perspiration, difficulty in speech, poor perception of lines and distance, memory loss
Narcotics / analgesics	Opium, morphine, codeine, heroin	Low raspy, slow speech, dry mouth, facial itching, track marks, drowsiness, slow reflexes, nausea

Additional notes for the facilitator

Addiction is a chronic, relapsing brain disease characterised by compulsive seeking and use of substances despite their harmful impact on the individual, family, and communities. Addiction causes the person to develop a bio-psychosocial dependence on the drug. Some substances are known to cause physical, psychological, and social dependence. The health effects of substance use differ from women to men. Women become physically dependent on substances more quickly than men, including fatal effects and deficits in parenting skills. Children's early use of drugs increases the chances of drug abuse and addiction, as well as their vulnerability to physical and social problems.

General signs and symptoms of drug use

- Physical: fatigue, repeated health complaints, red and glazed eyes (showing no expression due to fatigue or weakness), and a lasting cough

- Emotional: personality changes, sudden mood changes, low self-esteem, irritability, irresponsible behaviour, poor judgment, depression, and a general lack of interest
- Family: starting arguments, breaking rules, and withdrawing from the family
- School: decreased interest, negative attitude, drop in grades, many absenteeism, truancy, and discipline problems
- Social problems: new antisocial friends, problems with the law, and changes in their conventional styles in dressing and music preferences
- Lying and stealing: Most children who use drugs steal because they are dependent on the drug and will do anything to obtain them.
- Risky sexual behaviour

Why substance use prevention is important

- To help young people to avoid or delay the initiation of the use of substances
- To avoid people who have already started using substances from developing substance use disorders
- To keep children healthy and safe as they grow up to realise their full potential
- To reduce health, social, and economic problems associated with drug use

Impact of drug use

Facilitator tips

Alcohol and the liver: Demonstration activity

Get a glass of alcohol and a glass of water. Put a small piece of liver in each of the glasses and watch what happens. Discuss with the community members the effects of alcohol on the liver based on what they have observed.

The Pot Demonstration:

Other important effects of alcohol abuse

Standing in a circle, ask participants to write on a piece of a paper their greatest treasure (what they cherish or love most). Then ask them to say it out loud as they place it in the pot (which represents safety) that is being passed around from one person's hands to another. When the pot reaches the facilitator, place your most important treasure in it, and then drop the pot on the ground (without it looking intentional). Observe the group's mood for a while, and then discuss what each one has lost with the breaking of the pot. Link the breaking of the pot to behaviour like alcohol and drug abuse.

Use some strong tape to glue the pot back together. Discuss that even after alcohol abuse and all the effects, one can still pick up the pieces of their life and start afresh — with scars, but resiliently looking forward to a better life. Discuss the kind of things that one can do to move forward even after all the problems associated with alcohol drug abuse.

Make the following summary

Children who live in households where alcohol is abused face the following risks:

- Violence
- Sexual abuse and exposure to HIV and sexually transmitted infections
- Psychological and emotional problems from the lack of structure and discipline in their household
- Lack of basic necessities, such as food and clothing, if their parent or guardian is unable to work
- Health hazards, including accidents and injuries
- Lack of parental guidance or supervision because parents or guardians may be forgetful or even unconscious for long periods of time
- Copying their parent or guardian's behaviour and beginning to abuse alcohol
- Isolation and stigma from the community

Impact of drug use

Facilitator tips

Helping young people connect the effects of substance use to their lives

Activity: Pop and Inhale: Drugs and Inhalants

1. Give each participant a piece of paper to fold into four sections, like a square with four boxes. In each box, the participant should write four things that are very important to them, such as personalities, what they possess, something they really like to do, or something they treasure.

2. Participants can draw or write.

3. Participants will identify four different types of drugs, such as inhalants (thinner, glue, paint solvent), amphetamines or cough syrups, heroin, and marijuana. The participants share the information they have about the drugs.

4. As each drug is named, the participant will tear one box and place it on the floor next to him or her. When all four drugs have been called out, all four boxes will be on the floor and the participant will have nothing in his hand. Ask the participants to read what they lost.

5. The facilitator lists all that the participants have written and adds the following if not mentioned:
   - Family break up
   - Jobs are lost
   - Crimes like stealing start to pay for the drugs
   - Conflicts with friends

6. Ask a participant what problems one could have that would make a person want to try drugs. Take two or three examples, and ask the participants whether there are any other ways to handle those problems other than taking drugs. Do some brainstorming, and inform the participants that this will be explored in greater depth in the next session.

Review

- Why did you select these four important things among many others?

- Who uses these drugs?

- Are they available?

- How did you feel when all that you possessed and loved disappeared? How would the people you "lost" feel about you?

- What do you do if you have a problem? Where do you go?

Additional notes for the facilitator

Working with children 6-12 years

Family, guardians, and schools remain the principle sources of support. Here, cover parenting skills programmes, personal and social skills education, and classroom environment. This will involve improving family bonding with children, finding role models, setting rules for acceptable behaviour, monitoring free time and friendship partners, and using positive and appropriate discipline. Give less information on drugs. Generate more group sessions on the above activities using trained facilitators.

Early OVC adolescents 12-15 years

Interventions that work here are about prevention education. They are based on personal social skills and social influence of young people. You may also address individual psychological vulnerabilities, especially lack of skills in coping with emotions such as grief and loss.

Content should cover perception of risk or harm associated with substance use. Emphasise immediate age-appropriate consequences of substance use, address misconceptions and normalisation of drugs amongst peers, and discuss reducing availability and access to drugs in their families or communities. Drug testing of OVCs may not be helpful, but interactive preventive activities may help.

Later OVC adolescents 15-18 years

Most OVCs here are out of school and are beginning to take on adult roles (working and beginning families). They are becoming independent, and significant changes are occurring in their brains. This may come with stress, which causes poor decisions and involvement in risky behaviour such as sexual activity. The adolescent may be introduced to new ideas, including smoking, drinking, or using drugs. NGOs, public health organisations, and workplaces play an active role in preventing stress from leading to substance use. At this time, there is a need to introduce community-based initiatives with multiple components, such as sustained training; anti-drug coalitions;

and bylaws and other policies that reduce access and availability in communities, increase minimum ages to buy cigarettes and alcohol, and ban or restrict advertising. Using media campaigns based on formative research to change cultural norms and values is critical at this stage. Some interventions can target parents. Other interventions include workplace prevention, which includes stress management activities, one-on-one counselling, screening, referral for treatment, and career guidance provided by trained health and social workers.

Effective prevention involves instituting family programmes that focus on parenting skills and family engagement. It also relies on schools to provide counselling for individual OVCs and engage OVCs to improve their personal and social skills. There is a need to have effective policies that keep OVCs in schools and promote school bonding.

Prevention activities must be done regularly and frequently — not just via a one-day event — because OVCs need constant reminders.

Interventions

Addiction to substances may be complicated and may require professional support in terms of treatment and reintegration. Develop a referral system, and know which services are in your area. Some of the services may be free, but most private agencies charge money. You need to have this information early and perhaps even visit services before providing referrals.

Within a community where OVCs live, there are many different organisations and services relevant to drug abuse prevention.

Facilitator tips
- Identify services that are involved in drug and alcohol abuse in your communities.
- Who can provide services? What services can they provide?

Facilitator notes

Government Agencies	Non-Government Agencies
• Public health/hospitals • Mental health institutions • Judiciary • Education providers • Social services providers (probation officers) • Law enforcement officers	• Drug abuse treatment agencies • Community-based groups • Faith-based agencies • Businesses, such as media

Where to get help:

- Government mental health clinics/units in all government hospitals
- Teen Challenge Uganda, Ntinda, Kampala
- Uganda Youth Development Link (UYDEL) located in Masooli (Kampala); Nabulaggala (Rubaga, Kampala); and Kitega (Mukono)
- Alcoholics Anonymous (AA) Uganda holds meetings on alcohol and drugs every Tuesday and Friday at Christ the King Church in Kampala (1st Floor, room 3) from 01:00 to 2:00 pm. You can also visit AA centres in Masaka, Lira, Jinja, Kabale, Mbarara, Bushenyi, Gulu, Arua, and Rukungiri.
- Alcohol and drug Unit in Butabika Hospital
- Most hospitals/health facilities around the county
- Police Family Protection Unit in any police station countrywide
- Beam of Hope, Mbale
- Serenity Centre, Kabulamuliro, Namulanda (off Entebbe Road)
- Fresh Start, Kisaasi, Kampala (behind Temple Hill)
- Hope Rehabilitation Centre, Kampala
- National Care Centre: Kasenyi Road (off Gaba Road at Zebra Point, Katuso-Buziga, Kampala)
- Uganda Children's Centre (UCC) Kampala
- Transcultural Psychosocial Organization (TPO-Uganda)
- Recovery Solution Treatment Facility
- Naguru Teenage and Information Centre
- The Haven, Najjanankumbi
- Prevention of Alcohol and Drug Abuse (PADA), Mulago Community Hall
- Drug Abuse Prevention Initiative, Kampala

Summary

This module has covered the reasons why some children need additional psychosocial interventions and programmes, the difficult circumstances that put children at risk, and problems associated with adversity.

Module 4

Advanced psychosocial support

Introduction

This module focuses on very serious psychosocial problems that cannot be resolved through "focused non-specialised interventions". The module centres on the fourth level of the psychosocial interventions pyramid, which is called the "advanced psychosocial support". This module covers five sessions:

1 Kinds of problems that require specialised services

2 Serious psychological problems that require specialised support

3 Treatment options and services available for serious psychological problems

4 The mental health care system in Uganda

5 Referrals to specialised services

Module objective

By the end of this module, participants should be able to identify the kinds of problems that require specialised services and make appropriate referrals to available treatment options and services.

Resources
- Flip charts
- VIP/sticker cards
- Markers
- Masking tape

Session 1

The kinds of problems that require specialised services

Session objectives

- Identify problems that require specialised services

Time frame

45 minutes

Facilitator tips

Present five case studies of children who have managed to cope neither with their psychosocial problems through the psychosocial care and support given to them by their caregivers and community members nor with the focused psychosocial support provided through psychosocial programmes. Their problems are complicated and serious, and they need additional help. In small groups, discuss one case study each and respond to the following questions:

- What might be the problem with the child?
- Would everyone in the community understand the problem in similar way?
- What other explanations can there be for the behaviour?
- What can be done to help the child?

Facilitator notes

Case studies:

Case study 1: Rebecca

Rebecca grew up in her aunt's household from an early age because her mother worked in the city and could not look after her there. Rebecca never knew her father and was not close to her mother. Her aunt treated her harshly, giving her a lot of work to do and speaking unkindly to her. Rebecca stopped attending school when she was 12. When Rebecca was 13, her grandmother, who had been living in her aunt's house as well, died. She had been Rebecca's only source of support, care, and warmth in her home environment. She often felt like her grandmother was her only and best friend.

After her grandmother's death, Rebecca felt that she was alone and that no one cared for her. She cried and cried on the day of the funeral and could not be comforted. Rebecca had always been a quiet girl, but now she became more and more quiet every day and stopped talking to her aunt and cousins. She found it difficult to get up in the morning and, although her aunt scolded her, she started sleeping more and more during the day. Rebecca did not like to go out of the house anymore, and she did not enjoy the things she had enjoyed doing before, like going to the marketplace or stopping to chat to her neighbours. Most of the time, she just wanted to be left alone, and she cried a lot every day as she remembered her grandmother.

Case study 2: John

John's family lives in a semi-rural area close to a town that has seen sporadic fighting erupt between two different ethnic/clan groups. On one occasion, hostile armed groups attacked homes near John's house. John, age 10, is worried about these men coming and attacking him and his family. One day John's older brother Ray is caught up in an argument with one of these groups, and they kill him. John witnesses this killing and is extremely distressed and scared. After this event, John is changed. He constantly thinks of his brother's death, wishing he could have done something to save him. He keeps seeing the body of his brother after he was killed. At night he can't fall asleep for hours, and when he eventually does, he has nightmares about his brother's death. At school he finds it hard to concentrate and feels scared all the time. John stops meeting up with friends to play football because he feels they do not understand what he has been through. He thinks about taking revenge on his brother's killers all the time and can't let go of this idea.

Case study 3: Richard

Richard was 14-years-old when something happened to him that he didn't tell anyone about. He noticed that things like trees and plants would speak to him and give him messages. This didn't happen all the time, but when it did happen, it made him feel upset. The voices sometimes told him things; for example, if someone was a bad person or if he needed to do something to stop something bad from happening. One voice came to him most often. The voice told him his name was James and that he was giving Richard messages from God. If Richard didn't follow his instructions, someone in his family would die. Following the instructions often led to people in the family being very upset, as sometimes Richard had to break things, knock over pots of food, or talk back to James. Richard also found it hard to sleep when others were sleeping at nighttime, and he often was very restless and agitated. His friends started avoiding him because he acted strange and would sometimes talk to himself. Richard stopped his vocational training event though his mother pleaded with him to keep going.

Case study 4: Sarah

Sarah was 11-years-old when her mother died. Her aunt told her that her mother died because she had not been a good person and had gotten an illness because of that. Sarah started thinking that doing wrong things meant that she would get ill and die. She tried to be good all the time, but sometimes it didn't work. If she argued with someone, she would worry about getting ill, and the worrying stopped her from falling asleep sometimes. She worried about going outside the house in case she picked up an illness, so she tried to make excuses for staying inside. Sarah had other problems too. Some children at school teased her because she didn't have nice clothes and because she had no friends. She felt lonely and worried more about things like getting sick and dying. She felt her heart beat very fast, like it would burst when she got very worried. She also felt like the world was closing in on her and she couldn't breathe. She wanted to talk to someone about how she was feeling, but was scared that they would think she was crazy.

Case study 5: Jane

Jane is a 14-year-old girl attending a boarding secondary school. Her father and mother often have serious violent fights. Jane often tries to stop them, but they do not. This has affected Jane's performance at school, and she also doesn't sleep enough. Jane has lost a significant amount of weight. While at school, Jane complains of losing her ability to walk and see. Jane yells at night, insisting that she has seen a ghost. Following several nights of screaming, other children in the same dormitory began screaming and seeing ghosts as well. This soon became a threat to school activities. Jane's parents were called to the school along with other parents of children who showed similar symptoms. Some of the parents, including Jane's, took their children to a nearby hospital. All medical tests showed no neurological or physical problem.

Additional notes to the facilitator

All of the children above have serious psychological problems that require help. These problems may result in long-lasting behaviour and mood changes. In your small group discussions of the case studies above, you may have come up with some of these ideas yourselves. Session 2 provides descriptions of mental health problems that the three children above may have had.

Session 2

Serious psychological problems that require specialised support

Facilitator tips

Ask participants to brainstorm on the following:

- Definitions of depression, anxiety, posttraumatic stress disorders, conversion disorders, and psychotic disorders

- Causes and symptoms of depression, anxiety, posttraumatic stress disorders, conversion disorders, and psychotic disorders

- Ask participants to share any experiences they may have about children who showed the symptoms identified above

- What was done to help these children?

Facilitator notes

Depression is a feeling of sadness and hopelessness that is so strong that it changes the child's social life in a negative way and/or makes it impossible to go about their normal daily activities. It is sometimes described as an "overwhelming feeling of sadness that won't go away".[22] Depression may also lead to:

- The child sleeping too little or too much

- The child eating less or more than usual

- The child becoming irritable and having outbursts of anger

- The child losing the ability to hope for the future

- The child having difficulty concentrating

- The child crying and becoming tearful

- The child losing interest in things they previously enjoyed

Session objectives

By the end of this session, participants should be able to:

- Explain depression, anxiety, posttraumatic stress disorders, conversion disorders, and psychotic disorders

- Describe the symptoms of depression, anxiety, posttraumatic stress disorders, conversion disorders, and psychotic disorders

Time frame

2 hours 30 minutes

- The child changing mood (extreme sadness)
- The child having low energy
- The child feeling very sensitive about what people say and having low self-esteem
- The child complaining about pain that does not go away with treatment
- The child displaying behaviour from an earlier developmental stage (e.g., bedwetting or clinginess)

In the case study of Rebecca above, it is possible that she may be suffering from depression. However, we cannot rule out other possibilities. Only a qualified health worker can make this diagnosis. But if you see that the child is no longer going about life and activities because of strong feelings of sadness that do not go away, you will need to refer the child to a mental health worker or any other qualified health practitioners.

Posttraumatic stress disorder (PTSD) is a disorder that can happen after a distressing event, such as witnessing or experiencing a violent, life-threatening situation or hearing about it. This can affect the child so badly that they cannot go about their daily work and social lives in the way they did before. They feel overwhelmed by the event and unable to function in the way they used to. They have intrusive memories of the event. Usually people with PTSD have some of these symptoms[23]:

- Intrusive memories: They keep remembering the event and keep thinking about it over and over again. They may have dreams and nightmares about the event.

- They try to avoid anything that reminds them of the upsetting event (e.g., people who were there or places that look similar).

- They have negative thoughts and emotions that affect them and others in a negative way. For example, they blame themselves or others, even though this is not reasonable; they no longer want to interact with friends; or they lose interest in activities they used to enjoy before.

- They can be easily startled or very vigilant, even when there is no need for this. For instance, they may startle at loud noises, have problems sleeping, or become aggressive at the slightest provocation.

Most people have some of these reactions for a while after the event, and it is considered a "normal reaction to an abnormal event". After some time, these symptoms will slowly disappear until the person is able to continue with their normal life again. However, it is only when these symptoms seem not to be going away by themselves and have been present for more than one month that one may think that the person is suffering from PTSD. John in the

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23 Based on the DSM-V (2013) criteria for PTSD.

second case study, who witnessed his brother being murdered, may be suffering from PTSD. It is difficult to make a diagnosis of PTSD. It can only be done by a trained professional or mental health worker.

Anxiety is a situation where people may experience extreme fear, anxiousness, and nervousness as they try to meet the challenges they are facing. This is normal, and usually children and adults manage to cope with these feelings as they learn to overcome difficulties and become more resilient. However, sometimes the feelings of anxiety become very strong and stop children from doing their normal day-to-day activities, such as going to school, training, playing, or talking with friends. If this happens and the child is scared and nervous all the time, the anxiety may be more than a normal reaction. Sarah, in case study four, suffers from anxiety and possibly from panic attacks. Symptoms of anxiety in children may be:

- Difficulty breathing
- Very fast heartbeat (palpitations)
- Faintness or dizziness
- Profuse sweating
- Muscle tenseness
- Panicking or panic attacks (overwhelming feeling of strong anxiety)

When children experience very stressful situations or problems — such as the death of family members, displacement, a change of home or school environment — or experience physical or sexual abuse, it can lead to these symptoms of anxiety building up over time. Children who feel anxious a lot can[24]:

- Lack the confidence to try new things, face challenges, or even carry on as normal
- Find it hard to concentrate
- Have problems with sleeping or eating
- Have angry outbursts, in which they get very angry very quickly and feel "out of control"
- Constantly worry, have negative thoughts, or think that bad things are going to happen
- Feel scared, panicky, embarrassed, or ashamed most of the time.

This can lead to them withdrawing from friends and family, not wanting to go about their daily lives (perhaps refusing to go to school), and finding it hard to take part in activities.

Conversion disorder is a mental health condition in which a person has blindness, paralysis, or other nervous system (neurological) symptoms that cannot be explained by medical evaluation. Symptoms usually begin suddenly after a stressful experience. Children at risk of conversion disorders are those who might have some form of physical illness. Conversion disorders are based in failure to manage feelings and hence are a psychological attempt to escape from reality (dissociating). Persons who have conversion disorder are not making up their symptoms (malingering). Some doctors falsely believe that this disorder is not a real condition and may tell patients the problem is all in their head. But this condition is real. It causes distress and cannot be turned on and off at will.

The physical symptoms are thought to be an attempt to resolve the conflict the person feels inside. For example, a woman who believes it is not acceptable to have violent feelings may suddenly feel numbness in her arms after becoming so angry that she wanted to hit someone. Instead of allowing herself to have violent thoughts about hitting someone, she experiences the physical symptom of numbness in her arms.

Symptoms of a conversion disorder include the loss of one or more bodily functions, such as:

- Blindness
- Inability to speak
- Numbness
- Paralysis

Common signs of conversion disorder include:

- A debilitating symptom that begins suddenly
- History of a psychological problem that gets better after the symptom appears
- Lack of concern that usually occurs with a severe symptom

Jane in case study five above may have conversion disorders. However, a mental health worker or a qualified practitioner should make the diagnosis and assign treatment.

Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. About 1% of people worldwide develop a mental illness classified as psychosis (Centre for Disease Control, 2013). There are many different kinds of psychotic disorders, but most share the following characteristics:

- The person loses touch with reality in that they may find it difficult to know what is real and what is fantasy. They may hear voices that others can't hear, see things that others can't see, or feel or smell things that others cannot. Sometimes the voices tell them to do bad things or to hurt themselves.
- They may stop looking after themselves, forget to wear clean clothes, or cease looking after their hair.
- They may have fears that are unusual in the community, for instance, that someone famous or important is spying on them.
- They may talk too much or talk to themselves and behave in ways that are not culturally accepted.

Sometimes these illnesses first appear when the person is a child or adolescent, but sometimes they first appear during adulthood. These illnesses are not caused by witchcraft or by viruses. They cannot be contracted from someone else by touching them, sharing food with them, or talking to them. Richard in case study three could have a psychotic illness. He needs to be referred to a doctor who can prescribe medicines for him. Most people with this illness get better and can live normal lives when they take the right medication.

Additional notes for the facilitator

Alcoholism and drug use: In all four illnesses described above, children or adolescents may use alcohol and drugs to try to deal with the difficult emotions they are experiencing. This often leads to further problems for the child as well as their family and friends.

The WHO Mental Health Gap Action Programme (mhGAP): This is a programme initiated by the World Health Organisation (WHO) in 2008 to address the lack of services for people who suffer from mental illnesses in low- and middle-income countries. The programme asserts that with proper care, psychosocial assistance, and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, thereby preventing suicide and allowing them to begin leading normal lives — even where resources are scarce.

The WHO defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Information about the mhGAP Intervention Guide can be found at this website: http://www.who.int/mental_health/mhgap/en/

Session 3

Treatment options and services available for serious psychological problems

Session objectives

- Explain, identify, and refer cases of serious psychological problems to the relevant treatment options available

Time frame

45 minutes

Facilitator tips

Ask participants to brainstorm on the following:

- Available treatment options for serious psychological problems in their area and beyond

Facilitator notes

Note that only qualified and trained professionals should deliver these services but it is useful to know what types of treatment are available. One can divide them into two broad categories: **medication** and **therapies**. All of the treatment works better if there is home-based care for the ill child and if there is psycho-education for both the child and caregiver. These are also briefly described below.

Medication

For some psychological problems, it may be necessary to give the person medication, which can help to stabilise the person and make them better. Only a doctor or mental health nurse can give the right type and amount of medication. There are some general things to remember about medication for mental illness:

- Usually it can take some time, maybe days or weeks or even sometimes months, before the medication really works. It is important to be patient during this time.

- Different types of mental illness need different types of medicines. The most common ones are anti-depressants (given when the person is depressed), antipsychotic medications (given when the person is psychotic), and mood stabilisers (given if the person's mood varies wildly).

- It is important to take the medicine regularly and in the right amount.

- If the ill person changes his/her behaviour or mood suddenly, the caregiver needs to let the mental health worker know about this.

Medication for children and young people is typically discouraged, although treatment depends on the type of illness they have. The Mental Health Gap Action Programme (mhGAP) Intervention Guide does not recommend anti-depressants as the first line of treatment when a child or adolescent is depressed. Instead, it suggests that psycho-education and counselling be tried first.

Psychotherapies

Psychotherapy involves talking to a trained therapist either one-on-one or in a group. Patients can talk about their worries, problems, feelings, and thoughts, which helps them better understand why they are feeling the way they are. Thinking and talking about problems sometimes gives people new ideas about how to approach problems. Most therapies involve talking, but there are some special activities, such as art, drama, music, or movement, that can also be used to express feelings and worries.

There are a lot of different types of psychotherapy available. Some of the most common ones include:

- **Cognitive Behavioural Therapy (CBT)**: This therapy contends that thoughts and beliefs influence how people behave and feel. Many problems arise from the way in which people behave in stressful situations, and the way they behave is influenced by the way they think. The therapist works with the patient to try to first understand — and then change — the way the person thinks and behaves in certain situations.

- **Interpersonal therapy (IPT)**: This therapy contends that most problems arise through our relationships and everyday interactions with people around us. The therapist encourages the patient to talk about his or her relationships, conflicts with others, and interpersonal behaviour so that the patient can learn better interpersonal skills. IPT can also focus on grief, loss, and major changes that are happening in the person's life.

There are many other types of therapies, such as:

- **Solution-focused therapy**: This focuses on resolving a specific problem in a person's life through strengthening the person's own resources.

- **Eye Movement Desensitisation and Reprocessing (EMDR)**: This helps lessen negative emotions following a distressing event.

- **Group therapy**: Instead of talking one-on-one with the therapist, people who share similar experiences or problems talk with one another and the therapist about their issues. The group can also operate as a support network and as a point of social contact.

- **Arts therapy**: Here, creative arts and materials are used to explore feelings, issues, and problems. This helps people better understand the conflicts they are experiencing.

All of these types of therapies focus on the here and now and try to address the problems the person is experiencing at the moment. There are other types of therapies that focus on past experiences, such as childhood conflicts. These are called psychodynamic therapies. However, these are not very common in Uganda. They can be found through the Ugandan Counselling Association.

Home-based care and psycho-education

Regardless of whether the child or adolescent is receiving medication or therapy, it is still very important for the caregiver to complement/supplement this treatment through home-based care. Home-based care is when caregivers and family help the ill person cope with their illness by supporting them to look after their physical, mental, spiritual, and social well-being in their home environment. This means that they encourage the person to go to a clinic if they are unwell, look after their health and nutrition, provide them with care and love, and encourage them to make friends or go to support groups. This will help the ill person learn to take better care of him/herself. Psycho-education is important and involves explaining to the caregiver and child what the illness is and how it can be treated. Important psycho-education messages can include:

- Telling the person that adherence to the medication regime is important
- Encouraging the person to sleep at regular hours, take physical exercise, and try to participate in activities they used to do before if possible
- Discussing ways in which the person can cope with negative reactions from other people.

Sometimes these messages can be different and this depends on what illness the person has. Psycho-education should be offered by mental health workers who know the key messages that are to be communicated.

Session 4 > The mental health care system in Uganda

Facilitator notes

In Uganda, the provision of health services is the responsibility of districts, and the same applies to services and referrals for mental, neurological, and substance use disorders. Mental health is part of the Uganda National Minimum Health Care Package and has been identified as a priority in its Health Sector Strategic Plans (GoU, 2010). Mental health services are integrated into primary health care, which means that at the community level, there are primary mental health care workers (PMHCW), who are general health workers with additional training to assist people with mental, neurological, and substance use disorders. They may be nurses, doctors, or community health workers who have received specialised training that allows them to:

- Identify someone in need of help and take action, such as refer the person to a doctor for medication
- Diagnose illnesses
- Regularly treat the person with the disorder by administering medication
- Advise the family members on how to provide home-based care for the ill person.

Many districts in Uganda have PMHCW that one can turn to for help. The organogram on the next page shows how the different levels of the mental, neurological and substance use (MNS) care system relate to one another.

ORGANOGRAM FOR DELIVERY OF MNS SERVICES

DEVELOPMENT PARTNERS	**Ministry of Health** Mental Health Section → LINE MINISTRIES AND SECTORS

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┌──────────────────────┐   ┌──────────────────────┐   ┌──────────────────────┐
│ DEVELOPMENT          │ ← │ Ministry of Health    │ → │ LINE MINISTRIES AND  │
│ PARTNERS             │   │ Mental Health Section │   │ SECTORS              │
└──────────────────────┘   └──────────────────────┘   └──────────────────────┘
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National Referral Hospitals (General)

National Referral Hospitals →

Regional Referral
_____
Mental Health Units

NGOs

MEDIA

Traditional and Complimentary Healers

General Referral
_____
(District level)

Health Centre IVs

Health Centre IIIs

Health Centre IIs

Community/Villaage Health Teams (VHT)

Note: The NGO, media, and traditional and complementary healers interact with all levels.

Session 5 ⟩ Referrals to specialised services

Facilitator tips

Group participants to brainstorm on:

- The reasons for referring children to other service providers
- How and where to make a referral
- Challenges in referral

Facilitator notes

Referral means sending a person in need to another institution or caregiver for a service that the present caregiver cannot provide. Each caregiver or caring organisation has its own role and limitations, beyond which the person in need may not be assisted. Similarly, caregivers have specific roles and capacities to support orphans and other vulnerable children. If some of the needs of vulnerable children are beyond caregivers' capacities, then they need to be referred. It is important that all helpers and helping organisations know each other and know how to refer people in need.

Reasons for referral include:

- The client's problem is beyond the caregiver's skills or capacity; patient's situation is complex
- Need for specialised skills or services
- Present caregiver is taking leave time or leaving his or her job
- Need for a person of a different age or gender to handle the client's problems
- Language barriers
- Patient overload
- Conflict of interest
- Post-treatment or service handling

Session objectives

By the end of this session, participants should be able to:

- Explain the reasons for referring children to other service providers
- Describe how and where to make a referral
- Identify challenges in referral

Time frame
45 minutes

The child or family being referred needs to understand the honest reason for the referral. With the client's permission, it is helpful to give details of the problem, what you have already done, and what you recommend to be done by the referral point.

How and where to make a referral

Planning exercise

Prepare a list of all possible referral sources in your area from which vulnerable children and their families could benefit in one way or another. The list should include:

- All sources of individual and organisational help in the caregiver's working area, including, for example, healers, health centres and clinics, medical specialists, schools, educators, specialised counsellors, religious helpers, and community leaders
- Service points with the capacity to handle specific problems, such as specific AIDS organisations that can assist with AIDS-related problems or psychosocial organisations that can give support to people with psychosocial distress
- Services each referral point provides
- Specific costs, if needed
- Time of service
- Location of service point

An example of a referral list could look like this:

No.	Referral category	Name	Location	Type of service	Referral mode	Cost
1	HIV/AIDS	Busaana Health Centre	Busaana Trading Centre	Confidential testing; free ARVs	Written referral note	Free
2	Counselling	Church of Christ	Kaliro	Individual and group counselling	Phone call from a social worker	Free
3	Mental health problem	Local clinic	Busega	Psychoeducation; medication	Just go there	Free

Challenges in referral

- The referral source may not have the capacity to take care of an additional care seeker.
- CSO staff may lack properly established referral systems.
- The caregiver may lack up-to-date knowledge about the different organisations and individuals who could be possible referral sources.
- Some organisations and individual helpers do not recognise or respect the role of caregivers. This causes reluctance and unnecessary delays in attending to the person referred.

- There may be a lack of networking among community helping structures. Each institution or individual doing psychosocial-related work for vulnerable children does not necessarily know how other institutions work.

- In conflict situations when people have been displaced and most community support structures have been destroyed, the community relies on government services.

- Most communities affected by HIV/AIDS and war are extremely poor. A person referred to a facility far from his/her home may not be able to afford transport costs.

- Some vulnerable children and their families may need to be accompanied to the referral source by the caregiver.

- Corruption by government workers aggravates the distress of people referred for further assistance. For instance, some medical workers may ask for payment for services that are supposed to be free.

How can we overcome these challenges?

- Have an updated and comprehensive referral inventory and system in place.

- Increase community members' awareness of available referral points.

- Conduct regular coordination meetings.

- Integrate service delivery, for instance, health, legal, and psychosocial clinics on the same day in the same locality.

- Increase helpers through training and monitoring.

- Decentralise services.

- Carry out joint planning and support supervision activities.

How to refer a child or young person for mental health services

When referring a child for these kinds of problems, it may be better to talk to a mental health worker beforehand to see if and how the referral should be done. The child may feel shy or embarrassed about going to see someone and may be reluctant to go there. It is important to reassure the child that nothing bad will happen there and that the health worker will try to help them.

Summary

This module has covered the kinds of problems that require specialised services; serious psychological problems that require specialised support; treatment options and services available for serious psychological problems; the mental health care system in Uganda; and referrals to specialised services.

Module 5

Care and support for the caregiver

Introduction

This module focuses on issues among caregivers as they take care of vulnerable children. The categories of the caregivers targeted by this module include primary and secondary caregivers. The primary caregivers are those that are in daily and direct contact with the children in the family and community. These include parents, relatives who take care of the child, siblings, and teachers. Secondary caregivers are those that are in constant touch with children within institutions and in the community. These include health workers, social workers, psychologists, volunteers, para-social workers, paralegals, police officers in charge of family and child protection, military social workers, probation officers, and community volunteers. Secondary caregivers sometimes work directly with children, but their role is usually to support primary caregivers.

This module suggests ways to support primary and secondary caregivers to better take care of their own well-being as they also take care of the children. The four sessions covered are:

1 Qualities of good caregiving

2 Challenges experienced by caregivers

3 Looking after oneself

4 Additional psychosocial support to caregivers

Module objective

By the end of this module, participants should be able to identify qualities of good caregiving, challenges experienced by caregivers, additional psychosocial support for caregivers, and personal care.

Resources

- Flip charts
- VIP/sticker cards
- Markers
- Masking tape

Session 1 ▶ Qualities of good caregiving

Session objectives

By the end of this session, participants should be able to:

- List the qualities of a good caregiver
- Link good parenting to general psychosocial well-being

Time frame
45 minutes

Facilitator tips

Ask participants to brainstorm on the following:

- Reflect on their childhood and the kinds of parenting they received.
- Participants to compare their current parenting practices to those of their parents.
- Debate whether — and how — different parenting styles can affect a child's growth, development, and behaviour.

Facilitator notes

Parenting styles:

There are four major parenting styles that are described below:

- Authoritarian
- Authoritative
- Permissive
- Uninvolved

The Four Main Parenting Styles

Parenting style	Parent's behaviour	Child's behaviour
Authoritarian	• rigid • punitive • strict standards • harsh	• unsociable • less friendly • withdrawn • not creative • follow strict rules • obedient without questioning • unhappy • always seeing things as unfair • low self-esteem
Authoritative parenting/ responsible/caring	• firm • sets limits and goals • uses reasoning • encourages independence, e.g. will let siblings resolve their conflict by themselves • loving and ideal	• confident • controlled • feels secure • takes risks • successful at school • creative • likeable • social • self-reliant and independent
Permissive parenting	• relaxed with "I don't really mind/care-attitude" • inconsistent • undemanding • emphasises freedom • sets low expectations • can even use toys and gifts to achieve compliance • mostly a friend and not a parent to the child	• impulsive • low self-control • immature • moody • dependent • unable to make decisions, unmotivated at school • more likely to encounter problems with authority
Uninvolved parenting/laissez-faire or careless/neglectful	• sets low expectations • unresponsive • detached • neglectful • sees their role as only providing food shelter, clothing and not the emotional part	• indifferent • rejecting behaviour • no self-control • rebellious • unsuccessful at school

Facilitator tips

Ask participants to role-play the following scenario

As a parent, you are facing the following situation at home with your 15-year-old daughter, Violet. Violet has been struggling with her schoolwork and has been getting low grades despite making some attempts to study. She has now started saying that she's not very clever and that school is not for her. In the afternoons and evenings, she doesn't study much anymore and seems to be spending a lot of time with her friends. This morning you received a phone call from the school saying that Violet hadn't arrived.

- Adopt one of the parenting styles described above, and role-play how you would interact with Violet. One of the participants can play Violet, who will be reacting differently to the different types of parenting approaches you will role-play. Afterward, discuss what went well and what did not.
- Reflect on your own parenting style. What do you do most often?
- What styles do people in their communities tend to use?
- Which parenting style do you think children would prefer and why?

Facilitator notes

While it seems clear that the authoritative parenting style is best, it is not always easy for parents to use it. Parenting styles are developed through a combination of factors, and it is useful to think through how your own parenting style has developed. After learning about the impact of parenting styles on child development, you may wonder why all parents don't simply utilise an authoritative parenting style. After all, this parenting style is the most likely to produce happy, loving, confident, and capable children.

Some potential causes of the use of different parenting styles include:
- Culture
- Personality
- Family size
- Parental background
- Socio-economic status
- Training on parenting
- Influence of peers
- Change in policy or government regulations

- Stress
- Age
- Educational level
- Religion

Of course, the parenting styles of individual parents also combine to create a unique blend in each and every family. For example, the mother may display an authoritative style while the father favours a more permissive approach. In order to create a cohesive approach to parenting, it is essential that parents learn to cooperate as they combine various elements of their individual parenting styles. Reflect on the styles you use as parents in the same family.

Qualities of a good caregiver

Facilitator tips

In buzz groups, ask participants to list at least 10 qualities of a good caregiver.

Facilitator notes

Qualities of a good caregiver
- Compassionate
- Knowledgeable
- Good listener
- Good communicator
- Non-judgmental
- Respectful
- Trustworthy
- Confidential
- Genuine
- Honest
- Sociable
- Empathetic
- Role model
- Knows limits
- Warm and kind
- Responsible for their actions
- Has emotional control

This list sounds good, but it is not always clear what we mean with some of these qualities. There are some explanations on the next page.

Genuineness means being real, congruent, and honest with oneself and the person being helped. The genuineness should be constructive, if it is to contribute to the person's personal growth. For example, caregivers should be aware of all their feelings toward the child, such as love and attractiveness, as well as negative feelings such as anger, hatred, and jealousy. Caregivers should, however, communicate neither positive nor negative feelings when such communication would not be helpful. When caregivers are genuine, the person in need will also learn to be genuine with them.

Trust: Though caregivers may be accepted in the community or family, the children or other people they help may not automatically trust them. Caregivers need to earn trust from the people in need through their behaviour. Trust is built throughout the helping process Caregivers earn trust through, for example, keeping confidentiality and being respectful and honest.

Respect: The attitude of respect toward the people we are helping should emerge from our belief in their worth as human beings and our ability to accept and appreciate them as they are. Respect also implies that we are able to recognise people's abilities during the helping process and recognise that they have the freedom to make their own decisions. The communication of this attitude (respect) helps the child in need to build confidence, self-respect, and a sense of dignity.

Empathy: This is sometimes confused with sympathy. Sympathy means to share another's feelings and is predominantly emotional. The sympathiser identifies emotionally with the person and does not understand objectively where the person is and where he or she wants or needs to be. Empathy, on the other hand, simply means the ability to accurately understand what another person is experiencing and communicate back that understanding. Empathetic people temporarily empty themselves of their own world, enter the world of the person in need, and give feedback about feelings and thoughts that they find in that world. The communication of this understanding makes the person in need feel understood and, thus, stimulates deeper exploration of the problem.

Confidentiality: This simply means keeping any information shared in confidence between you and the person during the helping process. Sharing this information with a third party will require consent from the person being helped. Should the information warrant sharing with the third party, the person being helped needs to know the reasons for sharing the information and how this will help him or her. No one wants his or her problems to become an open discussion for everybody. Some problems are very sensitive and therefore require the helper to use confidentiality in order to be helpful and trustworthy. However, there are situations when confidentiality has to be breached, for instance, to save the lives of people who may harm themselves or others.

Non-judgmental: Helpers are not the judges of the lives of the people they are trying to help. As helpers, we need to recognise that we are invited guests who have been asked to help — but not to take over people's lives and begin telling them what to do and what not to do, or what they did wrong and what they did right. Judging people will only serve to lower their self-esteem, make them lose confidence in themselves, and make them dependent on the caregiver, which only worsens the problems of the person in need. As helpers, caregivers need to receive people in need without any prejudice and believe in people's ability to help themselves.

Self-disclosure: This implies sharing something personal with people in need (i.e., one's own feelings, attitudes, opinions, and experiences) for their benefit. Sometimes people in need are afraid and feel uneasy disclosing because they think the caregiver might ridicule them.

It is at such moments that the caregiver can disclose his experience about a similar problem for the benefit of the person in need. In this way, the helper acts as an agent of change and as an effective role model because the caregiver has been able to overcome a problem similar to the problem of the person in need.

Facilitator tips

Pair participants and ask them to think about the qualities of a good caregiver and discuss to what degree they exhibit them. Ask them to rate themselves on a scale from 1-5 and state which ones are their best and which are their poorest. Use the checklist below

CHECKLIST FOR QUALITIES OF AN EFFECTIVE CAREGIVER

1= Excellent   2 = Very Good   3 = Satisfactory   4 = Fair   5 = Poor

Sex: Male ☐   Female ☐

Quality	Rankings				
	1	2	3	4	5
Compassionate					
Confidential					
Respectful					
Good listener					
Non-judgmental					
Trustworthy					
Empathetic					
Patient					
Knows limits					
Flexible					
Available					
Genuine					
Knowledgeable					
Self-disclosure					
Calm					
Positive role model					
Common sense					
Approachable					
Self-aware					
Loving					

Session 2 ▶ Challenges experienced by caregivers

Session objectives

By the end of this session, participants should be able to:

- Discuss the challenges that caregivers face

Time frame
1 hour 30 minutes

Facilitator tips
- Ask participants to reflect on their own caregiving challenges.
- Ask them to share the problems associated with those challenges.

Facilitator notes

Challenges and stresses that caregivers face

- Financial constraints
- Age and gender challenges
- Failure to explain certain child behaviours, for instance, withdrawal, clinginess, or naughtiness and disobedience
- Failure to handle alcohol and drug abuse
- Failure to handle the transition from adolescence to adulthood
- Promiscuity among children
- Stress
- Mental health challenges
- Negative media influence
- Failure to separate rights from responsibilities
- Large families
- Cultural/religious conflicts
- Stigma and discrimination
- Legal and policy challenges

Most of the time, we can manage to meet the challenges that life puts in our way, but there are times when we feel stressed. **Stress** is a normal response to events that make you feel threatened or upset in some way. Stress response is the body's way of protecting you. When working properly, it helps you stay focused, energetic, and alert. In emergency situations, stress can save your life—giving you extra strength to defend yourself, for example, by spurring you to slam on the brakes to avoid an accident.

The stress response also helps you rise to meet challenges. Stress makes you focus your energy on achieving what it is that you want to do, for example, doing your best at work or during an exam. **So, generally a little bit of stress can be a good thing.** But beyond a certain point, stress stops being helpful and starts causing major damage to your health, your mood, your productivity, your relationships, and your quality of life.

Stress can have an effect on caregivers' well-being in many ways[25] :

- **Physical health:** feeling tired and exhausted; having aches and pains
- **Emotional well-being:** feeling anxious, sad, overwhelmed; having mood swings
- **Thoughts:** not being able to concentrate or think clearly
- **Behaviour:** not doing your tasks as well as you normally would
- **Spiritual:** having less or more interest in spiritual things

Often, as adults who are providing care to others, we tend not to pay too much attention to our own needs and stress levels. This can lead to burnout.

Burnout is when people feel overwhelmed by the demands placed on them and unable to cope. It occurs when someone is emotionally, mentally, and physically stressed for a long time, until he or she eventually feels like the demands are too much. Burnout is a gradual process that occurs over an extended period of time. It doesn't happen overnight. It can creep up on you if you ignore the warning signals. The signs and symptoms of burnout are subtle at first, but they get worse as time goes on.

Physical signs and symptoms of burnout:

- Feeling tired and drained most of the time
- Lowered immunity, feeling sick a lot
- Frequent headaches, back pain, muscle aches
- Change in appetite or sleeping habits

Emotional signs and symptoms of burnout:

- Sense of failure and self-doubt
- Feeling helpless, trapped, and defeated
- Detachment; feeling alone in the world
- Blunting of emotions
- Loss of motivation
- Increasingly cynical and negative outlook
- Decreased satisfaction and sense of accomplishment
- Feeling like life may not be worth living

25 Adapted from Catholic Relief Services (2009).

Behavioural signs and symptoms of burnout:
- Withdrawing from responsibilities
- Isolating yourself from others
- Procrastinating or taking longer to get things done
- Using food, drugs, or alcohol to cope
- Taking out your frustrations on others
- Skipping work or coming in late and leaving early

Common warning signs of caregiver burnout:
- You have much less energy than you used to.
- It seems like you catch every cold or bout of flu that's going around.
- You're constantly exhausted, even after sleeping or taking a break.
- You neglect your own needs, either because you're too busy or you don't care anymore.
- Your life revolves around caregiving, but it gives you little satisfaction.
- You have trouble relaxing, even when help is available.
- You're increasingly impatient and irritable with the person you're caring for.
- You feel overwhelmed, helpless, and hopeless.

Additional notes for the facilitator

Feeling burnt out or overwhelmed with responsibilities can sometimes reduce a caregiver's capacity to care. Caregivers often feel isolated from others due to the many challenges they face. It is essential that they receive the necessary emotional support so they don't lose their capacity to care. Without self-care, caregivers may be unable to be helpful, and in some cases may cause harm. It is also important to note that children also take on caring roles and can experience burnout when they are not supported.

Depression, anxiety and posttraumatic stress disorder

Some caregivers have also suffered loss, death of loved ones, displacement, violence, injury, illness, and other difficulties. It is normal for people to feel emotional and psychological turmoil after such events, including feeling tremendous sadness, questioning the meaning of life, and feeling agitated or angry. After a while, some weeks or months, these feelings start to subside and the person begins to feel better, taking an interest in activities and friends and family again. However, for some people the feelings don't go away and may stay the same or become worse. This might mean that they suffer from one of the following three conditions: depression, anxiety, or posttraumatic stress disorder.

Depression is an overwhelming feeling of sadness that won't go away and that affects your daily activities and relationships with others. Some common symptoms of depression are [26]:
- Not being able to sleep, or sleeping too much
- Not being able to concentrate, or finding that previously easy tasks are now difficult
- Feeling hopeless and helpless

- Not being able to control negative thoughts, no matter how much the person tries
- Losing appetite, or not being able to stop eating
- Being much more irritable, short-tempered, or aggressive than usual
- Drinking more alcohol than normal, or engaging in other reckless behaviour
- Thinking that life is not worth living (the person could be suicidal)

Anxiety: Everyone feels anxious when faced with certain challenges in life, such as moving or taking on a new job or task. In moderation, anxiety isn't always a bad thing. In fact, anxiety can help you stay alert and focused, spur you to action, and motivate you to solve problems. But when anxiety is constant or overwhelming, or when it interferes with your relationships and activities, it stops being functional—that's when you've crossed the line from normal, productive anxiety into the territory of anxiety disorders.

Some common symptoms of anxiety disorders are:
- Constantly feeling tense, worried, or on edge
- The anxiety is interfering with work, school, or family responsibilities
- Having fears that the person knows are irrational, but can't shake
- Believing that something bad will happen if certain things aren't done a certain way
- Avoiding everyday situations or activities because they cause anxiety
- Experiencing sudden, unexpected attacks of heart-pounding panic
- Feeling like danger and catastrophe are around every corner

These symptoms can make it very hard for people to go about their daily lives. Such people may also avoid telling anyone about what they are feeling because their fears are irrational. However, it is possible to treat anxiety disorders, and it is important to get help as soon as possible.

Post-traumatic stress disorder (PTSD) can develop following a traumatic event that threatens your safety or makes you feel helpless. This can happen to anyone who has experienced a distressing event such as violence, accidents, disasters, armed conflict, abuse, or attacks. PTSD can affect those who personally experience the catastrophe, those who witness it, and those who try to assist those who have undergone the event, including emergency workers and law enforcement officers. It can even occur in the friends or family members of those who went through the actual trauma. PTSD is not a sign of weakness or "going crazy" but something that can be treated with the right type of medication and counselling or therapy. Not everyone experiences PTSD in exactly the same way, but there are three main symptoms:

- Re-experiencing the traumatic event
- Avoiding reminders of the trauma
- Having increased anxiety and emotional arousal

Session 3 ⟩ Looking after oneself

Session objectives

By the end of this session, participants should be able to:

- Discuss the ways in which caregivers can look after themselves

Time frame
1 hour 30 minutes

Facilitator tips
- Ask participants to reflect on how they look after themselves and how they can cope with stress.

Facilitator notes

Reasons why caregivers should be supported when they feel stressed:

- If caregivers are supported, it reduces the risk that children or other vulnerable children will be neglected, abandoned, harmed, or placed in institutions.
- When caregivers' needs are not addressed, there is potential for harm. Children will receive better quality care from caregivers who feel confident and competent.
- Support to caregivers helps prevent negative coping strategies that caregivers may adopt in response to stress.

Coping with stress

In order to cope with stress, three things need to be done:

- Identify the source of the stress. Ask yourself what is causing the stress. Often there is more than one reason. It may help to discuss the reasons for feeling stressed with a friend or someone who can provide support.
- Develop constructive and positive coping behaviour. For example, try to organise your work and responsibilities more efficiently, and ask for advice on how to improve your way of responding to — and trying to solve — your problems.
- Look after yourself. To avoid stress from turning into burnout, you need to have time to look after yourself. Eat well, get enough sleep, look after your health when you are ill, and do not drink too much alcohol. Not only does your physical health need attention, but also

your emotional, social, and spiritual health. You need to think about doing things that you enjoy, for instance, visiting friends, taking trips, reading books, and doing positive things that take your mind off difficulties.

Facilitator tips

Ask participants to reflect on how they look after themselves and how they can cope with stress.

- What do you do to keep yourself healthy and happy?
- What resources do you call upon when times are tough?

Facilitator notes

Ways of coping with stress

Domain of function	Strategies
Physical	• Relax. • Exercise. • Maintain regular, restful sleep patterns. • Eat healthily. • Minimise caffeine, alcohol, and sugar. • Self-monitor your health status. • Seek medical attention if needed.
Emotional	• Identify feelings and needs and express them. • Nurture a positive view of yourself. • Be appropriately assertive to get needs met. • Express humour. • Maintain a hopeful outlook. • Accept and adapt to change. • Sing.
Spiritual	• Pray or meditate. • Discuss your beliefs with others with similar beliefs. • Look for opportunities for discovery and self-growth. • Find spiritual support.
Behavioural	• Engage in enjoyable activities. • Avoid risky behaviour. • Prioritise demands. • Take decisive action.

Social	• Spend time with others.
	• Maintain open communication with friends and family.
	• Seek professional support when needed.
	• Remember that social support is a cornerstone of resilience.
Cognitive	• Watch a film or read a book.
	• Take time off alone.
	• Talk to someone.
	• Take refresher courses or short courses.
	• Challenge and replace cognitive distortions.
	• Maintain perspective.
	• Avoid seeing crises as insurmountable problems.
	• Set goals and take steps to achieve them.
	• Solve problems.
	• Stay flexible.
	• Learn from past experiences.

Relaxation exercises

Relaxation is more than unwinding in front of a TV set or in the bathtub or having a chat and something nice to eat or drink. The type of relaxation that really makes a difference in dealing with stress is the regular, daily practice of some form of deep relaxation. Deep relaxation refers to a distinct physiological state that is the exact opposite of the way your body reacts under stress. It can lead to:

- Decreased heart rate
- Decreased respiration rate
- Decreased blood pressure
- Decreased skeletal muscle tension
- Decreased metabolic rate and oxygen consumption
- Decreased analytical thinking
- Increased skin resistance to infections
- Increased alpha wave activity in the brain

Regularly practicing deep relaxation for 20-30 minutes daily can produce, over time, a "generalisation" for the rest of your life. That is, after several weeks of practicing deep relaxation once per day, you will tend to feel more relaxed all the time. Other benefits of deep relaxation include an increase in self-confidence, a decrease in self-blame when things go wrong, prevention of stress from accumulating, and improved concentration and memory.

Deep relaxation can be achieved in many ways, but we will describe just three here:

- Using abdominal breathing
- Practicing muscle relaxation
- Visualising a peaceful scene

Abdominal breathing exercise

The two breathing exercises described below can help you change your breathing pattern. By practicing them, you can achieve a state of deep relaxation in a short period of time. Just three minutes of practicing abdominal breathing or the calming breath exercise will usually induce a state of deep relaxation.

Steps

1. Note the level of tension you are feeling. Then place one hand on your abdomen right beneath your rib cage.

2. Inhale slowly and deeply through your nose into the bottom of your lungs – in other words, send the air as low down as you can. If you are breathing from your abdomen, your hand should actually rise. Your chest should move only slightly while your abdomen expands. (In abdominal breathing the diaphragm — the muscle that separates the lung-cavity from the abdominal-cavity — moves downward. In so doing, it causes the muscles surrounding the abdominal cavity to push outward.

3. When you have taken in a full breath, pause for a moment and then exhale slowly through your nose or mouth, depending on your preference. Be sure to exhale fully. As you exhale, allow your body to just let go regularly, without gulping in a deep breath or letting your breath out all at once. Remember to pause briefly at the end of each inhalation. Count to ten progressively with each exhalation.

The progress should be like this:

Slow inhale…Pause…Slow exhale (count "one")

Slow inhale…Pause…Slow exhale (count "two")

Slow inhale…Pause…Slow exhale (count "three")

And so on, up to ten. If you start to feel lightheaded while practicing abdominal breathing, stop for thirty seconds and then start again.

Extend the exercise if you wish by doing two or three sets of abdominal breaths, remembering to count up to ten for each set (each inhalation counts as one number). Five full minutes of abdominal breathing will have a pronounced effect in reducing anxiety or early symptoms of panic. Some people prefer to count backwards from ten down to one on each breath.

Calming breath exercise
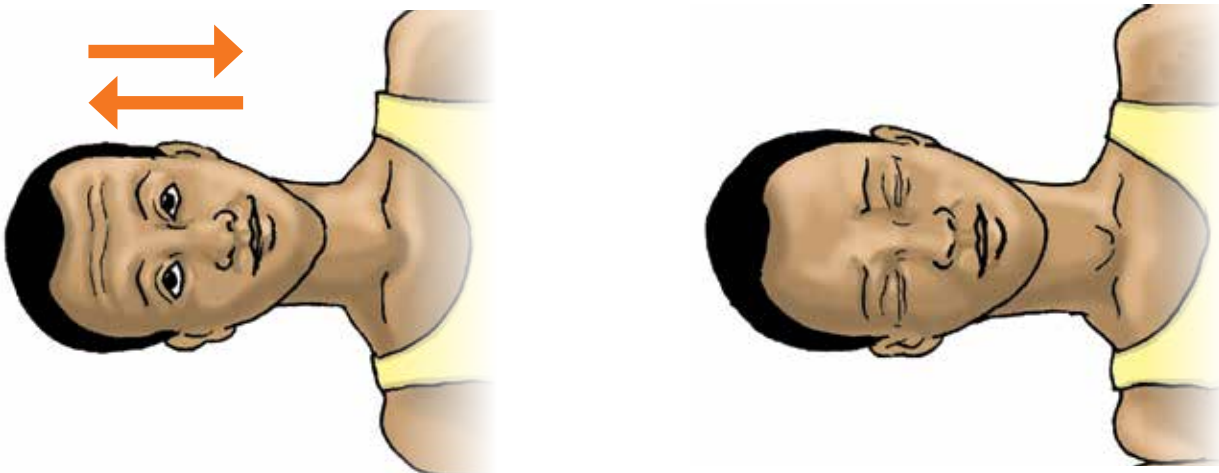
The calming breath exercise was adapted from the ancient discipline of yoga. It is a very efficient technique for quickly achieving a state of deep relaxation.

1. Breathe from your abdomen, and inhale slowly to a count of five. (Count slowly "one... two...three...four...five" as you inhale.)

2. Pause and hold your breath as you count to five.

3. Exhale slowly through your nose or mouth to a count of five, or more if it takes you longer. Be sure to exhale fully.

4. When you have exhaled completely, take two breaths in your normal rhythm, and then repeat steps 1-3.

5. Do the exercise for at least three to five minutes. This should involve going through at least 10 cycles (inhaling for five seconds, holding for five seconds, and exhaling for five seconds). Remember to take two normal breaths between each cycle. If you start to feel lightheaded while practicing this exercise, stop for 30 seconds and then start again.

6. Throughout the exercise, keep your breathing smooth and regular, without gulping in breaths or breathing out suddenly.

Optional: Each time you exhale, you may wish to say "relax", "calm", "let go", or any other relaxing word or phrase silently to yourself. Allow your whole body to let go as you do this.

The calming breath exercise can be a potent technique for halting the momentum of a panic reaction when the first signs of anxiety come on. It is also useful in reducing symptoms of hyperventilation (difficult breathing).

Progressive muscle relaxation

The following guidelines will help you make the most use of progressive muscle relaxation. They are also applicable to any form of deep relaxation you can practice regularly, including self-hypnosis, guided visualisation, and meditation.

Practice at least 20 minutes per day. Two 20-minute periods are preferable. Once a day is mandatory for obtaining generalisation effects (you may want to start your practice with 30-minute periods). As you gain skill in the relaxation technique, you will find that the amount of time you need to experience the relaxation response will decrease.

Find a quiet location to practice where you will not be distracted. Do not permit the phone to ring while you are practicing. Use a fan or air conditioner to blot out background noise if necessary.

- **Practice at regular times.** The best times are generally upon awakening, before retiring, or before meals. A consistent daily relaxation routine will increase the likelihood of generalised effects.

- **Practice on an empty stomach.** Food digestion after meals tends to disrupt deep relaxation.

- **Assume a comfortable position.** Your entire body, including your head, should be supported. Lying down on a sofa or bed or sitting in a reclining chair are two ways of supporting your body completely. When lying down, you may need to place a pillow beneath your knees for further support. Sitting up is preferable to lying down if you are feeling tired and sleepy. It is advantageous to experience the full depth of the relaxation response consciously without going to sleep.

- Loosen any tight garments and take off shoes, watches, glasses, contact lenses, jewellery, and so on.

- Make a decision not to worry about anything. Give yourself permission to put aside the concerns of the day. Allow taking care of yourself and having peace of mind to take precedence over any of your worries. Success with relaxation depends on giving peace of mind high priority in your overall scheme of values.

- Assume a passive, detached attitude. This is probably the most effective element. You want to adopt a "let it happen" attitude and be free of any worries of how you are performing the technique. Do not try to relax. Do not try to control your body. Do not judge your performance. The point here is to let it go!

- When you tense a particular muscle group, do so vigorously without straining, for 7-10 seconds. You may want to count "one-thousand-one", "one-thousand-two" and so on as a way of marking off seconds. When you release the muscles, do so abruptly and then

relax, enjoying the sudden feeling of limpness. Allow the relaxation to develop for at least 15-20 seconds before going on to the next group of muscles. Allow all the other muscles in your body to remain relaxed as far as possible while working on a particular muscle group.

- Tense and relax each muscle group once. But if a particular area feels particularly tight, you can tense and relax it two or three times, waiting for 20 seconds between each cycle.

- Once you are comfortably supported in a quiet place, follow the detailed instructions below:

1. To begin, take three deep breaths, exhaling slowly each time. As you exhale, imagine that tension throughout your body begins to flow away.

2. Clench your fists. Hold for 7-10 seconds and then release for 10-15 seconds. Use these same time intervals for all other muscle groups.

3. Tighten your biceps by drawing your forearms up toward your shoulders and making a muscle with both arms. Hold and then relax.

4. Tighten your triceps — the muscles on the underside of your upper arms — by extending your arms out straight and locking your elbows. Hold and then relax.

5. Tense the muscles in your forehead by raising your eyebrows as far as you can. Hold and then relax. Imagine your forehead muscles becoming smooth and limp as they relax.

6. Tense the muscles around your eyes by clenching your eyelids tightly shut. Hold and then relax. Imagine sensations of deep relaxation spreading all around the area of your eyes.

7. Tighten your jaws by opening your mouth so tightly that you stretch the muscles around the hinges of your jaw. Hold and then relax. Let your lips part, and allow your jaw to hang loose.

8. Tighten the muscles in the back of your neck by pulling your head back as if you were going to touch your head to your back. (Be gentle with this muscle group to avoid injury.) Focus only on tensing the muscles in your neck. Hold and then relax. Because this area is often especially tight, it is good to do the tense-relax cycle twice.

9. Take a few deep breaths and tune in to the weight of your head sinking into whatever surface it is resting on.

10. Tighten your shoulders by raising them up as if you were going to touch your ears. Hold and then relax.

11. Tighten the muscles around your shoulder blades by pushing your shoulder blades back as if you were going to touch them together. Hold the tension in your shoulder blades and then relax. Since this area is always especially tense you may repeat the tense-relax sequence twice or thrice.

12. Tighten the muscles of your chest by taking in a deep breath. Hold for up to ten seconds and then release slowly. Imagine any excess tension in your chest flowing away with the exhalation.

13. Tighten your stomach muscles by sucking your stomach in. Hold and then release. Imagine a wave of relaxation spreading throughout your abdomen.

14. Tighten your lower back by arching it up. (You can omit this part if you have lower back pain.) Hold and then relax.

15. Tighten your buttocks by pulling them together. Hold and then relax. Imagine the muscles in your hips going limp.

16. Squeeze the muscles in your thighs all the way down to your knees. You will probably have to tighten your hips along with your thighs because the thigh muscles attach to the pelvis. Hold and then relax. Feel your thigh muscles smoothing out and relaxing completely.

17. Tighten your calf muscles by pulling your toes toward you (flex carefully to avoid cramps). Hold and then relax.

18. Tighten your feet by curling your toes downward. Hold and then relax.

19. Mentally scan your body for any residual tension. If a particular area remains tense, repeat one or two tense-release cycles for that group of muscles.

20. Now imagine a wave of relaxation slowly spreading throughout your body, starting at your head and gradually penetrating every muscle group all the way down to your toes.

Guided imagery of a peaceful scene

The peaceful scene can be a beach, a stream in the mountain, a calm lake or any other beautiful and peaceful scene you can imagine.

The Exercise

1. Sit comfortably in a quiet place with your feet flat on the floor.

2. Close your eyes.

3. Breathe easily through your nose.

4. Fix your attention on your muscles. Feel how they become a little more relaxed every time you breathe out. Do this for 2-3 minutes.

5. Now imagine that each time you breathe in, you take in energy and health. Every time you breathe out you get rid of tension and stress. Do this two to three times.

6. Now remember a pleasant and beautiful place you have visited in the past. Imagine you are there now. Let your mind rest easily in this place.

7. When other thoughts come into your mind, just watch them come in and go out again. You see that thoughts come and go by themselves. Even worrying or unpleasant thoughts will go if you do not pursue them.

8. You are resting deeply in this pleasant place. Remember what it looks like, sounds like, and feels like. Let other thoughts come and go on the surface of your mind.

9. After about 10 minutes, say goodbye to this pleasant place, but remember that you will return there again.

10. Take some deep breaths and then open your eyes.

Session 4

Additional psychosocial support for caregivers

Facilitator notes

Support groups

These are groups that bring people together to discuss particular issues and problems that arise in relation to a shared challenge they experience. Support groups can be formed for a variety of reasons; for example, survivors of rape or other forms of violence, people with certain illnesses like HIV or cancer, or people who have a relative who is a drug user or alcoholic. Often people who are undergoing the challenging experience themselves initiate them, but sometimes they are formed by social or community workers. Support groups may also be referred to as peer groups.

In these groups, people find psychosocial support in the following ways:

- Finding shared experiences — members of support groups identify with others who share similar experiences, thereby reducing their loneliness
- Meeting other people in the support group who understand your experience due to the shared situation
- Forming social connections and friendships, which can be supportive and constructive (even outside of the group)
- Learning from other people's experiences and knowledge (a support group is a forum for exchanging information, skills, and knowledge, which may be helpful for addressing the challenge that brings you together)

Session objectives

By the end of this session, participants should be able to:

- Describe the additional psychosocial support services that can be given to caregivers and other service providers

Time frame
45 minutes

- Establishing a sense of purpose from belonging to such a group — having somewhere to go once a week or month can be an important anchor in life and can help shape how a person approaches their life

Types of support groups

In every community, there are many different kinds of groups available that provide people with a sense of belonging, a joint purpose, and social company. Some of these groups are formed because of a shared interest in an activity or belief (sports or religious groups); others have a particular goal that members want to achieve (income-generating groups or fundraising groups). Belonging to a group means that people have the opportunity to make positive connections with others and form relationships in which they gain recognition, support, and social and practical assistance. All of these factors form part of psychosocial support, and it is for these reasons that membership of a community group can be a positive and constructive way to cope with the challenges people face.

Counselling

Counselling is a type of talking therapy in which you can talk to a trained counsellor about your challenges and feelings. The counsellor will keep what you say confidential and is someone you can depend upon. Counsellors do not usually give advice but instead let you talk about how you feel and think about your problems. By doing this, you may start to see things in a different way or you may start to see solutions that you did not see before. You may also start thinking about what you are doing that may be contributing to the challenge.

There are many different types of counselling, which all work more or less the same way but may have some slight differences. Counselling can be done individually or in a group, but all involve building trust and a positive relationship with the counsellor. Counselling can be conducted through one session, a few sessions, or can carry on for quite a few weeks or months. Some of the most well-known forms of counselling are:

- **Bereavement counselling:** This is focused on helping the bereaved person express their feelings of sadness and grief at the death of their beloved ones. In counselling, the bereaved person can talk about the dead person and how the death has affected and changed their lives. Expressing these feelings helps the person begin to come to terms with the death.

- **Solution-focused counselling:** This type of counselling is focused on finding a solution to a problem that clients want to resolve. It is centred on the idea that clients can imagine themselves in the future when the problem is solved and think about how they could achieve this.

- **Person-centred counselling:** Here the idea is that it is not the problem that is the focus of counselling is not the problem, but the client him/herself. The counsellor accepts the client exactly the way she/he is and views them in a positively. The counsellor has empathy with the client and believes that the client can solve his or her own problem.

Psychotherapy

There are also many different kinds of psychotherapies available for people to use. The main differences between counselling and psychotherapy are:

Counselling	Psychotherapy
• Counselling helps people identify problems and crises and encourages them to take positive steps to resolve them. • It is the best course of therapeutic treatment for anyone who already has an understanding of well-being, and who is also able to resolve problems. • Counselling is a short-term process that encourages a change of behaviour. • A counsellor will have received training and supervision in counselling, but the length of time of training can vary and is usually shorter than that of a psychotherapist.	• Psychotherapy helps people with psychological problems that have built up over the course of a long period of time. • It will help you understand your feelings, thoughts, and actions more clearly. • Psychotherapy is a longer-term process of treatment that identifies emotional issues and the background to problems and difficulties. • A psychotherapist will have trained for a period of two or more years and is more specialised than a counsellor.

Each person can decide whether they prefer counselling or psychotherapies (unless a medical professional recommends a specific type of psychotherapy for a specific kind of mental health).

Below is an overview of the main types of psychotherapies:

1. **Humanistic psychotherapies:** These are focused on self-development, growth and the relationship between the client and the therapist. Healing occurs as a result of the clients discovering their own strengths through positive, trust, and encouraging relationship that the client builds with the therapist. Clients discover their own resources and strengths to deal with their problems. Examples of these types of therapies are transactional and person-centred therapies.

2. **Behavioural psychotherapies:** These are focused on analysing and changing the thought processes and behaviours that are contributing to the client's problems. The therapy is focused on not only helping the client understand that it is possible to change, but also provide him/her with the skills to do so. Examples of therapies that fall into this category are cognitive behavioural therapy (CBT) and behavioural therapy.

3. **Psychodynamic psychotherapies:** These therapies contend that one has to delve into childhood and other past experiences in order to understand why the client is experiencing the problem. Therapy focuses on talking about and analysing how experiences have shaped the client's unconscious thoughts and emotions. Examples of this type of therapy are psychoanalysis and Jungian analysis.

4. **Art therapies:** There are many different kinds of therapies that rely on using creativity to work through — and cope with — problems. Creative arts such as music, dance, drawing, and drama are used in a therapeutic environment to help clients express and understand their emotions and gain confidence in addressing their difficulties.

There are other types of therapies that fall outside of the categories above. Some of these are:

1. **Interpersonal therapy (IPT):** This is time bound (12-15 weeks), structured intervention usually for people suffering from depression. It is often used following complicated grief and is focused on helping the client understand what has contributed to the problem and what role the client's interpersonal relationships have played in aggrevating the problem (Markowitz & Weissman, 2004).

2. **Eye Movement Desensitisation and Reprocessing (EMDR):** This is an unconventional therapy aimed predominately at people who have experienced posttraumatic stress disorder (PTSD). The therapist asks the client to follow his finger with their eyes as it moves in front of their face while at the same time recalling distressing events. Research seems to indicate that doing this dampens the emotional distress experienced while recalling the event (Spates et al., 2008). This form of therapy may be useful for clients who find it very difficult to talk about the distressing experiences they have had and has been used war veterans.

3. **Others:** There are countless types of psychotherapies available. Before choosing one, the client should try to find out what the therapy is based on, into which category of therapy it generally falls into, and if he/she agrees with the basic ideas and goals.

Toolbox: Resources for additional information

In this section you will find some additional information and resources to explore if you want more details about a particular topic. We have selected some websites and manuals that you can use to deepen your knowledge on the issues raised in the particular modules, but there are many other resources available on the Internet and through organisations working in this field.

The **IASC (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings** provide a comprehensive overview of expert advice on how to provide psychosocial support during the different phases following an emergency (emergency preparedness, minimum response, and comprehensive response). They cover a wide range of issues and present action sheets with concrete suggestions for steps to take. The resource can be found at: *http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf*

The **Mental Health and Psychosocial Support Network** (MHPSS.net) is an interactive website for people involved in providing psychosocial support to people around the world. Practitioners and interested people can follow news, obtain manuals, and join discussion groups on particular topics. There are discussion groups of interest here such as "community mobilising and family support" and "psychosocial care and protection of children". Anyone can use the website or join the network at: *http://mhpss.net/*

The **OVC Support Network** provides excellent resources, toolkits, and training manuals on a range of topics affecting children, including HIV, child participation, and monitoring and evaluation of children's programmes. The website can be found at: *http://mhpss.net/*

The **Better Care Network** is a resource for people working with children who lack adequate care. Its mission is to make information, resources, academic papers, and training manuals widely available to all primary and secondary caregivers interested in improving the care of children. Their library of documents contains a section on "family and community care", which is particularly useful: *http://www.bettercarenetwork.org/BCN/*

The **International Committee of the Red Cross** (ICRC) produces training manuals on psychosocial care and support for children and adults. While much of its work focuses on emergency settings, its manuals also deal with other issues. Its website has a "resource centre" link that takes you to a large number of documents: *https://www.icrc.org/en*

Save the Children International (and its national organisations) produces a range of good quality materials that can be used for training purposes and for further analysing issues. Some materials produced by national Save the Children teams may only be available through their own websites, but the website of the international organisation can be found at: *http://www.savethechildren.net/*

The **WHO mhGAP website** provides useful information about severe and common mental disorders, including guidelines on how to deal with stress, suicide prevention, and mental health during emergencies. The following home website provides links to mhGAP publications: *http://www.who.int/mental_health/mhgap/en/*

Mental Health Innovation Network: This is a website for mental health practitioners who work in low-income settings and want to discuss how to improve mental health provision for people suffering from mental disorders. It is aimed at providing the opportunity for knowledge exchange. The network is run by the Centre for Global Mental Health (London School of Hygiene and Tropical Medicine) and the WHO's Department for Mental Health and Substance Abuse. The network is located at: *http://mhinnovation.net/*

Other resources:

In addition, there are manuals available on a number of different topics. These are just a few:

Community-based psychosocial support: ACT Alliance (2011). Community-based psychosocial assistance. Guiding principles. Geneva: ACT Alliance. Website: *http://www. actalliance.org/resources/policies-and-guidelines/psychosocial/FINAL_ACT_CBPSGuidingPrinciples_ apprDec2011.pdf*

Psychological first aid: Save the Children (2013). Psychological first aid training manual for child practitioners. Copenhagen: Save the Children. Website: *http://resourcecentre. savethechildren.se/sites/default/files/documents/final_pfa.pdf*

Disclosure of HIV-positive status: WHO (2011). Guidelines on HIV disclosure counselling for children up to 12 years of age. Geneva: WHO. Website: *http://whqlibdoc.who.int/ publications/2011/9789241502863_eng.pdf?ua=1*

Communicating with children: UNICEF (2011). Communicating with children: Principles and practices to nurture, inspire, excite, educate and heal. New York: UNICEF. Website: *http://www.unicef.org/cwc/files/CwC_Web(2).pdf*

Working with adolescents: ICRC (2014). Psychosocial support for youth in post-conflict settings: A trainer's handbook. Copenhagen: ICRC/Danish Red Cross. Website: *http:// reliefweb.int/sites/reliefweb.int/files/resources/1679_rcy_youth_manual_T2.pdf*

Monitoring and evaluation: Ager, A., Robinson, S., & Metzler, J. (2014). Methodologies and Tools for Measuring Mental Health and Psychosocial Well-being of Children in Humanitarian Contexts: Report of a Mapping Exercise for the Child Protection Working Group (CPWG) and Mental Health & Psychosocial Support (MHPSS) Reference Group. New York: Columbia University, Columbia Group for Children in Adversity and Child Protection in Crisis (CPC) Network. Website: *http://www.cpcnetwork.org/wp-content/uploads/2014/06/ Measuring-Child-MHPSS-in-Emergencies_CU_Mapping-Report_March-2014+-1.pdf*

Resources for additional information

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Ministry of Gender, Labour and Social Development, 2012). *Monitoring and Evaluation Framework and Plan:* Interventions for Orphans and other Vulnerable Children. Kampala: MGLSD.

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