HUMULIZA / terre des hommes switzerland

MANUAL

PSYCHO-SOCIAL SUPPORT

OF

ORPHANS

BASEL / NSHAMBA 1999

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1. Introduction

Psycho-social support for orphans – Why? To what end?

Andrea Ledward wrote in her study about Zimbabwe: "For many African peoples, illness and death are parts of the fabric of life; crises which are dealt with by existing coping mechanisms. Past experience allows adaptation to take place, and rehearsed responses strategies to be used. The AIDS pandemic, however, is different. There are usually no rehearsed coping responses, and limited experience of a disease with such widespread, rapid and cumulative effects. The HIV/AIDS pandemic creates a situation of growing uncertainty and instability at global, family and individual levels." (Andrea Ledward: Age, gender and sexual coercion: their role in creating pathways of vulnerability to HIV infection", London 1997, p. 11).

Representing a different crisis, our aim is to contribute to the discussion of and the search for new coping mechanisms needed in such a situation. Our focus goes on children and the way how the Tanzanian society is looking to them.

1.1. Facts and Figures

The news reaching us from UNAIDS and from other international and national organisations dealing with AIDS, are frightening:

- Following Dr. Peter Piot, head of the AIDS programme of the United Nations, 34 million of all the people who are infected with HIV/AIDS live in sub-Saharan Africa (Herald Tribune, July 19,1999)
- During the year 1998 only, at least 4 million Africans got infected by HIV/AIDS
- In the countries of Botswana, Namibia, Zambia and Zimbabwe, already between 20 and 26% of the population between 15 and 49 years is infected, in 12 countries (among them Tanzania) the corresponding rate is between 9 and 20%.
- In all these countries, AIDS is today the most frequent cause for death, even more frequent than malaria. In 1998,

HIV/AIDS accounted for 1.8 million deaths in sub-Saharan Africa, nearly double the 1 million deaths from malaria and about nine times the 209'000 death from tuberculosis, according UNAIDS. Since 1981, HIV/AIDS killed 11.5 million, leaving about 6 million of orphans behind.

- In some areas of Zimbabwe or Zambia, already 20% of girls and young women at the age of 15-20 years are infected by HIV/AIDS.
- World-wide in every minute five adolescents are infected with HIV/AIDS (following UNAIDS)
- The medium life expectancy is supposed to drop around 17 years if the actual tendency is proceeding.
- In 1995, the number of orphans in Tanzania was estimated between 260'000 and 360'000, for the year 2000 there will be between 490'000 and 680'000 orphans. In the prospective study "Children on the brink" it is estimated that in the year 2010 - which is quite near - Tanzania will account for a number of around 4.2 million orphans which corresponds to 27% of all children under age 15.
For Zimbabwe the correspondent figures are 1.5 million (= 35% under age 15 years), for Uganda 3.5 Million (28%), for Malawi 2.6 million (35%) and for South Africa 2.6 million (17%).

1.2. The various effects of the HIV/AIDS epidemic: economical, social and psychological

It is obvious that this pandemic will affect the society as the whole and in different aspects.

There are **economic** effects: the people die in their most productive age; savings are used for medicaments, treatments, and ceremonies; trained people (teachers, doctors, nurses, economists, agricultural staff, mechanics, etc.) disappear and force the national education system to invest once more in new people to replace them; affected people are no longer able to be fully productive etc. etc. If a male or female farmer dies at the age of 30 years, the national economy looses not only his/her labour force, but also his/her production for the next 20, 30 years. In other words - during all these years he or she is expected to produce not only for him/herself and the family, but also a surplus for the market. The Worldbank estimates that a rate of infection of 10-13% amongst the adults could result in a reduction of the national income up to 30% (figures from "Macroeconomics effects", E+Z 1999:5, page 137).

There are also **social** effects. The life expectancy will drop by an estimated 17 years if there is a rate of infection of

10% amongst the adult population. Old people will remain
behind without their sons and daughters who are supposed to
support them. The mortality of children will rise due to their
infection through the HIV-positive mother.

The health services will be overburdened by the increasing
number of HIV/AIDS cases. The already limited budget of
Government for the health sector will be more and more
consumed by the expenses caused by AIDS - and other diseases
as malaria, TB etc. will remain behind with an even more
restricted budget. Already today the AIDS-patients occupy
between 25% and 50% of all hospital beds.

Many children will no longer be able to go to school because
the parents or carers can no longer pay for school fees and
school uniforms. Children will leave the school because they
have to care for their sick parents and their younger siblings
and/or because they have to work in order to economically
support their families. If it is true that there is a close
relationship between education and socio-economic development,
then the fact that increasingly children drop out of schools
may once again influence the long-term economic future of the
countries concerned.

Another fact is that more and more children will become
orphans. Compared with other children, orphans are normally
heavily underprivileged: there is a greater possibility that
they are undernourished, that they don't go to school, that
they don't receive appropriate medical treatment etc. Even if
many orphans are integrated in the extended family or adopted
by community-members, there will be an increasing number of
orphans who will grow up outside the normal social network -
e.g. as street children or sex workers. They are in a great
risk to become infected by HIV/AIDS and to spread the disease
among their partners and clients.

Another social consequences of the AIDS-epidemic is the
growing poverty and the growing inequality of income
distribution. Poor families with a low income will be
especially affected by the loss of a member of the family and
may become impoverished for ever. It is also true that social
inequality means less social power for one side and more
social power for the other side. Less social power means less
power to negotiate conditions e.g. in relationships between
women and man. A rich "sugar daddy" has the power to impose
conditions on the economically dependent young girl or woman,
e.g. to have sex and to do it in a unprotected way. Thus,
growing social inequality creates on its own conditions to
increase the spread of the AIDS disease.

There is a third effect although this effect is not so directly visible: the **psychological** effect. This impact is very often neglected. It is considered as a mere transitional stage of some individual difficulties and disorders which would pass after some time.

Why is the psychological impact is not visible?
1. This impact is - as it was already mentioned, a "private" one and not a public phenomenon - so it is a hidden impact.
2. This impact appears in very different forms: one person may become depressed, the other may start to consume alcohol or drugs, the other may become aggressive, another may have difficulties to sleep or to eat etc. So it is sometimes difficult to recognise that there is a link between a certain stressing and painful event and the corresponding reaction.
3. This impact can arise even months after the event (i.e. the death of the beloved persons, such as partner, a child or a parent)
4. Additionally, in the case of children, adults often lack the understanding of what happen inside children, and children are sometimes unable to express their grief in a form that we adults can understand. Children construct their "hidden world" where we, the adults, do not automatically have access, because we are adults. So it seems we need some more specific information and training in order to understand children and to assist them in this difficult period.

1.3. To develop a person, a community, a country, a person (also) has to be psychologically fit

Psychological disorder seems to affect first <u>only</u> the individual that experienced severe stress and maybe even a traumatic event. Maybe we can also understand that the closer social environment - relatives, close friends etc.- may equally be involved and affected. But is it possible that also the community or even a country can be affected - in the medium- and long-term run? It seems difficult to see any linkage.

In reality, however, it will be difficult for psychologically unfit and distressed persons to efficiently develop a community or a country. Of course, the relationship between psychological health and development is not so obvious. Let's look closer into this relationship:

Economic and social development (of a person, of a family, of a community or of the society as the whole) needs at least

three components which have to play their role in a successful development:

1. the <u>material base</u> such as tools, raw-material, instruments, goods (e.g. maize and beans; a bicycle)
2. the <u>knowledge and skills</u> (e.g. if I don't know how to cook the maize and the beans, there will be no food; if I don't know how to ride the bicycle, it will be useless, unless I use it only for transport).
3. There is a third component: If I have maize and beans and I know to process it, but I'm not motivated to cook, because I'm so depressed and I feel that nothing makes sense, then we will have no result, i.e. no food. If I have the bicycle and I know to ride it, but I'm ashamed to do it in the community and I'm not self-confident enough to expose myself in the public, then the bicycle will remain useless. This third component has different names: some people call it <u>"social energy"</u>, others <u>"emotional intelligence"</u>. This third component has something to do if I'm able to say "I will... and I can.....", "I feel competent to..." and "I feel socially allowed to... I'm not inhibited to...".

Five dimensions of the emotional intelligence or social energy

<u>Self-Conscience</u>
The ability of a person to accept and to understand his/her feelings, moods, and needs, *and* the capacity to asses the effects of one's own feelings, moods, and needs for other persons.
Elements: Self-confidence, realistic self-assessment, some humour about oneself

<u>Self-Steering</u>
The ability to control or to divert violent-tempered stimulus and moods; the tendency to reflect first and to act afterwards, the tendency to let judgements about things and persons mature.
Elements: to trust and be trusted and to be a person of integrity; to be open for changes and modifications: to be able to cope with unclear and ambiguous situations.

<u>Motivation</u>
The ability to get enthusiastic for a task independently from the financial or social rewards; the attitude to pursuit goals with dedication and perseverance.
Elements: readiness for performance and achievement; to be optimistic even if something fails; ability to identify with tasks.

> Empathy
> The ability to understand the emotional being and situation of
> other persons and to react more or less appropriately on it.
> Elements: To be able to listen and to observe: to recognise
> and to promote the capacities of the others persons; to be
> sensitive to other "cultures" and to respect them (e.g. an
> adult towards the "hidden world and culture of children" or a
> man towards the culture of women or the urban based academic
> towards the rural peasant etc.).
>
> Social competence
> The ability to make contacts and to build up strong
> relationships, to feel well in a human network
> Elements: to be open for other persons, self-confident , to be
> able to explain and to argue, to be able to ask for help and
> support and to accept it, to be able to convince others; to be
> able to work in groups, to assume responsibilities and to feel
> responsible for my human and social environment (family,
> community, even nation).

Exercise:
1. Look for a concrete example for each dimension
2. Try to give negatives examples for each dimension (e.g. How
can we find out that somebody is not motivated, or socially
not very competent?

Claudia Jewett uses a very impressive picture to make clearer
how this social energy or emotional intelligence is formed and
what is the impact of losses and separations on the building
process of the social energy: :

"One way to understand how loss affects children is to imagine
that each child enters this world with a tiny arm through the
handle of a tiny bucket. As children grow larger, so do their
buckets. Much of how they react and how they see themselves is
determined by what goes into this bucket. If children make
secure attachments to other people, positive energy pours into
their bucket. As they continue to experience good nurturing
and positive interaction, their buckets fill up with good
feelings about themselves , which enhances their self-esteem,
promotes ample physical and psychological energy, and allows
them to give freely of themselves. In time, they dip into
their bucket and ladle good feelings into the buckets of those
around, only tentatively first and then more freely as they
discover that their sharing brings other good feelings. ...
Separation and loss interrupt or end the interaction with the
person who is gone, lowering the level of the good feelings
and energy and challenging the security of children's
attachment and their positive self-regard. " (Claudia Jewett:

Helping Children Cope with Separation & Loss, London 1994, p.153).

1.4. The special situation of children

HIV/AIDS affects children in many way, because HIV/AIDS is in many ways a family disease: it takes some members and leaves the others to cope with. And among these "others" are mostly children and the old people.
The children affected in one or the other way by HIV/AIDS fall into the following categories:

- Children with the disease: Between 15 and 20% (other sources claim that it is about one third) of babies born from a the mother with HIV/AIDS are themselves infected, mostly shortly before or during the birth. They can be also infected by breast feeding. Infected infants generally develop AIDS symptoms more rapidly than do adults - especially if they have been already infected in early pregnancy. Following WHO/UNICEF (in "Action for Children affected by AIDS"), "it has been estimated that globally about half of the children infected at birth die before age two. By age five, approximately 80% will have died"(p.5) .But there is also a growing evidence that some children may survive considerably longer. In Switzerland e.g. 50% of the infected children even at the age of nine years are still healthy and don't show symptoms.

- Children whose parents are sick or have died of HIV/AIDS. This rapidly growing category is confronted with a number of problems:
  - Psycho-social: The illness and the loss of the parents is stressing and often traumatic for the child; it is accompanied by deep emotional suffering
  - The loss of consistent nurture and the physical child neglect can produce serious development problems.
  - Loss of guidance: The loss of parental guidance will make it more difficult for children and adolescents to reach maturity and to be successfully integrated into the society
  - Education and training: The economic resources of the remaining family may not be enough to allow the children to continue in school or any formal training. Traditional skills (such as agricultural knowledge) may not be passed on.
  - Subsistence: Illness and loss of a parent may reduce the capacity of a rural family to produce crops or an urban family to generate income.

- Shelter: The loss of income or the inability to repair or maintain the home can result in shelter being lost or deteriorating.
- Health: Increasing poverty multiplies health risks and reduces ability to obtain health services.

The children's psychological (and economic) problems start long before a parent dies of HIV/AIDS: reduction of the family income, growing uncertainty about their own future, experience of a long period of losing their parents, because where one parent is infected with HIV/AIDS the other usually is as well.

- <u>Children whose siblings, relatives or friends have the disease or have died</u>. These children are confronted essentially with the psychological effects of loss and death.

- <u>Children whose household is stressed by AIDS orphans</u> coming from relatives etc. There are more and more families who accept five, six, and more children from their already deceased brothers and sisters. This reduces e.g. the emotional and economical support which was given until now to their own children.

- <u>Children on the street</u>. A growing number of orphans has no other way to survive than to work, to beg or to steal in cities and towns. HIV/AIDS is a serious threat to the health and survival of those children. Sexual activity (voluntary, coerced or for money) and injection drug use is high among street children putting them at risk of HIV/AIDS infection.

Although children are in many ways victims of the actual HIV/AIDS disease, children should be presented and viewed not only as "victims", "AIDS orphans" etc., but also as social agents, as boys and girls who will act and intervene in this new reality created by the pandemic, developing their own strategies in order to survive and to cope with the new situation.

1.5 Some conclusions why HIV/AIDS will probably endangers our future

To be infected by HIV/AIDS is first and foremost a personal, individual and private disaster for the patient and for his or her family and relatives. But HIV/AIDS-disease reveals more and more dimensions which affect the future of the whole society. HIV/AIDS becomes more and more an obstacle for

further economic and social development. And this may be also true for the third mentioned dimension: the development of the internal psychological capacities and abilities such as self-confidence, social competencies, motivations etc. which are necessary for successful development. We know that in the past so many development projects failed because of the lack of these factors, and it seems that these factors are fundamental for the actual and future development. If it is true, as Claudia Jewett pointed out, that the loss of a beloved person, of the mother or the father, will put in danger the children's development of their "social energy" and their "emotional intelligence" - indispensable and essential tools for any personal and social development -, Tanzania or any other country with a high HIV/AIDS rate may in the next years faces additional serious problems for development, additional to the lack of capital and the others already known problems. There will be a lack of knowledge and skills, and particularly a lack of confidence in his or her own resources and capacities among the young generation. A boy in Kagera who is an orphan, described his future with the following words: "I'm now 14 years old, but I do not expect any further change - I will die in the same situation and conditions as I am now".
If we, the adult generation of this society, will not care about this already enormous and further growing number of distressed children and adolescents, they may loose a lot of confidence in themselves and in us. If there is no positive response from our side - from "the society"-, many orphans will become run-aways and we will find them later in the streets of the cities. Then we will need much more energy and funds to integrate them later.
It is obvious that - as a result of the AIDS - the already large and still fast growing number of orphaned children has been so unexpected that the traditional kinship system may not be able to cope and may be over-saturated. So the society has to "invent" new social strategies.

There are fortunately many well-minded and responsible people in the Communities, in the Local Governments, in NGOs, and in churches who feel a deep responsibility to care this young generation who is involuntarily a victim of the AIDS-disease, and to avoid that they became marginalised. We know that we lack funds and money, but all of us, we have a heart to understand the distress and the grief of these children, eyes to see, ears to listen to them and we have words to talk to them. We have a smile and we have time. These resources are gratuitious - and they may be among the most powerful resources to support distressed children to cope with their difficult situation and to give them hope for a tomorrow. And they may be also among the most powerful resources to protect the "capital of social energy, motivation and self-confidence"

of this young generation for the next years, for their own
benefit and for the benefit of the whole society.

So their is a big challenge to all of us to make our level
best to keep the orphans and the community "mentally healthy"
during this terrible time when HIV/AIDS is devastating our
societies.

1.6. What means "community based mental health"?

The term "mental health" has nothing to do with "mental
disorder" (e.g. to be crazy etc.), but means that "health" is
more than just absence of illness. Apart from a person's
physical condition this concept encompasses also
- his/her psychological and social competencies
- his/her social status in the community
The notion gives the idea that there should exist a certain
balance between these three levels of physical health, of
psychological well-being and of social acceptance and
appreciation.

In this sense a person is comprehensively "healthy" if he or
she is
- physically fit
- accepts himself/herself to some extent as a valuable person
  and therefore he/she has a good self-esteem
- feels integrated in a network of human relations i.e. he/she
  is not marginalised or discriminated
- is sufficiently prepared to respond to the demands of the
  others or the own demands made on him or her
- is capable to express his or her emotions to others persons
  reasonably well i.e. to express happiness, anger, sadness,
  concern, doubts, joy.
It is obvious that especially orphans might fall in the
dangers
- to be physically unfit, because there may be not enough food
  or no money for medical care for them
-   to be not accepted in the society, e.g. to be
  discriminated in the school, because she or he has no school
  uniform, can't pay the school fees and other contributions
  etc. which may induce a process of marginalization
- to be not confident in his or her capacities in order to
  fulfil the (external and internal) demands which may be now
  higher than before the death of the carer. It may also be
  possible that the child or the adolescents is not prepared
  to fulfil the new responsibilities which are assigned to him
  or her such as to care for the sick parent, to organise the
  cooking and other housework, to care for the younger
  siblings, to do the field-work etc.

- to loose the person(s) to whom the child or the adolescent was trusting to express his/her deeper feelings and to loose this person who was able to understand and to accept such feelings.

So we can conclude that the "community" (the neighbours, the extended family, the clan, the local government, the teachers, the women groups, the religious leaders etc.) have to play a fundamental role to contribute to safeguard the children's "mental health" which finally can't be separated from the "mental health" of a community. With other words: If a community doesn't consider the orphans as "their younger community brothers and sisters" who may need some material and psychological support, probably such a community will fail to have internal peace and will fail to be proud and strong in developing their own strategies for coping with their own problems. Such a community will probably be overwhelmed by the problems (caused by HIV/AIDS or others factors) and the community members will learn, that they have no power and no strength to influence the actual situation

What we can learn from other countries such as Nicaragua or El Salvador, is that the participation of the community is crucial in bringing about integral health as it was mentioned above. Thus, the members of the community, by practising solidarity, responsibility and mutual aid, are enabled to tackle common problems (provided those problems are defined as being "common") and therefore enhance the self-esteem, and offset or limit the loss of control and the feeling to be helpless and powerless.

2. Concept of childhood

2.1. "Childhood" is not equal "childhood" – there are different concepts and understandings about childhood.

We may assume that "to be a child" signifies the same all over the world. But this is not true. Let's look closer to an example:
Kurt M., a Swiss who worked for many years in Mozambique, tells the story of his (at this time) five years old son Grischa: "We lived (as the only white persons) in Malhangalene, an area of Maputo-town. All the friends and classmates of Grischa were Africans. When we were invited by our (African) neighbours, Grischa automatically sat with the other children on the floor. When we invited our neighbours to our house, Grischa automatically sat at the table with his parents." Grischa's behaviour gives evidence that he had two different conceptions of "how a child behaves correctly" in his mind: the African conception (children are a special group, separated from the adults, sitting on the floor) and one of various possible European concepts (children are the "young partner" in the family and as such sitting at the table).

"To be a child" doesn't mean to play the same role in every place of the world, just because of being a child. Even in the same society, children are regarded differently: a girl is confronted with different expectations than a boy, a child in a big town makes other experiences than a child in a remote rural area, a child from a rich family has other possibilities, perspectives, strategies, than a child from a poor family. And it makes a difference if a child is a single child in a nuclear family or if there are five siblings around with aunts, grandfather, cousins etc.

Conclusion:
Children are immature and they are involved in a maturation process - this is a biological and psychological fact. But the way how this immaturity and the maturation process of children is understood and defined, differs from society to society and is a part of the culture. It is in this sense, that one can think of the "social construction of childhood", i.e. the way in which the society defines what is good care or bad care, what is a good behaviour or a bad behaviour, what is a happy childhood and what is an unhappy childhood, what are the main needs of children and how these needs should be satisfied.

In the Northern countries of the globe we can observe a
tremendous change in the perception of "childhood" during the
last two hundred years.

Jo Boyden writes: "Childhood has not been a matter of much
concern until the time during the eighteenth and nineteenth
centuries that qualities of innocence and nobility were first
associated with children and the desire to foster these
qualities through conscious parenting emerged... The expansion
of capitalism, however, has given the greatest impetus to
contemporary images of an ideal childhood. Industrial
production and urbanisation had a dramatic impact on the lives
of children in Europe. with mechanisation in its early stages
resulting in a marked increase in the exploitation of child
labour. But mechanisation also highlighted the need to foster
socially responsible and economically useful individuals to
supply a skilled and differentiated labour force. It was
eventually realised that such individuals would not flourish
by labouring while young in mines and factories. Besides
which, with economic specialisation and the advance in complex
technologies, children were becoming less useful materially.
Schools then become a training ground for industrial workers
and a place for containing and shaping childhood" (JO Boys: A
Comparative Perspective on the Globalisation of Childhood, in
"Construction and reconstructing childhood, 1990, p. 186).

In the so-called "modern" nations childhood is "regulated"
through an increasingly sophisticated policy to guarantee "a
normal childhood". The four main components of this childhood
policy are:
- to guarantee the physical survival of children in order to
  reduce the infant and child morbidity and mortality
  (vaccination, clean water provision, breast feeding etc.)
- regulation of population: family planning and family policy,
  children allowance etc.
- schooling and education
- legislation against child-labour-

2.2. The discussion of the children's "needs"

A child is born, apparently helpless and completely dependent
on our care. Portmann, a biologist, concluded from his
research that human children are born too early - maybe one
year - compared with the animal-children. So human children
have an extended period of maturation, and they need to be
especially protected.

This biological and psychological fact is the background of the definitions and the discussion of what we call "needs" of children. That children are "needy" is obvious. When we argue about the "correct" education we justify our educational behaviour with the "need" of children - i.e. our education has to respond to the (apparently objective) needs of the children.

It therefore is not astonishing that the actual western notion of childhood is essentially based on the discussion and the acknowledgement of the "needs" of children. Conceptualising childhood in terms of "needs" reflects a distinctive status accorded to young humanity. It gives priority to protecting and promoting their psychological welfare; by contrast, in former times and other societies adults gave priority to children's economic value and to their assigned duties and obligations.

Considering that the notion of the "needs" is a central concept in the discussion on conception of childhood, we have to look closer into the use of this concept. Martin Woodhead distinguish three different categories of usage or definitions of "needs":

1. Model of the biological/psychological nature: "Need" as a description of children's biological and psychological nature: The need XYZ is identified as lying within every child as a child.
    In this model "needs" are identified with the biological/psychological make-up of young humanity: with their instincts, drives, wants. They are considered as "intrinsic", as part of the internal biological/psychological program - in this sense their satisfaction is a "must".
    Example: the need for food IS an intrinsic drive, and even the very young infant start to suck when we offer him/her the breast, or a finger etc.
    Or: Young infants are predisposed to pay attention to the human face, and they protest vigorously if they are separated from attachment figures (at least after 7 or 8 months of age), and this is not modified by the cultural setting in which they have been brought up.

2.   Model of pathological consequences: "Needs" are identified with the certain quality of care to assure the psychological well-being in children and to avoid negative consequences in their later development. This model acknowledges the relative helplessness and dependency of children (especially infants) and stresses the important role of the care-givers. The reasoning within this models is the

following: If we don't care about the child in a certain
minimally qualified manner, the child will start to show
various disorders. If the child has certain negative
experiences in is/her early childhood, then it will get
difficulties. So, the negatives outcomes are projected on to
children as their (unfulfilled) "needs": if we don't satisfy
the need Y, there will be a negative outcome Z - if we satisfy
the need Y good enough, there will be a positive outcome Z .
So - as a consequence - only through the negative outcomes we
have an insight in the "real" needs of children. (The most
interesting cases for discussion of this model are the so-
called "wolf-children" who have been raised by animals. World-
wide there are about 40 cases known and described. One
characteristic of the wolf-children seems to be that they
never laugh or that they show no interest in sexuality).

   Example: There are a good number of long-term studies about
   children who spent their first years of their life in
   institutions (orphanages etc.). Most of these studies come
   to the conclusions that due to the missing close emotional
   attachment and emotional security in the first years these
   children and adolescents showed some disorder in their
   behaviour such as an almost insatiable desire for adult
   attention, or a difficulty in forming good relationships
   with their peer group etc. So the disorder in the
   behaviour is explained as a sign that their needs for
   binding and attachment to others failed to be satisfied in
   early childhood.

3.   Model of social adjustment and cultural prescription:
   "Needs" are identified with those behaviours and values
   which are appreciated in a given society.

   Examples: Bowlby argued that children have a predisposition
   to become attached to one major figure, which is normally
   the mother. This reflects the "normal" pattern in western
   society: it knows only the nuclear family without the
   presence of members of the extended family (aunts, uncles,
   grandparents etc.); in this pattern the father is given the
   role of (the more or less absent) breadwinner. In
   "adapting" this social-cultural concept the attachment to
   only one major identification figure was considered a
   "need". But in other cultures other patterns are observed:
   children are able to form strong and secure relationships
   with up to five, possibly ten care-givers, including the
   (in African societies) very central relationships with
   their siblings. According to these cultural patterns, there
   is probably no "need" for ONE major figure, but maybe much
   more for a secure environment.

In a cross-cultural study of parents' attitudes to children (the "Value of Children Study", 1987) the psychologist Hoffman found that parents in the USA laid much importance on a child becoming "independent and self-reliant" and that this was the right way how a child could become a good person. In contrast in countries such as Turkey, Indonesia and the Philippines, parents placed much greater importance on "deference to elders" and "obedience". He concludes: "Presumably parents in the two societies would view their children 'needs' quite differently". We can assume - so the conclusion from Hoffman - that in a society where children have to contribute to the material needs of the family (especially to support the parents when they are old), parents will more likely focus on educating their children to obey, to adapt, to assume social responsibilities and to accept their role within a social group. If the cultural value of children is less determinated by the material contribution and support to the parents and the family and the children fulfil more the emotional needs of the parents, then the parent will treat the children probably more as "independent" and will strengthen their autonomy.

Paul Riesman did some research in West Africa among the Fulbe and the Riimaybe. The Fulbe and the Riimaybe live together in the same area, but they have quite a different self-image and behaviour. Riesman's question was: "How is it possible that in the same society adults can become so different (as a group)?". He observed that children, both from the Fulbe and the Riimaybe did not differ so much from each other. They are "unstable " in the sense that they are able to play various roles and they are able to adapt themselves to very different situations. So the child has in principle a rich potential to develop various possibilities. Riesman observed now in the Fulbe/Riimaybe case, that during the maturation process from child to adult, only those possibilities became stable (as a part of the later Fulbe or Riimaybe personality) which were more or less compatible with the cultural and social expectations within the Fulbe or Riimaybe community or family. So, the cultural and social expectations functioned as a selection pattern to define "needs".

(We will return to this point later, but let's already put the following question which seems to be crucial in the actual - involuntarily - transformation process caused by HIV/AIDS: If it is true that the social and cultural expectation toward a child in Tanzania has the tendency to strengthen obedience, submission, or even passivity, and if it is equally true that more and more children becoming orphans are charged with a lot of new and great

responsibilities (to care for themselves, for their younger
siblings, for their sick parents etc.), then the question
might come up, if such a cultural and social expectations of
obedience and submission is still functional and helpful to
those children?).

Within this perspective of the cultural determination of
"childhood", various models of children's welfare based on a
concept of "need" still retain some validity, but the needs
would be more relative. They may still make part of the
psychological make up of the child (as in model 1 and 2),
but they are satisfied according to the values and norms of
the social environment. Or they may not even be a part of
the psychological make up of the child (e.g. "children needs
to go to school and to learn physics and mathematics"), but
these "needs" belongs in reality to the top cultural values
of the respective society.

Conclusion
Children inherit a human nature (which includes children's
dependency on others to protect their interests during the
long period of human immaturity called childhood). At the same
time they are brought up in a particular society. The length
of their dependency as well as the cultural forms of what is
understood to be in their best interest will vary from society
to society and from one period to another. This plurality of
pathways to maturity must be in our mind when "needs" are
discussed.

2.3. Where are the differences in the conceptualization between the Northern and Southern countries?

Concepts of childhood favoured in the industrial countries of
the North have been exported in the last years to the South.
The view that childhood seems to be (from the Northern point
of view) a fixed notion, "determined by biological and
psychological facts and the corresponding needs" rather than
by culture and society is explicit laid down in international
children's rights legislation. (There was a strong reaction of
the African countries against this international and global
children's rights legislation and a proposal to elaborate a
specific chart with the rights legislation of the African
child.

The increasingly global uniformity in policies towards
children is often justified through the patterns of socio-
economic changes in the South in the present days which seem
to resemble closely those in the North in the past:

- recent research indicates that in urban areas in the South
  the extended family has largely been replaced by the nuclear
  family
- problems such as alcoholism, prostitution, crime etc. have
  apparently increased in the cities of the South so that
  traditional solutions are becoming progressively less
  viable.
- the decline of traditional values and social control and the
  loss of critical support mechanisms with the dispersal of
  joint or extended families and the weakening of clan and
  other collective structures has justified or even requested
  the state intervention
- changes in the roles within the family, with the husband and
  father no longer playing the central part in income
  generation have apparently led to a widespread abandonment
  of women and children and have been cited as causal in abuse
  and neglect, homelessness and other problems of children. In
  many countries in the South the number of women headed
  households is tremendously increasing
- globalisation (for example through the intervention of the
  International Monetary Fund IMF in the national economic
  policy) brings today new economic and social rules into each
  society. These new rules have the tendency to strengthen the
  individual and private initiative and to weaken traditional
  forms of mutual solidarity.

Another important factor we also have to keep in mind, when we
discuss "childhood" is that all children all over the world
also influence themselves their environment. They are
definitely not just passive "object" of our care and education
efforts. All children in every culture will call for care and
nurture and will try to influence their environment to get
these basic needs fulfilled. Children everywhere construct
their own world trough playing etc. Children will make choices
and they will try to control - or at least to influence - the
shape of their lives. And in a growing interdependent world,
the means for control and influence might become more and more
similar (such as the growing children's prostitution). All
these factors might contribute to a situation in which
"childhood" is no longer perceived to be completely different
from one society to the other. These factors might act as
"streamlining" and "harmonising" elements in the different
cultural conceptions of childhood.

But even if all these processes take part, this
"globalisation" of the concept of childhood is very
questionable because it does not take into account the variety
in which each society deals with child care and the socio-
economic and cultural realities of countless children in the
South (and the North, which also is not homogeneous!) Just to

give two examples: While in Britain it is forbidden and illegal to leave infants and small children in charge of juveniles under the age of 14, in most of the countries of the South children are sometimes heads of households and often a very important person in charge of the care of younger siblings. While in the countries in the North "family" is mostly defined as "parents and children" where the parents have special rights and obligations with regard to children, in most countries of the South these rights and obligations are the responsibility of the extended rather than the nuclear family and the role of relatives other than parents (grandparents, aunts, uncles etc.) in child care is vital. It is in Africa absolutely normal that a child lives some years with an aunt, an elder sister etc. This "rotation of children" is unthinkable in Germany or Switzerland.

Conclusion
More important than "established solutions" imported from abroad are innovative responses to the problem of childhood which are sensitive to customary law and practice and to the existing local resources.

2.4. Social orientation versus individual orientation as cultural values.

Cultural values have an effect like a broad street in the bush: when there is a street, everybody will use it - its simpler and more comfortable. As it is normal to use the road, so cultural values define what we consider as "normal".

In a simplified way we can consider two different cultural systems or - to remain with the picture: two different "broad roads".

One road is called "social orientation". People on this road are expected to behave more or less as the neighbouring walkers, to go in the same direction, with more or less the same speed. In other - more sociological word - they are expected to subordinate their personal and individual interests, needs, and goals to the expectations of their environment. They are expected to teach their children to look for integration, to become an accepted part of the community and to avoid conflicts or disharmony.

People on the other road which we call "individual orientation" are expected to behave differently. They will walk with their own speed - some very fast, even running, other will sit down. They will go in different directions.

Maybe one or two will start to clear a new small path into the bush. Sociologically we say that they try to realise themselves and to use and to shape the environment following their own personal interests, needs, and goals. They probably will see their children since the early years as quite autonomous, with a own will, able to carry through their plans. They expect from their children that the children will be increasingly able to make their own decision.

In order to get a clearer idea about the main road in Tanzania, we have a look at some proverbs concerning children and their education. We use two sources: our own collection in Kagera among the Wahaya (marked with *) and the collection published by Carol Eastman.

For Carol Eastman who collected proverbs among the coastal Waswahili, proverbs "are a central form of the expression of the culture of the Swahili's. They are dominated and used exclusively by adults". (Carol M. Eastman: Was Kinder wollen, was Kinder sollen, in "Kinder" 1993, p.82). The adults use the sayings to express and to explain HOW things really should be.

In the opinion of Eastman, one of the most important cultural values of the Waswahili is represented in "adabu" (virtue, good manners) which refers to the rules of behaviour. A person with "adabu" is able to avoid "aibu" (shame, disgrace). So one of the main concerns of parents might be to educate their children to a correct behaviour, for example to go behind the father or the teacher and not in front of him.
"Na asipofanya hivo, amemtukanisha mzee wake na mwalimu wake, naye mwenyewe amejitukana, sababu watu watamwuliza:'Baba yako hakukufundisha adabu, wala mwalimu wako hakukufundisha adabu, ndiyo maana usishike adabu?" (If the boy doesn't follow the rule, he will shame his parents, his teacher and himself, and people will ask him: "Did your father and your teacher also not teach you adabu,? Is this the reason why you do not yet understand adabu?").

This might (still?) be the general background for the following proverbs.

1. Proverbs concerning discipline, obedience, respect for parents
- Adabu ya mtoto humapatia sifa bora wazazi. (The child is the mirror of the parents)
- Fungato haliumizi kuni. (The string doesn't hurt the firewood: be severe to the child, even punishment will not hurt the child
- Adabisha mtoto awap mdogo. (Teach the child while it is still small)

- Rada ya mwana ufito. (The discipline of a child is a small stick)
- Kuamuru na taa, huanza kwa jamaa. (Good governance starts at home)
- Mam'ako ni mungo wa pili. (Your mother comes just after God)
- Mwana mwena ni taji tukufu kwa wazazi wake. (The good child honours the parents).
- Mwenye mwanawe, n'akanye. (Parents should punish their children)
- Teke la kuku halimumizi mwanawe. (The kick of the hen doesn't hurt the chick)
- Asiyesikia onyo hupata majanga*. (Who refuses warnings always faces difficulties)
- Mtoto anayelia mara kwa mara hasaidiwi hata akiliwa na siafu*. (The child who is crying all the time will not be helped even if red ants bite him)
- Yatima asiyesikia ushauri wa mkubwa hafanikiwi maishani mwake*. (The orphan who does not accept the elder's advice will never achieve a thing in his life).
- Mtoto mwenye baba hajimegei ugali*. (The child whose father is still alive never takes decision himself)
- Ngono (river in Kagera) alipotea njia alivyokwenda peke yake*. (Ngono failed to know the way as it went alone)
- Asiyeheshimu baba hamheshimu kaka yake*.(Who does not respect his father does not respect even his brother)
- Mnyama atakayeuawa haskii mbiu*. (The animal who will be killed does not note the sound of hunter's horn)
- Mtoto hukanywa na mtu wa nje*. (The child can be disciplined by outsiders)
- Mtoto mwenye heshima hukanywa kwa jicho*. (The well mannered child is disciplined by eye)

2. Proverbs concerning the responsibility of the parents
- Kufunza, kutunza (To teach the children is to care for them)
- Mtoto wake amepotea katika mgogo wa fisi. (The parent didn't care for the child, so it got lost on the back of a hyena)
- Kweli mwana ni mamae, na mlezi akalea. (The child is primarily dependent from the mother, and only thereafter from the wet-nurse or foster-mother)
- Mcha mwana kulia, hulia yeye. (Who is afraid of the tears of the child, will cry himself)
- Mtoto asumbuliwaye hujisaidia mara moja kutwa*. (The child who has to work too much does even not get time for a 'short call')
- Mtoto ni maboga hufanyiwa palizi*. (The child is a pumpkin plant, it needs weeding)
- Mtoto ni kikapu kizuri kidogo kinachochungwa na mwenye nacho*. (A child is a nice small basket which is taken care of by the owner)

3. Proverbs concerning care, love, importance of a child, tolerance, understanding and empathy

- Kuku havunji yayile. (The hen doesn't smash her own egg)
- Azaaye kinyago akinyonyesha. (Even if the child is crippled the mother will feed it)
- Mama hawezi kumkana mtoto, hata akiwa na vilema. (The mother cannot reject the child, even if the child has faults and shortcomings)
- Mtoto ukimnyang'anya kisu, mpe banzi achezee. (If you take away the knife, give the child a stick so it can play).
- Uchungu wa mtoto u katika nyonga'ya mama yake. (The mother knows the pain of her child).
- Uchungu wa mwana aujua mzazi. (The parent know the pain of their child)

4. Proverbs concerning the relations between the generation and the importance and function of children

- Mama kwa mwanawe, mtoto kwa mamaye. (The mother exists for the child, the child exists for the mother)
- Mlimwengu ni mwanawe. (The adult person depends on his/her child)
- Mwana huan mzee, mzee haui mwana. (The child kills the parent, not the parent the child. If you try to educate the child, and the child fails to become a good person, then it is like killing the parent)
- Mwana kidonda, mjukuu kovu. (Parents are much more sensitive for their child than for their grandson).
- Mwana mukwa nawe ni mwenzio kama wewe. (The child who grows with you, is your friend. When the child marries early, then parent and children grow together).
- Mtoto ya kwanza ni ngao. (The first-born is a shield)
- Yai litakuwa juu, la mamaye kuku kuu. (The egg will sit on the head of the hen. The next generation will try to correct the old generation).
- Asiye shirikiana na watoto huangaika peke yake*. (The one who does not co-operate with children will suffer in preparing the local beer)

5. Proverbs concerning the responsibilities of the community or the situation of orphans

- Yatima akiota ndevu fikra huota mvi*. (Meaning: the death of the carer makes an orphan to assume responsibilities before time)

- Yatima kufa pale anapofikia kutegemewa* (An orphan dies at the stage when he/she starts to be responsible)
- Kabakye nkategele kaba rukondo* (Kihaya) (Care is needed while the child is still young)

We attempt a short analysis and interpretation of the proverbs and a comparison with the actual situation.

1. If we analyse how children have been conceptualised in former times in Tanzania and other African societies (and maybe even still today), we find that high priority is given to their duties and their obligations against their parents and the community. In order to become a valuable and accepted adult person, the child had essentially to obey orders and guidelines of the adults (see group 1)

2. The proverbs stress also the economic utility and importance of the children, especially for the old days of the parents (see group 4).

3. The proverbs insist also on the obligations of the parents, on their love and care (see group 2 and 3).

4. We could not find any proverb which encourages the child to develop his/her own ideas, forces etc. and which acknowledges or praises the child's initiatives and activities.

The last point might constitute a severe additional obstacle to cope with the consequences of the HIV/AIDS disease. The actual understanding of the role of the "well mannered child" (mtoto mwenye adabu) might enter into conflict with the real situation orphans are confronted with, with real possibilities which orphans encounter, and new duties which orphans are forced to assume.

To give an illustration of what is meant, I will refer to a discussion we had in Nshamba during a meeting with community members. A respected (male) community member complained about a boy who "hana adabu".
Question: Why?
Answer: He misses often the school, and sometimes he is not at home in the evening.
Question: What does he when he is not at home or at school?
Answer: Ah, he goes around to sell fish.
Question: Why does he sell fish?
Answer: Oh, his father died and the mother is sick. So he has to bring some money to the mother and the siblings.
In fact, the community should thank and praise the boy because he assumes the responsibility to maintain the family. Instead

of praise and acknowledgement, he is blamed, maybe also because he develops an autonomy (which is necessary and given by the death of his father), but culturally not yet accepted.

So it might be an urgent point to review how the actual Tanzanian society defines "a well mannered child", defines "adabu", It might be necessary, in order to cope with the social and economic - and even psychological - consequences of the HIV/AIDS disease to adapt all these concepts and to be able to support the youngsters initiative, to liberate their potential and to give credit to their activities. But this would definitely constitute a deep internal transformation which would go in line with other cultural transformations caused by HIV/AIDS (e.g. the fact, that parents or adults talk with children about death).

There is a growing evidence that children are far more resilient than earlier psychologists appreciated, if they are given alternative caregivers and community support. Nevertheless, some of these initiatives, coming from the children and adolescents, might not only be "comfortable" and the choices, they opt for, might not have our approval. Andrea Ledward observed in Zimbabwe in her study "two examples repeatedly mentioned by children and adults, of refusal and rebellion, which appears to be strategies used by the children to negotiate their sense of self. Refusal, in this case of going to school, appears to be an effective means of attracting attention. It is perhaps also a method of identifying the boundaries of other people's and society's expectations, and mapping the values held by figures of authority. Negotiation of choice may be one of the most effective means which children have of expanding their limited range of choice. Rebellion, in this case interpreted as entering sexual relationships at a young age, is a method of obtaining resources and attention with other people normally will not give" (Ledward, p. 44) .

3. Children and Grief: When a parent dies

In this manual we shall adopt Worden's definitions for "bereavement", "mourning" and "grief":

- "Bereavement" describes a new status of "to be an orphan", to have physically lost a person (to be without one or both parents). Feelings of "being bereaved" may occur also in situations of separation, migration, death of a beloved animal, etc.
- "Mourning" means the process children go through on their way to adaptation to the loss, i.e. to accept the loss, to be able to start to organise the life in a new way etc.
- "Grief" describes the child's personal experience, thoughts, and feelings associated with the loss

(Worden, "Children and Grief" 1996, p.11)

3.1. Do children mourn?

There has been a lengthy and often contradictory debate among professionals as to when children are able to mourn.

Most professionals agree that the child must have achieved two developmental tasks to be able to mourn in the classical sense:

1.The baby has to learn that an object can be <u>permanent</u>. "Permanence of a object" means that an object exists independently if I can see it or not. If the baby has not yet acquired this capacity, he or she thinks that a toy has definitely disappeared or has been wrecked if you hide it behind your back. Only if the baby has learned that an object can also exist even if he/she can't see it, you can start to play with the baby "hide and search" and the baby can guess where the (no longer visible) object may be.
Between 8 and 12 months the children extend this concept of "permanence" also to the persons. Now the baby starts to distinguish the "known" persons (that are now existent even if they are not present) from the "unknown". Consequently they start to be afraid of the "unknown" persons and they may start to cry. In the case of a parental loss, the young child will now really "miss" his mother or father.

2. The young child replaces the concrete object by what we call "the mental representation": The psychologist Piaget studied the psychological development of children. He observed how children become able "to think". Formerly - as babies or toddlers -, the starting point for reasoning was something very concrete: an animal, the food, a present person. Now children become more and more independent of direct observation and direct presence. They can think about a dog without a dog really being present, or about the grandfather even when the grandfather is not around and may live in another house or village. So children are able to think about concrete events not only on the level of concrete observation, but also on the level of their imagination and fantasy. They create a world in their mind. This is what we call "mental" or "inner representation".

So if the child is mentally able to think and to reason about something which is not present, the child is also able to think and to reason about the late mother or father. With other words: it is able to mourn.
Most children have developed these mental and cognitive capacities to mourn by around 3 or 4 years of age. But even infants as young as 6 months experience sometimes grief reactions resembling those seen in adults.

3.2. The tasks of mourning for children

Worden proposes to use the concept of "tasks" instead of stages or phases (as we did in the manual). He argues that "tasks" haven't to be accomplished in any specific order (first, second etc.). One task or several tasks can be started at the same time, can be revisited or reworked later over time. Worden points out that the mourning process is a dynamic and fluid one.

Task I: To accept the reality of the loss:

"I thought when she died, 'It's all a dream' and then I wake up and it's true (10-year-old boy)

Like adults children must learn to accept that the deceased is indeed dead and will no more return to life before they can deal with the emotional impact of a loss. The child has to understand that death is final and irreversible. This understanding of death starts to emerge only with 3,4 years. Especially young children ask repetitively about the death of the parent. This is their way to test the reality (to be sure that the story hasn't changed) and to grapple with the

reality of death. They have to be confirmed in an accurate way and in a language appropriate to their age.

Task II: To experience the pain or emotional aspects of the loss

"If it was something I liked doing with him, I start crying. I remember doing it and I can't do it again" (8-year-old boy).
"I missed her on graduation, I would show her my diploma" (17-year old girl).
The loss of a parent will produce a lot of emotions such as sadness, anger, guilt, anxiety, or other feelings associated with the loss. If it is not possible to work through and to acknowledge theses feelings, this emotional energy will manifest in other ways, perhaps as headache or problems of the stomach, or as behavioural problems or as aggression etc.

It seems that children between ages of 5 and 7 years are a particularly vulnerable group. This may manifest itself in nightmares, high levels of anxiety etc. The reason: their cognitive understanding is so far developed that they understand something of the permanency of the death, but they still lack the social skills (e.g. to dominate the language and to talk about) to deal with the intensity of the feelings of the loss. Playing and drawing may be a good instrument to support them to deal with these feelings.

Task III: To adjust to an environment in which the deceased is missing.

"I always used to talk to my mother when I returned from the school" (8-year old girl)

A mother, a father fulfilled a whole set of roles in the daily life of the child: to call it for sleeping, to watch if the child washed his/her body, to listen to the complaints, to joke with the child etc. etc. With the death of the parent the daily routine has broken down and will change. In most cases the death of the mother results in more daily changes than the death of the father.
These changes significantly affect the child's emotional outlook and create major disruptions to which the child must adapt.
This adjustment extends over a long time until adulthood, for example when the former child will marry or will become father or mother and realise anew that the parents are missing during these important points of their adult life. .

<u>Task IV: To relocate the dead person within one's life and find ways to memorialise the person.</u>

"Does everyone die? Yes, physically, but not in your heart. If you admire the person that much you can say 'No, they are not dead in my heart, only a rough person would feel that way and I don't feel that way about Mom" (teenage boy)

If it is truly necessary that the bereaved need to "let go" of the deceased (what we call in psychology "detachment"), then it is equally true that one never forgets a significant relationship. Especially bereaved children have to find a new and appropriate place for the late parent in their emotional lives.

Worden observes: "Children seek not only an understanding of the meaning of death but also a sense of who this now-dead parent is in their lives. While the loss of a parent is permanent and unchanging, this process of "relocation" is part of the child's ongoing experience. The child must be helped to transform the connection to the dead parent and to place the relationship in a new perspective, rather than to separate from the deceased" (Worden, Children and Grief, 1996, p. 16).

The Child Bereavement Study gives some insights how children maintain an ongoing connection to the dead parent:
- Through locating the deceased parent - mostly in a specific place, for example heaven, which often is seen as an extension of life on earth: "If there are beaches, she's lying on a beach somewhere" (teenage girl about her late mother)
- Feeling watched by the dead parent, especially in the early months after death: "When I wake up early in the morning and it's really quiet, I always think that she is in the room" (11-year-old boy). A few of the children in the study expressed fear: "When I'm alone in the house, I get scared...I feel like she's always right behind the door of my room waiting for me to come in" (teenage girl). Much of the fear has to do with the belief that the dead parent would not approve of what the children were doing.
- Dreaming: "I dreamed he met me on the way home from school and that he hugged me".
- Some children maintain a connection to their deceased parent by speaking to them: "In my mind I talk to him. I tell him what I did today, about the fish I caught, and that it did really good" (10-year-old boy). "I ask him for advice. I ask him to make things better" (teenage boy).
- Regular visits to the cemetery
- Remembering the deceased several times a week

- Attached through something that belonged to the late parent (we call this a "transitional object" which allow to "transit" to the lost beloved). This can be a cloth, a tape, a photograph, a pin, a letter etc., given to the child either by the dead parent or by the surviving parent. A 11-year-old girl explained about a tape: "We used to listen to it together".
  Jess Gordon proposes to help children to make a "memory book" or a "memory store" with photographs, something what was produced by the late parent etc.: "A memory book or store is especially important for younger children who can begin to suffer intense distress when they realise that they are 'forgetting' the dead parent" (Intervention with bereaved children, 1995, p. 129 and 267). In Kagera usually a cloth from the deceased parent is given to the child.
- Involving family members talking about the loss (which will be difficult if the orphans are 'distributed' to different families).

3.3. What influences the mourning process

Each child has to go through the above mentioned tasks in a very individual way. Many children manage the tasks of mourning in a healthy way. Nevertheless, the "Child Bereavement Study" found that during the first 2 years after the death of the parent about one third of the children was found to be at some degree of risk of high levels of emotional and behavioural problems

Worden and Silverman identified six major categories of factors that influence the course and the outcome of adaptation to loss

3.3.1. The death and the rituals surrounding it

- There is no clarity whether a sudden death (e.g. an accident) is more difficult to mourn than a death where some prior warning was received.

- In cases of terminal illness (for example in the cases of HIV/AIDS) it may be possible and even helpful to give the children the chance to begin the preparation to cope with a loss before the loss changes their life. We call this the "anticipatory grief" which can consist to prepare the child carefully on the impending loss of a loved person. Mr. Joel from HUYAWA in Bukoba refers to a ceremony called "ushuhudu" where the dying persons calls the relatives, the neighbours, the friends, some clan members etc. to tell them that he or she feels that he/she will die soon. "They express their

feelings and they give advises". Children are also allowed to assist in this ceremony.

Mr. William Rugaimukamu did for Humuliza a research in 4 wards in Muleba district/Kagera to find out if parents communicate with their children about their illness, the imminent death and the children's future. He found that (contrary to the expectation that it is not allowed to talk to children about the imminent death) that many terminally sick parents indicated to their children that they will die soon:
"I'm soon going to die and leave you in problems" (ninyija kufa mbasige omu taabu)
"You children, see that you obey and take care of your mother when I'll be no longer here"
"I tell my children that there is a time I will no longer be able to look after you. Look, you have neither uncle nor aunt to take care of you in my absence. You will have to look after yourselves. Work hard, be firm, till the land, do not steal, do not ignore work"
"When I fall sick and this is very frequent, the older children , 14, 11 and 9, look after me. When I say to them than one day I may die the become very sad and depressed". In the same research most of the interviewed older orphans expressed their wish that the sick parent would have talked to them" "I would have wished and appreciated very much if my father or my mother would have talked to me. I would recall this always". Similarly most of the widows expressed their wish that their late husbands would have talked to their older children about their conditions and their children's future.

Poulter et.al. write in their study from Zambia about the urgent necessity to communicate with children during the illness: "Despite the parents realising that their children were affected by their condition, most parent did not talk to their children about any aspect of their illness, partly out of fear of causing distress. Yet the children were already distressed, and their parents not talking to them left them without the opportunity to discuss and to cope with their fears" (Safaids, 1998, Vol. 6/4, p. 5).

David A Waskett observes "Today, some adults still believe that the best way for a child to get over a death is for them to be 'protected' from pain and that the path to follow is to ignore the loss or marginalize the child so much that they feel excluded" (In: "Interventions with bereaved children", 1995, p. 49).

- Family rituals generally are important - a key family ritual
  is the funeral. Children should have the possibility to
  attend the funeral but they have to be prepared if it is to
  be a positive part of the mourning process. Children should
  be given a choice if they will see the body or not, if they
  will attend the funeral or not, and they need to be informed
  clearly what will happen and what they will see and
  experien-ce.

  It seems that the funeral can help to meet three important
  needs of children around the time of death
  - a way to acknowledge the death
  - a way to honour the life of the deceased parent
  - to get support and comfort from other persons
  Worden states in his study that most "children were included
  in funeral planning and in the funeral itself in various
  ways. This participation did not lead to later
  behavioural/emotional difficulties; on the contrary most
  children felt positive about their involvement." (p.23).

3.3.2 The deceased parent

- The gender (being male or female) has an influence. When the
  father dies it is more likely that the economic conditions
  will become worse. When the mother dies, the child will
  usually lose the primary and most important emotional
  caregiver as well as the stability of the daily routine.
  Consequently the loss of the mother may have a greater
  impact and result in a lower self-esteem, a feeling of loss
  of control, higher level anxiety and a more acting-out
  behaviour.

  The "Child Bereavement Study" observed that the loss of a
  father was more frequently associated with the development
  of health problems. Worden gives as a possible explanation
  that "when the mother was the surviving parent, mothers are
  more likely to give hugs and tender loving care to a sick
  child whereas fathers generally give medicine". (p.76).

- An important factor is the relationship of the child with
  the parent prior to his/her death.

3.3.3. The surviving parent

- Of major importance is - if there is one - the surviving
  parent. If counsellors, neighbours, relatives, teachers etc.

can lessen the stress of the surviving parent, they
contribute indirectly to the child's welfare.

- Another important aspect of the parent-child relation is how
  accurately the parent can see how the child is feeling or
  behaving. A more or less accurate perception of the child is
  needed in order for the child to feel secure and validated.
  Children look to parents (and other supporting persons) for
  validation of their own feelings.

  But it may be difficult for the bereaved parent to perceive
  the feelings and the behaviour of the child accurately. The
  parents themselves may be plunged in a deep grief. Children
  may try to protect the parent by not revealing all their
  feelings. So it is important that other support person try
  to perceive as exactly as possible the child's feelings.

- Setting limits and asking for discipline may be difficult
  for adults dealing with a child who has lost a parent.
  Worden points out that their study found that consistent
  discipline in the pre- and post-death period led to a better
  outcome for children, giving them some stability. Consistent
  discipline means: neither to become lax and overly indulgent
  nor to become very restrictive, over-protective, and over-
  controlling.

3.3.4.The family

- The size of the family affects the functioning of the
  surviving parent. Parents with a greater number of younger
  children at home tend to function less well, but at the same
  time, large families, especially the presence of more
  siblings, could be also a source of support for children.

- Conflicts with relatives, dependence on alcohol, conflicts
  between children and parents, unresolved problems, economic
  problems etc. act as causes of family stress ("stressor")
  and may influence negatively the experience of bereavement.

- Especially economic problems seems to be a considerable
  cause of stress. Adolescents are normally more sensitive
  about their possibilities for the future (school, clothes
  etc.). The results of the "Child Bereavement Study" confirms
  that generally children in families with higher incomes had
  higher self-esteem than children in families with lower
  incomes. They showed fewer learning problems, less sleeping
  disturbances and fewer difficulties in concentration. Income
  levels however, this as another result from the study, did

not affect self-efficacy - the degree to which children felt able to effect change in their lives and environment.

Also the three recent studies from Zambia, Zimbabwe and Malawi (discussed in Safaids News 1998 Vol 6/4) confirm the heavy impact of the economic deprivation: "In the Malawi study, the attitudes and aspirations for the future of the adolescents were investigated by studying their estimates of lifespan, the fears and excitements they have for the future, and other confidence indicators, such as the influence of peer pressure. Measures of these variables indicated a strong sense of hopelessness and fatalism amongst the adolescents with a lower economic status, less so among the affluent. Knowledge of AIDS, which was high, added to this sense of hopelessness.... The life experience of poorer rural students in Malawi appear to lead to a serious level of despondency and low self-esteem, likely to reduce capacity to prevent HIV infection. Young people can be presumed to be less likely to practise abstinence of safer sex if they truly believe that they will be dying within the next few years regardless of what they do.. Grabbing what short-term pleasures can be had and living for today seems to be a rational decision... Also the Zambian study suggests that the poverty related issues have had a worse immediate impact on orphans from AIDS than measurable psychological impacts since their parents died or became sick. On of the reasons for this finding could be that it is much easier to talk about material deprivation than emotional effects, so the findings could be biased"

3.3.5. Support from peers and others outside the family

- Peer groups (groups of children or adolescents of more or less the same age) can provide a safe context in which children can express feelings without worrying about the presence of their family members. Peer support can be especially helpful for bereaved adolescents, who, as to be shown later, struggle for autonomy and issues of separating from parents. Grief can complicate this process. Most bereaved children do not want to appear different or strange by crying or expressing sad emotions in front of their friends. This is in particular true for adolescents. Consequently, adolescents may close doors of support from both the surviving parent and friends.

  In a bereavement support group adolescents receive peer support from others who have sustained a similar loss. Peta Hemmings focuses an the importance of the role of establishing bereavement groups for young children and

adolescents because it is through such groups that the child can develop an appropriate peer group for their bereavement: "It is also true that a bereaved child feels different from her peers. Her experience of death and her knowledge of bereavement set her apart from her friends who are too young to know about such things. Their ability to empathise is limited by their developmental immaturity. The peer group contributes to our self-image, but this aspect of the bereaved child's self-image cannot be supported by their friends and needs to be explored in other social settings" ("Interventions with bereaved children, 1995, p. 17). (This view is confirmed by our own experience in Kagera).

- Different recent studies in Malawi, Zambia and Zimbabwe stressed the role of the <u>extended family</u>. It is in the African context common for children to move around the extended family, staying in different households and receiving emotional support and care from a wider adult group (than it would be usual in a western-style nuclear family). This may help to mitigate the sense of the psychological loss when the biological parents die.

3.3.6. Characteristics of the child

- The <u>age of the child</u> has a clear impact on the child's adaptation to loss. Younger children (up to around 11 years) have less well-developed skills understanding the context of events. This influences their ability to understand death and to cope emotionally with the loss.
  Adolescents are in a specifically difficult situation. They are at an age where they have to separate emotionally from the parents, to develop new competencies for their future life as adults and to develop and explore intimacy. The death of a parent can affect these developmental issues - either positively (to speed up the process of becoming grown up) or negatively (to feel abandoned in this difficult period and the feeling, to belong to nobody).

- To be a <u>girl or a boy</u> influences also the course of the mourning. In the "Child Bereavement Study" girls showed more anxiety than boys. The anxiety manifested itself in concerns about the safety of the surviving parent, as well as their own safety. Somatic symptoms (headache, troubles with the stomach, pains in the back etc.) were also more likely to be experienced by girls. Boys were more likely to have learning difficulties.

3.4. How life changes

When a parent dies, life changes for the child, for the surviving parent, and for the whole family. Using an image, we can say that the family acted like a balance with the weights on both sides. If you remove or change the weight on one side, the whole system will be affected. The same is true for a family: most families exist in some type of balance where every members has his or her role. The loss of any member of the family, together with the roles played by this member, will imbalance the family.

Researchers have observed that bereaved children need three things to help them to cope with the disruption in the family system caused by the death of a parent:
- Support: The child will feel supported when the parent or another person provides feedback and encouragement about the child's feelings and behaviour following the death.
- Nurture: A nurturing parent not only provides food, clothes, and shelter but is there to listen and use this information to help the child.
- Continuity: The child needs a sense that the family will continue, that there will be a connection between the past and the future.

To maintain a certain continuity can imply the following issues

- Physical availability. Most families depend on the father as their primary means of economic support. Fathers – especially in the African countries – are often forced to migrate for work to the towns or even to other countries. There is an increasing number of children-headed households, where mother and father died. In both cases - absence of the father or of both parents - the community (neighbours, relatives, teachers, CBO's) should contribute to assure a minimal physical availability.

- Emotional availability. The same is true for the emotional availability. Here, the grandparents, the school and peer-groups may play an important role.

- Changes in the daily life. There will be a lot of changes concerning chores and household duties, as various roles and responsibilities are reallocated among family members. Girls are supposed to replace the deceased mother. In our bereaved children groups in Nshamba also the boys reported that they have to assume new roles which were until now done either by

the late parent or by the female siblings such as to prepare food, to assist cooking etc.

Ledward found in Zimbabwe that children in families hit by HIV/AIDS appeared to adopt adult roles earlier than reported in rural areas in general. Girls and orphans in particular were taking on extra roles and responsibilities within the household, revealing pressures that the other children did not experience.

The changes in the daily life of children start already when parents become sick by HIV/AIDS. William Rugaimukamu reports in his already mentioned study in 4 wards in Kagera several cases where children and adolescents care for their parents or grandparents. One child told us that she had to walk each day about two hours to bring food for her sick father in the Rubya hospital.

It seems from the "Child Bereavement Study" in Boston/USA that even high changes in the daily routine were not associated with more emotional/behavioural disturbances. We don't know exactly what is the impact in the African context where orphans are often overburdened by the (new or additional) daily work. But we felt also in the Nshamba bereavement group that children are also somehow proud about the contribution they achieve in order to maintain the household functioning.

An important part of the continuity of the daily life is the continuation of schooling.

The worst thing that can happen to bereaved children concerning the continuity of the daily life is the separation from their siblings in the case that both parents died. The community and the extended can help bereaved children significantly if they find solutions where the children can remain together.

- For most children, having lost one or both parents created a sense of stigma, especially if the cause of the loss was HIV/AIDS. Nearly all children in our bereavement group in Nshamba/Kagera reported that they have been harassed by schoolmates and peers (which is confirmed by other oral or written reports from WAMATA or churches). For that reason it may be possible that bereaved children avoid their former friends.

3.5. How children respond to the loss of a parent

We will discuss the major possible and observed reactions on four levels:
- emotional life
- health
- school performance
- self-perception

5.1 Emotional life

- Sadness and crying. Sadness is expected when a parent dies – and the most frequent and obvious expression of sadness is crying. Nevertheless sometimes children, especially boys, get the direct or indirect message that crying is not accepted for a boy or that the child must now act more "grown up". A girl in Nshamba told us that she cries often at night, so that nobody is aware about it . In such a way she intends to avoid that the guardians would be worried. Additionally night-time might bring frequently sad feelings and feelings of loneliness.
  Some children, especially younger children, believes that if they cry hard enough, they might get the parent to return. This is understandable when one realises that crying behaviour brought normally a comforting response from the parents.

  In the "Child Bereavement Study", for most children sadness came when they realised that they could not longer have the presence of the deceased parent or that they could no longer receive advice and counsel from the parent: "It's just, like , not having a man to help me out; it's like being deserted. That the worst part of losing a father" (16-year-old boy).

- Anxiety. Anxiety can appear as the fear losing another loved one (which is very rational and probable when the first parent died because of HIV/AIDS) or as a concern with the child's own safety. Worden and Silverman observed that "many children do feel fearful, but significantly more so a year after the death than right away. Anxiety was highly associated with an increased number of changes and disruptions in daily life, and with feelings to be less in control over one's circumstances" (p.58). They observed also, that greater fear for the surviving parent's safety was found in children whose parent died of natural causes (illness). We can expected that this is also true for children, whose parent died because of HIV/AIDS.

- Guilt. Guilt is a common feeling after the death of a loved one. Guilt mostly take the form of regrets of things done or

not done: "I never said, 'I love you' to her. Now I wish she could be back and I could say it. Maybe when she died she didn't know that I loved her. I didn't want her dying thinking that" (11-year-old girl). "I can't change what already happened. I didn't spend enough time with him. After they are gone, they are gone. Maybe if I had said 'I love you' to him. I never said" (17-year-old boy).

In particular small children aged 4-6 years may sometimes think that the disappearance of the parent has something to do with their own behaviour - that something they did or said caused mother/father to leave them, which can produce profound feelings of guilt. (We call this stage in the child's development "egocentric thinking" and "magic thinking": small children feel that they can do everything and they are not yet able to grasp that there are circumstances in the relationship between themselves and their parents over which they have no control).

- <u>Anger</u> and aggressive behaviour. Feelings of abandonment often produce anger: "I get angry. He was too young to die, too nice a person to die" (14-year-old boy). Claudia Jewett refers to the findings of John Bowlby: "The psychologist Bowlby found that one-forth to one-third of the children he studied following a significant loss were overactive and aggressive, engaged in unprovoked violence toward peers and adults and destroyed property. Anger is an almost universal response to loss...Children whose anger at being deprived as a result of loss may act as if the world owes them, yet nothing is good enough to please them. No matter what they are given, nor how generously they are treated, they may explode when told no." (Claudia Jewett: Helping Children Cope with Loss and Separation, p. 88). Worden guesses that aggressive behaviour may be also an expression of fear: "The children who showed more aggressive behaviour were also more fearful of the safety of their surviving parent.." (p. 62).

Another unusual finding of the "Child Bereavement Study" was that delinquent behaviour was clearly related to loss of a mother and was found more frequently in the group of adolescent girls. Worden explains that often the eldest female in the family took responsibility to care for the younger children and the management of the household: "I was angry at my mother because she left me all the responsibilities. I'm still angry" (13-year-old girl). The girls miss also their mother as the same-sex parent in early adolescence when this close relationship may be of particular importance.

5.2. Health

The stress of dealing with the loss of a beloved person often has consequences for the health status

- Body symptons
  Somatic symptoms as headache, pains in the back or the stomach do not necessarily reflect an illness. In particular younger children who have still limited possibilities to talk and to express their grief and inner pain, might react on the loss with psycho-somatic symptoms. "I just get headaches a lot and I never got them before" (7-year-old boy). In the Child Bereavement Study, Worden observed that a fifth of the children experienced frequent headaches, with a larger percentage of girls.

  Higher level of somatic symptoms were most likely found in children whose family experienced a large number of disruptions after the death. Only to remember: Sometimes we use the word "headaches" also symbolically. We say: "This problems causes me headaches", without feeling really pain. So, to suffer really from headaches may be just another expression of pain.

- Illnesses
  The "Child Bereavement Study" observed a significant increase in the number of children who experienced a serious illness.

- Accidents
  There was another significant increase of the percentage of children experiencing accidents. This affected more boys than girls.

5.3. School performance

It was reported from the teachers in Kagera that bereaved children showed learning difficulties and difficulties in concentration in school. Additionally there might be now nobody who checks the progress of the child in the school.

5.4. Self-perception

Self-perception means that everybody has an image about him or herself: you find yourself intelligent or stupid, more or less beautiful, more or less strong or weak, more or less kind to other persons etc. It is evident that a child whose self-perception (or self-image) is: "I'm intelligent, beautiful,

kind, strong" acts in a different way towards other children, schoolmates and teachers, than a child who is convinced to be stupid, ugly, weak and withdrawn. Such a child is considered by the others as "stupid etc." which reinforce the self-perception of being "stupid etc.". (In sociology, we call this circular process "self fulfilling prophecy"). Important components of self-perception are the self-efficacy, the self-esteem and the maturity.

- Self-efficacy. Self-efficacy describes a person's perceived ability to influence and to change what is happening to him or to her. It is opposed to feel helpless, controlled by the fate or other outside influences.
  It is not astonishing that in the "Child Bereavement Study" bereaved children believed they were less able to effect change than the non-bereaved children. Worden observes that "at 1 year after the death of the parent, bereaved children who have a lower sense of self-efficacy tend to be socially withdrawn; they had fewer friends and were less socially active".

  In order to maintain or even to strengthen the self-efficacy of bereaved children it might be useful to ask children either to participate in important decisions which consider their future, or at least to keep them informed about what is being discussed. This may reduce considerably the feeling to be just an object without any possibilities to influence the future.

- Self-esteem: While self-efficacy focuses on the child's estimation of "power of influence", self-esteem looks more closely to the question: "What is my value? How am I valued by the others? Am I a *worthy* person?"

  The "Child Bereavement Study" doesn't note significant differences in the level of self-esteem between bereaved and non-bereaved children. Nevertheless our experience with the group of bereavement children in Nshamba gives some evidence that most of these children showed a low self-esteem (for example the way to talk etc.) which was confirmed by the teachers. But we couldn't compare these children with non-bereaved children, so we just assume this relationship. If we take into consideration that even after 15 year after the outbreak of HIV/AIDS, this disease is still highly stigmatised we might conclude that this stigmatisation and discrimination has a negative impact on the self-esteem of AIDS-orphans.

- Maturity. In the "Child Bereavement Study" children felt after one year more "grown up" because of experience of the

loss than other children. This may also be true in the
African context, where children have to take in new roles.
It is in this context extremely important that the social
environment (family, school, neighbours, community in
general) recognises and acknowledges the performance of
these children (instead, as we observed in Kagera, blaming
the children because they work for their and their siblings
survival and couldn't go to school!).

**Appendix: A look into the research: how to arrive at results
concerning bereaved children**

You got a lot of information about grieving and mourning of
children. These informations allow us to forecast and to plan
appropriate interventions and measures.

But you may ask if these information are reliable and
trustworthy and how it was possible to get these results.

There are two main methods to have deeper insights in the
grieving and mourning process of children:

1. To study systematically single cases of bereaved children
2. To make a systematic research including a greater number of
   bereaved children and compare them with non-bereaved
   children in order to discover the differences

1. To look into single cases
Some authors work themselves as child psychologists or
clinical child psychiatrists. They had to treat children with
different forms of emotional or behavioural disturbances or
problems. They observed that the parental loss caused in many
cases such disturbances and they started to study
systematically the relation between the loss of a parent and
the further psychological development of the child. Doing so,
they got a lot of useful insights concerning these relations.
But they met only those bereaved children who showed some
significant problems (and who had a remaining parent who was
sensitive enough to look for treatment and had enough money to
pay for it). Not each bereaved child will develop serious
symptoms, even when for every child the loss of a parent is a
very stressful event.
The question came up what happens generally with a child who
loses a parent? To get an answer on this question it was
necessary to make some larger systematic studies with bereaved
and non-bereaved children

2. Bereavement Studies
Let's take as an example the "Child Bereavement Study" by
Phyllis Silverman and William Worden (published 1998).

1. The first step was to identify 125 bereaved school-aged
   children in 70 families. Parallel Silverman and Worden
   identified the same number of non-bereaved children from the
   same communities as a control-group.
   The children were assessed during two years.
2. The next step consisted in conducting semi-structured
   interviews with the children and the care-givers/surviving
   parents about different topics such as learning of the
   death, circumstances of the death, funeral and other family
   rituals, ongoing relationship with the deceased parent,
   changes in daily life because of the death etc.
3. Additionally they used some instruments for observation and
   interviews which had been applied in many previous
   researches on children in general. These tests have been
   applied to the bereaved and the non-bereaved children.
   They used among others the
   - CBCL (Child Behaviour Checklist by Achenbach) which
   consists of 118 behaviour problem items rated by
   parents/care-givers as "not true", somewhat or sometimes
   true" and "very true or often true" of their child (example:
   "The child plays now significantly less with his/her friends
   than some months ago")
   These 118 items are bundled in eight areas: 1) social
   withdrawal, 2) somatic complaints (stomach, headache etc.),
   3) anxiety-depression, 4) social problems, 5) thought
   problems, 6) attention problems, 7) delinquent behaviour, 8)
   aggressive behaviour.
   - "Perceived Competence Scale for Children" which consists
   of 28 pairs of statements describing two opposite ends of a
   specific behaviour. Six areas of perceived competence were
   assessed through self-report from the children: 1)
   scholastic competence, 2) social competence, 3) athletic
   competence, 4) physical appearance, 5) behavioural conduct
   6) global self-worth.
4. Finally the results have been analysed and the two groups
   have been compared.

We have to be aware that the major part of research on
bereaved children has been done in the Western countries
(Europe, North America, and Israel). Only very few scholars
started to reflect the situation in the African context. Such
examples are:
Little, M.L.: Adolescents and AIDS in Malawi: "Issues of
Hopelessness and Fatalism in Effective AIDS Education" (19969

Poulter C, Kangwa C,, Machande M, Zimba P: "Psychological and Physical Needs Profile of Families Living with HIV/AIDS in Lusaka" (1997).

4. Basic concepts – a set of tools for comprehension

Silvermann and Worden state in their book "Children and Grief":

"The death of a parent is one of the most fundamental losses a child can face. Ideally, parents support their children, both physically and emotionally; they provide a stable home environment in which children can grow and mature; and they serve both as the children's protectors and as their models. In reality, the extent to which parents fulfil these roles varies. Nevertheless, for the great majority of children, parents remain their most significant others; in effect their partners accompanying them in the essential development tasks that will take them to adulthood. The loss of a parent to death and its consequences in the home and in the family change the very core of the child's existence" (Children and Grief, 1996, p.9).

In essence, this may be true also for the African context, even when the family has a different structure (extended family, role of the clan or the community). Elizabeth Jareg from "Redd Barna" facilitated a number of "Community Diagnosis related to the Child development through Community Dialogue" in Uganda which confirmed (among others) that the loss of a parent to death is also considered as a drastic and far-reaching experience for children.

Poulter e.al. found in Zambia that the children of sick parents were significantly more likely to show signs of psychological disturbance: to be unhappy, depressed, worried, solitary or fearful of new situations: "Children as young as one-year-old changed their behaviour noticeably when their parents were unwell. They become concerned and upset" (In "Safaid News, dec. 1998, Vol 6/4, p.5)

Despite of the existence of only a few systematic African studies, we can assume that the loss or the terminal illness of a parent will cause considerable emotional stress for the children which may develop further into emotional and/or behavioural disturbances.

In order to be in a better position to act in the new situation caused by HIV/AIDS , we need to learn about some basic conceptual tools.

If you intend to prepare a meal, you need some tools such as a knife, a pot or a pan, the mortar etc. - and you have to know how to handle these tools. If you would like to sew clothes, you need certain tools such as a needle, thread, and maybe even a sewing machine - and you have to know how to handle these tools. If you know the tools you can describe the activity you intend to do: I take the knife, I cut the meat in small pieces etc.

The same is true for the very complicated process which occurs when children lose a parent or a close care-giver. We need to have some "tools" in order
- to perceive in our mind and to describe for ourselves what happens inside the child
- to have a possibility to support actively the child with something which probably may be "good" for him or her.

We therefore need to learn some of the basic concepts which are used in psychology in order to be better equipped with appropriate tools to support orphans. These basic concepts are
- risk
- vulnerability and protective mechanisms
- stress
- trauma
- coping,
- resilience

4.1. Risk

Let's start with a simple example: I jump from a two meter high wall. There is a risk that I can sprain or even break my leg. If I'm a trained "jumper", the risk is less than if I never do physical exercises. If I'm seventy years old, the risk of injuring my leg will be much higher than if I'm seventeen years old.
Conclusion: Jumping from the two meter high wall constitutes a certain risk, i.e. the probability of an injury. It is not at all sure, but it may happen due to the special situation - so it constitutes a risk. And of course we can list "risk factors" (such as age, training, type of shoes etc.), but we can't predict in advance what will really happen. Only when the event has occurred we can evaluate the facts.

To lose a parent constitutes a risk for high levels of emotional and behavioural difficulties, but these difficulties

do not necessarily appear. And in fact, all studies in bereaved children indicate that in general bereaved children are at a greater risk to be withdrawn, to be anxious, to have a lower self-esteem or to experience learning difficulties than compared to non-bereaved children. But there are also orphans who never show significant disturbances or difficulties.

Phyllis Silvermann and William Worden concluded in their "Child Bereavement Study " that "The bereaved children showed higher levels of social withdrawal, anxiety, and social problems as well as lower self-esteem and self-efficacy. Although most bereaved children do not show signs of serious emotional/behavioural disturbance, there is a significant large group of bereaved children who do show serious problems". (OMEGA, Vol.33(2), 1996, p. 91.

They indicate especially the possibility that the full risk-effect of a parental loss may come to the fore only after two years: "However, 2 years after the death, there were significantly more bereaved children than non-bereaved children in the risk group.. Our results show that the attributable risk percentage doubled from Year 1 after the death to Year 2 , further indicating the existence of a 'late effect' phenomenon by which more of the serious emotional/behavioural problems at 2 years could be attributed to the experience of losing a parent to death" ("Children and Grief", 1996, p.98).

These results concerning the "late effect" of the "Child Bereavement Study" done in the USA seems to be consistent with a recent study from Zambia where Poulter emphasised that the effects of loss of the parents may not be apparent until years later.

The loss of parents may also constitute a long-term risk e.g. for depression in adulthood, but the results of the research is still inconsistent. Also it is not easy to separate the risk-factor "parental loss" from other risk factors (e.g. poverty, or social discrimination) and thereby attribute due weight to it.

Silvermann/Worden, after reviewing the different existing studies, state: "It may be that the most important long-term consequence of parental death during childhood is neither depression nor anxiety disorder, as important as these are, because these only affect a small percentage of adults with childhood parental loss. Rather, the most important long-term impact may be their continuing sense of emptiness and an ongoing need to rethink who his parent would have been in

their lives had he or she remained alive. This ongoing presence of the lost parent is strong for most people, even though they may have had adequate parenting by the surviving parent or parent surrogate" (p. 110).

In accordance to a great number of investigations looking into individual biographies and case studies, psychologist admit today that exposure to <u>one</u> psychological risk-factor will not automatically be to the detriment of the child's further psychological development.

The main reasons for this (positive) prospect are

a) that in the normal, daily life-situation there may be other effective factors (e.g. a trusted teacher, peer-group etc.) which can compensate the risk-factor.

b) that the child develop itself very often coping strategies which may help him / her to cope with the stress caused.

Psychologists, however, agree that if <u>four</u> risk-factors (e.g. terminal sickness of a parent, separations from the siblings, exclusion from school, poverty) coincide on top of each other then it is almost inevitable that the child will show some disorder in the development and/or behaviour.

> **Risk means a certain probability that in an event (e.g. parental loss) may have certain consequences (e.g. anxiety, withdrawal etc.). But we must be clear that the selfsame event with the selfsame risk may be apprehended by one individual as normal event and by another as a personal disaster.**

4.2. Vulnerability and protective mechanisms

The concept of the "risk" directs our attention to the actual situation, to the "Here and Now". When it comes to the two following concepts - vulnerability and protective mechanisms - they are linked up to the past, to the live story of the concerned person, and to the future.

Let's first go back to our example with the wall. If I have once, one year ago, already broken my leg, it will be more likely that by jumping againfrom the wall, I will hurt my leg again. Through the accident in the past I'm "vulnerable" concerning my leg. But if I did a special training as a parachutist, I learned how to jump without any accident. So this training acts as a "protective mechanism" in the moment, I'm jumping from the wall.

"Vulnerability" and "protective mechanisms" which have been built up in the past, increases (in the case of acquired vulnerability) or minimises (in the case of acquired protective mechanisms) the risk to develop the harmful potential of a stressful event. They influence my "response" or my "reaction" to an event - for example the loss of a parent. Rutter compares these mechanisms with the immunisation in medicine: "Thus immunisation does not involve direct promotion of positive physical health. to the contrary, it comprises being exposed to, and successfully coping with, a small (or modified) dose of a noxious agent."

We can find in the psychological research a number of mechanisms which may act as mechanisms of vulnerability or as protective mechanisms.
So Garmezy, reviewing the research in Western countries into stress-resistant children, concluded that three broad sets of mechanisms operated as protective mechanisms:
a) personality features as autonomy, self-esteem, and a positive social orientation
b) family cohesion, warmth, and an absence of discord
c) the availability of external support systems (such as the school, church, neighbourhood, extended family, peer group etc.) that encourage and reinforce a child's coping efforts.
(Rutter in "Risk and protective factors in the development of psychopathology", 1990, p. 182)
But once again: these mechanisms do not act "automatically" as protective mechanisms or as mechanisms of vulnerability. We have to consider the live story of each child in order to understand how the former lived situations and experiences influence the coping capacity of a child in the case of parental loss.

Werner and Smith did a (longitudinal) study among 698 children from birth up to the age of 20 years. Among those children some of them have been exposed at the age of 2 years and later to four or more risk-factors. Nevertheless, some of them did very well and developed quite normally - they seemed to be "invincible".
Werner and Smith believe to have detected two groups of possible "protective" factors (or, in the case of their absence, factors of an increased vulnerability):

1.   The external protective factors

1.1. A good and safe relationship with the mother
1.2. An emotionally safe relationship with other persons in the family (siblings, aunt, grandfather etc.) or with

friends - relations which are marked by mutual confidence
and which tolerate stressing events.

2.   The internal protective factors within the child itself:

2.1. The capacity to stimulate and create positive reactions
     in the social environment (e.g. orphans of TAPA Primary
     School coming to the office to talk etc.).
2.2. The capacity to cope with the developmental tasks (the
     "invincible" children were good students) commensurate to
     the age group.
2.3. To be a good oral communicator.
2.4. To have good and joyful relationships with children of
     the same age (function of the peer group).
2.5. To have a positive self-concept (e.g. to have a realistic
     feeling for one's own capacities)
2.6. To be exposed to relatively high expectations (end even
     control) from outside , so that the child hasn't the
     feeling that nobody is interested in it and that they can
     do whatever they want.
2.7.   To be physically healthy and resistant.

Many events - and especially such shocking ones as parental
loss - contribute to the future vulnerability (and, when the
coping was positive, also to the growth of future protective
mechanisms). Mireault and Bond studied a group of college
students who experienced parental death in childhood. They
found that this group perceived themselves as more vulnerable
to future loss or separation than the nonbereaved control
group. With other words: it seems that an adult who lost the
parents during childhood, may be more sensitive and anxious to
different forms of separation not only during childhood, but
also later as an adult person. Peta Hemmings who worked during
many years with orphans concludes that orphans may make the
very special experience of a certain "insecurity" which can
act as a form of "vulnerability" in the future: "A bereaved
child has a knowledge beyond his or her years. He or she knows
how fragile the world is .. His or her knowledge of death can
be a burden and a source of great anxiety as she/he knows that
nothing can be taken for granted any longer. The world has
become a fearful and dangerous place " (Peta Hemmings:
"Interventions with bereaved children", 1995, p.9).

Rutter guesses that many vulnerability or protective processes
concern key turning points in people's lives - and the loss of
a parent is surely such a "turning point". What happens in
these key turning points will determine the direction of the
trajectory of following years. When the loss of the parents
(which is a risk for many processes such as poverty, lower

self-esteem, anxiety) is changed in a more positive direction with a greater likelihood of a certain satisfactory adaptation, a "protective mechanisms"will grow. Conversely, the process will turn to a vulnerability process if the outcome will be mainly negative.

The recent research done in Zambia, Malawi and Zimbabwe indicates that already existing poverty might be one of the strongest vulnerability mechanisms: "The prevailing poverty destroys the confidence of children growing up. If there is an overriding feeling of hopelessness towards the future and what life has to offer, then even extensive education on HIV/AIDS may not make a difference in changing behaviour. In Malawi, 12-year-old girls were driven to have sex for a Coca-Cola and to fulfil short-term needs. They do not have many options open to them, nor realistic channels in which to improve themselves and escape their poverty. It is a circular relationship in which the more hopeless people become, the less motivated they are to change their lives. The results of the Malawi study show the strong presence of such feelings in all adolescents group studied, and how these feelings intensified in the rural poor." (SafAIDS News, 1998, Vol.6/4, p.4).

Ledward insists that the individual acquired vulnerability or protective processes are embedded in a social and cultural context: "The impact of the epidemic will be mediated by pathways of vulnerability which are carved out by pre-existing social, cultural and economic values. Within a disease affected society individuals adopt new social roles, and social support mechanisms will be tested." (Ledward, p.1). She demonstrates how vulnerabilities are constructed at different levels: at the level of the individual, the family, the community, the regional national economy, the value system etc. To give some examples from her study in Zimbabwe:

- Women and often children, especially girls, are in a social and economic unsecured situation and they have to pursue survival strategies and undertake work which further increases their vulnerability, in order to earn money such as sex-work.
- Girls in general and orphaned girls in particular take on extra roles and responsibilities within the household, revealing pressures and risks which the other children didn't experience.
- Little attempt is made to talk directly and specifically to children. Because AIDS is considered primarily as a sexual problem, there is a reluctance to admit the relevance of this to children. So the adolescents - again especially the girls, become particularly vulnerable for AIDS-infection and for early pregnancy.

Vulnerability and protective mechanisms mean a tendency which was acquired in the past to react on an event (such as parental loss). An already vulnerable child will probably have less possibilities to cope with the death of a parent while a child with protective mechanisms will be able to cope better. The event itself may increase existing vulnerabilities or create new ones. It may also strengthen existing protective mechanisms or create new ones.

4.3. Stress or distress

The concept of stress or distress is - unfortunately - a quite unclear concept.
Unclear because firstly it is used in the daily language and with slightly different meanings: "Tomorrow, I have an examination - I'm very stressed". "Driving a car during rush hour stresses me". "When XY comes for a longer visit, I feel a lot of stress" "The seminar I'm participating in is stressing me" etc.). All these sentences will express that there is some additional tension, more nervousness, less calmness and peace. You may realise a high stress situation through body reactions such as heart beating, sweating, difficulties to sleep, difficulties in concentration, or problems with the stomach.

Secondly each person will define the same situation differently in regard to the amount of stress produced by a given situation. What may be stressing for one person is not or less so for the other.

Thirdly: the psychological stress-research also focused on different topics. While some focused on acute life-threatening stress (e.g. in war, disasters, accident, serious illness, assault, rape etc.), other researcher have concentrated on "sub-acute life-changing stresses" (with changes for probably the better - as a wedding, a birth, a new job etc. or for probably the worse such as parental loss, other separations, to be forced to stop schooling, to be disabled due to an accident or an illness etc.). Recently some research examined chronic life-irritating stresses (e.g. to be very shy and withdrawn, to react with extreme awareness to the slightest threat from outside, to compete constantly and excessively against everyone and everything, to collapse into helpless and hopeless positions).

Last but not least we can't, from the ethical point of view, expose people systematically to some experimental stress such as frightening or painful situations - so it's also difficult to get systematic information.

Although it is difficult to find a definition for the concept of stress or distress, we have to clarify how we understand this word. We can <u>define</u> "stress" or "distress"
- as a loss of a former existing balance which has been disturbed by a harsh event or a harsh experience
- as a process which involves often pain, insecurity, i.e. mostly negative feelings
- and as a process which needs some extra energy to restore the former balance or to built up a new balance.

The psychological research on stress points out that stress can produce two very different types of responses:
- "Stress" can induce a process of becoming weaker, of loss of strength, of loss of capacity to control the environment, to be reduced to a mere "object" of the other persons, to get isolated – to be a "victim" of the event etc.
  The psychologists call this "stress induced illness"
- "Stress" can induce a process of becoming stronger, to be productive in finding new solutions, to develop new capacities and abilities, to remain self-confident or even to develop a growing self-confidence ("Even in this bad situation I was able to survive") etc. – to overcome the threatening situation.
  The psychologists call this "stress induced resilience"

4.4 Trauma

"Trauma" is another concept which is difficult to handle. We can read in newspapers or hear in the radio, that the war in Kosovo or Rwanda "traumatised" the people, that sexual violence against woman produced a "trauma", that an earthquake "traumatises" the whole population etc. but mostly we use the word without knowing the meaning.
What do we mean by "trauma"? The word "trauma" is a Greek word and means "wounding, wound".

1. First it says that – using our initial jumping-example – I jumped from the wall and I injured the foot. I can't really stand on it and walk. The other day, the foot is swollen and it pains even more than the day before. I have to see the doctor. Maybe he will find out that something is broken and it needs a special treatment. So the event (to jump from the wall) produced some effects which will last for some days or weeks or even months.
Similarly an event as war, rape, accident, or natural disaster as an earthquake can produce <u>long-lasting effects</u> in our feeling and behaviour such as

- strong feelings of helplessness and to be at the mercy of
  something or somebody
- to have strong feelings of guilt or shame ("I'm responsible
  for all what happened")
- to be depressed
- to be afraid of the future
- to have "flashbacks" (the terrible event comes always again
  into the mind as it would be repeated, i.e. re-living the
  traumatic situation in thoughts or images) or to have gaps
  in the memory (in order to avoid to deal with memories of
  the past)
- to be afraid to become mad
- to have a damaged or even destroyed self-image ("I'm
  nothing")
- crisis of sense (Why I? Why my baba?)
- crisis of confidence in other persons because they fear to
  get hurt again
- isolation and withdrawal
- self destruction (biting nails, cutting the skin, suicide)
- absence of feelings, to be numb
- numbness in some parts of the body and other somatic
  disturbances (sleeping or eating disturbances, pains)
etc.

It is important to remind ourselvesthat these effects can
appear even weeks or months after the causing event, so that
sometimes it is difficult to perceive that this behaviour
might be a consequence of the traumatic event.

2. Secondly - and here we can't use our jumping-from-the-wall-
example - the origin of a trauma has something to do with the
limited capacity to cope with an event. Let's take another
example: There is a small river. In normal times the river's
bed is broad and deep enough for the water flow. But it's
possible that after a heavy thunderstorm with very heavy rains
the river bed is too narrow to absorb all the water - the
water will burst the river's banks.

This image of the river can help us to understand the dynamic
of a trauma: A person is exposed to an extreme stressful
situation which may "flood" and burst the banks, i.e. the
"normal" coping mechanism, and overburden the hitherto
developed capacities. So the "trauma" is an indicator that a
person is struggling to survive in the time of "floods" and
"disasters", in the "abnormal" time. The psychologist E. James
Anthony describes the trauma in scientific terms: "In the
psychoanalytic concept of trauma, the basic function of the
mental apparatus is the re-establishment of stability after a
disturbance by external stimuli... When the balance is

affected, a state of emergency exists, and one is concerned with the capacity to master the situation. This capacity was thought to depend on both constitutional and acquired experiences" (Anthony/Cohler: "The invulnerable child" 1987, p.9).

Elizabeth Jareg, an experienced child psychiatrist who worked with many "traumatised" children, insists that

1. Not every situation which we can consider as "traumatic" has to produce a trauma. Some individuals will recover, others not. The coping capacity (the embankment in our picture) isdifferent from one child to the other. Anthony observes that "following a traumatic exposure, very vulnerable individuals do not move towards a spontaneous recovery, but toward the development of lasting defects of the personality, such as a diminished interest in the external world, and a readiness to withdraw from contact with reality.."

2. A trauma can also build up future resistance.

Elizabeth Jareg writes about the reactions caused by a traumatic event:

"These reactions are not symptoms of mental illness, but describe reactions commonly seen in children and adults when they have been severely overburdened psychologically.

The significance of such reactions is that they interrupt the normal course of development for the child or young person - they are the reactions to a severe crisis in the child's life.

Like all crises, this may be the starting point of a destructive train of events which has life-long negative effects on the future life of an affected child and can lead to mental illness. On the other hand, a crisis may lead to a personal growth in a young person and lead them to take decisions early in their lives which they otherwise would not have taken. This development is largely dependent on timely and appropriate support. An experience can be considered "traumatic" in a true sense only in retrospect, i.e. once it has produced a lasting effect on symptoms or character formation. The observer's judgement or empathy is inadequate to measure trauma; only the specific meaning the experience has for the individual can decide that question.

It is of course very difficult to predict what course the lives of children will take after they have been affected by such an experience. ... Severely distressed children may suffer in many ways: they may be very lonely and suffer from the loss of their parents and being separated from their siblings; they may be hungry cold, ill. They may be in a situation where they are being abused or neglected. They may grieve

over lost opportunities and be deeply worried about the future. The may have nobody they can talk to or who can give them comfort. They may, in addition, have some of the disturbances described above.

Children in such circumstances are in great need of assistance from concerned, committed and informed adults, be they parents, guardians, foster-parents, teachers or other members of the community, government representatives etc." (Elisabeth Jareg: Trainung Module 2: Children under severe stress).

Also Bessel van der Kolk insists on the same point regarding treatment of traumatised children : "Since safe attachment appears to be the primary way in which children learn to regulate internal status changes caused by a traumatic event, the negotiation of interpersonal safety needs to be the first focus of treatment... Since distrust and lack of social safety are critical parts of developmental trauma, safe structures and predictability of the future are essential" ("The psychology of developmental trauma", Praxis der Kinderpsychologie 47 (1998), p. 19).

Maybe we have to stress once more one core finding of recent research, as it was already pointed out above, that no single event is likely to cause developmental harm. Significantly, it is the context of a traumatic event more than the event itself, that is most influential on the child's development.

4.5 Coping

Diana is a 4-year-old girl in Kagera who lost first her mother when she was not yet one year old. Three years later her aunt who had taken care of her, died because of cancer. Diana then became very afraid of big animals like cows or dogs. When such an animal appeared only from far, she scared and started to cry, to cling, to look for protection, and she was extremely exited and irritated. In order to calm her it was necessary to hold her. Afterwards she showed what we call a "defensive response": to stay close to the accompanying person, to avoid to go far alone etc.
During some weeks we walked together every evening. Holding her hand, we approached together the scaring animals, but never more than she herself accepted and supported. The next step was to go together, holding her hand and offering protection if she would need it. After some weeks she develop a new response: she went alone in the direction of the cows (and even to the dog of the farm) and talked to them. She was still a little bit scared and ready to withdraw, but she managed to deal with the situation from her own resources. She

developed a "coping response" which is not primarily avoidant and which transforms situations rather than permitting herself to be transformed (in an anxious child) by the situation.

Coping as a concept is more and broader than purely defensiveness and passivity. Coping verges on the areas of competencies and creativity. Coping can be taught and learned. Lois Murphy and Alice Moriarty did an intensive study concerning coping from infancy to adolescence. They concluded: "We were surprised to learn that support for the child's spontaneous coping efforts can begin at birth, and that coping capacity develops from, let us say, 90 percent helplessness at birth to 90 percent autonomy in maturity. .. Child rearing is not just a matter of taking care of the baby and the young child, but supporting the child's efforts to take care of himself. This implies respecting the baby's signals as to what is comfortable, what is enough or too much, what is too hot or too cold, what tastes good or tastes bad, what feels good to the touch. It implies respecting the baby's effort to look and scan, reach, push away turn over, move toward something... Much of the time the child knows, what it is ready for...It is important to provide the child with opportunities for managing small responsibilities as well as self-care... When new challenges are feared - as going to school, moving to a new house - parents can help not by forcing the child to cope alone, but by the reassurance of their presence and help and by allowing the child to show how much can be managed independently. The parent of good copers respected their children's capacities, encouraged and rewarded their efforts, and offered reassurance in times of frustration and failure" (Murphy/Moriarty: "Vulnerability, Coping, and Growth, 1976 p. 349).

In the bereaved children group-work that Humuliza does in Kagera, we tried to build up the coping capacities of the children: There is one training-module dealing with anger. First the children try to identify their anger. Afterwards we look at possible reactions when a child is angry: "How can a child act out anger?" We write the children's contribution on the blackboard. Normally there are very different strategies of the children to deal with anger, from talking to a trusted person up to aggressive behaviour e.g. throwing stones. Then we ask each child to select one or two behaviours (or "coping strategies") that the child finds adapted to him/herself and that he/she will try to implement next time when anger comes. In the handout about "Stress and coping" you can find a profile of children who normally are "good copers".

One of the main conclusions of the different research (in the Western societies) was that the good coping depends largely on

the family and the community. Such families and communities
that creates good coping facilities, had the following
profile:
- children feel accepted and beloved
- For the children family and community both function as a
  holding and facilitating environment
- the environment permits children to be active or inactive as
  the circumstances requires, to let of "steam" and to
  discharge tensions without provoking catastrophic
  consequences
- the environment supports the children to build up inner
  resources and to reach self-generated conclusions
-    the environment support's the children's efforts to care
  for themselves
- the environment is highly sensitive and receptive to the
  "understanding of the world" developed by the children
- the environment support the children's effort to be self-
  reliable
- the environment does not resort to rigid sex-typing, so that
  children without shame or discomfort were able to resort to
  both "masculine" and "feminine" modes of coping.

4.6. Resilience

Resilience is quite a new term in psychology. The dictionary
defines resilience as "1. the power or ability to return to
the original form, position etc. after being bent, compressed,
or stretched; 2. to recover readily from illness, depression,
adversity".

It is in the same sense we use the term in psychology.
Resilience means
 - the faculty to recover relatively fast and comprehensively
   from severe events, if there is a supportive environment
 - the maintenance of competencies even under severe current
   strain and stress
 - the fact that children are not just passive objects but
   that they actively shape their development in a positive
   way - again - if they are supported).

Anthony/Cohler titled their book "The invulnerable child" and
Emma Werner called her book "The invincible children". It is
true that children have an enormous capacity to survive and to
recover, IF they get at least some minimal support and if
there is a supportive environment. It is always admirable and
wonderful to see how children are able to use the least
support to push further their lives and their own emotional
and intellectual development. Children have enormous energies.
But they still need our minimal support. In this sense, the

titles cited might give a wrong idea about the self-reliance
of children.

A policy which supports children to build up their resilience
- should directly help them to recover from the shock to loose
  the parents
- should make them aware of the resources they have themselves
- should contribute to overcome the feeling of helplessness,
  that everything is
  lost and "that there is no future" (15-year-old boy in
  Kagera)
- should help to maintain and to develop their self-esteem and
  self-confidence
- should make them feel that the community does not abandon
  them.

Appendix: Some selected research hypotheses by Andrea Ledward:

1. An individual's vulnerability is carved our by factors at
    the individual, family and wider social level. Individual
    vulnerabilities the also expose and create weakness at the
    wider levels.
2. Children's lives are structured primarily by the family.
    Within this framework they can make choices.
3. As childhood is gendered in the domestic sphere so is
    vulnerability.
4. Because children are increasingly adopting adult roles the
    need to delineate them as a separate interest group and
    ensure that their (new) needs are addressed, is also
    increased.
5. The impact of illness is shaped by the socio-economic
    context.
6. The impact of HIV/AIDS is felt most strongly along pre-
    existing routes of vulnerability, which, for adults and
    children, are drawn primarily along the boundaries of age
    and gender.
7. Perceptions of illness vary for boys and girls.
8. Orphaned children have weaker kin ties which may allow
    them to make more choices. (Ledward, p. 4)

5.1. Counselling and intervention issues for bereaved children

The "Child Bereavement Study" confirms what we already know
from our experience: Many bereaved children are able to adapt
to loss without any special intervention at all. But it is
also true that all children who lose a parent obviously suffer
and have to cope with the loss. And it is also true that
losing a parent constitutes a risk for developing further
emotional or behavioural disorders. Addressing certain basic
needs in this situation can help to minimise the possibility
that children develop more serious problems.

Ben Wolfe once used the picture of the broken glass to help us
understand the situation of children who experienced a loss:
"The story describes a window that is broken and the
realisation that no matter how hard one tries, after being
glued together the glass will never be the same again. We also
know that of our lives. We know when significant events take
place in our lives, we too may never be who we used to be
before. Major transition points shatter the glass. Some
individuals think they can quickly find all the pieces and
glue them back together as they were previously for either
themselves, other members of their family or friends. Others
learn that part of the window will become blurred. Transition
is not always negative, but are 'windows in time'. They are
events that reshape us. They remind us that although we want
predictability and control in our lives, neither is
guaranteed. Life changing events challenge our coping skills
and force us to re-examine our priorities. Youngsters who have
experienced the death of a family member, relative or close
friend have an entirely different perspective on what the
'glass' looks like today compared to youngsters who never had
a similar experience. They are changed because of death".

Forster from FACT found in a research in Zimbabwe that there
were few differences in measure of health, nutrition and
education between orphans and non-orphans, but that there were
important behavioural and attitudinal differences, which may
be more crucial indicators of well being. Morreira reports
from Uganda and Rudd from Zambia that orphaned children are

"poorly socialised and lack emotional support. They often suffer from stigmatisation.

In the following we mention some concrete possibilities how responsible adults can support bereaved children in this critical process of "gluing the glass" and how they can meet some specific needs of bereaved children.

5.1.1. Adequate information

When children do not have sufficient information, they will make up a story in their fantasy to fill the gap. Worden tells the story of a girl whose favourite uncle died of AIDS. She was not told about the cause. She made up an elaborated story about how he had eaten poisoned meat, meat that had been nibbled on by a rat who had eaten some poisoned ugali, and that is why he died.

It is very helpful for children to get clear, comprehensible and age-adapted information about an impending death and about the cause of the death. Worden points out that "a lack of information can make a child feel anxious and less important; and in the worst-case scenario, the child can feel responsible for what is happening to the dying person." Without a clear and adequate information the child can develop unrealistic fears about death and disease. Children may wonder "Will it also happen to me? Is the death and the disease contagious?" Helping them to know that "Daddy died because of cancer" or "of AIDS" and that they cannot "catch" cancer or AIDS (at least at this age of young children) can somehow reassure especially younger children.
Barbara Monroe, head of the Department of Social Work of the St. Christopher's Hospice in London insists that it is impossible not to communicate with children: "A terminal illness or death in a family causes enormous changes and children quickly sense when something so serious is happening. They pick up the emotions around them, notice changes in the routine, read body language and overhear conversations. However, a child's silence, lack of questions or apparent indifference may be interpreted by adults as a lack of awareness or a state of coping which should not be disturbed. Children want to protect their parents and often attempt to obey family (and cultural) rules even if they are unwritten. If the whole emotional atmosphere of the family and/or the social environment is saying 'don't ask, we don't talk about it' children may try to join in the pretence that nothing is happening, and they may develop fantasies which are sometimes worse than the reality and can be very frightening." (Interventions with bereaved children, 1995, p. 88).

Parents have, of course, good reasons for their reluctance to
share information about illness
- It may be culturally not allowed or practised
- They are struggling to maintain some control over themselves
  in an uncertain situation.
- They can feel overwhelmed by their own raw and confused
  emotions
- They may wonder if they themselves may cope with the child's
  reaction and grief
- They themselves may try to avoid the truth
- They may underestimate or be anxious about what their child
  understands
- They might be worried that they don't know how to
  communicate with the child and to say the wrong thing which
  may make an already difficult situation worse.

5.1.2. To address fears and anxieties

The loss of a parent generates a lot of fears and anxieties.
Will the other parent also die? Who will pay for my school
fees? Will I myself also die? To whom can I go when I'm sick?
Will I be separated from my sisters and brothers? Can we stay
in this house? etc.

All these fears need do be addressed directly by those
attending to the needs of these children. Even if the adults
can't give an appropriate answer because it is not yet clear
or decided it seems to be important that children can address
these questions.

5.1.3. Reassurance that children are not to blame

Bereaved children may wonder: "Did I cause the death because
of my anger or my short-comings?" Children learn early that
strong feelings can hurt another person. They may be angry at
the per-son - and then this person dies. Adolescents, in
particular, have often ambivalent feelings of love and hate
toward a parent. And children around the ages 4 and 5 (known
as the "magic years") believe that they have "superpowers" to
make things hap-pen. Could such feelings have contributed to
the death?

These children need to know that they didn't cause the death,
that their negative feelings toward the deceased did not
contribute to or cause the death. Children have to be
reassured that they have not (yet?) the power to harm a
person, that they are not "*mganga's*". Giving children the

opportunity to talk about their feelings for the deceased, both positive and negative, can help parents or counsellors to identify any problem of guilt that the child may want to test against reality.

To deal with the positive of the parents is much easier than to deal with the negative which also is always around. But to accept the reality means to accept both. Peta Hemmings describes a beautiful way how to approach this sensitive issue with children and adolescents: "One of the ways in which I have approached this sensitive subject is by using a picture of the old fashioned weighing scales, the sort that have two balancing pans. The first stage to this exercise is for the child to think about herself and to list all the things she enjoys about herself and place them in one of the pans. The she considers the things about herself which she would like to change or which cause her difficulties, and these are placed in the other pan. The instruction is carefully phrased in this way to avoid using the words "good" and "bad" because of the value judgements implicit in both terms.
The child is then asked to think of all the ways in which the deceased person pleased him/her and showed his/her joy and appreciation of the child. She then writes and draws symbols of those qualities in one o the pans and spends time thinking on those positive aspects , giving examples and remembering shared activities. She is then asked to think of times when things did not turn out as she would have liked, or when it was more difficult to be with the deceased person. The positive memories help the child to tolerate the more difficult ones which are placed in the other pan."
(Interventions with bereaved children, 1995, p. 21).

5.1.4. Careful listening

Children have fears, fantasies, and questions, and they need persons who will listen to them. It is very important not to give children superficial answers, even if to us adults the questions seem strange or even uncomfortable. A question such as "Does Mama still goes to the toilet?" expresses that the child is very concerned with different aspects of the life of the deceased person and needs a serious answer.
The listener may be someone other than the parent: teachers, counsellors, relatives, neighbours, or parents of peers.

5.1.5. Validation of individuals' feelings

Feelings must be acknowledged and respected as valid. It is a big temptation to tell a child "how she or he should feel". We

can't and we shouldn't stop for example the feelings of
sadness trying to convince the child that this feeling should
now be over, showing that the brother or sister stopped also
to cry. If the feeling is there, it is there. We also have to
keep in mind that each child has a distinct personality and
each child had a different relationship with the deceased
parent.

5.1.6. Help with overwhelming feeling

One cannot protect children from these intense feelings and
emotions provoked by the death of a parent. These feelings
might be very strong and too scary for the child to express
directly.
What we can do as adults is to work out with them
possibilities of expressing these feelings or to help them to
find safer ways of expressions. (See the example in the
bereavement group in Nshamba in the section "coping").
We have also to be aware that children often cope and
communicate through playing activities. Worden reports an
example where a mother, returning from burying her husband,
saw their two children playing funeral with the two neighbour
children. They had set up three chairs side by side - one
child was on the chairs as the body, one was the preacher, and
the two neighbour children were the mourners.

5.1.7. Involvement and inclusion

Children need to feel important and involved before the death
as well as afterward. The youngest children in the family, and
often also the girls, are frequently those who are treated as
the less important and involved. One possibility to address
these needs of feeling important is to include children in
funeral planning and the funeral itself.
Children, like adults, need rituals, but there are in general
few rituals in the society that include children.
We learnt in Nshamba that the classmates participated in the
mourning process of deceased parents of a schoolchild: They
visited together the house, and especially the child. This is
one important possibility to validate the child who has lost a
parent.

5.1.8. Continued routine activities

Children need to maintain age appropriate interests and
activities. Children worry about who will wash them tomorrow
or if they can continue to attend the school.

5.1.9. Opportunities to remember

Children need to be able to remember and to memorise the lost parent not only after death but continuously as they go through the remaining stages of their life. There are various ways to support children: Pictures and other things belonging to the deceased can be useful reminders. In Kagera there is a habit to give to the children a piece of cloth which used to belong to the deceased parent. Shared reminiscences in a family can also be very helpful.

5.1.10 Girls are especially vulnerable

It was already mentioned that the HIV/AIDS epidemic has apparently a special negative impact on the life-chances of girls. They are more vulnerable than boys in terms of their social status and their economic dependence. Ledward reports an increase of sexual exploitation in Zimbabwe. Rape of girls has become one of the most common offences appearing before regional magistrates' court. Elliotts reports that 70% of rape cases involve children under 13 years of age. Ledward guesses that the risk of sexual exploitation (we use the term "exploitation" and not abuse, because there is no "correct" sexual use of children) might still increase as children are increasingly placed with caretakers who are not their biological parents, and fear causes older man to pursue strategies to avoid older women.

5.2. General Strategies

5.2.1. Care by the surviving parent

Advantages
- The child remains in the family with his/her siblings; to a great extent continuity is retained and guaranteed
- Children probably get best possible emotional support and understanding
- The family (including the children) will probably remain with the property of the deceased.
- Financially it is the least expensive way to deal with the big number of orphans

Disadvantages or difficulties
- The surviving parent is him/herself stressed and occupied by the loss of the spouse
- Financial and economical difficulties especially when the father died and the mother is the surviving parent.

- The surviving parent is frequently also infected by HIV/AIDS which is a strong additional stressor
- The surviving parent is overburdened with work
- Insecurity regarding the goods (house, shamba) when the father died

Possible interventions to reduce disadvantages or resolve difficulties
- Writing a will by the deceased parent will strengthen the security of the remaining family
- Support by a "home care" programme prior to the death of the parent can establish a supportive emotional relationship with the remaining parent and with the children.
- Possible financial and material support and interventions from the community to reduce disadvantages or resolve difficulties. The support can range from funding school expenses to food, soap, medical supplies, renovation of the house etc. and can reduce the economic burden.
- Providing legal procedures and support to protect the rights of the children and the widow.

5.2.2. Care by the extended family (relatives, for example the grandparents, uncles, aunts etc.)

Advantages
- Traditionally accepted way of caring for orphans
- Children stay in a familiar and well known social context
- There is a chance that siblings can remain together
- Children are often given good emotional support
- Seldom direct legal (inheritance) problems. Nevertheless legal problems may arise later, when the children become mature and may ask for their inherited property
- Less expensive than institutional care

Disadvantages or difficulties
- Financial capabilities of the extended family are limited
- Siblings may be separated and distributed to different families because of limited economic resources of the respective families
- Emotional capabilities are limited - especially those of the women, who have to deal with the orphans -. To care for additional children constitutes an additional stress.
- Difficult integration of the newcomer (orphan) with the children of the related family already present (jealousy, mistrust etc.)
- Children may be neglected, even abused (by excessively workload or sexually abused) or battered.

Possible interventions to reduce disadvantages or resolve difficulties

- Financial and material assistance (see above)
- Participation of the women in the decisions to care for related orphans. We have been told that in Kagera normally the men of the extended family or from the clan decide after the burial who will care for the orphans. The women who have to do the main workload with children, are excluded from such decisions. They just have to accept and to implement the decision which makes it difficult for them to accept the orphans emotionally. They often are angry and worried about the new "burdens" which create a difficult situation for both, the orphans and the caring person.
- Psychological support and counselling for the guardians ("carer's school") if they express correspondent needs.
- HUMULIZA reports a case in Muleba district where the members of the extended family decided to contribute financially to one family who accepted to care for all four orphans in order to avoid the separation.
- Legal support (see above)

5.2.3. Foster care or adoption (non related care for the child / care outside of the extended family)

Advantages
- Guarantee for the satisfaction of the basic needs
- Emotional and social support by a family and creation of a feeling of "belonging" to somewhere
- Existence of a adult guidance
- Providing a new stable setting and a stable outlook for the future and releasing the stress of the orphan

Disadvantages and difficulties

- Guardians may not have the necessary financial means
- Foster parents might be interested mainly in external support or in some goods belonging to the orphans
- Danger of economic/working exploitation (cheap labour force) and/or sexual exploitation.
- Adoption might create culturally defined difficulties (see annex)

Possible interventions to reduce disadvantages or resolve difficulties

- Financial and material support by the community etc.
- Psychological support and counselling of the guardians if they feel correspondent needs. Maybe a short preparation of foster parents can be helpful.
- Supervision by an (elected) Committee in the Community to avoid any form of abuse. (In France, any adopted child is

visited at least once an year by a social worker of the
social department - this without any announcement).
* Legal support might play an important role when it comes to
the question if the foster parents should get some
compensation for the care in the form of land etc.

5.2.4. Group support to orphans living either alone as
"children-headed household" or in decentralised family-type
groups.

More and more frequently, children-headed households will
appear. In case of single or rather young orphans without any
elder siblings for whom no relative or foster parent is
available, a substitute mother or father might be employed to
form a "substitute family" with a group of orphans

Advantages
* No disruption of the actual social life (schools,
neighbours)
* Offer of some adult guidance
* Reduction of the feeling of the children to be abandoned
* Active support and validation of the children own resources
* No separation of/from the siblings

Disadvantages or difficulties

* Less constant emotional support and less constant caring
* Children staying alone might be overloaded with work and
with responsibilities
* Children are not prepared in activities of daily life (ADL)
in the areas of cooking, budgeting, hygiene and health,
maintenance and cleaning, etc.

Possible interventions to reduce disadvantages or resolve
difficulties

* Constant and reliable economic support of the community
* Availability of at least one person (better two or three)
who constantly acts as counsellors for the children who live
alone.
* Forming support groups in the community with a clear defined
commitment (for example: "I promise to bring each month two
soaps to the substitute family or to the children-headed
household")
* Training the children in "Activities of Daily Living" and
live-skills.
* To have a fixed weekly meeting with the children to plan the
next week and to discuss the major problems.

5.2.5.Temporary residential care

Children are temporarily taken care of in institutions such as day care centres or vocational training centres

Advantages

* No or less disruption of the actual social life
* Day care on working days gives relieve to the surviving parent or the guardians
* Children have contact with other children
* In the case of vocational training centres: Adolescents will return to the extended family and to their community.

Disadvantages or difficulties

* Less emotional support than in families
* Number of staff is seldom sufficient
* Staff is not very prepared to deal with orphans
* Expensive: the teachers have to been paid, the building has to be organised etc.
* Danger of alienation between the child and the extended family

Possible interventions to reduce disadvantages or resolve difficulties

* Financial or labour force support by the community (and/or by the district, by NGO's etc)
* Training of the teachers concerning the special needs of orphans
* Regular contacts and relations between the extended family members and the institution.

5.2.6. Permanent residential care: orphanages

Advantages

* Access to some care if there are no other opportunities for care and all other forms of support have been exhausted.

Disadvantages and difficulties

* Any form of residential care is very costly
* Number of staff is not enough - so orphanages are overcrowded
* Lack of adequate individual love, emotional support and care

Possible interventions to reduce disadvantages or resolve difficulties

- Employment of enough, trained and motivated staff.

Appendix: Culturally defined barriers to adoption: the example of Zimbabwe

"The spirits of the deceased in patrilineal societies continue to protect those of their own blood who are still living. They continually monitor the activities of the family members and are able to reprimand or give guidance as appropriate. Where normal practices are deliberately mocked there may be serious repercussions not only for the offending family member, but for the whole family.
It is expected by the ancestral spirits that those within their family have an obligation to care for those of their own blood. Caring for a relative is therefor seen as both spiritually correct and a virtue and may result in favourable treatment by the ancestral spirits. To foster a non-related orphaned child, however, is a taboo, since these children will also have their own ancestral spirits. The host ancestral spirits do not want to be over-burdened by protecting strangers, nor do they want the stranger's spirits coming into the homes of their progeny in search of the child.
Therefore, if a couple do foster an unrelated child or in other ways flout normal practice, they will be subject to the wrath of angered spirits that visit the living to correct the wrong doing. This is called "*ngozi*" (in Shona language).
Fostered children might become *ngozi* when, for example, their ancestral spirits are blocked from receiving recognition by their progeny; the foster child is mistreated in any way; or when in the event of a marriage or death, here is no blood relative to handle the bride price (*lobola*) or make the ceremonial first dig of the grave.
The family can appease only their own ancestral spirits, but not the alien spirits as they would not know the appropriate procedures or references. Since decisions with spiritual implications can have such serious consequences on the whole family, They must be family decisions and not individual ones, in consultation with the spirits through a traditional healer (*n'anga*).
Research on commercial farms has shown that many people do believe in and fear *ngozi*. However preliminary results of the study suggests that while the spirit world is a significant stumbling block, the problem can be resolved within the traditional system. For example, parents can simply consult a *n'anga* who can advise them about a potential foster child. An

interview with two foster parents on one farm revealed that they are quite aware of the existence of *ngozi* and the greater risk they faced of being victimised by the spirits. "But merely looking after a fellow human being is not criminal in itself, and spirits are also rational. As long as one is honest enough and does not ill-treat the foster children *(and even encourages them to remember the shades of the clan they came from)* there is no reason to fear *ngozi*. "(Media for Development Trust: "Children under stress", p.7).

6. Facilitation

Let's start this section with an exercise: Remember some occasions when you participated in courses, seminars etc. Which venue you consider among the most profitable for yourself, where you increased your knowledge and your skills, where you still remember the content, you found it interesting, you understood the content and you have been motivated to put it into practice? Remember also one or two events which were the least profitable in the same terms. Form groups of three. Explain your two examples to your group members. Find out and discuss the reasons for the difference between the most profitable and the less profitable experience under the following aspects
      - teaching method
      - what was your contribution?
      - was your life and work experience also considered?
Report back to the plenary.

6.1 Three insights into the learning process

1.The learner does not assimilate the information straight in the same way in which information is presented to him/her. He or she
      - selects and structures the information following his/her former experience and his her already existing knowledge
      - gives meaning and interprets the information following his or her interest and needs.

It seems that the memory does not function like a sponge absorbing all the information but more like a radar or like a lamp turning around and picking up for him/her important items.
Example: those participants who are directly confronted with the HIV/AIDS victims (e.g. teachers or counsellors) will probably select other information which seem relevant to him/her than a member of the Village Government who has to find, for example, economic solutions.

2. More important and decisive for a fruitful learning process is the individual processing of the information instead of just "storing the information" (e.g. through learning by heart and simply memorising). "Processing the information" means building-up of "inner patterns" which can be used in the coping process of future situations and which can direct the learner in future reality.
Example: Nearly every month a teacher is confronted with the death of one of the student's parent's. When he/she "learns" that children can react very differently to the loss of a parent, he/she will probably develop a new understanding and interpretation of the children's behaviour and act in a different way.

3. Central to the process of absorbing and processing information is not so much the "additional" knowledge but much more the change and further development of the already existing knowledge, i.e. the patterns of perception, cognition and action.
Example: When you say "AHA! Now I understand..." you indicate that you "organise" something you have already observed before, in a new way.

Conclusion:
Learning must be understood as a process of restructuring and enriching the already existing knowledge. In this sense, "to learn" is an active and creative examination of new information and experiences.

Based on these insights we can distinguish two models of teaching:

A: the model of transferring knowledge with the following characteristics
  A1: The teacher/trainer presents the "final products"
  A2: Successful learning means to be able to reproduce as exactly as possible the learned items
  A3: The learners are primarily "recipients"
  A4: The trainer is a "teacher" who "presents"

B: the model of organising the learners process to discover new insights by him/herself with the following characteristics:
  B1: The teacher/trainer steers and animates the learning processes
  B2: Successful learning means that the learner afterwards has an individually available knowledge which may be adapted to new situations.

B3: The learners are primarily "discoverers" and "explorers" of situations and of problems
B4: The trainer is a "facilitator" who accompanies the learning process.

Finally remember that people retain by reading 10% of what has been presented , by hearing 20%, by seeing 30%, by seeing and hearing 50%, by saying it themselves 80% and by doing it themselves 90%.

> **Increasing participation by the trainees leads to a much stronger and more lasting impact. Experience through real life situations is the most effective form of learning. Self involvement motivates people to learn more.**

6.2. Training methods

After having understood more exactly what happens in the learning process we now come to different training methods:

Lecture

The trainer speaks (or reads a paper) - the participants listen. This method, where the participants are "condemned" to be passive receivers, may be useful to introduce the participants to a new topic in form of a short input.
A lecture addresses mainly the ear only (maybe also the eye, watching the body language of the trainer).
Be aware that listeners are not able to listen attentively more than 20 minutes!
Example: To give an overview about the four tasks of the mourning process.

Demonstration

The trainer explains a process or a procedure by showing the operation. The participants is still a "passive" receiver of the message, but he/she will use also the eyes to assimilate the message.
Examples: To build a wall with chairs in order to understand the secondary stress factors, or to use an elastic to demonstrate what "stress" means.

Question-answer technique

The trainer formulates questions and stimulates the participants to give answers out from their own experience. Ask "why", "how" or other "open-end" questions to encourage discussion and to encourage participants to argue. Avoid any questions that can be answered with a "yes" or "no" only. Good questions should sometimes already been prepared in advance to better steer the discovery process.

Example: Can you describe the mourning process in your community? (open end question). What is your experience with students in the school who have lost their parents? How do you react when a child comes to you and tells you that the father will die soon?

Group discussion:

Group discussion is a very useful instrument animating the participant's activity and learning process. It is a common method which opens the possibility for learning from the experience of other members of the group.

Speaking in smaller groups or even pairs enables less confident people to participate more fully and to build up confidence for speaking in the plenary session. The facilitator should encourage equal participation and discussion between participants.

Procedure: Two or more participants sit together and discuss and talk together about a given topic and exchange experiences. It is important that the objectives of the group discussion is clear to every group members. It usually helps when one participants repeats the task to accomplish by the group.

Don't forget to ask the group to indicate a member to report back to the plenary session.
During the group work, visit the different groups, especially at the beginning of the group work. Doing so you can avoid that the group gets on a "wrong track".
Examples: group work with the handouts.

Debate

Two or more participants prepare themselves to defend a certain view of a topic. Doing so they illustrate a variety of opinions about the topic to the plenary. The plenary should be included after a certain time to ask questions, demand more

explanation, or to offer other ideas for scrutiny in the debate etc.
A debate must be well prepared by the trainers.

Example: What are the advantages or disadvantages of different strategies to cope with the rising numbers of orphans: care by the extended family, foster care, group support to guardians, group support to children living alone, orphanage.

Brainstorming:

The aim of brainstorming is to collect from the participants as many ideas as possible on a specific topic. The brainstorming has some "rules" which have to be communicated before to the participants. Brainstorming is a technique which works
1. within a given time (you have to limit the time and announce it to the participants: "now we will five minutes just collect...)
2. in an uninhibiting way: Neither the facilitator nor the participants should comment on each other's suggestions. People should feel free and feel what they say is not evaluated or judged. Write all contribution in a short form or a keyword on the blackboard or flip chart as the ideas come up.
3. After finishing the collection of ideas, you can start to form categories, rejecting some, prioritising others, discussing them, and so on.
Brainstorming can be a good technique to start off an activity on a new and unknown topic and to explore new possibilities (e.g. to think what can be done to reduce discriminations of orphans). The list of ideas can be used as a basis for further work.

Flash
To break up monotony or to ensure that every participants give his/her opinion to a certain topic, you ask each participant to give a short statement in two, three sentences concerning a certain topic or feeling. The topic must be clear (e.g. "Do you think that there is any discrimination against orphans and, if yes, where can you observe it?). This methods gives you and the group an idea, "where" everybody is. The sentences do not need to be commented or discussed afterwards.
You can also ask each person to write a question or an opinion concerning the topic on a slip of paper. You collect the papers, shuffle them, and each person takes one paper slip and reads it out. Thus everyone's feeling are obtained anonymously.

Role play
Role play or simulation games imitate reality by assigning
roles to participants and giving them a situation to act out.
It is important that each person in a role play has a clear
idea of the role they have been assigned.
The aim of the role play is to make attitudes, situations and
experiences come to life in a dramatic and enjoyable way. Its
also an effective way of enabling adults to experience what it
is like to feel powerless or invisible in a situation when
they play a child/orphan.
The role play can also be a good training possibility to
invent new behaviour patterns or to experiment with new
attitudes. So, role play can be like a "laboratory" where
participants can try to think new things without risking
sanctions from the community, neighbours, family members etc.
There is one important rule to be considered in the role play:
There is a strict separation between the role and the person
who plays the role. This separation allows the participant to
invent new things or to play drastically a role. To give an
example: If the participant Maria plays the cruel teacher
"Amos" who batters an orphan, then you have to assure that in
the following discussion people do not use the participant's
name "Maria" to discuss the teacher, but they should use the
role name "Amos".

It is also very important to allow sufficient time after role
plays for a thorough debriefing (for each player to say how
they felt in the role) and ″de-rolling″ (for each player to
come out of their role and realise that they are themselves).
Otherwise there is a danger that participants may be carrying
on inappropriate feelings and thoughts.

Statement ranking

Participants are asked to rank statements according to how
much they agree or disagree or to accord statements the
priority they attach to them.

Example: You may have ten written statements (as a result of a
group work) how to diminish discrimination on orphans. To find
out which statement has the highest chance to be practised in
the community, you can tell the participants that each
participant has three (or two, four etc.) point to distribute,
and that he or she should give the points to these statements
which seem to him or her to be most appropriate to be put into
practice. The facilitator will ask the first participant to
give his or her ranking, and he or she may say: I give one
point to the second statement, one point to the seventh
statement and one point to the ninth statement. The
facilitator puts the point on the blackboard or flipchart

beneath the statements. The second participants may say: I give two point or the second statement and on point to the sixth statement." etc. Already now it is visible that at least two participants think that the second statement may be important to follow for the practice.

Sentence completion

You can give the participants sentences as
"An orphan says: 'I feel well accepted in this community because....'"
"A Village Executive Officer had the idea to collect money for the orphans so that they can join the schools but the villagers resisted to support the idea. They said.........".
The participants are requested to complete (individually) the sentence.
This technique allows people to work on their own to express ideas and later to discuss these with others. Each person has to come up with her or his own statement.

Guided fantasy

The facilitator reads out a prepared fantasy (e.g. a burial ceremony from the point of view of a child). Observe that, between the different inputs, you must give time to the par-ticipants to develop their own imagination.
It is useful to start with general relaxation to enable individuals to let go and free their imagination.

Case studies

Case studies may be based on real cases or be designed as a hypothetical situation which could be real.
Case studies should be carefully designed with specific objectives in mind. They need a very careful preparation.

Moderation
"Moderation" can only partly be called a "teaching technique". It is in fact the art of the facilitator to summarise, visualise and stimulate the production process of the participants.

Conclusion
General principle: Select and use a method which is as participatory as possible
But keep in mind that you have to check the following question before you decide for one method:
- Do I myself dominate the method?

> - **Is the method compatible with the participants - or do I**
>   **have to adapt the method for the participants?**
> - **Does the method correspond to the subject I intend to**
>   **transmit?**

6.3. To become a good facilitator

The facilitator occupies a key position to ensure a successful training. Facilitating is a hard and tiring duty, where you have to be fully concentrated. But concentration alone is not enough, you have to acquire a number of capabilities to become a good facilitator .

Once the workshop starts, you are responsible as facilitator for ensuring

- that <u>the group accomplishes the task</u>. This includes
  - setting and following clear programme objectives,
  - providing clear introduction and instructions to the participants,
  - having a clear idea about the different steps of the training unit
  - providing prepared material,
  - keeping the time schedule,
  - summing up and concluding

- that <u>the group maintains itself as a group</u>. This may include
  - observing and listening to the participants
  - to be aware of the way how individuals react
  - enabling each person to feel accepted as part of the group
  - enabling participants to listen and to learn from each other
  - to deal constructively with dominant members of the group
  - pointing out differences of opinions
  - building confidence and trust within the group by working in small groups

Here is some advice how you become a good facilitator:

- Once again: be a facilitator, not a teacher! As a first priority, you have to organise the learning process of the participants, not to deposit your knowledge within them. Try to bring out all knowledge already available among the participants.

- Be well prepared and organised. Read the material well in advance of the session. Make sure that you have all the material you need (handouts, chalk, pins etc.) Did you have

a look at the room where you are facilitating? Are there enough chairs? Is there a blackboard or something similar? How would you like that the participants sit? In a circle? Then prepare the tables and chairs.

- Prepare also (mentally) what you would like to write on the blackboard. How much space would you probably need? How would you like to organise the written material? In columns? And how many? Don't start to write in the middle of the blackboard.

- Be aware that according to communication-research less than 50% of the perceived communication is transmitted through words, but more than the half through voice and intonation (loud, low, etc.), gesture and body language in general. Therefore:

- Keep eye contact with all participants and avoid that you always look to the same persons.

- Don't turn your back to the participants frequently and for longer periods. Prepare all what you can prepare, in advance - so you save time in writing.

- Move around and do not stay in "front" on the same spot.

- Use visual aids to back up what you are saying and to resume what the participants are contributing. Visualisation brings clear lines in the discussion. When participants can SEE the different contributions, they can better refer to them when they discuss it.
Train yourself in visual techniques (such as mind mapping etc.)

- Condense what you want to say to the bare essentials that people absolutely have to know (e.g.: "the three key points" or "the four guiding principles". You can expand or give brief illustrations to other points, but people must go away remembering the main points.

- If some individuals speaks too much and dominate the group, you can:
    - use the "talking stick" or another object, which is passed around the group in turn, and people speak only when they hold the object; no interruption is allowed
    - divide people into small groups, with the quiet ones together and the talkative ones together
    - speak privately to the individual concerned
    - ask the dominant individual to present a topic which others then discuss

      - introduce a rule that no-one speaks twice before
        everyone has spoken once

- A method which is helping to bring forward the participant's
  learning process is the "store" or the "fridge". If
  participants raise questions and the facilitators is not in
  the position to answer (because it lacks still some
  preliminary and previous learning work) the question is
  written on a special paper or on the blackboard. Later, the
  question is brought "out of the store" and answered. With
  this method you can avoid that the ongoing process is
  disturbed, this without frustrating the (interested)
  participants. Only: you have later to come back to the
  questions raised!

Important: You can't become a good facilitator in one day. So
choose for each training one or two qualities of the above
list which you concentrate on during the session and try to be
specifically aware of it in order to improve your capacity as
facilitator (e.g. 1. visualisation and 2. keeping eye
contact).

6.4. Monitoring and evaluation

Monitoring and evaluation are important instruments to keep
track of the training and to improve the efficiency of the
training.

We should distinguish

1. Monitoring of the training should be done throughout the
training in order to assess task accomplishing, to check
feelings in the group as well as to make clear practical
details. It can be done
- at the end of each day to discuss shortly the day's
   activity (e.g. discussion in the group or an open round
   about "What I have learned today?" "What I still want to get
   out of the training?" "What did you enjoy most, what least?"
   or "How I'm going to put into practice?"
- through election of a group representative for liaison with
  the facilitators who gives a daily feedback
- through keeping individually a learning record-book ("What
  have I learned this day? What are open questions and doubts
  I would like to ask tomorrow?")

2.Short "on-the-spot" evaluation which is more a spontaneous reaction on the training than a true evaluation. Possible methods are:
- Verbal evaluation at the end of the training. It helps if the facilitators gives two or three questions (such as: "A new thing for me was..." or "This I'm going to put into practice") as guidelines.
- You can prepare some five, six cards with different (positive and negative) sentences (e.g. "I'm now better prepared for my work", "It was just to waste my time", "I would advise my colleges to come also to a such training", "Sometimes I had difficulties to understand the content" etc.). You hang up the card in different places in the room. You ask the participants to go around, to read all sentences and finally to stand to this sentence which is the most significant for them in relation to the yet finished training. Every participants explains shortly the reason why he or she chooses this card.
- Ask all the participants to go round saying one word, one phrase or sentence to summarise the workshop.

3. Deeper evaluation allows the facilitator to measure the result of a workshop against the original objectives. Possibilities are:
- Written "test": The same "test" can be given at the beginning and at the end of the course to evaluate changes in knowledge, skills and attitudes. The questions chosen should reflect the very specific objectives of the training-course. You have to make clear that it is definitely not a exam paper. One can lessen this fear by allowing each person to score their own evaluation sheet.
- Evaluation form to be filled by he participants with questions as
  - What did you find most useful about the workshop?
  - What did you find least helpful about the workshop?
  - Was the content a) not useful, b) about right, c) very useful
      (tick the appropriate word)
  - Was the style of the workshop a) unhelpful, b) about right,
       c) useful? (tick)
  - What do you think you have learned in the workshop?
  - How will you use what you have learned, in your job?
  - What might stop you using what you have learned? (Include your own attitudes and fears)
  - How would you like to see this taken forward?
  - Any other comments.

- Evaluation questionnaire (where you have questions and a scale from 1-5 to tick. 1 means "not at all", 5 means "completely")

Glossary

self-efficacy
the degree to which a person feels able to effect and induce changes in his/her live and to influence the environment

self-esteem
self-esteem is a more comprehensive basic feeling concerning the own personality. It looks more closely to the question: "What is my value? How am I valued by the others? Am I a*worthy* person?"

self-perception
the way how a person looks him/herself in his/her different qualities (intelligent, beautiful, loveable, strong or weak etc.) and how he/she interacts with the other persons. The reactions of the others will confirm probably how the determined person sees him/herself

stressor
factors which produce stress (for example: poverty or quarrels in the family

PROCESSES IN THE PAST   **ACTUAL PROCESSES**

which produced <u>vulnerability</u>   Events

_____   _____

_____   _____

_____   _____

which produced <u>protective</u>   _____
<u>processes and factors</u>

_____   Events represent the <u>risk</u> to become
more or less stressed or even
_____   traumatised

_____   vulnerability, protective processes
from the past, actual social environ-
ment, cultural values and beliefs etc.
will decide if the child and to what
SOCIAL ENVIRONMENT   extent the child

_____   - **can <u>cope</u> with the events,**
- **is "resilient"**

_____   or

- **will be helpless for some time**
CULTURAL VALUES/BELIEFS   - **will be traumatised**
- **will suffer psychological and**
_____   **emotional problems**
   etc.
_____

_____