

Supporting orphans and other vulnerable children through communication and basic counselling

A reference guide for service providers



MINISTRY OF GENDER LABOUR AND SOCIAL DEVELOPMENT

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FOREWORD

The Government of Uganda is committed to ensuring that all Ugandan children have their rights protected in order for them to realise their full potential. In this regard, the Government of Uganda, through the Ministry of Gender, Labour and Social Development (MGLSD) developed the National Orphans and Other Vulnerable Children Policy (NOP) and the National Strategic Programme Plan of Interventions (NSPPI) to guide interventions for Orphans and Other Vulnerable Children (OVC) in Uganda.

There are a number of service providers for OVC but significant gaps have been realized in their delivery of comprehensive and quality services. As part of the response, MGLSD has developed a number of technical resource materials (manuals, guides, toolkits) to be utilized in strengthening the capacity of implementers of OVC activities at various levels.

This reference guide for supporting orphans and other vulnerable children through communication and basic counselling aims to 1) strengthen the capacity of service providers to address the individual and collective psychosocial needs of children and young people 2) provide an easy to use two-in-one guide and reference material for child counsellors 3) promote the personal and professional development of counsellors working with children and young people 4) help service providers to assess and deal with challenges in working with OVC.

I extend my sincere appreciation to all partners from within and outside Uganda who have made valuable contributions and participated in the development of this Guide. I am especially grateful to CORE Initiative for spearheading the development of the Guide and to USAID for their financial assistance. I would also like to extend my appreciation to the Civil Society Organizations that pre-tested the Guide and the line ministries (particularly Health and Education and Sports) that provided technical support.

I urge programme implementers involved in OVC activities at various levels (including counsellors, child workers in institutions, those implementing religious-oriented activities for children and young people) to utilize this guide in pursuit of quality service delivery for OVC.

Hon. Syda N.M. Bbumba

Minister of Gender, Labour and Social Development

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List of acronyms and abbreviations

ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
AIDS	Acquired Immuno-Deficiency Syndrome
CBO	Community Based Organization
CDO	Community Development Officer
CORE	Community Responses to the HIV/AIDS Epidemic
CPA	Core programme area
CRC	United Nations Convention on the Right of the Child
FBO	Faith Based Organisation
CSO	Civil Society Organisation
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced People
INGO	International Non-Governmental Organisation
LC	Local Council
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-Governmental Organisation
NOSC	National Orphans and other Vulnerable Children Steering Committee
NOP	National Orphans and Other Vulnerable Children Policy
NOSC	National Orphans and other Vulnerable Children Steering Committee
NSPPI	National Strategic Programme Plan for Interventions
OVC	Orphans and Other Vulnerable Children
PSWO	Probation and Social Welfare Officer
QS	Quality standards
QSTF	Quality Standards Task Force
QSWG	Quality Standards Working Group
SDIP	Social Development Sector Investment Plan
SPPO	Strategic Programme Plan Objective
STI	Sexually Transmitted Infections
TSO	Technical Support Organisation
UNCRC	United Nations Convention on the Rights of the Child
UNGASS	United Nations General Assembly Special Session (on HIV and AIDS)
UNICEF	United Nations Children's Fund
USH	Ugandan Shillings

INTRODUCTION TO THE GUIDE

Background to the national response to orphans and other vulnerable children

The Ministry of Gender, Labour and Social Development is the part of the Ugandan Government that is responsible for children and youth. The Ministry has established a framework for responding to the concerns and needs of orphans and other vulnerable children. This is the National Orphans and Other Vulnerable Children Policy (NOP).

To achieve the aims covered by this policy, and to help organisations to do their work according to the policy, the Ministry has also written a set of guidelines. This is the strategy. It provides advice on work with vulnerable children and is known as the National Strategic Programme Plan of Interventions (NSPPI) for Orphans and other vulnerable Children. Both of these documents are available to everyone whose work involves helping orphans and other vulnerable children.

How do psychosocial support, counselling and communicating with OVC fit into the national response?

The basic goal of the NSPPI is simple: to increase the number of activities being carried out to help orphans and other vulnerable children, either directly or through the household in which they live.

For this reason, the Strategy defines four specific “**Building Blocks**” to achieve the main goal; these areas are the objectives that any interventions should strive to achieve.

Each of the four building blocks consists of **Core Programme Areas (CPAs)** that have been selected for programming prioritisation. These core programme areas were selected through a national consultative process. Interventions in the core programme areas are considered to be key to improving the quality of life of vulnerable children and their caregivers and mitigating the negative impacts on their lives

In the box above we can see that **psychosocial support** is one of the Core Programme Areas of the Strategy. The Strategy defines psychosocial as follows:

Psychosocial is about the relationship between the social environment and mental wellbeing. Children who have suffered a lot due to abuse, conflict, discrimination or other hardships are sometimes in need of “psychosocial support”, which is aimed at enabling them to live meaningful and positive lives.

Building Block A: Sustaining Livelihoods

- CPA.1. Socio-Economic Security
- CPA.2. Food Security and Nutrition
- CPA.3. Care and Support
- CPA.4. Mitigation of the Impact of Conflict

Building Block B: Linking Essential Social Sectors

- CPA 5. Education
- CPA 6. *Psychosocial Support*
- CPA 7. Health

Building Block C: Strengthening Legal and Policy Frameworks

- CPA. 8. Child Protection
- CPA.9. Legal Support

Building Block D: Enhancing the Capacity to Deliver

- CPA.10. Strengthening Capacity and Resource Mobilisation

 MGLSD, *National Strategic Programme Plan for Interventions. p.31*

Psychosocial support for OVC

Psychosocial support helps vulnerable children and their caregivers to cope with mental and emotional challenges. Primary areas of focus of those providing psychosocial support in Uganda have included:

- Recreational activities
- Training
- **Counselling**
- Rehabilitation
- Case Referral
- Youth Mentoring
- Psychosocial assistance related to illness and death, especially due to AIDS (will writing, succession planning, prevention of stigma and discrimination)
- Community involvement
- Life Skills

Counselling, therefore, is one of the approaches to providing psychosocial support to orphans and other vulnerable children. Counselling is process which helps people (both adults and children) to help themselves, recognise their strengths, and identify the resources available to help them overcome problems and make healthy decisions. It is a process that involves someone listening to a child's problems and building the child's resilience and coping skills. It requires the counsellor to create a supportive environment and is based on a positive relationship of trust between the counsellor and client. The child is allowed to tell their own story **without fear of judgement** or interrogation, in a safe reassuring environment. We will look more closely at how counselling works, the different forms it can take and how and why we use it in our work with OVC in Sections 1, 2, 3, 4 and 5.

Counselling can be very helpful for orphans and other vulnerable children. Good counselling helps children to tell their story, make choices, recognise their strengths, develop a positive attitude to life and cope with problems. It can also help them to deal with fear and anxiety about their own illness or family illness and death.

☞ Building Blocks Africa-wide briefing notes – Young children and HIV, p.10

Why was this Guide developed?

There have been many counselling interventions since the onset of HIV/AIDS in Uganda but most have focused on adults. The Ministry of Gender, Labour and Social Development (MGLSD) with CORE Initiative and CORE Initiative partners identified that the specific needs for counselling of orphans and other vulnerable children (OVC), defined under different categories within the National Orphans and Other Vulnerable Children's Policy (NOP), still need to be addressed. The recent report on Lessons Learned from the MGLSD / CORE Initiative Research on Psychosocial Support (see reference in Section 7) also highlights the need for more people to be involved in child counselling. This guide has therefore been written as a reference resource for non-professional counsellors who need to provide some basic counselling as part of psychosocial support for the children in their care or through their projects. This guide does not diminish the need for formal training and additional professional support. However, it aims to provide information and guidance which can be used together with other MGLSD resources, which it complements, such as:

☞ MGLSD, Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda, (2009)

☞ MGLSD Integrated care for orphans and other vulnerable children: A training manual for community service providers, 2005

☞ MGLSD, Integrated care for OVC: A toolkit for community service providers, 2006

Who is this Guide for?

This Guide will be useful for anyone working with children including people who may not necessarily be professional child counsellors. The Guide will benefit those who need some basic knowledge and skills for providing guidance and counselling in a non-professional way to children and for those hoping to improve the services they are providing to child clients.

In particular, this manual will be used to provide project staff in MGLSD Government departments, NGOs and CSOs with a resource to enable them to build their capacity to adequately respond to the counselling needs of OVC.

What are the aims of this Guide?

The aims of this guide include:

- strengthening the capacity of service providers to address the individual and collective psychosocial needs of children (including young people under the age of 18 years);
- providing an easy to use two-in-one guide and reference material for non-professional child counsellors;
- promoting personal and professional development of non-professional counsellors working with children;
- helping the service providers to assess and deal with challenges in working with vulnerable children.

This resource aims to be a guide rather than a training manual. The purpose of the guide is therefore to provide a generic approach to counselling OVC through the following:

- highlighting the broad categories and circumstances of OVC and their households as outlined in the National Orphans and Other Vulnerable Children's Policy;
- providing basic information concerning the underlying emotional and psychological issues that children in difficult circumstances have to deal with on a day-to-day basis;
- presenting counselling as a helping relationship where one person talks through a problem with another (or others) which helps them to make their own decisions and take action;
- describing generic counselling session processes that can be adapted to address the unique nature and diversity of the issues experienced by individual children;
- highlighting some examples of challenges that counsellors may face and how to overcome them;
- referencing information as a source of useful learning activities and to develop training programmes for specific groups, for example, CSOs, peer counsellors, etc;
- Highlighting when there is a need to use professional support and referral systems;
- focusing on supporting children to address some of their own problems rather than victims or people who cause problems.



Photograph caption: A Karamojong girl solves an arithmetic problem using plastic bottle caps in an open-air classroom at the Namijij ABEK Centre, in Moroto District, one of the five districts making up the agro-pastoralist Karamoja sub-region in north-eastern Uganda.

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A note on the use of the term ‘counsellor’

In different countries, and even in different organisations within a country, those people who provide counselling to, for example, people living with HIV are called by different titles. There are some standard titles for people with particular trainings or degrees. People with advanced training in psychology may be called psychologists. A person with a medical degree and specialised mental health training may be called a psychiatrist. But what title is best for people who do not have this type of formal education? There is no agreement on this. Some people prefer the term “lay counsellor”. Others dislike it. This Guide acknowledges that many titles may be used for those people who provide this particular type of psychosocial support, but for the sake of simplicity and consistency, it uses the term “counsellor”.

☞ For further explanations of some of the terms and concepts used in this guide please see: Annex 2

SECTION 1 – UNDERSTANDING ORPHANS AND OTHER VULNERABLE CHILDREN

Summary – This section looks at the needs and rights of children, how children develop and what can make them vulnerable. It considers psychosocial factors affecting those children outlined in Uganda’s *National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI)* and gives an introduction on how counselling can build resilience in vulnerable children.

Key topics

- 1.1. Child Development
- 1.2. All children have needs and rights
- 1.3. Orphans and other vulnerable children
- 1.4. Psychosocial impact of vulnerability on children
- 1.5. How can we tell when a child needs support?
- 1.6. Coping with adversity

1.1. Child development

A child in Uganda is defined as a person below the age of 18. As a child grows and develops, they will change physically, emotionally, mentally and socially. All children have needs, some basic needs, such as shelter, food and water, are constant throughout their life; others change as a child grows.

Organisations and institutions working with children should have a basic understanding of the stages of child development to ensure that they use approaches in line with the developmental stage of the child or children they are working with. A child’s experience or understanding may not always correlate with the different stages of child development and their age. Remember when working with children not to assume a child’s knowledge and development based on age alone.

It is important to learn about and understand child growth and development in order to:

- Understand a child’s needs
- Detect problems
- Communicate with and counsel children.
- Understand how psychosocial issues influence how a child views him/herself and the world.
- Appreciate the effect of losing care and support at an early stage.

• From birth to five years old - early childhood development

The first five years are very important in a child’s life. Growth and learning is very rapid, and a lot of brain development happens during this period. Young children need attention, love and mental stimulation, through social interaction and play. They need a stable and predictable home environment, ideally with one or two ‘primary caregivers’ - adults who are a relatively constant presence in children’s lives. The relationship between the young child and their caregivers has a big influence on their development.

• From 6 to 12 years old – pre-adolescence

This is a period in a child’s life when they start to become more independent. Their reasoning develops; they ask a lot of questions and begin to enjoy problem solving.

They learn the importance of rules, and can appreciate their value, both in games and daily life.

Children at this age need appreciation for their growing skills, and a reasonable amount of trust so that they can make appropriate choices in their lives. They should begin to take responsibility for their own actions and the consequences of these, while being supported in a loving environment.

As children approach puberty, physical changes begin to take place, and these influence changes in children's attitudes, values and behaviour. Children begin to be more challenging, of themselves and others, and often ask questions which adults may find difficult to answer.

Belonging to a peer group is extremely important to this age group and they like to spend time with friends of the same age and sex. This is a chance for them to learn about life outside the family home, and to develop important social skills. Going to school is a chance not only to learn, but also to build social networks and support groups.

- **From 13 to 18 years old - adolescence**

This is a period of change, when a young person is neither a child nor an adult. Rapid social and physical changes, and the search for identity, can make this period unsettling. Young people at this age start to become sexually aware and begin to form friendships and relationships outside of their existing family in the wider community. They learn social skills such as leadership and decision making and develop attitudes and behaviours that prepare them to be responsible adults. They may start to have feelings about what other people may think or say about they way they appear and behave. Although in this stage their reasoning power increases, they are still developing emotionally and they still need a lot of support and understanding to prepare them for roles and responsibilities of adult life.

For more information on the needs of children at different developmental stages see:

- ☞ **MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda*, (2009), Module 1 Topic 1 – Child growth and development.**
- ☞ **International HIV/AIDS Alliance, *Growing up together: experiences of care and support for children*, (2004)**

1.2. All children have needs and rights

All children in Uganda have needs and rights to enable them to fulfil their potential in life. The United Nations Convention on the Rights of the Child (CRC) and Uganda's Children's Act (Cap 59) 2000 set out the rights children in Uganda are entitled to. Organisations supporting children need to be aware of the legal protection afforded children under Ugandan law to ensure their work is enforcing these rights.

Vulnerable children and their families share these protection, care and support needs and the NSPPI has categorised them into ten core programme areas:

1. Socio-economic security
2. Food and nutrition security
3. Care and support
4. Mitigating the impact of conflict
5. Education
6. Psychosocial support
7. Health
8. Child protection
9. Legal support
10. Strengthening capacity

Uganda has also adopted both national and international policy and legal instruments that concern and protect children. Two key legal instruments in this regard are the Constitution of the Republic of Uganda (1995) and the Children’s Act (2003).

The **Constitution** of the Republic of Uganda is the most important national legal framework for ensuring that the rights of children and the general population are protected. The Constitution provides special protection to children in general and vulnerable children in particular. It makes specific mention of the rights of children to know and to be cared for by their parents or guardians, access medical treatment, and be protected from all forms of exploitation and abuse.

The **Children’s Act** (2003) seeks to address all constitutional issues concerning children in Uganda. Other relevant legislations include:

1.3. Orphans and other vulnerable children

An orphan is a child below the age of 18 years who has lost one or both parents. A vulnerable child is one who is at risk from significant physical, emotional or mental harm which may result in their rights not being fulfilled.

In Uganda the national government strategy (NSPPI) recognises that all children in the country can broadly be considered vulnerable. If a child is not able to grow and develop in a protected and caring environment, they become more vulnerable.

The National OVC Policy identifies the following categories of children as vulnerable:

<p>In Uganda, the following groups of children are thought of as vulnerable.</p>	<ul style="list-style-type: none"> Orphans (children who have lost one or both parents) Children affected by armed conflict Children abused or neglected Children in conflict with the law Children affected by HIV/AIDS and other diseases Children in need of alternative family care Children affected by disability Children in “hard to reach” areas Children living under the worst forms of labour Children living on the streets
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👉 **National Policy and Strategy for Orphans and Other Vulnerable Children – Popular version, p.6.**

The NSPPI also addresses the needs of vulnerable households recognising that most children form part of households. Due to limits on resources, OVC programmes target the most vulnerable children and households. The NSPPI provides guidance on the process of selecting vulnerable children outlining that communities should come together and by consensus prioritise the most vulnerable children and households.

<p>SUGGESTED CRITERIA FOR CHOOSING VULNERABLE CHILDREN AND HOUSEHOLDS</p>	
<p>Selecting vulnerable children</p> <ul style="list-style-type: none"> • Children living alone or in institutions • Children in a poor psychological state • Children in an unstable environment, due to conflict, abuse, migration etc. • Children orphaned or otherwise vulnerable • Children the community agrees are in need for any other reason. 	<p>Selecting vulnerable households</p> <ul style="list-style-type: none"> • Households headed by a single or widowed person • Households headed by a very sick adult • Households headed by a woman • Households headed by an elderly person • Households which include orphans or other vulnerable children

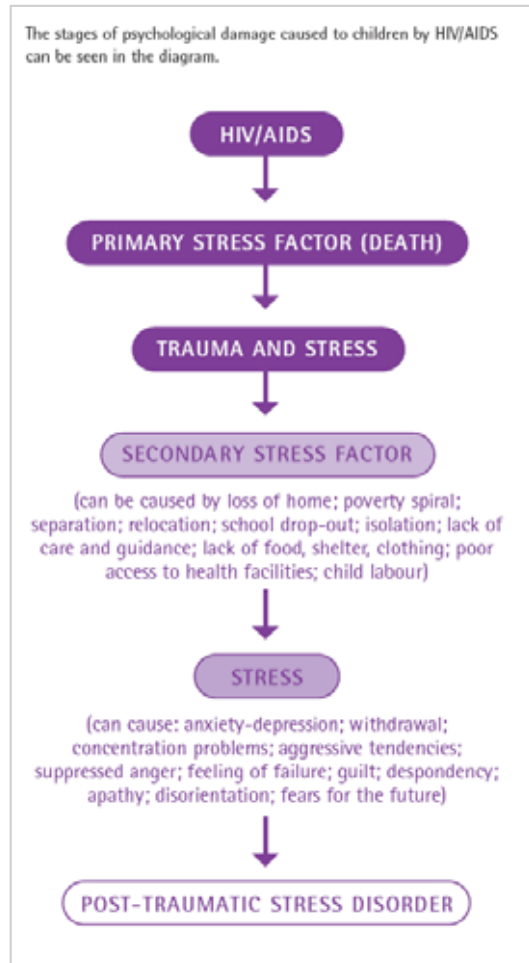
👉 **MGLSD, National Policy and Strategy for Orphans and Other Vulnerable Children – Popular version, p.24.**

1.4. Psychosocial impacts of vulnerability on children

The different factors that can contribute to making a child vulnerable can have a psychosocial impact. HIV and AIDS can make a child vulnerable by leaving them orphaned or living alone. The diagram to the right demonstrates how a child can suffer from psychosocial damage as a result of HIV and AIDS.

☞ See: **Building Blocks: Africa-wide briefing notes – Psychosocial support**, p.4.

Explanations of different psychosocial conditions help us to understand how a child feels when they experience negative emotions such as stress. **Stress** is experienced or felt when a child has to cope with unsettling, frustrating or harmful situations. Stress can make a child feel helpless, unable to cope with the situation and can create a sense of uncertainty and self-doubt. A child may become **anxious** and worry a lot about what is happening in their lives. A child suffering from stress may **withdraw** and **lose self confidence and react differently to other children** who may not have suffered in the same way and they may feel **angry** at their situation.



Key factors that may bring stress to OVC could include, but are not limited to, the following

- **Death of a parent / guardian**

Children who have lost a parent or close family member are particularly vulnerable. The psychosocial impact of losing the person responsible for a child's well being can be enormous. The psychosocial factors experienced through the loss of a parent / guardian can affect a child's development. Not only will the child experience grief, sorrow and loss but they have lost the person who provided them with the psychosocial support.

- **Caring for a sick parent / guardian / family member**

A child caring for an ill parent / family member may not receive the attention required to properly grow and develop. They may feel guilty for going to school if they are required to care for a sick relative or lose out on building friendships with others outside of the home or participating in community and social activities worsening the effect of losing the psychosocial support they themselves require.

- **Illness and / or living with HIV**

Children coping with illness including HIV may have additional psychosocial and emotional needs to assist them to come to terms with managing and living with the condition.

- **HIV related stigma and discrimination**

Stigma is used to describe how people discriminate other people as a result of perceived negative attributes such as gender, race and health status. Discrimination is the action resulting from stigma which may deny a child their right to access services or psychosocial support. A child may be stigmatised due to their family situation, as a result of their HIV status, gender, race and any other social factors.

- **Psychosocial impact on care-givers**

Care-givers themselves may also be affected by HIV, stigma, the loss of family members and increasing responsibility for orphans who have lost their parents. If a care-giver is under a lot of stress this will affect the psychosocial well-being of a child as they may be unable to support a child adequately.

For more details on grief and bereavement and stigma and discrimination see:

☞ **MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda* (2009), Module 3 Topic 1 – Grief and bereavement, p.152 and Topic 3 - Stigma and discrimination, p.194.**

1.5. How can we tell when a child is vulnerable and needs support?

Behavioural signs

- ✓ Not playing with other children, not interested in what is going on
- ✓ Sadness, fear, withdrawal, not talking
- ✓ Too talkative, aggressive, restless, constant repetition of the same activity
- ✓ Cries easily, gets irritable and angry quickly
- ✓ Sleeping problems, bedwetting
- ✓ Using abusive language and swear words - vocabulary that is not appropriate for the child's age.

For training exercises on how to identify children in difficult circumstances, see:

☞ **MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda* (2009), Module 2 Topic 3 – Reactions of children to difficult circumstances, p.130.**

5.6. Child abuse and neglect – what to look out for

Sometimes children, especially those who are vulnerable, become subject to abuse or neglect. This is more likely in situations in which a child's caregiver is overwhelmed and the child's needs do not receive enough attention.

☞ Examples of Child Abuse and Neglect ☜

At household level	At school	At community level
<p>Stepmothers/fathers</p> <ul style="list-style-type: none"> • Denial of food • Child labour • Corporal punishment/child battery • Separation from family members <p>Parents</p> <ul style="list-style-type: none"> • Failure to provide basic needs • Child battering • Discrimination • Incest <p>Relatives</p> <ul style="list-style-type: none"> • Incest • Child neglect • Property grabbing 	<p>Teachers</p> <ul style="list-style-type: none"> • Sexual harassment • Discrimination against children with disability • Emotional / psychological torture 	<p>Strangers traditional healers</p> <ul style="list-style-type: none"> • Defilement • Abductions • Sacrifice <p>Traditional Healers</p> <ul style="list-style-type: none"> • Defilement • Abductions • Sacrifice <p>Local Leaders</p> <ul style="list-style-type: none"> • Denial/delayed justice • Negligence • Mishandling assets of orphans <p>Police</p> <ul style="list-style-type: none"> • Torture • Mixing young offenders with adults • Discrimination in the criminal justice system • Negligence <p>Army/Rebels</p> <ul style="list-style-type: none"> • Abduction • Recruitment into the army <p>Prison Staff</p> <ul style="list-style-type: none"> • Torture • Hard labour for juveniles • Denial of justice <p>Judiciary</p> <ul style="list-style-type: none"> • Denial/delayed justice • Defilement • Assault

☞ See: *MGLSD, Integrated care for OVC – a training manual for community service providers*, p. 136.

It is important that counsellors are aware of the signs of child abuse and neglect and that the organisation they work with has policies in place that guide the counsellor on actions to take when he or she suspects abuse or neglect. This will often involve working with other agencies and legal entities.

Physical abuse

Signs of physical abuse

Children may show the following marks:

- Cuts
- Fractures
- Patches of hair missing
- Pinch marks
- Bruises
- Burns
- Bite marks
- Old scars (not fresh ones)



Behaviour that an abused child may demonstrate

- Sleeping problems
- Increased aggressive behaviour
- Withdrawal
- Concentration difficulties
- Running away
- Role-playing scenes in which children are beaten frequently or pushed around

Sexual abuse

Sexual abuse includes fondling the child's genitals, penetration (inserting the penis into the child's mouth, anus or vagina as well as inserting objects into the child's mouth, anus or vagina), indecent exposure (another person revealing his or her sexual body parts to a child), using a child to earn money through sex and producing pornographic pictures or videos of children.

What physical signs may indicate sexual abuse?

- Unexplained pain, swelling, bleeding or irritation of the mouth, genital or anal area
- Sexually transmitted infections (STIs) – sores, a discharge, frequent itching of the genitals
- Pregnancy
- Unexplained difficulty in walking
- Increase in headaches or stomach aches

What behaviour may indicate sexual abuse?

- Withdrawal
- Loss of interest
- Clinging to one person; unwillingness to be left alone with a person
- Increased anxiety
- Mood swings
- Concentration difficulties
- Sleeping problems
- Nightmares
- Using words with sexual connotations that are not age-appropriate
- Increased knowledge of sexual terms and acts
- Aggression
- Auto-aggression (self-mutilation like cutting and burning)
- Feeling dirty, needing to wash him or herself over and over
- Attention-seeking behaviour
- Frequent drawing or acting-out of sexual scenes
- Playing sexual games (fondling), usually with other children (usually with younger children)
- A sudden increase in gifts or money
- Absenteeism from school
- Decreased school performance
- Secretive behaviour

Sexually abused children may act or speak in a way that shows that they have sexual knowledge that is unusual for children of their age. Abused children learn that sexual behaviour is a good way to get attention and rewards. These rewards may include money, food or clothing.

☞ See also: MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda (2009)*, Module 2 Topic 2 – Child abuse and neglect, p.116.

Counselling children who have been sexually abused

While the counselling principles and techniques discussed in this guide, also apply when working with children that have experienced abuse, there are special considerations. The Ministry of Gender, Labour and Social Development Training Manual on Integrated Care for OVC dedicates one of its modules to child protection and legal support and provides guidance on procedures to follow when child abuse is suspected:

☞ See MGLSD, *Integrated care for OVC – a training manual for community service providers*, Module 10 Child protection and legal support, p. 135 onwards.

The Southern African AIDS Trust has produced valuable counselling guidelines on child sexual abuse:

☞ See: Southern African AIDS Trust (SAT), *Counselling guidelines on child sexual abuse*, 2004, www.satregional.org

1.6 Coping with adversity

The ability for a child to cope with hardship is related to their ability to withstand or adapt in difficult circumstances. A child's resilience is the capacity to face, overcome and be strengthened by or even transformed by the adversities of life and the ability to bounce back after stressful and potentially traumatising events. Resilient children are more likely to be able to cope with life's adversities.

What do children need to cope with adversity?

Children cope better when they have three capabilities:

- ✓ the capability to understand an adverse event (e.g. death of a parent)
- ✓ the capability to believe that they can cope with a crisis because they know that they have some control over what happens
- ✓ the capability to give deeper meaning to an adverse event

The development of these three capabilities must be encouraged. Most children will develop all three capabilities as they grow. The development of these capabilities is greatly influenced by factors external or internal to a child.

Factors that influence resilience

What makes a child resilient?

- **What the child has ('I have')** - A child is more likely to be resilient if they have close and secure relationship with a caregiver, who set limits that stop them getting into danger or trouble, who set an example of how to behave, who encourage them to do things on their own and praise them for showing initiative, who show a strong sense of purpose and optimism and who help when they need access to services.
- **Who the child is ('I am')** - A child is more likely to be resilient if they have a sense of who they are, feel likeable and loveable, are intellectually mature, have high self-esteem, can do kind things for others, are proud of themselves, take responsibility for what they do and think things will be alright.
- **What the child can do ('I can')** - A child is more likely to be resilient if they can talk to others about what worries them, can solve problems, have capacity to control strong feelings, understand how others feel, establish relationships and find someone to help when they need it.

👉 See: *Building Blocks: Africa-wide briefing notes – Young children and HIV*, p.15

1.7. The role of counselling in building children's resilience

All children are born with the potential to be resilient, but resilience has to be developed, just like other skills and capacities. Resilience prepares children for hardships and suffering that they may face in the future – not only when they are young, but also when they are adults. Counselling can support a child to build their resilience and overcome psychosocial suffering.

Counselling can help a child to:

- ✓ Tell their story and make sense of difficult or negative experiences.
- ✓ Understand, accept and live with strong feelings brought about by difficult situations
- ✓ Make choices
- ✓ Recognise their strengths
- ✓ Deal with fear and anxiety
- ✓ Develop a positive attitude to life
- ✓ Problem solve
- ✓ Move forward with their lives

See also:

☞ **MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda* (2009), Module 3 Topic 4 – Coping and resilience, p.200.**

☞ **Catholic AIDS Action, Sr Silke-Andrea Mallmann CPS, *Building Resilience in Children Affected by HIV/AIDS*, Namibia, 2003**

As all our work with children, counselling always has to be conducted with the best interest of the child in mind and must never cause harm (see p.19). As we will also see later on, counselling has its limits – it can not help all children all of the time.



Photograph caption: Peter Lugudde (15), Bugolobe Village. Peter is the head of his household caring for his two siblings (aged 12 and 14).

Each month he has to raise 7000USH which he does by getting water for people - "If I don't, we find food from the garden and have no sauce. I want some shoes. That way I can travel further and work for more people".

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SECTION 2 - PREPARING TO WORK WITH ORPHANS AND OTHER VULNERABLE CHILDREN THROUGH COUNSELLING

Summary – This section looks at some of the issues people need to think about and prepare for before starting to support orphans and other vulnerable children through counselling and communication. Whilst they are presented as initial considerations for individuals working with children, they also outline some of the basics that OVC programmes need to consider, plan for and put in place in preparation for this work.

Key topics

- 2.1. Issues for the counsellor
- 2.2. Confidentiality
- 2.3. Child protection
- 2.4. Record keeping
- 2.5. Making Referrals
- 2.6. Involving caregivers
- 2.7. Where and when to do counselling
- 2.8. Materials and resources
- 2.9. Advocacy

Before starting to work with orphans and other vulnerable children through counselling and communication, the organisations and individuals involved need to be aware of some standard good practice components of psychosocial support and counselling. There are a number of key personal, ethical, legal and practical considerations to take into account, agree on and put into place.

2.1. Issues for the child counsellor

Working with orphans and other vulnerable children experiencing distress or trauma can be challenging and highly emotional, even for an experienced counsellor. It presents personal and professional issues that need to be considered:

Personal issues

- It is vital to be honest about your own feelings. These might include doubts about your own HIV status, fears about the status of your own children and concerns about working with children facing abuse, death or bereavement.
- You must consider how such feelings might influence your behaviour and counselling skills when working with children.

Some basic questions for adults working with children

- ? *Do you like children? Do you feel comfortable when talking and being with them?*
- ? *Are you able to consider the world from a child's point of view?*
- ? *Do you have enough patience to listen without interrupting?*
- ? *Are you able to listen to a child telling you about their pain without telling them what to do?*
- ? *Are you able to deal with a child crying in a natural way, without embarrassment or crying yourself?*
- ? *Can you take children seriously and accept that they have their own feelings and ideas about the things that they have experienced?*
- ? *Are you judgemental about situations? What are your personal feelings, attitudes and values about HIV, street children, child abuse, child sex workers, children in conflict with the law, drug use, etc?*
- ? *Are you willing to question your ways of doing things and learn new ones?*

- You need to separate emotional involvement with the children and households you are working with from emotional issues in your own life. To do this you need to have your own support system in place. (See: Section 7)

Cultural, traditional, religious and gender issues

- You need to be aware of your own opinions about and reactions to the cultural, traditional, religious, and gender norms that influence children.
- You need to consider which norms it would or would not be appropriate to raise and / or challenge during counselling.
- When dealing with, for example, death and dying you might be tempted to impose your own religious beliefs on the children you are working with. You need to be very cautious about this, as your beliefs may not be the same as the children's and it may make them feel confused or pressured.

Organisations considering training community volunteers in communication and basic counselling skills for supporting children, will find the following useful for working on adult's attitudes towards children:

☞ *The MGLSD **Integrated care for orphans and other vulnerable children: A training manual for community service providers** has an activity to explore attitudes towards OVC. See: Module 2 - Understanding OVC work, Session 2.2. Attitudes towards OVC, p.21*

☞ *The **Understanding and challenging HIV stigma: Toolkit for action - Module 1 - Children and stigma** has a section designed for adults working with children. Through a series of exercises it aims to help adults reflect on and understand their own attitudes towards children and the kinds of stigma that different groups of children face – for example, street children, children living with HIV – as well as the effects that these have on the development of children. See: Activities for adults – pp. 19-34*

Personal attributes of counsellor

When counselling and communicating with children you need to have the following attributes:

- | | | |
|------------------------------|----------------------|-----------------------|
| ✓ Compassion | ✓ Empathy | ✓ Knowledge |
| ✓ Confidentiality | ✓ Interest | ✓ Calm |
| ✓ Respect | ✓ Imagination | ✓ Positive role model |
| ✓ Good listening skills | ✓ Patience | ✓ Common sense |
| ✓ Non-judgmental attitude | ✓ Knowing own limits | ✓ Approachability |
| ✓ Use simple, clear language | ✓ Flexibility | ✓ Self awareness |
| ✓ Trust worthiness | ✓ Availability | ✓ Warmth and love |
| | ✓ Be genuine | |

In addition you need to:

- ✓ Be trusted and respected in your community.
- ✓ Like children.
- ✓ Not have a criminal record!

Understanding when counselling is helpful and when it is not

Counselling is not appropriate in every situation and counsellors need to think carefully about what is helpful for each individual. For some children counselling activities can provoke extreme reactions and secondary trauma.

- Counsellors need to understand the child and monitor their response to counselling support.
- Counsellors need to respond to extreme reactions and seek further professional support
- Where a child does not seem to have inner resources or protective mechanisms and does not respond to the counselling consider other approaches and seek guidance.

2.2. Considering confidentiality

Shared confidentiality and disclosure

Before finally sharing the child's information with others like the parents/caregivers, referrers, etc.:

- Remind the child of previous discussions and agreement about sharing information.
- Ask the child what she/he thinks about shared confidentiality and what the outcome might be when information is shared with others - exploring both the positive and the negative consequences.
- Deal with the child's anxieties about sharing the information.
- Give the child control over the timing and conditions surrounding the disclosure.
- Ask questions like:

? *'What would you like to tell your parents / caregiver yourself?'*

? *'Would you like me to be around as you tell them?'*

? *'Would you rather prefer that I tell your parents/caregivers without your presence?'*

? *'Would you wish that I tell your parents/caregiver with you present?'*

? *'Would you like this to happen today? Tomorrow? Or when?'*

- Confidentiality covers every aspect of a child's information including issues about self, family and parents/caregivers. After a full discussion with the child, the counsellor must accept and respect the child's decision to share or not to share information.

However, the counsellor has a responsibility to ensure the **safety** and **protection** of the child, for example, in the case of abuse by referring and following up with child protection mechanisms. In this instance safety is the priority! In the case of rape and defilement there are laws for protecting children that can be used to ensure the perpetrator is apprehended and the child is safe.

Confidentiality is about respecting and withholding private information. It can pose challenges in relation to counselling children who are infected or affected by HIV and AIDS, as well as those children that have been abused or neglected, or involved in armed conflict or sex work. For example, you might feel that releasing information about a child's situation would be in his or her best interest, but this might go against the child's or their family's/guardian's wishes. It can also be a burden for children to keep their own information confidential – as they tend to be naturally spontaneous and struggle to keep 'secrets'.

Whatever the problem of the child, there is usually a need to involve parents or caregivers in finding long-term solutions to the problem and also as a way of helping parents understand the child's problem. It is important to maintain the child's confidentiality even when you talk to the parents or caregiver. You can encourage their involvement without revealing all the child has told you. Encourage communication, mediation and problem solving between parents / caregiver and the child. You need to be careful not to aggravate a situation and antagonise a parent/guardian so that after you leave the child is further abused and feels unable to speak with you again.

As a counsellor you need to:

- Reassure the children and their caregiver, if the child is accompanied, that things discussed during counselling sessions will remain confidential.
- Explain when confidentiality might be broken, such as when there is danger of harm to the child or to others.
- Explore the children's underlying fears about disclosing information and empower them to talk freely about the difficulties involved in keeping information confidential.
- Encourage the children and family/guardian to reach consensus about confidentiality. If this is not possible, get permission from them as individuals to share the relevant information with the others involved.

Organisations working with children should have a code of conduct for their staff and volunteers, which should include a confidentiality policy.

2.3. Considering child protection issues

As we have seen in the previous section, child protection includes actions that aim to provide an immediate response to children's rights being violated, and reducing chances of subjecting them to serious risks and dangers. Violations of the rights of vulnerable children take various forms, such as physical abuse, and other forms of domestic violence; property grabbing; sexual abuse which could lead to HIV infection and early pregnancies; or even the death of children.

In order to support and protect a child, you therefore, need to be:

- Aware of the relevant laws and the policies in place regarding child protection (*see: Section 1*).
- Knowledgeable on existing structures handling child abuse, particularly within your own community. The table above summarises various levels of child protection structures in Uganda.



'Different actors who play a role in addressing legal issues facing OVC'

At Village Level	At Sub-County Level	At District Level
<ul style="list-style-type: none"> • Clan elders • Family members • Parents • Guardians • Opinion leaders • Church leaders • LC1 and LC2 courts • LC1 and LC2 Secretary on children's affairs 	<ul style="list-style-type: none"> • Police • NGOs/CBOs/FBOs • Health centres • Administrators of schools and tertiary institutions 	<ul style="list-style-type: none"> • Probation and Social Welfare Office • Police • Administrator General/CAO's Office • Family and Children's courts • Hospitals

☞ See: **Integrated care for OVC - A training manual for community service providers.**
See: *Module 10 Child protection and legal support – p.128*

Things to consider for child protection and to ensure safe working with children

- In accordance with the United Nations Convention on the Rights of the Child, ensure that all work with children is in their best interests and does them no harm.
- Always let your organisation know where, when and with which children you are going to be working. Consider protection issues in deciding the time and location of the activity (for example, whether the children are to be going home alone in the evening, or whether the venue is isolated).
- Inform parents, adult carers or any authorities responsible for the children you are intending to work with of your plans.
- Find out if other institutions / non-governmental organisations are working with the children you intend to work with.
- Establish boundaries and good practice before working with children.
- Unless you are experienced in this work, avoid working with children or young people who have been affected by alcohol or drugs. Arrange for them to see professional counsellors and therapists.
- When using more active games, be aware of physical safety issues. Check the area you'll be working in for physical hazards.
- Consider and plan for professional referrals to respond if children disclose or raise issues of inequity, exploitation or abuse.
- Remember the issue of consent - just as it is a child's right to participate, it is also their right not to participate if they do not wish to.

☞ See: *Adapted from Rogers (2000) and Save the Children UK (2000), cited in A parrot on your shoulder. A guide for people starting to work with orphans and vulnerable children, p.5.*

2.4. Keeping records

Keeping good records is an important part of effective support provision. These records may also include, among other things, consent forms and contracts with the child about the relationship and the process. You and your organisation should agree on a format for record keeping and use this consistently. Reasons why records should be kept include:

Types of records:

- ✓ If the child has been referred to you, information from the referring source
- ✓ Consent forms
- ✓ Notes from the first assessment – having a standard assessment checklist and summary form, developed by the organisation is extremely useful.
- ✓ A work plan with the short-term and long-term goals for each child
- ✓ Notes from each counselling session (with dates)
- ✓ Information about any referrals that you make (see below)
- ✓ Final evaluation when the counselling relationship ends.

- For planning and organising.
- As a reminder of what you discussed in the previous session.
- To improve your future work and that of your colleagues by noting what went well and what did not, or in terms of techniques, what worked and what did not.
- As a reminder of anything you agreed to do or find out.
- In case you need to refer the child or caregiver.
- Because you are part of a team of people who see this child.
- For identifying sources of support.
- For ensuring quality standards.

☞ See: *MGLSD, A Guide for Interpreting and Applying National Quality Standards for the Protection, Care and Support of Orphans and Other Vulnerable Children in Uganda, p.25*

Records contain confidential information and must be kept in a safe and secure place. Most counsellors keep the names and addresses of the children they work with separate from other information, so that if the records are lost, stolen or read by an unauthorised person, nobody will be able to tell whose notes they are.

☞ See: *Annex 1 for some sample record keeping formats*

2.5. Making referrals

The NOP and NSPPI both emphasise the need for an integrated and holistic approach to the care for orphans and other vulnerable children. Because of their different needs there are a series of institutions, agencies and organisations involved in the provision of services for OVC. It is important for anyone working with children to be informed about all the services available in their community and, if necessary, beyond – if this has not already been done, consider doing a mapping of existing services in your community. This is also useful to identify gaps.

In order to ensure the integrated care for OVC, there should be an effective **referral system** at the local level. This should include all those providing services for OVC and their households. Mechanisms for making referrals between all those involved, such as a **referral directory** and two-way **referral forms**, need to be in place to ensure the best possible care and efficient use of resources.

If a child has been referred to you from another source (e.g. health care worker, school or caregiver), you need to ensure that you have information about why the referral was made before you start to work with the child. This may include information about the child's behaviour, emotional state, personality, his or her history, cultural background and environment. All of this will help you to understand the child better. Some caution needs to be exercised though - information from a referral source may be inaccurate, incomplete or distorted by the referrer's point of view. For example, a counsellor may be told that a child is disobedient when actually it is the child's caregiver who is overbearing.

No one organisation or individual can meet all the needs of a child that they are supporting and it is vital to know when and where to refer a child for additional support. When making a referral it is important that you are able to ensure the following:

For the child/caregiver:

- Clear instructions on where to go, who to see, and what times or days a service is available.
- A formal 'introduction', for example a referral form that explains why the child needs to access the service.
- Information from you (the referrer) and the provider on why the referral is necessary, what actions the provider proposes and why.
- For the service provider:
 - Information about why the child is being referred.
 - Name and address of the child/caregiver being referred and of the person/organisation (you or your organisation) making the referral.

For the person/organisation (you or your organisation) making the referral

- Feedback from the service provider on what has happened and suggestions for further support to the child. This can be provided on a two-part referral form, which includes a tear off section for feedback.

 For an example of how to set up a community referral system, see: *International HIV/AIDS Alliance, The health journey: A community-centred methodology, 2007, p.23.*

2.6. Involving caregivers or others in the child's household

Consent

Whether you will be working with the child on their own, with a caregiver present or as part of a family or household intervention, before starting the counselling process all parties need to be informed and give their consent.

All those involved need to understand what counselling is, why you are doing it, how it works, where and when and how often it will take place and what the hoped for outcomes are. Issues of confidentiality will have to be explained and agreed (see above).

Ensuring cooperation and on-going support

Counselling does not occur in a vacuum. Those close to the child in their home environment need to understand the problem that the child is being counselled for, the feelings that the child may experience, as well as the changes that the child may undergo during the counselling process. For example,

- Sometimes, when change occurs, there may be resistance from other household members
- The child may experience periods of setbacks and regression which those close to him or her need to be prepared for with understanding.
- Other household members may intentionally or unintentionally sabotage newly acquired behaviour.
- Involving the household helps individual members to express their feelings and emotions regarding the process of change.

- There may be issues within the household that have contributed to the child's problem in the first place. In this case, these will have to be addressed at the household level.

2.7. Considering where and when counselling takes place

Ideally more formal counselling should take place in a room where the child feels safe and with a door that can be closed during visits. The room should have solid walls so that conversations inside the room cannot be overheard from outside. There should be no barriers, such as a desk or other furniture, between the counsellor and the child. If working with very young children the counsellor will need space on the floor to sit with them at their level during the session. Depending on the ages of children counselled here, and what is locally available, a friendly atmosphere could be created by having pictures or drawings on the wall, as long as these do not distract from the counselling process. The counsellor could offer the child something to drink, if it is available.

The 'ideal' scenario mentioned above, may be easier to achieve if counselling takes place in, for example, clinics, schools, youth or out-of-school clubs or CBOs / NGOs / FBOs that have their own offices.

However, the reality in many Ugandan communities is that a private room is not available. Some counsellors work with children in the open air, other locations by arrangement with the child, or if part of home based care programme, in their homes.

The following need to be considered in all cases:

Consider privacy

Counselling, particularly for older children, needs to take place somewhere where the child feels secure enough to talk with you about their issues, without being overheard by others. As we have seen above, the issue of confidentiality is an important aspect of the counselling relationship.

Consider access - distance, timing and safety

Counselling that takes place anywhere that is not the child's home needs to be accessible. Lessons learned from the MGLSD/CORE Initiative Research on Psychosocial Support Interventions in Uganda; show that participation in programmes is often limited by children not being able to get to the site of the activities. This may be due to long distances to the site or the timing of the activities that conflict with household and other responsibilities of the children. Those involved in this research said that long distances may prevent girls from attending when there is a threat to their safety as they travel to and from the site.

Access also needs to be considered when working with physically disabled children, who, for example, may find it difficult or not be able to climb stairs.

☞ See: *University of Makerere Institute of Psychology, Makerere Institute of Social Research, Ashinaga, **Lessons learned from the MGLSD / CORE Initiative research on Psychosocial Support and Economic Strengthening Interventions**, December 2008; p.17.*

2.8. Gathering materials and resources

We will look more closely at the preparation needed for each counselling session and at the different ways of using drawing, story telling, drama and play in counselling later on in this guide. However, when preparing to work with children, it is very useful to prepare a collection of materials and resources for future use. These can be shared among a group of counsellors. Depending on local availability, these may include the following:



- Drawing materials – coloured pens, paints, chalk, paper, card, sticks to draw in sand with etc.
- Play materials – simple everyday objects, such as boxes, string and sticks, as well as toys, such as human or animal figures, cars, clay, balls, etc.
- Materials to make finger or glove puppets and / or masks – old bits of cloth, paper, card, plastic bottles, etc.
- Musical instruments, recorded music, a radio, songs
- Scenarios for role plays
- Stories, fables or folk tales that may convey a message to the child

2.9. Considering advocacy issues

Advocacy involves standing up for the rights of your clients and helping them overcome obstacles by taking action with the community and authorities. Advocacy is particularly important when working with children because their opinions are often ignored. Where possible they should be supported to speak for themselves. Where not possible, you must ensure that you accurately represent their feelings and situation. When advocating for children it is vital to:

- Have all the necessary information available to you. Otherwise it might be difficult to get others to support you up or to convince the authorities to take action.
- Agree on issues of confidentiality with the children, such as whether they are happy for the authorities to know their names.

☞ See: *MGLSD, Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda (2009), Module 5 Topic 3 – Referral, advocacy and networking, p.296.*

SECTION 3 – COUNSELLING ORPHANS AND VULNERABLE CHILDREN: LISTENING AND TALKING

Summary – this section starts with a brief review of the basic principles of counselling and the different types of counselling there are. It then considers communication with children and the basic skills needed for counselling and communicating with them, looks at factors that can affect this communication and lastly, outlines the counselling process itself.

Key topics

- 3.1. Principles of counselling
- 3.2. Types of counselling
- 3.3. Communication with children
- 3.4. Basic counselling skills
- 3.5. Additional factors affecting communication with children
- 3.6. The counselling process

3.1. Basic principles of counselling

As we have seen in Section 1, counselling is one of the ways of providing psychosocial support to vulnerable children. The aim of all counselling is to help people cope better with situations they are facing. This is true for counselling children and young people too. It involves helping the child to cope with their emotions and feelings (building resilience) and to help them make positive choices and decisions.

Counselling children includes:	Counselling children does NOT include:
<ul style="list-style-type: none"> ✓ Establishing helping relationships with children ✓ Helping children tell their story ✓ Listening attentively to children ✓ Giving children correct and appropriate information ✓ Helping children make informed decisions ✓ Helping children recognize and build on their strengths ✓ Helping children develop a positive attitude towards life. 	<ul style="list-style-type: none"> ✗ Making decisions on behalf of children ✗ Judging children ✗ Blaming children ✗ Preaching or lecturing to children ✗ Making promises you cannot keep ✗ Imposing your own beliefs on children ✗ Arguing with children

3.2. Types of counselling

There are different ways of providing counselling support to children:

- **One-to-one counselling** – working with children and young people as individuals.
- **Family counselling** – working with a child as part of a family or household. This is a form of group counselling.
- **Group counselling** – working with a group of children who share similar experiences and problems and are of a similar age.

- **Peer counselling or peer support** - children who share similar experiences and problems and are of a similar age providing emotional and practical help to each other. Children can be trained as peer counsellors or supporters. This approach works better with older children.
- **Traditional or community counselling** – working as an intermediary to facilitate a dialogue between the child and the family; often including significant and relevant people in the counselling process, such as grandparents, community leaders and traditional healers.
- **Ongoing counselling** – when the counsellor and those they counsel agree to work together regularly on an issue or a series of issues over a longer period of time.
- **Crisis counselling** – when a crisis or particularly traumatic event has occurred and the child feels intensely threatened, completely surprised and caught unaware, emotionally disturbed or paralysed because of the event. Examples can be the unexpected death of a close loved one, rape, witnessing violent death, etc. or generally when a child shows extreme reactions – see: *Section 6*. Crisis counselling can be short-term or turn into on-going counselling.

Some common situations which mean children need counselling include:

- Bereavement and loss – supporting children before and / or after the death of a parent or loved one.
- Sexual and reproductive health – talking about sex and reproductive health with children / young people.
- Counselling for HIV testing – pre and post test counselling.
- Disclosure of HIV test result – supporting children with sharing their own or finding out about their parents' HIV positive test result.
- Positive living – talking to children with HIV about how to live positively with the virus.
- Treatment and adherence – talking to children about ARVs and how to stick to taking them.
- Experience of trauma - supporting children, for example, when they have experienced rape, abduction, or witnessing violence.

Each of these requires some specific knowledge and training.

☞ See: *MGLSD, Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda (2009), Module 1 Topic 4 – Children with disability, p.61; Module 1, Topic 5 – Child soldiers, p.70; Module 2 Topic 2 – Child abuse and neglect, p.116; Module 2 Topic 4 – Reproductive Health, p.138; Module 3 Topic 2 – Substance abuse, p. 177;*

3.3. First things first - communication with children

Children often find it particularly difficult to recognise what fears and emotions they are experiencing, let alone put these into words. Communication is the foundation of the relationship between counsellor and child. For this reason, practical ways must be found to communicate; ways that are effective not only for the counsellor, but more importantly, for the child.

During counselling, children should never be forced to tell their 'story'. If children cannot communicate about something, there will usually be good reasons for this. These might include:

- Traditions and customs can pose barriers to their communication, such as children not being allowed to disagree with adults in some communities.
- Children may be scared of their caregivers and be worried that what they say to the counsellor will get back to them.
- Children may feel embarrassed or ashamed to discuss certain things with adults because it relates to taboo subjects such as sex.
- Children may be too young to put their feelings or experience into words. In practice, the counsellor must always consider the developmental stage and age of the children, how much they know, and their ability to express their knowledge and emotions.
- Children often fear hurting those they love. For example, they might hide their feelings in order to protect their parents, particularly if their parents are sick or unhappy.

How children communicate

- Verbally and non verbally – more verbal with age usually
- Play, touch, drawings, colour, story telling and music
- Children cannot always tell the difference between imagination (fantasy) and reality
- Children may need to escape into an imaginary world at times to cope with what is happening to them
- Children who have been abused or neglected may be afraid of touch – be aware of the child's response and do not force physical contact until the child is ready for this
- The **basic** communication skills used with adults apply to children as well

Remember Section 1 and children's different developmental stages.

It is the counsellor's role to help the child overcome these barriers and to communicate freely. As a starting point, the counsellor needs to meet children on their level. This involves using creative and non-threatening methods of exploring sensitive issues and helping children to express their feelings. We will explore some specific methods in more detail later on in this section and in Sections 4 and 5.

3.4. Basic counselling skills

While we can see on the right that the basic communication skills used in counselling adults also apply to children, we will explore some of these in a little more detail here.

Language needs to be clear and simple. It should be adapted to the child's developmental stage, age, culture and background. Adolescents in particular often use different terms or codes to set themselves apart from adults, and it helps the counsellor to be aware of these. The child's local language should be used.

Observation plays a particularly important role in working with children as it will provide a lot of important clues that can help the counsellor to understand the child better – assess their underlying emotional state, their circumstances, their needs – and thus help to plan their work with that particular child.

Observation begins early on while the counsellor starts to build a relationship with the child (the 'joining' phase) and continues throughout the counselling process.

BASIC COMMUNICATION SKILLS

BEING PRESENT: physically and psychologically → open communication and trust.

- ▶ Be aware of body language
- ▶ Be natural and relaxed

LISTENING: Actively listening → help you identify and understand child's needs and make child feel respected and loved.

- ▶ Listen to verbal and non-verbal messages
- ▶ Listen with empathy
- ▶ Avoid distractions and stay focused while listening
- ▶ Avoid being judgmental
- ▶ Be aware of your attitude
- ▶ Avoid giving instructions

EMPATHY: Having empathy → better understanding of child's needs, trust and open communication between child & caregiver

PROBING/ QUESTIONING: Asking questions → identify issues and concerns of the child.

- ▶ Ask open-ended questions that do not have a yes or no answer. Begin questions with who, where, why or how (e.g. "How are you feeling this morning?" rather than "Do you feel well this morning?")
- ▶ Avoid asking too many questions.

☞ *MGLSD, Integrated care for OVC – a training manual for community service providers, p. 120.*

- **Observing general appearance** – dress; level of alertness; cleanliness/hygiene; physical development and level of nutrition; peculiar mannerisms
- **Observing behaviour** – is the child: quiet and careful; aggressive and destructive; easily distracted or has good attention span; willing to take risks; what is the response to physical contact; does the child have appropriate boundaries?
- **Observing mood** – is the child happy, sad, angry, depressed, excited, overly talkative, nervous; does he or she show little or no emotions, is he or she self-absorbed or withdrawn?
- **Observing speech and language abilities** – does the child get frustrated at not being able to say what they want to say; rely more on using non-verbal communication; is their speech unclear?

Attitude and approach to communicating effectively with children:

- ✓ Introductions are important.
- ✓ Respect confidentiality.
- ✓ Use simple language.
- ✓ Use a friendly, informal and relaxed approach
- ✓ Allow adequate time
- ✓ Allow for children's limited concentration span.
- ✓ Be non-judgemental.
- ✓ Seek the child's permission before taking notes – better to do this after the session
- ✓ End the session appropriately.

- **Observing tasks and play** – is the child’s play or task performance generally age appropriate; is it creative, limited or repetitive? For example, destructive play can indicate anger, and very repetitive or limited play can indicate anxiety.
- **Observing motor skills** – does the child sit most of the time; walk, jump, run squat; does the child seem inhibited in physical expression or free? For example, anxious children sometimes show differences in breath control, such as holding their breath, sighing or gasping.
- **Observing relationships with others** – how does the child interact with others – caregiver, siblings, the counsellor and other children? What is eye contact and social skills like? Is the child clinging; withdrawn; friendly; trusting; suspicious; competitive; cooperative?

☞ See also: **Section 1** of this Guide – *How can we tell a child is vulnerable and needs help?*

Active listening

For the child to tell their story and for the counsellor to identify troubling issues, the child need assurance that the counsellor is paying attention and that the information being shared is valued and respected. There are four major components of active listening:

Communicating with distressed children:

- ✓ Allow the child to set the pace.
- ✓ Give adequate time to the child.
- ✓ Provide emotional support and encouragement to the child.
- ✓ Accept the child’s emotions such as guilt and anger.
- ✓ Never give false reassurance.
- ✓ Talking about difficult situations may enable children to work out their own solutions.
- ✓ Sometimes it is necessary to allow regression

- **Body language** – for example, joining the child on their ‘level’ if they are sitting on the floor or playing from there; gauging the level of eye contact and physical contact each child is comfortable with and using this appropriately; not being distracted, fidgeting or taking notes while the child is speaking.
- **Use of minimal responses** (these include verbal expressions such as “yes, I see”, “really”, as well as making noises to show one is listening, or using gestures such as nodding of head) – they need to be spaced appropriately, if used too often they become distracting; they should not lead the child to draw conclusions about the counsellor’s beliefs and attitudes, since this might inhibit the child.
- **Use of reflection** – verbally reflecting (paraphrasing) what a child has said does not mean repeating word-for-word, but rather picking out the most important details and rephrasing these in your own words. It shows the child you have been listening and can also help to give clarity. Reflection is also about holding a mirror to the child’s feelings, for example, if the child is crying and not saying anything, the counsellor may say “you are so very hurt right now”, thus naming the feeling and opening up the possibly for exploring it. Reflection of both words and feelings, can also allow the child to correct the counsellor if he or she has not understood well.
- **Use of summarising** - this is reflecting back information from a number of statements which a child has made; summarising draws together the main points and also acknowledges feelings the child has described. For example, children may be confused by the details of their own stories and summarising organises and clarifies these to help the child gain a clearer picture and become more focused. Summarising is useful when the counsellor wants to move towards

ending an individual counselling session, as it helps the child to reflect on what has been shared during the session.

Asking questions

Type of question	Purpose	Example
<i>Open</i>	<ul style="list-style-type: none"> Encourage children / people to express themselves freely and share their ideas Allow wide range of different answers To understand silences 	<ul style="list-style-type: none"> What has happened since the last time we met? What is happening in this picture? I notice you are very quiet today. What are you feeling?
<i>Closed</i>	<ul style="list-style-type: none"> To get specific factual information 	<ul style="list-style-type: none"> What's your name? How old are you?
<i>Probing or follow-up questions</i>	<ul style="list-style-type: none"> To open up and deepen the conversation and bring out more ideas or information To explore feelings 	<ul style="list-style-type: none"> Could you tell me more about why? Could you give me an example of?
<i>Clarifying</i> – re-phrasing in your own words what was said	<ul style="list-style-type: none"> Check whether you have understood and mirror back to the speaker To help the child to focus 	<ul style="list-style-type: none"> So you feel that ... – is that right? You said that ... - did I understand that right?
<i>If working with a group – Re-directing</i> to others in the group	<ul style="list-style-type: none"> To get others involved in the discussion and encourage other views. Can also help if a group member gets stuck or embarrassed 	<ul style="list-style-type: none"> Lydia feels that – what do others think?

Types of questions to use carefully or to avoid:

- **Why questions** – although they can be useful sometimes, they can often feel threatening or judgmental.
- **Leading questions** – lead the child to a particular answer, are often based on the counsellor's assumptions and don't help the child to be open about their true feelings or actions.
- Don't ask **questions to satisfy your own curiosity!**

In Sections 4 and 5 we will explore some specific methods to use in counselling and communicating with children further, but here are some initial ideas of 'tools' to use in communication with children:

☞ Aids to promote Communication with Children ☜

- Toys that they feel comfortable with; handmade toys out of old tins, pieces of cloth, etc.
- Finger, sock, glove/cloth puppets that they can "safely" talk to.
- Paper and coloured crayons. Both what they draw and the colours they choose may tell you what they are feeling (if no crayons available use ball pens or pencil).
- Balls can be thrown back and forth to develop an unthreatening bond of communication for children afraid of direct touch. Balls can be made from scraps of material and old cloth or stockings for fillings.
- Blowing bubbles together (made from soap and a wire loop) forms a bond and relaxes children.
- Simple musical instruments - can be played in a group to enable them to feel safe within a group and part of it; or to express their emotions.
- Dancing together with others also allows them to feel safe within a group and helps them to develop the confidence to be part of a larger social group.
- Storytelling - listen to the stories that children tell, often over and over - they are often telling you of their emotions in a story. Looking at pictures together may help them develop "their" story.
- If they feel safe with you - touch and being held lovingly.
- Continuity - one person that they can identify with and in whose presence they feel safe and accepted.
- Patience and perseverance - children may need a lot of time to relate to an adult.
- Work with children in a place where they feel comfortable (in a room, corner of a compound,...)



☞ *MGLSD, Integrated care for OVC – a training manual for community service providers, p. 121.*

3.5. Additional factors affecting communication with children

These include:

- Developmental stage and age of the child.
- The counsellor being identified with (reminding the child of) another adult that the child has feelings about - either loving feelings or fear when the child has been badly treated or abused. This is known as 'projection'.
- The gender of the child and the gender of the counsellor.
- The cultural environment in which the counsellor and child are working.
- The child's health and/or nutritional state.

- Whether the child has a physical or mental disability
- Consistency and continuity of the counselling relationship – it is important that the child can depend and rely on the counsellor being there throughout the counselling process. Changeover in counselling staff once the counselling relationship has been established has been shown to be unhelpful.
- Power relations – if the counsellor is seen as (and assumes the role of) an authority figure and is feared, there may be resistance from the child.
- The degree of trauma that the child is experiencing – we will look in a later section at when specialist help will need to be sought.

3.6. Counselling process

Initial assessment stage

We have seen in Section 2 that part of the preparation for starting to work with a child on their own, or as part of family or group counselling, is to review any information that may have been received from a referral source.

We have also seen that, even when planning to work with the child on their own, it is important to involve the primary caregiver / family in the initial assessment. This is because:

- it contributes to understanding the child's environment and the issues the child may be facing, and allows the counsellor to observe interactions between the child and their caregiver / family;
- ensures that there is follow-on support for the child during and after the counselling process;
- makes whatever changes are achieved as a result of the counselling more sustainable;
- depending on the age of consent for working with a child on their own, is a child protection requirement.

When working with a child as part of family or household counselling, the counsellor should allow for time with the child away from the adults. This is so that the counsellor can begin the 'joining' and trust building process with the child, as well as to observe how the child behaves when its caregiver / other household members are not close by.

Agreement with the child and caregiver / family

Part of this initial stage is to explain how counselling works and to reach an agreement concerning the relationship with child, the possible frequency and duration of the counselling and issues of confidentiality. It allows for exploring the child's, the counsellor's and the caregiver's / family's expectations and is the point at which ground rules for working together should be worked out. It is important to explain the temporary nature of the relationship.

Reminder – *it is vital to remember that in accordance with the NOP, this guide promotes a rights-based and child centred approach to working with children. This means that the child has to be an active participant in any decisions made.*

‘Joining’ with the child

To counsel children, the counsellor must form a good relationship with them from the very beginning. This is often called ‘joining’. It includes greeting the children and talking about something that is easy for them to discuss with you. As you talk together, they can get to know the counsellor and decide whether they are comfortable with him or her. Some examples of how to join with children of different ages include:

- For children under 5 years: Get down on the floor with them and find a game they like to play.
- For children of 6-12 years: Find a fun, relaxing activity to do together with them, such as discussing a magazine or an interesting object.
- For teenagers of 13-18 years: Find out about their interests, such as sports or music, and ask them about their likes and dislikes.



Setting goals

While the overall goal of counselling children is to help them to understand and deal with their particular situation and problems and to build their resilience and life skills so that they are better equipped to develop to their full potential, each counselling intervention needs to have long and short-term goals.

This involves the child and the counsellor agreeing on what these long and short-term goals of their work together will be. The child needs to be encouraged to articulate their own goals and these must always be the basis of the counselling relationship.

Clearly, when working with a caregiver, the family or household, their goals also need to be established, as do those of any agency referring the child.

Developing an action plan

Having done an initial assessment of the child, its environment, its problems and the possible causes of these, and having agreed goals for the counselling process, it is the role of the counsellor to support the development of an action plan.

It should set out the short and long-term goals and how these will be reached. It should include initial ideas about methods to be used and about who else / which other support provider it may be useful to involve.

The action plan will need to be reviewed before and after each session with the child and needs to be kept updated and amended with new information as the counselling process unfolds.

The action plan forms part of the **records** (see: section 2) that the counsellor should keep, as does the initial assessment checklist and the assessment summary.

Ongoing work with the child

As we have seen in Section 1 where we considered the needs of children at different developmental stages, some of the constant needs throughout the development process are for safety, security, trust and structure – things that many vulnerable children lack.

The aim of the counselling relationship and process is to provide these. Through the behaviour and attitudes of the counsellor, the regularity of meetings in a safe, enabling and neutral environment and the choice of methods for working and communicating, the process of healing and resilience building should be facilitated. Once again, it is important to explain the temporary nature of the counselling relationship.

Some good practice guidelines for each meeting or session:

- ✓ The counsellor should prepare in advance – reviewing notes from the previous meeting and the work plan, and preparing any materials to be used during the meeting
- ✓ If unable to attend, the counsellor should let the child / their family know in advance
- ✓ If the child or family are unable to attend they should let the counsellor know in advance
- ✓ The counsellor should be there at the agreed time
- ✓ At the beginning of each meeting, the counsellor should greet the child
- ✓ The counsellor should provide a brief summary of what happened during the last meeting and explore what the child has been doing, thinking or feeling since then
- ✓ At the end of the session the counsellor should summarise what happened during the session and any agreements made as well as discuss goals for the next visit
- ✓ When drawing or making things that have been used as part of the session, joint decisions should be made on what to do with, e.g., the sculptures, drawings etc. The decision might be to arrange them in one corner so that during the next session “we can begin where we ended today”
- ✓ After the session the counsellor should make notes of what happened during the session, including what worked well and what did not.

Ending the counselling process and review of outcomes

The ideal is that the counselling process should end when the counselling goals are met. The decision whether they have been met needs to be mutual.

Since it is natural that a degree of dependence on the counsellor by the child will have developed, it is important to prepare with the child for the counselling process coming to an end. This time is called the ‘termination process’ and means saying goodbye.

The time spent together should be reviewed and the focus should be on the child’s achievements and successes. Strategies for moving forward need to be agreed.

It is important to acknowledge feelings that have developed between the counsellor and the child. Depending on organisational policy around this, the counsellor can also ‘keep the door open’ and tell the child that they can return if they need to in the future.

Outcomes and any agreed strategies also need to be reviewed with the family and others involved in supporting the child. And they need to be documented.

Having looked at the most desirable way to end the counselling relationship, the counsellor and organisation they work for also need to be prepared and have practices in place for dealing with situations such as the child disappearing (this may

be particularly relevant when working with street or hard-to-reach children, migrants, etc.); the child is no longer able to attend for physical reasons; or, if the child dies.

Support for the counsellor

The last example above is just one which highlights the need for ongoing support to the counsellor. We will explore this further in Section 6. Finally, it helps to always remember where we are heading and what are we aiming for in our work with children!

☞ See: *REPSSI, The Journey of Life: A community workshop to support children, 2004*

Characteristics of a strong child

- ✓ Can ask for help
- ✓ Is positive and has hope for the future
- ✓ Can set goals
- ✓ Puts effort into work
- ✓ Plays well with other children
- ✓ Looks clean and can take pride in his/her appearance
- ✓ Can deal with challenges and frustrations
- ✓ Takes responsibility and cares for siblings and family members
- ✓ Is confident
- ✓ Has good relationships with peers and adults
- ✓ Puts ideas into action
- ✓ Despite tragedies and difficulties, can continue with routines of life (going to school, etc).

SECTION 4 – COUNSELLING ORPHANS AND VULNERABLE CHILDREN: EXPRESSION THROUGH PLAY, ART AND GAMES

Summary – In the previous sections we have looked at the needs of children and considered how some of these vary and change at different developmental stages and at what happens to children when some of these needs are not met and they become vulnerable. We have explored what needs to be in place before starting our work with children and have looked at the principles and good practice of working and communicating with vulnerable children through talking and listening. At several points we have highlighted the importance of choosing appropriate methods of working with children of different ages and developmental stages. This section will provide examples of some of these methods, looking at expression through play, art and games, and how these can be integrated into the counselling process.

Key topics

- 4.1. Different methods to use in counselling
- 4.2. Some sample activities

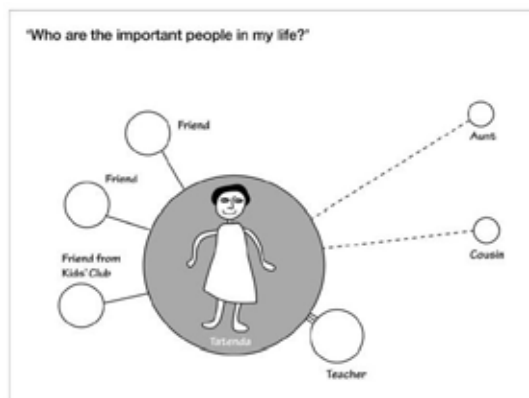
4.1. Different methods – using the right tool

Using drawings to facilitate communication

Drawing can be a powerful activity for opening ‘hidden cupboards’ in a child’s life. Drawing enables children to communicate their emotional state without having to put it into words. Most children enjoy drawing, and it is a useful, practical tool for counselling.

When using drawing as a counselling tool, it is helpful to

- Give the child different materials to use, such as pencils, pens, paint, chalk, etc.
- Ask the child to draw something related to what you would like to explore. For example, ask them to “*Draw a picture of who the important people in your life are*”, or “*Draw a picture of something that makes you angry*” (or happy, sad, scared, etc.).
- Gently follow up by asking the children to describe what is happening in their drawing.
- 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 to facilitate communication

Children tend not to like lots of direct questions or long lectures. When they are finding it difficult to talk about painful issues, listening to a story about someone in a similar position can be very comforting. It can give them the sense of being understood, and it can help them to recognise that they are not alone. A story can also serve as a useful tool for problem solving around their situation.

When using story telling as a counselling tool, it is helpful to:

- Use a familiar story, fable or folktale to communicate a message to the child, perhaps using animals to represent humans.
- Avoid using real names or events.
- 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 its relevance.
- If helpful, ask children to make up their own story, based on a topic that you give them. For example, *“Tell me a story about a little girl who was very sad.”*

Using drama to facilitate communication when working with groups of children

Drama or role-play is an excellent way for children (and family members) to raise issues they want to communicate with others, but find it difficult to discuss directly.

When using drama as a counselling tool, it is helpful to:

- Give the children a topic to perform, such as *“A day in my life”*, that is related to issues you want to explore with them.
- After the performance, encourage the children to discuss what happened in the drama and what issues came up.
- Ask questions to explore specific areas, such as *“What was the happiest / saddest part of the play?”*

Using play to facilitate communication

Some adults think that play serves no serious purpose. Nevertheless, play is an important way that children explore their feelings about events and make sense of the world. When children play, much of their activity involves imitation or acting out. This helps us to begin to understand what type of emotions they are experiencing.

When using play as a counselling tool, it is helpful to:

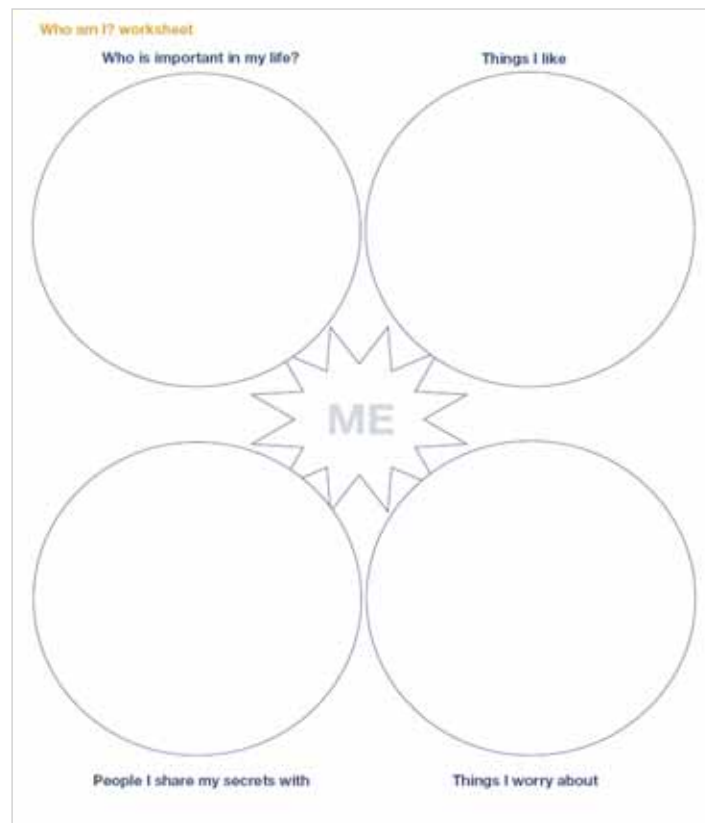
- Give the child a variety of play materials (see: *Section 2*)
- Ask the child to show you parts of their everyday life using the play materials. For example: *“Show me what you like to do with your family / friends”*. While the child is using the objects to show you, you can also ask him/her to describe to you what is happening.
- Follow and observe what the child is doing and do not take over the play. If you want to check that you have understood what the child is communicating, make comments, such as *“I see that the mama doll is so sick that she cannot get out of bed”* and see if the child agrees.
- If the child stops and cannot go on, ask him or her questions such as, *“What is going to happen next?”* or *“Tell me about this person”* (while pointing at the character that you are interested in). Such questions can help them to continue.

Next we will see some sample activities. They are **examples only**. They are intended to get counsellors thinking about how to use some of the different tools discussed above. If counsellors decide they like them, they will need to adapt the activities to their own local context – be it rural or urban, with an individual child or with a group.

4.2. Some sample activities for counsellors to consider and adapt

WHO AM I?

Activity for work with individual children or groups of children. You can design your own *Who am I?* worksheet and translate it if necessary – this one is just an example.



The worksheet is titled "Who am I? worksheet" in orange text at the top left. It features a central starburst shape with the word "ME" inside. Surrounding the starburst are four large, empty circles. The top-left circle is labeled "Who is important in my life?", the top-right circle is labeled "Things I like", the bottom-left circle is labeled "People I share my secrets with", and the bottom-right circle is labeled "Things I worry about".

Objectives

- Getting to know the child
- Identifying who or what is important in their lives
- Can be used when working on preparing to talk about disclosure

Step-by-step activity

1. Give the child / children a worksheet and have crayons and pens available. Tell the child to fill in the sheet, one balloon at a time. You can also adapt this activity by asking the child to draw the balloons, or any other shapes they like, themselves.
2. Tell them to start with the first balloon – Who is important in my life?
3. Now continue with the next balloon – Things I like. Give the child time to fill in their balloons.
4. If you are using this activity to prepare children for disclosure, continue until you reach the last section – People I share my secrets with? Tell them that there may be people with whom they might share some things and others they share different things.

DRAWING AND COPING

Part 1 of the activity – Picture drawing – can be used with individual children. Part 2 can be adapted, by asking the child to draw another picture, instead of using the buzz cards. If you are working with a group you can also adapt this activity to use locally appropriate materials or ways of exploring the issues.

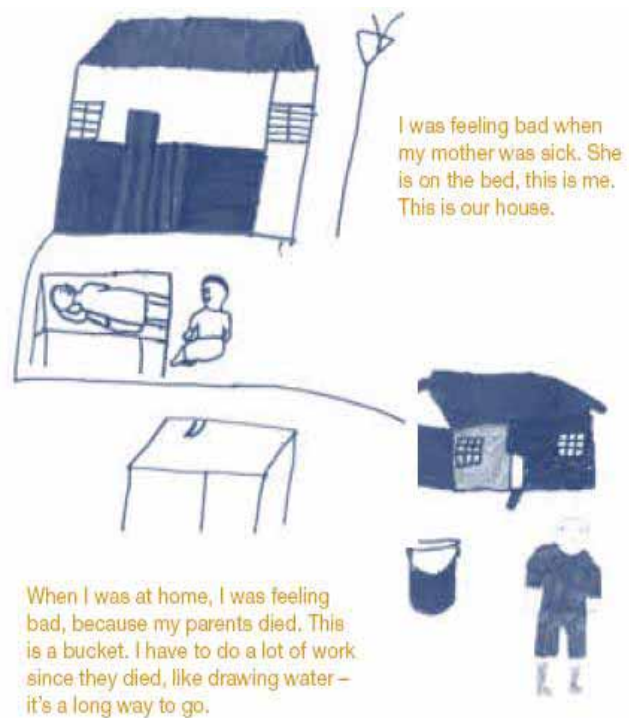
Objectives

- Helping children to talk about difficult times
- Exploring some of the situations they have been through
- Talking about what helped them to cope in these situations.

Step-by-step activity

Picture drawing

1. Ask the children to think about a difficult time in their life – a bad time when they were feeling sad. Ask each child to draw a picture to show what happened.
2. When the pictures are finished, stick them on the wall and ask the children to come and look at them. They can ask each other if they want to check anything.



Buzz and card storm

3. Now ask the children to think about what helped them get through that bad time. Ask them, 'Who or what gave you hope and support?' Ask pairs to discuss and write their points on cards. Tape the cards on the wall.

Role playing

4. Divide into small groups and ask each group to take one of the coping strategies and make a role play to show how it can help children in difficult situations. Ask groups to perform their role plays. After each performance, ask:
 - What was happening?
 - What helped the child?
 - How can we help children to cope better in situations like these?

NAMING STIGMA THROUGH PICTURES

Again, this is an activity that can be adapted and used with an individual child, a pair or a group of children. You could use the pictures provided, prepare your own (e.g. using pictures from newspaper or magazines) or ask children to draw their own pictures. Choose the pictures according to the age group you are working with.

Objectives

- Identifying stigma and its effects
- Discussing their own experiences of stigma
- Exploring some of the different forms of stigma.

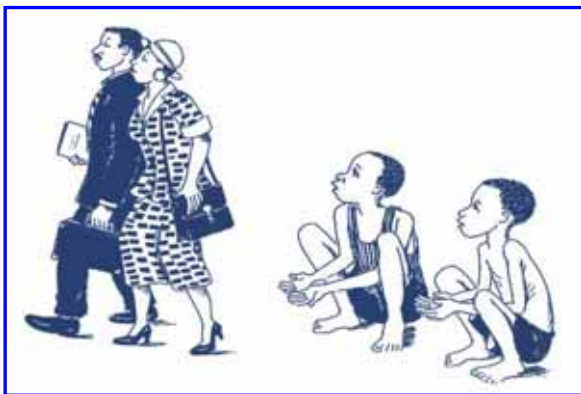
Step-by-step activity

Fun group-splitter

1. Divide the children into pairs using a fun group-splitter, e.g. draw pictures of different animals on slips of paper. Each child takes one, opens it and starts making the noise of that animal – they have to find others making the same noise to form their group.

Picture discussion

2. Lay out the pictures and ask the pairs to walk around and look at all the pictures.
3. Get the pairs to pick one picture and sit down together to talk about what is happening in the picture.
4. Give the children a few minutes to talk in their pairs. Circulate around the pairs and check that they know what they are doing.
5. Come back to the group and sit down together for feedback.
6. Each pair takes turns to show their picture and describe what is happening. Use gentle prompts to get more information, e.g. How do you think she is feeling? Why is he doing that? Does this really happen? Can you tell us more? Applaud after each pair. Ask the group if they want to say anything about the picture when the pair has finished.



☞ If you like these and would like to see more activities like them, see: **Understanding and challenging HIV stigma toolkit for action – Module I Children and stigma**. This toolkit is available free of charge from the International HIV/AIDS Alliance and can be ordered from: www.aidsalliance.org

USING PUPPETS

This is a creative activity that can help to explore issues that are you want to explore with children.

What will you need?

Materials to make finger or glove puppets and/or masks – old bits of cloth, paper, card, plastic bottles, and so on.

How does it work?

- Ask children to make their own puppets or masks out of any locally available material and do a performance.
- You can determine a theme, for example, something that you want them to think about, or let them choose.



Adaptation/variation

- Rather than doing a performance, this activity can also be used to help children talk about difficult issues by allowing them to talk as the puppet and not as themselves.

A PARROT ON YOUR SHOULDER

This is an activity to engage young children's attention using toys and stories. It is particularly good for the 'joining' phase.

What will you need?

- Toys or puppets.
- Story books or stories that you can tell.

What do you need to look out for?

- Engage the children in discussion, don't just keep reading.

How does it work?

- When working with young children, read aloud from a storybook to a toy parrot that you have fastened to your shoulder or you have sat next to you, or to any other toy.
- The children will engage out of curiosity and you can start talking to them.



Adaptation/variation

- You could also use a musical instrument and song to engage the children and get them to join in.

☞ For more activities like these, see: **A parrot on your shoulder – A guide for people starting to work with orphans and vulnerable children.** This guide is available free of charge from the International HIV/AIDS Alliance and can be ordered from: www.aidsalliance.org

HOW ADULTS AND CHILDREN GRIEVE

More ideas of **using picture stories to work with children** - this time to communicate about issues around death and grieving. The pictures below are part of *The Journey of Life*, a methodology developed by the African Regional Psychosocial Support Initiative to work with communities on supporting children. They are available at: www.repssi.org. The toolkits that accompany this methodology are very useful for working with caregivers and other adults on how bereavement affects children.

As we will see in Section 5, the issue of bereavement has to be worked through sensitively and how and when to use these sort of pictures needs to be thought about carefully.

We need to remember that:

- Both children and adults have similar feelings when someone they love has died. They may feel sad, angry or hopeless.
- Adults and children show their feelings in different ways. Children's feelings may change more quickly between sadness, happiness and play or they may rarely show their sadness.
- Though children may be sad one minute and playing and laughing the next, they still feel deeply and care about the person who has died.

Objective:

- Exploring how death and grief affect adults and children (we will see in the next section that children often feel excluded from the grieving process of adults and feel that they are very much alone)



Sample questions to engage children:

- What is happening in this picture?
- What is the adult man thinking / feeling?
- What is the child thinking / feeling?

MEMORY AND RITUAL

See above.

Objectives:

- Help children to talk about the person who has died and remember the happy times shared with them.
- Show them how to benefit from using religious rituals, like prayer, to give them a spiritual tool to deal with grief.
- Introduce them to other rituals like lighting candles that allow the child to express their feelings about the departed person and to remember them.



Sample questions:

- What is happening in this picture?
- What do you think she is doing?
- What is the girl thinking / feeling?

SECTION 5 - HOW TO GO DEEPER: ADDRESSING SOME SPECIFIC ISSUES

Summary – This section looks at some of the specific issues that counsellors may have to support children and caregivers with. It first considers HIV testing for children, disclosure of HIV status and talking to children about death. It then provides some ideas for helping children who show specific reactions. Lastly, it provides some information on the signs of neglect and abuse that counsellors should watch out for and which will need the involvement of other people to address.

Key topics

5.1. HIV testing

5.2. Disclosure

5.3. Talking to children about death

5.4. Case studies and suggestions for helping children showing specific reactions

5.5. Ideas for working with older children on grief or trauma

5.6. Child abuse and neglect

5.1. HIV testing for children

HIV testing for children raises many complex issues. Counsellors need to be aware of these and discuss them with children and their families or caregivers. It is important to think about both the advantages and disadvantages involved.

The advantages of testing are the same for children as for adults. However, there are disadvantages or concerns that need to be taken into account. If children know they are HIV positive, they might:

- * Not fully understand the situation. They may only understand the negative implications and not be aware that they can live positively.
- * Disclose their status without being aware of the possible consequences.
- * Feel angry and resentful, or depressed and hopeless.

When to test

Ideally the child decides this, with guidance from the family or caregivers (if appropriate). In practice, parents or caregivers might consider testing their child if:

- They themselves are HIV positive and their child is very young;
- The child is sexually active, or there is strong evidence of sexual abuse;
- The child has been at risk because of unsafe blood or un-sterilised needles;
- A confirmed HIV diagnosis would have important implications for medical treatment of the child.

Should a child be informed about being tested?

As we have seen in Section 1, children have the right to voice their opinions about issues affecting their lives. Even if they are young, they have the right to be given

information and support to help them understand their situation and be involved in making decisions about what is in their best interest.

In practice, exactly what a child should be told depends on his or her level of development and emotional maturity. Counsellors face the challenge of finding a balance between listening to the child's concerns, respecting the parents' or caregivers' wishes and ensuring the child's overall welfare.

To achieve this balance, you need to:

- Make sure that you are well informed about the law regarding the age of consent for testing for HIV;
- Discuss with the parents or caregivers what information they have given the child so that you can reinforce what has already been said and correct any misconceptions or misunderstandings;
- Ensure that the child feels in control and listened to. Give the child information appropriate to their level of development and, using tools such as some of the ones we discussed in the previous Section, explain what an HIV test involves;
- Be aware that an HIV test may raise different issues for children of different ages and from different backgrounds;
- Give honest answers and not hide information.

Pre-test counselling

Children should never be rushed into making decisions. In a pre-test session, a child might come alone, or with a caregiver or friend. As a counsellor, you should:

- Remember that if the child has come alone, family or caregiver consent may be needed before going ahead with an HIV test;
- Create a welcoming and private environment. If adults are present and the child is comfortable with this, you can go ahead. If the child is not comfortable, ask the adults to wait somewhere else;
- Explore the child's feelings about being in the session and address any fears.
- Assess the child's knowledge and understanding of HIV and AIDS and find out what else the child wants to know;
- Answer the child's questions accurately and honestly, but remember that the information you provide must be age and development appropriate;
- Explain the testing procedure accurately and explore and try to address any worries, fears and anxieties;
- Talk about who will receive the results, how they will be given and who can provide support;
- Stress the benefits and importance of coming back for the result;
- If the child does not seem ready for the test offer them a further pre-test counselling session.

Post-test counselling

In a post-test counselling session, a child should not be rushed into receiving the result, but should be gently prepared and supported to accept the outcome. One or more sessions should be offered to the child to cope with the result, especially if it is positive. As a counsellor, you should:

- Remember that if the child has come alone, family or caregiver consent may still be needed before going ahead;
- Creating a safe environment and gaining the child's trust is as important as in pre-test counselling;
- Briefly re-assess how much of the information given in the pre-test counselling the child has retained;
- Assess if the child is ready for their result. Assess any preconceptions and explore any fears;
- If the child is ready, give the result. Follow the usual good practice procedure for post-test counselling but adapt the approach to the development stage of the child;
- Whether the result is positive or negative, allow the child time to react. Be supportive and allow for tears, silences, anger and despair;
- Provide any additional information the child may ask for or need, and refer them to another source of support if needed;
- Arrange another session if necessary.

5.2. Disclosure of HIV status

Issues around disclosure

Whether it is the child or a member of the family or household that is HIV positive, counsellors need to consider the disclosure of an HIV positive status to a child very carefully. This is because it may have a number of implications depending on:

- To whom the status is disclosed – for example, the child, siblings, relatives, the school, the community;
- When the status is disclosed;
- How the status is disclosed.

Counsellors and caregivers often find it difficult to explain to children that they or someone they love is HIV positive. This can be because of:

- Traditional and cultural taboos, such as talking about sex, death and witchcraft, which prevent adults from talking openly and honestly with children;
- Strong emotional reactions that may make talking about the child or relative's status difficult;
- Not knowing what to say to the child and being afraid of being asked difficult questions;
- Adults' desire to protect children from bad news.

With support, children are usually able to cope with the realities of HIV and AIDS. Problems are more likely to when adults try to hide the truth and their emotions.

As we have seen previously, when children cannot express their emotions, they may act them out in their behaviour, for example, wetting their bed or lying; or they may have physical reactions such as having frequent headaches or stomach upset. By giving children simple and direct information, their confusion, fantasies and nightmares can be avoided. It also means that children will not discover information through rumours or jokes in the wider community.

When a child is HIV positive

- Ideally parents or caregivers should be the ones to tell children their HIV test result. The counsellor can help parents to explain things and to provide practical and emotional support.
- The time to disclose an HIV positive result to a child should be determined by the child's level of development and emotional maturity, together with the readiness of the parents or caregivers.
- The disclosure of an HIV test result to young children should be a process, which should be started as soon as the caregivers know the child's test result. The speed and the way in which they do this will depend on the individual child and the circumstances.

When a parent or sibling is HIV positive

As a counsellor, you can also facilitate this disclosure process and you will need to:

- Encourage the children to discuss their anxieties. For example, help them to express fears for both the HIV positive person and for themselves.
- Help children to establish support systems from the start so that they are in place if the parent or sibling gets sick.
- Gently explore thoughts about death. Talk openly, but in a way that is appropriate to the child's age and cultural and religious background.
- Make sure that children know how to avoid HIV infection.
- Encourage children to join their HIV positive parent/s or siblings in positive living. This helps to build a sense of cooperation and helps children to stay healthy and occupied.

Ongoing counselling support

The role of the counsellor does not stop with the disclosure of HIV status. In fact, a counsellor's work may be even more important over the next months or years.

 *Also see: MGLSD, **Integrated care for OVC – a training manual for community service providers**, Module 9 Psychosocial support, Session 9.5 Disclosure of HIV status to children, p. 122.*

5.3. Talking to children about death

Depending on their age, children go through a variety of stages in their understanding of death. It is useful for counsellors to be aware of this:

Below 5 years

Children aged less than two years cannot understand the idea of death or what has happened. Children aged three to five years may have brief, frequent and intense episodes of grief but seem unaffected in-between. They may not understand that death is final and often expect the deceased parent to come back. They may ask the same questions over and over again. They do not see that death may happen to them and they may believe it is something they can avoid. They may also have misconceptions about what causes death. Explanations about death to children of this age should be brief, simple and concrete, such as: 'when people die they do not breathe anymore' or 'when dogs die they do not bark anymore'.

From 5-10 years

At this age, children gradually develop an understanding of death as irreversible. They come to understand that all living things die and that they too will die some day. At around the age of seven, children grasp that death is unavoidable and universal. Even though they often resist the idea of death as a possibility for themselves, like younger children, they need concrete explanations, although sometimes they exhibit 'magical thinking', such as thinking that the dead can see or hear the living.

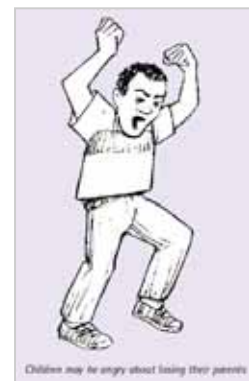
From 10 years through adolescence

After the age of ten, children come to understand the true long-term consequences of death. They begin to reflect on fairness and unfairness and fate. During adolescence, children are able to pick up inconsistencies in the information they receive. Teenagers may also become interested in looking for the meaning of life. If children in this stage experience death within the family, they tend to be able to understand the explanations about the facts surrounding the death.

How do children react to parental death?

Common reactions include:

- Fear, confusion and insecurity (for example, clinging, fear of going to sleep, nightmares, bed-wetting)
- Sadness, depression and withdrawal
- Anger, aggression and tantrums
- Guilt (for example, thinking that the death is their fault)
- Bargaining and denial (for example, "If I am good, my mother will come back")
- Regression (for example, talking like a baby or wanting to be fed instead of feeding themselves)
- Physical symptoms (for example, feeling sick)



Reactions depend on a child's age:

- Children aged less than six months old cling, cry and may reject comfort from others;
- Children aged six months to three years show grief physically, through eating and sleeping problems, regression (for example, not walking or talking as well as they did), comfort habits such as thumb-sucking, crying and clinging behaviour. They may also be very sad and quiet;
- Children aged over three years show grief through feelings (for example, guilt, fear) and behaviour (for example, aggression, being naughty) as well as physically.

Talk to children about illness and death in the family

As we have seen, it is important to talk to children about illness in the family. Children may worry that a sick parent is going to die because other adults in their community have died from the same illness. If an adult is taking antiretroviral medicines they should get better, and it is important to help children deal with their fears and to reassure them that their parent will be well again. It has been shown that children can play an important role in reminding parents to take their medicines. If an adult is very sick and likely to die, it is important to prepare children for the death.

Encourage parents who are very sick and may die to explain what is happening to their children. Explain why it is important to prepare children in advance and to answer their questions. Prepare children before they visit a sick or dying parent in hospital, as this can be upsetting.

Memory boxes or books help parents to discuss death with children and to collect information about the family and childhood memories. Parents can write their favourite memories of a child, the family tree and relatives, family traditions and special events, a letter describing their hopes and special feelings for the child, and include items such as a child's drawing and family photographs. Compiling a memory book or box with a child enables the child to ask about their past and plans for their future. These tools are especially valuable for children whose parents die when they are very young, providing insights into parents they do not remember and giving them a sense of identity.

Why prepare children for the death of a parent?

- Talking to children in advance gives them time to get used to the idea and helps them cope better with death and grieving.
- Children like to have the opportunity to ask parents how to do things and to be given last words of advice.
- Having a chance to say goodbye is very important. Exchanging wishes and blessing can stop children from blaming themselves for the death of a parent.

Plan for the future

Preparing for death should include planning for children, as children often worry about what will happen to them after a parent dies. Support parents to make a memory book or box with their children. Encourage parents to think about who will care for children after they die and to involve children in choosing their future guardian. Help parents to write a will so that children do not lose their inheritance. Advise parents to make sure that they have important documents that children will

need, such as birth registration, as well as a will and legal papers about guardianship.

Help children who are grieving


Families / caregivers need information about how grief affects children and what they can do to support them. They need to be aware that children, like adults, are affected by illness and death and that they too experience anxiety, stress and grief. Parental illness and death can cause long-term emotional and behavioural problems if children do not receive help.

Practical tips you can give families / caregivers include:

- Acknowledge the death and explain that adults in the family are also sad. Explain that the death was because of illness and reassure the child that they were not responsible.
- Maintain as normal a routine as possible, as this helps children feel more secure. Try not to send the child away to a new environment. Make sure that the child feels safe and loved, and give them consistent care, physical affection and attention.
- Include children in family rituals, as this helps them to feel they are not alone in their grief, but do not force children to attend funerals if they do not want to or might find the experience frightening.
- Children could be helped to hold their own ceremony for a parent or sibling who has died or to plant a tree or garden in memory of the person.
- Accept children's reactions and behaviour. Try to be patient and do not be angry if a child is naughty, has tantrums, wets the bed or starts behaving like a baby.
- Comfort children when they go to sleep and if they wake up in the night.
- Let the child express their feelings. Talk to them about their loss and the person who has died. Help the child to remember the parent and to talk about happy memories. Answer any questions the child has about the deceased parent.

👉 See also: *MGLSD, Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda (2009), Module 5 Topic 5 – Psychosocial helping skills (includes bereavement), p.315.*

5.4. Case studies and suggestions for helping children showing specific reactions



My name is Opio. I am 6 years old. My mother died last year and now I live with the neighbours. Sometimes I have dreams that the house is on fire. The dreams make me sad and frightened.

Why do you think Opio might be having nightmares?

- He may have seen a fire or heard adults talking about the danger of fires.
- The fire may be symbolic of Opio's fear of losing all his belongings, including his security, warmth and shelter.
- Some children have recurrent nightmares and this might be a sign of a deeper issue perhaps related to the death of his mother.
- Some children have night terrors where they don't wake up but may call out in their sleep. If the child does wake they usually have no recollection of the event and fall asleep again easily.

What can you suggest his caregivers do to help him?

- Encourage them to comfort and reassure him in the night.
- If he is awake they should help him see his surroundings are familiar and safe.
- When he is ready they should ask him to describe the dream.
- Encourage them to talk to him about why he thinks he has this dream and if there are things that he think would help him stop the nightmares.
- Suggest that during a night terror, they should sit next to Opio and watch – not him wake up. If he does wake up, they should help him to relax, make him comfortable again and let him fall asleep again immediately.
- Encourage caregivers to make sure Opio has his own place to sleep even if shared with sibling.
- Encourage them to ensure Opio is getting a healthy amount of regular sleep.

What can you do as a counsellor?

- Using different tools talking, drawing, stories, try to find out what scares Opio in his dreams and ask him what scares him when he is awake.
- Talk to him about the things that he finds frightening. Ask him to draw you pictures about these frightening events. By talking about them, or putting them down on paper during the day, Opio will begin facing the fears. Ensure before you do this that you know where you can get extra support for Opio if he should need eg. Professional counselling
- Help him identify strategies he uses for other situations that might help- talking to friends, reading something 'nice' before bed, thinking positively, writing things down.



My name is Dembe. I am seven years old. My father passed away and my mother works in the town, I hardly ever see her. I live with my brothers and sisters in my grandmother's house with seven other cousins. Sometimes I wake up in the night and I have urinated in the bed. I am ashamed to tell my grandmother. My cousins and brothers laugh at me and call me "baby". They told people at school and now everybody laughs. I don't like going to school. I miss my mother and I wish my father could come back.

Why do you think Dembe is wetting the bed?

- Bed-wetting can be a serious problem for many children. It is often to do with emotional reasons like fear and insecurity.
- Bed-wetting can occur when there are changes in the family, like the death of a parent, a parent moving away from the home, a divorce or the unexpected birth of a baby.
- For some children, it can be a physical problem and this should be checked as well.

What can you suggest to Dembe caregivers do to help her?

- Ask them not to scold, blame or punish Dembe. He doesn't wet his bed on purpose. Suggest that they make sure he has clean sheets and clean clothes so that he doesn't smell of urine when he goes to school.
- When Dembe wakes up during the night, they should comfort him calmly and change his linen. It would be best for Dembe to sleep in his own bed or on his own mattress so that he doesn't wet other children.
- His caregivers could have a quiet time with him before he falls asleep and chat about the good things that happened during the day. Bedtime routines always help children and adults to relax and prepare for sleep.
- Suggest that the caregivers help the other children to be more supportive and not to laugh at Dembe
- After a night when Dembe did not wet his bed, he should be praised and it should be acknowledged that his bed is dry.
- Suggest that they help Dembe draw up a calendar to monitor the dry and wet nights. In the beginning they could reward Dembe after he has one dry night in a week. After he manages one dry night in a week, they can gradually increase the number of nights

What can you do as the counsellor?

- When you talk to Dembe try to find out what is upsetting him. Ask him why he thinks he is wetting the bed.
- Tell him there are many children with the same problem and tell him you will try to help him solve the problem. Tell him that you know that he does not wet the bed deliberately.
- If Dembe decides to tell you about things that scare him, listen carefully and encourage him.
- Tell him how well he is doing despite his problems. Make a point of noticing his skills and give him positive feedback as often as possible. Focus on encouragement and positive assurance to build up his self-image and self-confidence.
- Talk to him about the name calling at school and at home and ask him to think about why people say things. Think about ways to cope with it and also how he might start by talking to his brothers to get them to be more understanding and supportive.



Akelo is four years old. Her mother, my daughter, died two months ago. Akelo has never met her father. Akelo and her siblings are living with me. Each time Akelo is separated from me she starts to cry and scream. Akelo does not play with other children but tries to stay near me all the time. At night she sleeps in my bed. Akelo is very anxious and she cries easily. When other people come to the house, Akelo clings to her me and is always very frightened.

Why do you think Akelo finds it so difficult to be separated from her grandmother?

- Perhaps Akelo clings to her grandmother because she fears that her grandmother will leave her, like her mother “left” her.
- Perhaps she has no experience that separation can be temporary.
- Perhaps she is not comfortable with the people she is left with.

What can you suggest to Akelo’s caregivers do to help her?

- Try to find out why Akelo does not want the grandmother to leave. Is there anyone else with whom Akelo likes to stay? Are there certain people with whom Akelo does not want to stay?
- Suggest to Akelo’s grandmother that she reassures Akelo and allows her to be close. Suggest that she take only short periods away from Akelo to begin with and she explains clearly when she will be back. ‘ I will be back after your sleep’ ‘ I am going to the market and will be back in 1 hour’
- Encourage her to gradually increase the time away and build Akelo’s trust in her grandmother returning and trust in the people she is left with. This will help her understand that separation can be temporary. Ensure they praise her on return
- If there is enough space, Akelo should sleep in her own bed or on her own mattress. She could be told that she is big enough to sleep in her own bed. The bed could be made next to the grandmother and she could be allowed to sleep with a favourite toy (or something else that gives her comfort). She should be praised her for her independence every time she sleeps in her own bed.

What can you do as the counsellor?

- Use drawings to talk with Akelo about her feelings. Help her draw people in the family she likes to be with and ask why.
- Try playing **games** with Akelo. Hide and seek can help her understand objects and people can disappear and return again.
- **Hide-and-peek with an object**
Play hide-and-peek with Akelo, using an object. There are two ways of doing this. Either you can hide the object (like a handkerchief or a spoon) and let Akelo look for it while you help her by saying, “Look far away, even further,” or “You’re close, very close! “, or you let Akelo hide the object and you must look for it. Make Akelo give you directions while you search for the object. This teaches her that although something can’t be seen, it still exists.
- **Ordinary hide-and-peek**
Teach Akelo how to play ordinary hide-and-peek. Tell her to hide while you close your eyes and count to ten. Then go and look for her. Then swap over: while Akelo closes her eyes you must hide, but let yourself be found by Akelo! Make sure the area in which you play is safe so that Akelo can’t hurt herself. Agree that some places are not good hiding places, like fridges and cars. Agree on these before you start playing.

5.5. Ideas for working with older children on grief or trauma

MEMORY OR COMMUNICATION BOOKS

Older children and adolescents may not want to draw. Writing stories down on paper is another way of structuring memories and feelings. The memory book is a tool that is suitable for working with individual or groups of children. Give each child an exercise book and a pen that may only be used for the communication book. The child may decorate the exercise book to make it special.

Encourage the child to write about events that have taken place in his or her life. Tell the children that these books are their personal property and that no one may read the book except the children themselves. There is only one exception to this rule: if a child feels that he or she wants to share his or her story with you, you will read the story the child has written and you will write a comment in the book. This book then becomes part of a dialogue.



It is up to the child to decide whether or not to agree to this. Never force a child to let you read his or her thoughts. Tell them that spelling mistakes and bad handwriting don't matter either!

Communication books can be developed into diaries. Adolescents normally find it difficult to relate to a person, who is not one of their peers, but adolescents who head households have little time to socialise with their friends and so this is an opportunity to express their thoughts and feelings. Most children like to take a few minutes once a day to think about themselves and to write their thoughts down on paper. Putting thoughts and feelings down on paper promotes creative writing skills and encourages self-control, self-knowledge and problem-solving skills.

HERO BOOKS

The Southern and Eastern Africa Regional Psychosocial Support Initiative (REPSSI) has developed a methodology for working with children called Hero Books. You can access their: ***Making a Hero Book: A guide for facilitators*** at: www.repssi.org



Photograph caption:

A child stands in a cluster of huts in Agweng Internally Displaced People (IDP) camp in northern Uganda's conflict-affected Lira District. Children in IDP camps often come from unstable environments where there is armed conflict and require psychological support.

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SECTION 6 –THE SUPPORT NEEDS OF THE COUNSELLOR

Summary – This section looks at some the challenges a counsellor can face when children show extreme reactions. It then moves on to consider the support needs of the counsellor and some of the strategies that can help to avoid stress and burnout.

Key topics

6.1. Challenges in counselling children

6.2. Why counsellors need support

6.3. How counsellors can get support

6.1. Challenges in counselling children

There are many challenges you will face when counselling children. Some of these will be unique to a particular child; others are more common. Sometimes children do not respond to counselling and it is important to recognise one's own limits as a counsellor.

Some severe problems and extreme reactions which may need additional support when they do not respond to the counselling you are providing, are outlined here:

Complicated grief

Complicated grief refers to grief and mourning reactions that cannot be expressed, even when you have worked with a child. Although the child may accept that the parent has died, they may not be able to experience the pain and the emotional response to the death – almost as if his or her feelings have been frozen. This is known as “prolonged emotional numbing” because the whole grieving process freezes and the child is unable to experience any feelings at all.

Severe depression

A child suffering from severe depression feels sad all the time and cries a lot. The child may refuse to eat and lose a lot of weight. The child feels tired all day long, wants to stay in bed all day but finds it difficult to sleep at night. The child seems to withdraw from all activities, may talk a lot about wanting to die and has suicidal thoughts. The child says over and over again that he or she wants to be where the deceased parent is. The child may show self-destructive and auto-aggressive behaviour like cutting himself or herself, pulling out his or her own hair, deliberately causing hurt to his or her own body, destroying objects that were formerly precious to him or her.

Severe and persistent feelings of anxiety

A child may feel fear and anxiety all the time so that he or she cannot carry on with a normal life. Children affected by this withdraw from others can become isolated. With some children, the fear becomes so irrational (lacking in reason) and so great that it leads to irrational anxiety and recurring panic attacks that do not respond to your counselling.

Delinquent or anti-social behaviour

- Behaving sexually “promiscuously” or engaging in prostitution / transactional sex. Remember that for some children this is the only way that they can earn some money.
- Missing a lot of school.
- Engaging in risk-taking behaviour and impulsive behaviour
- Breaking into houses and stealing.
- Staying out all night, or staying away from home for several days in a row.
- Showing signs of substance abuse – this could be alcohol, drugs or glue sniffing. Signs of substance abuse include restlessness, being unable to sleep and slurred speech.

6.2. Why do counsellors need support?

Counselling vulnerable children can be very emotionally draining. This can lead to stress and burnout. Counsellors need to be aware of their own responses to stress and trauma and be clear about their personal limits. They need to develop individual coping mechanisms as well as identify where they can get support. It is important for counsellors to have a support network. Having other counsellors to share experiences, challenges and strategies with is a vital part of this. It is also helpful for the organisations that counsellors work with, to have procedures in place to guide their staff and volunteers as to when and where they should refer children showing extreme reactions.

Signs of stress and burnout

Psychological	Behavioural	Physical	Relationships
Anger	Irritability*	Nausea	Lack of interest
Hopelessness	Reduced activity*	Heartpalpitations	Argumentative
Feeling helpless	Alcoholism	Headache	Rough play
Worry	Sleep problems*	Difficulty breathing	Uncooperative
Loneliness	Inability to complete task	vague body pains	No teamwork *
Frustration*	Lack of concentration*	Exhaustion/fatigue*	Jealousy
Inability to decide	Over-activity	Dysmenorrhoea	Loss of sensitivity in dealing with clients
Confusion*	Impulsive behaviour	Impotence	Feeling of inadequacy*
Forgetfulness*	Intense cynicism*	Gastrointestinal problems*	Tearfulness*
Absenteeism	Loss of appetite	Loss of self-esteem*	
Loss of interest	Neglect of duties*	Commitment to work*	

☞ See: MGLSD, *Holistic Approach to Psychosocial Support: A National Training Manual for Caregivers of Orphans and other Vulnerable Children in Uganda* (2009), Module 4 Topic 5 - Care for Caregivers.

Causes of stress and burn out

Causes related to organisational factors include:

- Too many children to support – never-ending workload
- Lack of training and orientation
- Inadequate leadership and supervision
- Lack of social support
- High staff turnover rates

Causes of burn out particularly associated with HIV/AIDS related counselling include:

- Stigma associated with working with HIV positive children or families
- Over-involvement with children and their families
- Personal identification with the suffering of children and families living with and affected by HIV/AIDS
- Unmet needs of children
- Lack of recognition and appreciation for their work
- Inadequate training skills and preparation for the work

6.3. How can counsellors get support?

Professional strategies

Counsellors need to:

- Have a connection with other counsellors so they can share professional issues with colleagues and supervisors
- Set and maintain clear boundaries
- Build a network of professional connections
- Develop a balance of professional skills
- Work within a supportive organisational environment

Organisational strategies

- Counsellors should have adequate training and supportive supervision
- Organisations should provide resources for the comfort of its staff and volunteers e.g. incentives, leave time, continuing training, opportunities for discussing work-related problems
- Encourage mutual support groups
- Provide periodic burn out check-ups for staff and volunteer counsellors

Personal Strategies

One of the most important strategies for a counsellor to deal with work related stress is to have personal interests and to find time to:

- Enjoy life with family and friends
- Self care
- Stress management exercises can be helpful
- Connect with community, friends, etc
- Spend time on supportive relationships outside of work
- Set clear boundaries between home and work.

SECTION 7 – RESOURCES, REFERENCE MATERIALS AND ORGANISATIONS THAT CAN HELP THE COUNSELLOR

7.1. Government of Uganda resources and reference materials

Government of Uganda; Poverty Eradication Action Plan (PEAP) 2004/5–2007/8

Government of Uganda; The Children’s Act, (Cap 59) 2000

Government of Uganda; The National Equal Opportunities Policy (2006)

Government of Uganda; The Policy on the Universal Primary Education (2002)

Ministry of Gender, Labour and Social Development; A guide for interpreting and applying national quality standards for the protection, care and support of orphans and other vulnerable children in Uganda (2007)

Ministry of Gender, Labour and Social Development; A training guide for implementing orphans and other vulnerable children (OVC) quality standards (2009)

Ministry of Gender, Labour and Social Development; Basic counselling and guidance for orphans and other vulnerable children: A reference guide for service providers (2009)

Ministry of Gender, Labour and Social Development; Guidelines for coordination of the response to orphans and other vulnerable children in Uganda (2009)

Ministry of Gender, Labour and Social Development; Guidelines for conducting training of trainers programme (2009)

Ministry of Health; The Healthcare Policy (1996)

Ministry of Gender, Labour and Social Development; Human Resource Development Planning Guide (2008)

Ministry of Gender, Labour and Social Development; Integrated care for OVC: A toolkit for community service providers (2006)

Ministry of Gender, Labour and Social Development; Key steps in development and usage of technical resource materials (2008)

Ministry of Gender, Labour and Social Development; National Child Labour Policy

Ministry of Gender, Labour and Social Development; National orphans and other vulnerable children policy (2004)

Ministry of Gender, Labour and Social Development; National strategic programme plan of interventions for orphans and other vulnerable children (2004)

Ministry of Gender, Labour and Social Development; Orphans and other vulnerable children (OVC) civil society organisations capacity analysis tool: assessing capacities for quality OVC response (2009)

Ministry of Gender, Labour and Social Development; Orphans and other vulnerable children (OVC) service level standards in Uganda (2009)

Ministry of Gender, Labour and Social Development; Orphans and other vulnerable children (OVC) Technical Support Organisations capacity assessment tool (2009)

Ministry of Gender, Labour and Social Development; Poster National Quality Standards for the Protection, Care and Support of Orphans and other Vulnerable Children in Uganda (2007)

Ministry of Gender, Labour and Social Development; Social Development Sector Strategic Investment Plan (SDIP) 2003/4–2007/8

Ministry of Gender, Labour and Social Development; Support Supervision guide for orphans and other vulnerable children service delivery (2009)

Ministry of Gender, Labour and Social Development website: for other useful references and information; <http://www.mglsd.go.ug/ovc/default.htm>

UNICEF, Implementation handbook for the CRC (2002)

University of Makerere Institute of Psychology, Makerere Institute of Social Research, Ashinaga, *Lessons learned from the MGLSD / CORE Initiative research on Psychosocial Support and Economic Strengthening Interventions*, December 2008

7.2. Toolkits and manuals

Ministry of Gender, Labour and Social Development, *Integrated care for OVC - A toolkit for community service providers*, 2006

Ministry of Gender, Labour and Social Development, *Integrated care for OVC - A training manual for community service providers*, 2005

Ministry of Gender, Labour and Social Development, *A Holistic Approach to Psychosocial Support: A National Training Manual for Care Givers of Orphans and other Vulnerable Children in Uganda*, 2009

Ministry of Gender, Labour and Social Development, *Move Together Now! Community and youth mobilisation for the Sexual and Reproductive Health of Young People in Uganda*, 2008

Catholic AIDS Action, Sr Silke-Andrea Mallmann CPS, *Building Resilience in Children Affected by HIV/AIDS*, Namibia, 2004, <http://www.fhi.org/en/HIVAIDS/pub/guide/caacounseling.htm>

Clare Hanbury, *Life Skills: An active learning handbook for working with street children*, VVSO, 2002

International HIV/AIDS Alliance, *Understanding and challenging HIV stigma Toolkit for action - Module I - Stigma and children*, 2007

International HIV/AIDS Alliance, *Understanding and challenging HIV stigma Toolkit for action – Module J – Young people and stigma*, 2007

International HIV/AIDS Alliance, *Building Blocks: Africa-wide briefing notes - Psychosocial support*, 2003

International HIV/AIDS Alliance, *Building Blocks: Africa-wide briefing notes - Young children and HIV*, 2006

International HIV/AIDS Alliance, *A parrot on your shoulder – A guide for people starting to work with orphans and vulnerable children*, 2005. This toolkit is available free of charge from the International HIV/AIDS Alliance and can be ordered from:

International HIV/AIDS Alliance, *The health journey: A community-centred methodology*, 2007

International HIV/AIDS Alliance, *Sexuality and life-skills: Participatory activities on sexual and reproductive health with young people*, 2008

International HIV/AIDS Alliance, *Let's talk about HIV counselling and testing – tools to build NGO/CBO capacity to mobilise communities for HIV counselling and testing*, 2006

Southern African AIDS Trust (SAT), HIV Counselling Series No. 1, *Counselling Guidelines on Disclosure of HIV Status*, 2004

Southern African AIDS Trust (SAT), HIV Counselling Series No. 2, *Counselling Guidelines on Child Sexual Abuse*, 2004

Southern African AIDS Trust (SAT), HIV Counselling Series No. 3, *Counselling Guidelines on Palliative Care and Bereavement*, 2004

Southern African AIDS Trust (SAT), HIV Counselling Series No. 5, *Counselling Guidelines on Survival Skills*, 2003

Southern African AIDS Trust (SAT), HIV Counselling Series No. 6, *Basic AIDS Counselling Guidelines*, 2004

Southern African AIDS Trust (SAT), HIV Counselling Series No. 7, *Guidelines for counselling children who are infected with HIV or affected by HIV and AIDS*, 2004

SWAA, *HIV/AIDS psychosocial counselling manual for women and children in conflict and difficult situations*, 2006

African Regional Psychosocial Support Initiative (REPSSI), *Journey of Life: A community workshop to support children*, 2004

SAFAIDS, WHO, IFRCRC, *HIV prevention, treatment, care and support – Training Package for community volunteers, Module 5, Community-based counselling, Session 4: Counselling children*, 2007

IPPF, *Programme guidance on counselling for STI/HIV prevention in sexual and reproductive health settings*, 2002

FHI, *Interpersonal communication and counselling manual on HIV and AIDS*, 2002

7.3. Websites

There are many useful practical and theoretical resources about psychosocial support, counselling and OVC that are available free of charge and can be downloaded from the internet using the following websites:

www.repssi.org

www.ovcsupport.net

www.unicef.org

www.aidsalliance.org

http://www.satregional.org/html/publications_en.html

7.4. Organisations in Uganda

- Ugandan Society for Disabled Children (USDC) - Plot 1 Kanjokya Street, PO Box 16346, Kampala, Uganda, Tel: + 256 041 530 864, Fax: + 256 401 532 589, Email: usdc@ugasoc.org, Website: www.usdc.or.ug
- Uganda Child Rights NGO Network, PO Box 10293, Kampala , Uganda , Tel: 00 256 41 543 548 , Fax: 00 256 41 543 548 , Email: ucrn@utlonline.co.ug, Website: www.kampala-city-guide.com/ngo/ucrn
- African Network for the Prevention and Protection Against Child Abuse and Neglect - Jinja District (ANPPCAN - Jinja), PO Box 1962, Jinja, Uganda , Tel: +256 077 640 013

ANNEX 1 – SAMPLE RECORD KEEPING FORMATS

CLIENT'S CARD

Date:

Name:

Age:

Sex:

Clients number:

Status: Not orphan Single Orphan
Double orphan

Surviving parent: Mother Father

Name of care giver:

Relationship with caregiver:

Address:

.....

FILE COVER

Client's Code
.....
.....

Date opened
.....
.....

Date Closed
.....
.....

Name of Counsellor
.....

Signature
.....
.....

OPENING FILE SHEET

Initial Assessment Form

Client's code:

Background Information:.....
.....

Initial Assessment/observation
.....
.....

Counselling goal:
.....
.....

Media:.....

Conclusion

.....

Signed:.....

SUBSEQUENT SESSION SHEET

Session: (e.g., 1, 2, 3, etc.):

Client's code:
.....

Date:
.....

Emerging issues:
.....
.....

Session goal:
.....
.....

Media:
.....
.....

ANNEX 2 - CONCEPTS AND DEFINITIONS

Absolute Poverty: The state in which a person is living at a subsistence level that is below the minimum requirements for physical well-being, usually based on a quantitative proxy indicator such as income or calorie intake, but sometimes taking into account a broader package of goods and services

Advocacy: The process of persuading influential or powerful people to make changes in policies, laws and practices. Advocacy can be used to change existing policies and laws and to make new ones. It can also be used to make sure policies really are put into practice.

Aim: The broad, long-term goal set for a piece of work or project.

Assessment: The process of identifying and understanding issues or problems.

Building Blocks (BB): The four main themes of the National Strategic Programme Plan of Interventions around which major initiatives for orphans and other vulnerable children are structured and that will serve as an advocacy tool for the NSPPI.

Capacity-building: The process of enabling people, groups or organisations to build their knowledge, skills and resources in order to undertake activities more effectively.

Caregiver: The individual, usually the mother, who takes primary responsibility for the physical, mental and emotional needs and well-being of a child.

Child: A person who is below the age of 18 years.

Child abuse: Refers to all forms of mistreatment or neglect of children that deprives them of their conventional rights; the following categories of abuse will be considered: • Neglect; • Sexual; • Physical hurting; • Psychological (emotional, verbal abuse, constant insulting); and • Spiritual

Child neglect: The failure to provide for the child's basic needs; neglect can be physical, educational or emotional.

Child-headed household: This is a household in which the oldest person living there, the authority figure in the house, is below the age of eighteen. This usually means that the adults of the household have died, leaving orphans to look after themselves.

Child soldier: Any person under 18 years of age who is part of any kind of regular or irregular armed force or armed group in any capacity other than purely as a family member. It does not only refer to those carrying arms, but includes cooks, porters, messengers and those accompanying such groups, including girls recruited as concubines or those forced into marriage.

Children affected by natural disasters: These children are those who suffer great hardships because of unusual natural events. These may include floods, earthquakes or famines caused by lack of rain.

Children in hard to reach areas: These are children who live in remote, physically inaccessible places or who belong to nomadic, pastoral communities.

Children who abuse drugs: Children who have introduced to addictive substances such as alcohol, tobacco and stronger, illegal drugs. Dependency or addiction to drugs is often thought of as an urban, city problem and is a potential threat to street children.

Community: A group of people, usually living in an identifiable geographical area, who share a common culture, and are arranged in a social structure that allows them to exhibit some awareness of a common identity as a group.

Community mobilisation: This is a capacity-building process through which individuals, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

Comprehensive OVC package: Refers to having various players offering services in a coordinated, unified and linked manner with referrals.

Core Programme Areas (CPAs): These are the ten programme areas that have been identified during the NOP and NSPPI articulation process as being essential to the well being of orphans and other vulnerable children. They include socio-economic security, food security and nutrition, care and support, mitigation of the impact of conflict, education, psychosocial support, health, child protection, legal support, and capacity strengthening.

Counselling: Counselling is a process which helps people (both adults and children) to help themselves, recognise their strengths, and identify the resources available to help them overcome problems and make healthy decisions. It is a process that involves someone listening to a person's problems and building the person's resilience and coping skills.

Defilement: Defilement may be defined as sexual intercourse with a person considered legally below the age of consent.

Duty-bearers: Individuals or institutions that have the responsibility for the progressive realisation of specific rights. Duty-bearers acquire duties through designation, position or election. They will include the family, the community and national as well as local government.

Disability: Substantial functional limitation of daily life activities of an individual caused by physical, sensory or mental impairment and environmental barriers.

Discrimination: These are acts of treating individuals or groups differently in relation to services, privileges rights and benefits.

Empowerment: This is the process by which an individual acquires the knowledge, skills and capacity to improve the quality of their lives for their own benefit, their families, communities and nation.

Epidemic: A localized outbreak of a disease within a population that is limited in location, magnitude and duration.

Essential Services Package: These are the priority interventions that will provide a supportive environment for orphans and other vulnerable children to live to their full potential. The priority areas of focus include socio-economic security, food security and nutrition, care and support, mitigating the impact of conflict, education, psychosocial support, health, child protection, legal support and capacity enhancement.

Extended family: A collection of a number of individuals, families or households who are related biologically, often with social ties and responsibilities towards one another that lead to the provision of material support and other services for those members of the family in need.

Family: A group consisting of one or more parents and their offspring that provides a setting for social and economic interaction, the transmission of values, protection and affection.

Fostering: The act of taking on the responsibility of a child whose parents cannot do so for one reason or another.

Gender: Refers to the social relationship between women and men as opposed to biological sex differences.

Gender equality: Equal opportunity and equal enjoyment by women and men, girls and boys, of rights, resources and rewards.

Gender equity: Means fairness and justice in the distribution of benefits and responsibilities between males and females.

Gender roles: This refers to the culturally constructed activities carried out by women and men and the way in which these may complement or conflict with each other.

Gender sensitivity: refers to the ability to recognize issues related to the relationship between males and females, and especially the ability to recognize differences in perceptions and interests between males and females arising from their different social position and different gender roles.

Guardian: Any person caring for a non-biological child whose parents cannot do so for one reason or the other.

Household: A group of people who normally live and eat together in one spatial unit and share domestic functions and activities.

Human Rights: These are inalienable entitlements that are agreed upon through consensus that they can be claimed by anyone based on their needs and aspirations.

Impoverished: The state of being deprived of the opportunities and choices that are essential to the enjoyment of a healthy and fulfilling life.

Indicators: Objective ways of measuring (indicating) that progress is being achieved. Activity indicators will tell us that we are doing the activities that we planned. Change indicators will tell us that we are making progress towards our objectives and having an impact on HIV/AIDS issues.

Intervention: Intervention is used in this context as a general term to describe all programmes, projects and activities that are started or carried out by any person, group or organisation for the benefit of orphans and other vulnerable children.

Mainstreaming: The effective integration of crosscutting policy themes such as gender, rights, environment, HIV/AIDS in a manner that ensures they are integral to all development decisions and interventions.

Marginalised: This is a term used to refer to persons in society who are deprived of opportunities for living a respectable and reasonable life that is regarded as normal by the community to which they belong.

Maternal orphan: A child below the age of 18 years who has lost their mother.

Monitoring and evaluation: **Monitoring** means “watching” and here is used to mean “collecting information” about activities and projects and also about the strategy as a whole. **Evaluation** means measuring the success or failure of activities or projects. The evaluation usually follows the monitoring, and uses the information which was gathered during the monitoring process.

Multi-sectoral approach: The process of involving and bringing together all essential service providers including government, private sector, development partners, and civil society organisations such as international and national NGOs, faith-based organisations, religious institutions, cultural leaders and community-based organisations, in order to plan on and maximize how a population is best served and provided with a comprehensive set of services.

Objectives: Statements about the specific, measurable, time-bound goals a project hopes to achieve by the end of its life. A project achieves its aim by meeting its objectives.

Orphan: A child below the age of 18 years who has lost one or both parents.

Pandemic: A wide spread outbreak of a disease within a population that is extensive in location, magnitude and duration.

Paternal orphan: A child below the age of 18 years who has lost their father.

Peer education: A process by which community members are trained to promote learning and facilitate discussion with their peers on particular issues.

Psychosocial Support:

'Psycho' refers to the unseen emotional and spiritual process that takes place in a person's mind.

'Social' refers to the relationship between an individual and those that live around him/her.

'Support' is to keep something from falling, sinking, or slipping; to help it bear a weight and maintain. Similarly supporting a family or a child is to help them bear and withstand their circumstances, to prevent them from collapsing under pressure or the weight of their situation.

'Psychosocial support' (PSS) is thus the total help given to an individual which takes into account the psychological (or unseen aspects) of a person and his or her social life. It gives the child skills to cope with stress of difficult situations. The caregiver is also equipped with skills to provide better care to OVC.

Poor or needy: people whose lives are characterised by such constraints as illiteracy, disease, powerlessness and inability to meet the basic necessities of life.

Poverty: The inability of an individual, family or community to attain a minimum standard of living. This is evidenced by the lack of basic needs and services such as food, clothing, bedding, shelter, paraffin, basic health care, roads, markets, education, information and communication.

Quality standards: Standards, which, if attained, meet the needs of OVC and enable them to realise their rights.

Rights: See human rights.

Responsibility: The social force that binds one's obligations that result in a specific and individualized course of action.

Stigmatisation : This is wide spread behaviour of societal attitude that renders a person or a group of people feel worthless or helpless as a result of an ailment, disability or inferior social status.

Social inclusion: This is the act of ensuring that concerns of the vulnerable and those at risk are taken care of in development policies and programmes.

Social protection: formal and informal initiatives that provide assistance to the extremely poor individuals and households; services to groups who need special attention or would otherwise be denied access to basic services; insurance to protect against risks and consequences of livelihood shocks; and equity to protect people against risks such as discrimination and/or abuse.

Stakeholder: A person, group or organisation with an interest (a stake) in a project or initiative. A primary stakeholder is a person or an organisation who the community mobilisation process primarily aims to benefit (e.g. a young person in a youth prevention process). A secondary stakeholder is a person who may not benefit directly but will be affected or involved in some way (e.g. a teacher in a youth prevention process).

Strategy: A long-term plan of action designed to achieve a particular goal.

Values: A set of ideals that are normatively shared by members of a community and are shaped by several influences including ideology, religion, culture, history and political systems.

Vulnerability: A state of being or likely to be 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.

Vulnerable Child: A child who, based on a set of criteria when compared to other children, bears a substantive risk of suffering significant physical, emotional or mental harm, including:

- Street children;
- Unsupervised children and child labour;
- Children in child-headed households;
- Children in alternative/residential care;
- Children with HIV/AIDS;
- Children with multiple/severe disabilities;
- Children in conflict areas;
- Children of chronically ill caregivers;
- Children in household headed by a very old caregiver (60+); and
- Children in single, widowed, female-headed households

Yellow Ribbon: A symbol that has been selected for purposes of advocacy for the improvement of the lives of orphans and other vulnerable children.

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