

Guide to Mobilising and Strengthening Community-Led Care for Orphans and Vulnerable Children



HIV/AIDS Hope Initiative

This guide is intended to provide useful tools for individuals and organisations seeking to mobilise and strengthen community-led care for orphans and vulnerable children (OVC). It is based on an OVC programming strategy developed by World Vision, an international Christian relief and development organisation.

In line with global best practice, World Vision's OVC programming strategy focuses on strengthening family and community care for OVC, primarily through support of **community care coalitions (CCCs)** that bring together churches and other faith-based organisations, government, local business, traditional structures, and other NGOs. Building on efforts already underway in the community, these coalitions support **home visitors**: women and men who volunteer to take responsibility for identifying, monitoring, assisting, and protecting OVC. CCCs facilitate both co-ordination and expansion of OVC responses within the community.

The guide is composed of two units. Unit 1 is a resource for mobilisers of community-led OVC care using the CCC strategy. Unit 2 is a resource for facilitators who lead training to equip CCCs and their home visitors to provide effective, sustainable care for OVC.

The guide was developed through World Vision's HIV/AIDS Hope Initiative, working to expand and enhance responses to HIV/AIDS in the nearly 100 countries where World Vision works around the world.

Guide to Mobilising and Strengthening Community-Led Care for Orphans and Vulnerable Children

HIV/AIDS Hope Initiative

All contents of this toolkit are copyright © World Vision International, 2005.

All rights reserved.

Portions of the toolkit may be reproduced with written permission from World Vision International. For more information, email models_of_learning@wvi.org.

Acknowledgements

The *Guide to Mobilising and Strengthening Community-Led Care for Orphans and Vulnerable Children* has been developed by the Models of Learning programme, the research and development arm of World Vision's global HIV/AIDS Hope Initiative. This document has evolved through more than a year of field-testing and review, beginning in late 2003.

Special thanks is due to the OVC specialists on the Models of Learning team, Grace Mayanja and Faith Ngoma, who authored the initial version of the guide in response to the need expressed by World Vision field staff and community partners. Sincere gratitude is also owed to the World Vision staff and community care coalition members in Mozambique, Uganda, and Zambia with whom the Models of Learning team worked to pilot the guide.

We are grateful to consultants Deborah Forbes and Michele Gaudrault, who revised the guide based on the learnings of this pilot process and produced a review draft for the Bangkok International AIDS Conference in July 2004. We very much appreciate the input of the more than forty World Vision national HIV/AIDS co-ordinators and regional HIV/AIDS staff from across Africa who reviewed the guide in September 2004 and made excellent recommendations for further refinement. We also wish to thank the participants in the World Vision Africa regional OVC training of trainers workshop in November 2004 for their guidance on additional improvements needed.

We are indebted to the South Africa-based team of consultants managed by Neil Verlaque-Napper for their excellent work on a tight production schedule to finalise the guide for publication. Sincere thanks to team member Alastair Findlay for his illustrations throughout the guide and on the cover, as well as to team member Gill McDowell for her work to design, format, and edit this version of the guide.

We gratefully acknowledge the following Models of Learning staff for their contributions to the development of the guide: Namposya Chitanika, Angela Mubangizi, Kennedy Nkwemu, Maurice Sepiso, David Serukka, and Richard Wamimbi. Models of Learning director Mark Lorey's leadership of the overall compilation, refinement, and production of this guide is appreciated. Finally, we offer thanks to World Vision Africa HIV/AIDS director Martha Newsome and World Vision Africa communications director Nigel Marsh for their ongoing support and wise counsel.

This guide will continually evolve as additional experience is gained and new lessons are learned. Input is welcomed and appreciated. Please send comments and suggestions to the Models of Learning programme: models_of_learning@wvi.org.

Ken Casey
Special Representative to the World Vision International President
HIV/AIDS Hope Initiative
2005

Acronyms

| | |
|--------|--|
| ADP | Area Development Programme |
| AIDS | Acquired Immune Deficiency Syndrome |
| BCC | Behavioural Change Communication |
| CA | Correspondence Analyst |
| CBO | Community-Based Organisation |
| CCC | Community Care Coalition |
| CCF | Community Care Facilitator |
| CDF | Community Development Facilitator |
| CRS | Customer Relations Services |
| FBO | Faith-Based Organisation |
| FGD | Focus Group Discussion |
| GIK | Gift in Kind |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education and Communication |
| IGAs | Income Generating Activities |
| LC | Local Council |
| NGO | Non-Governmental Organisation |
| OVC | Orphans and Vulnerable Children |
| PLWHA | People Living with HIV/AIDS |
| PMTCT | Prevention of Mother To Child Transmission |
| PSS | Psychosocial Support |
| PTA | Parents and Teachers Association |
| SMART | Specific Measurable Attainable Relevant Time-Bound |
| STI | Sexually Transmitted Infection |
| SWOT | Strength Weaknesses Opportunities Threats |
| TB | Tuberculosis |
| ToT | Training of Trainers |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UPE | Universal Primary Education |
| WV | World Vision |

CONTENTS

INTRODUCTION

UNIT 1 - Mobilising Community-Led Care for OVC: A Guide for Mobilisers

Module 1: Overview of the Mobilisation Process

| | |
|--|----|
| Introduction | 5 |
| Stage 1: Preliminary Institutional Mapping | 6 |
| Stage 2: Community Stakeholders' Meeting | 8 |
| Stage 3: Forming a Community Care Coalition (CCC) | 10 |
| Stage 4: Action Planning | 11 |
| Stage 5: Training Community Care Coalition Members | 13 |
| Stage 6: Identifying OVC | 14 |
| Stage 7: Identifying Home Visitors | 15 |
| Stage 8: Training Home Visitors | 16 |
| Stage 9: Supporting Home Visitors | 17 |
| Stage 10: Monitoring and Reporting | 18 |
| Stage 11: Mobilising Resources | 20 |

Module 2: Detailed Instructions for the Mobiliser

| | |
|--|----|
| Introduction | 21 |
| Step 1: Preliminary Institutional Mapping | 22 |
| Step 2: First Community Stakeholders' Meeting: Assessing the OVC Situation | 27 |
| Step 3: Second Community Stakeholders' Meeting: Forming a Community Care Coalition (CCC) | 35 |
| Step 4: Action Planning | 40 |
| Step 5: Monitoring and Reporting | 45 |

UNIT 2 - Strengthening Community-Led Care for OVC: A Guide for Facilitators

Facilitator's Guidelines

| | |
|--|----|
| Background Information | 51 |
| Part 1: The Key Issues of Training | 53 |
| Part 2: The Seven Steps of Planning | 59 |
| Part 3: Running the Training Programme | 71 |
| Part 3: Sample Training Agenda | 83 |

| | |
|--|-----|
| Module 1: HIV/AIDS and the Situation of OVC | |
| Topic 1: Basic Information on HIV/AIDS | 87 |
| - Activity 1: What are HIV and AIDS? | 89 |
| - Activity 2: Modes of HIV Transmission - Facts and Misconceptions | 90 |
| - Activity 3: Preventing HIV Infection | 92 |
| - Activity 4: HIV Self-Risk Assessment Quiz | 93 |
| - Activity 5: General Trends in HIV/AIDS Infection | 94 |
| - Activity 6: Preparing for Home Visits: Information on HIV/AIDS | 95 |
| Topic 2: The Impact of HIV/AIDS | 97 |
| - Activity 1: The Definition of <i>Psychological</i> and <i>Socio-Economic</i> | 99 |
| - Activity 2: The Psychological and Socio-Economic Impact of HIV/AIDS on Children, Families and Communities | 100 |
| Topic 3: National Frameworks for Supporting OVC | 103 |
| - Activity 1: National OVC Policy | 105 |
| - Activity 2: Government Strategies and Responsibilities | 106 |
| - Activity 3: Other Stakeholder Responsibilities | 108 |
| - Activity 4: The Seven Components of OVC Support | 111 |
| - Activity 5: CCCs and OVC Support | 113 |
| - Activity 6: Preparing for Home Visits: Elements of OVC Support | 114 |
| Topic 4: Children's Rights and How They Apply to the Care of OVC | 115 |
| - Activity 1: What are <i>Children's Rights</i> ? | 116 |
| - Activity 2: Categories of Children's Rights | 118 |
| - Activity 3: Abuse of Children's Rights: Forms, Causes and Consequences | 120 |
| - Activity 4: The Sexual Abuse of Children | 123 |
| - Activity 5: Protecting Children | 125 |
| - Activity 6: Preparing for Home Visits: Monitoring for Signs of Child Abuse | 126 |
| Topic 5: The Implications of Gender-Based Roles for OVC | 127 |
| - Activity 1: The Gender Roles of Girls and Boys | 129 |
| - Activity 2: The Advantages and Disadvantages of Gender-Based Roles | 131 |
| - Activity 3: Strategies to Overcome Gender-Based Discrimination | 133 |
| - Activity 4: Preparing for Home Visits: Gender Awareness | 135 |
| - Activity 5: Review of the Home Visitor's Handbook | 136 |

Module 2: Addressing the Psychosocial and Spiritual Needs of OVC and Their Caregivers

| | |
|---|-----|
| Topic 1: The Different Needs of OVC | 137 |
| - Activity 1: The Different Needs of Children | 139 |
| - Activity 2: How Children React to Unmet Needs | 141 |
| - Activity 3: Problems Experienced by OVC in the Community | 142 |
| - Activity 4: Preparing for Home Visits: OVC Needs | 144 |
| | |
| Topic 2: Psychosocial Support for OVC | 145 |
| - Activity 1: What is <i>Psychosocial Support</i> ? | 147 |
| - Activity 2: What Psychosocial Support is Being Provided to OVC? | 148 |
| | |
| Topic 3: The Stages of Development and Understanding in Children | 149 |
| - Activity 1: Growth, Development and Change in Children | 151 |
| - Activity 2: Indicators of Development in Children | 153 |
| - Activity 3: Theories of Age and Understanding in Children | 155 |
| - Activity 4: Environmental Factors in Children's Development | 157 |
| - Activity 5: The Community's Role in Children's Development | 159 |
| - Activity 6: Preparing for Home Visits: Child Development | 160 |
| | |
| Topic 4: Counselling and Communicating with OVC | 163 |
| - Activity 1: The Characteristics of a Children | 165 |
| - Activity 2: How Children Communicate | 166 |
| - Activity 3: Effective Methods for Communicating with Children | 168 |
| - Activity 4: The Do's and Don'ts of Communicating with Children | 171 |
| - Activity 5: Practising Effective Communication | 173 |
| | |
| Topic 5: Accompanying OVC through Grief and Bereavement | 175 |
| - Activity 1: Grief and Loss | 177 |
| - Activity 2: The Signs and Symptoms of Grief | 179 |
| - Activity 3: The Understanding of Death at Different Ages | 180 |
| - Activity 4: Preparing Children for Death in the Family | 181 |
| - Activity 5: Support Strategies to help Grieving Children | 183 |
| | |
| Topic 6: Using Play in Counselling Children | 185 |
| - Activity 1: Why is Play Important for Children? | 187 |
| - Activity 2: Play as an Indicator of a Child's Well-Being | 188 |
| - Activity 3: Methods for Using Play in Counselling Children | 190 |

| | |
|--|-----|
| Topic 7: Spiritual Care for Orphans and Vulnerable Children | 191 |
| - Activity 1: Signs of Spiritual Problems in Children | 193 |
| - Activity 2: Signs of Spiritual Health in Children | 194 |
| - Activity 3: Strategies for the Spiritual Care of OVC | 195 |
| Topic 8: Support for Caregivers | 197 |
| - Activity 1: Enhancing Self-Awareness in Caregivers | 199 |
| - Activity 2: The Tree of Life | 200 |
| - Activity 3: Me Drawings | 201 |
| - Activity 4: Me Boxes | 202 |
| - Activity 5: Support Groups | 203 |
| - Activity 6: Review of the Home Visitor's Handbook | 204 |
| Module 3: Addressing the Physical Needs of OVC | |
| Topic 1: Food Security for OVC | 205 |
| - Activity 1: The Meaning of <i>Food Security</i> | 207 |
| - Activity 2: Threats to the Food Security of OVC | 208 |
| - Activity 3: Community Initiatives to Enhance Food Security for OVC | 209 |
| - Activity 4: Preparing for Home Visits: Food Security and OVC | 210 |
| Topic 2: Improving the Nutrition of OVC and Those Affected by HIV/AIDS | 213 |
| - Activity 1: The Meaning of <i>Nutrition</i> | 215 |
| - Activity 2: Identifying Important Foods | 216 |
| - Activity 3: Nutritional Support for Children with HIV or Those Born to HIV Positive Mothers | 218 |
| - Activity 4: Nutritional Support for HIV Positive Pregnant Women and Breastfeeding Mothers | 221 |
| - Activity 5: Nutritional Support for Adults Living with HIV/AIDS | 222 |
| - Activity 6: The Causes and Effects of Poor Nutrition | 223 |
| - Activity 7: Steps to Help Malnourished OVC | 224 |
| - Activity 8: Preparing for Home Visits: Nutritional Information | 225 |
| Topic 3: Monitoring the Health of Orphans and Vulnerable Children | 227 |
| - Activity 1: Basic Healthcare and the Needs of OVC | 229 |
| - Activity 2: Immunisation | 231 |
| - Activity 3: Common Diseases that Affect Children | 233 |
| - Activity 4: Barriers to Healthcare and Ways to Ensure Access | 235 |
| - Activity 5: Basic Hygiene Practices | 236 |
| - Activity 6: Access to Sanitation and Safe Water | 239 |
| - Activity 7: Sexual and Reproductive Health | 240 |
| - Activity 8: Preparing for Home Visits: Monitoring the Health of OVC | 241 |
| - Activity 9: Review of the Home Visitor's Handbook | 242 |

Module 4: Equipping Orphans and Vulnerable Children for the Future

| | |
|--|-----|
| Topic 1: Ensuring Access to Education for OVC | 243 |
| - Activity 1: The Importance of Education for OVC | 245 |
| - Activity 2: Barriers to Children's Access to Education | 246 |
| - Activity 3: Community Action to Ensure OVC Access to Education | 247 |
| - Activity 4: Preparing for Home Visits: OVC Access to Education | 248 |
| | |
| Topic 2: Life Skills for OVC | 249 |
| - Activity 1: The Importance of Life Skills | 251 |
| - Activity 2: Types of Life Skills | 252 |
| - Activity 3: Strategies to Equip OVC with Life Skills | 255 |
| | |
| Topic 3: Supporting Behaviour Change in OVC | 257 |
| - Activity 1: What Does Behaviour Change Mean? | 259 |
| - Activity 2: Factors that Influence Behaviour | 260 |
| - Activity 3: The Behaviour Change Process | 262 |
| - Activity 4: Helping Children to Change Behaviour | 264 |
| - Activity 5: Preparing for Home Visits: Behaviour Change | 265 |
| | |
| Topic 4: Succession Planning | 267 |
| - Activity 1: What is Succession Planning? | 269 |
| - Activity 2: Protecting the Inheritance Rights of Children | 270 |
| - Activity 3: The Importance of Making a Will | 271 |
| - Activity 4: Practising Making a Will | 273 |
| - Activity 5: Memory Books and Memory Boxes | 275 |
| - Activity 6: Disclosing Sensitive Information to Children | 277 |
| - Activity 7: Separation Issues for Children | 279 |
| - Activity 8: Identifying a Standby Guardian | 280 |
| - Activity 9: Supporting a Standby Guardian | 281 |
| - Activity 10: Preparing for Home Visits: Succession Planning | 283 |
| - Activity 11: Review of the Home Visitor's Handbook | 284 |

APPENDICES

| | |
|---|-----|
| Appendix 1: Handouts | 297 |
| Appendix 2: Further Facilitation Notes | 347 |
| Appendix 3: References | 365 |

INTRODUCTION

Mobilising and Strengthening
Community-Led Care for Orphans
and Vulnerable Children

Overview of the Guide

This guide is intended to provide useful tools for individuals and organisations seeking to mobilise and strengthen community-led care for orphans and vulnerable children (OVC). It is based on an OVC programming strategy developed by World Vision, an international Christian relief and development organisation. This strategy emerged from World Vision's experience in OVC programming over more than a decade, combined with careful examination of many other organisations' approaches to OVC care. World Vision's OVC programming strategy is guided by and aligned with the global *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, developed by the United Nations Children's Fund (UNICEF) with input from World Vision and a wide range of other stakeholders.

This guide is composed of two units. Unit 1 is a resource for mobilisers of community-led OVC care. Unit 2 is a resource for facilitators who lead training to strengthen the range of capacities needed by community members caring for OVC. Most of these mobilisers and training facilitators work for national or international non-governmental organisations (NGOs), faith-based and other civil society organisations, or government agencies. This guide may also be used by people living in communities caring for OVC, to help in catalysing and strengthening a broader community response.

The Crisis of Orphans and Vulnerable Children

HIV/AIDS has created a humanitarian and development crisis of unprecedented scale. More than 15 million children under the age of 17, most of them in sub-Saharan Africa, have lost one or both parents to AIDS. This number is expected to increase to more than 25 million by the year 2010. In addition, millions more children have been made vulnerable by the HIV/AIDS pandemic. These include children living with HIV, children whose parents are living with HIV, and children in households that have absorbed orphans.

Children orphaned or made vulnerable by AIDS face a wide array of severe and interlinked problems. In addition to the deep psychosocial distress of losing one or both parents, they may also lack food, shelter, clothing, or health care. They may be required to care for chronically ill adults or younger siblings and forced to drop out of school. They may face discrimination, abuse, or exploitation. Deprived of parental guidance and protection and in need of financial and emotional support, they may themselves become vulnerable to HIV infection.

In many communities, traditional ways of caring for orphans and vulnerable children, such as the extended family system, are being severely strained by the multiple, mutually exacerbating impacts of HIV/AIDS. The critical challenge is to find ways to help communities care for the unprecedented number of children and families rendered vulnerable by HIV/AIDS.

World Vision, HIV/AIDS and the OVC Crisis

In 2001, World Vision launched the HIV/AIDS Hope Initiative to increase and intensify responses to HIV/AIDS in all of the nearly 100 countries where World Vision operates. The overall goal of the Hope Initiative is to reduce the global impact of HIV/AIDS through the enhancement and expansion of World Vision programs and partnerships focused on HIV/AIDS prevention, care, and advocacy.

The highest priority in World Vision's global HIV/AIDS response is care for orphans and other vulnerable children. Rooted in its commitment as a child-focused organization, this priority also reflects World Vision's assessment of the most imperative and strategic ways to invest resources in the fight against HIV/AIDS. Although they are among those most severely affected by HIV/AIDS, OVC are among the most neglected in global HIV/AIDS programming. This clearly stands at odds with the calling within most of the world's faiths to reach out to the vulnerable, and especially to those who are widowed and orphaned. Moreover, investing in OVC is a critical investment in the future strength and security of their communities and countries.

In keeping with global best practice, World Vision's OVC programming strategy focuses on strengthening family and community care for OVC, primarily through support of **community care coalitions** (CCCs) that bring together churches and other faith-based organisations, government, local business, and other NGOs. Building on efforts already underway in the community, these coalitions include home visitors: women and men who volunteer to take responsibility for identifying, monitoring, assisting, and protecting OVC. CCCs facilitate both co-ordination and expansion of OVC responses within the community.

World Vision's roles in facilitating OVC care are to mobilise these coalitions where necessary, strengthen their technical and general organisational capacities, provide modest amounts of financial and material support, link them to other sources of support, and advocate for more resources to be made available for their work.

World Vision has found the CCC strategy for OVC care to be an effective programming model that merits widespread replication because it:

- ◆ Builds on local structures and strengths
- ◆ Can be implemented rapidly through existing channels and partners
- ◆ Complements other initiatives underway
- ◆ Helps reduce stigma and discrimination in the community
- ◆ Provides a developmental channel for delivery and monitoring of multiple resources to OVC, including financial, material and food aid, as well as other forms of assistance
- ◆ Enables communities to leverage many more resources to benefit OVC
- ◆ Is developmentally sound and sustainable
- ◆ Results in tangible, measurable, meaningful impacts in the lives of OVC and their families
- ◆ Is adaptable to diverse contexts.

Contents of the Guide

Units 1 and 2 of the guide are designed to complement and reinforce one another. Unit 1 is designed to equip mobilisers of community-led care. Module 1 of Unit 1 gives an overview of a process for community mobilisation focused on OVC, leading to the development of a community care coalition. Module 2 provides detailed instructions for mobilisers seeking to put this process into practice.

Unit 2 is intended to provide a comprehensive set of resources for the facilitators of training for coalition members, including OVC home visitors. Unit 2 is comprised of four modules. Each module in Unit 2 is divided into multiple topics, and each topic contains several activities. Each activity includes the time and materials required for the activity, facilitator's notes, and an image of any handouts to be used in the activity. All handouts are compiled in Appendix 1. Unit 2 begins with guidelines that help a facilitator to design a training course, selecting the modules, topics, and activities appropriate for the group to be trained.

This 2005 edition of the guide is available in printed, CD, and PDF versions. It has been developed through more than a year of field-testing with HIV/AIDS-affected communities in several countries in east and southern Africa. It has also benefited from the suggestions provided by World Vision staff and partners in several rounds of review. Feedback for the next edition is welcomed. Please send comments, questions, and requests for additional copies to models_of_learning@wvi.org.



UNIT 1

Mobilising Community-Led Care for Orphans and Vulnerable Children

A GUIDE FOR MOBILISERS

Module 1

Overview of the Mobilisation Process

| | |
|---|-----------|
| Introduction | 5 |
| Stage 1: Preliminary Institutional Mapping | 6 |
| Stage 2: Community Stakeholders' Meeting | 7 |
| Stage 3: Forming a Community Care Coalition (CCC) | 10 |
| Stage 4: Action Planning | 11 |
| Stage 5: Training Community Care Coalition Members | 12 |
| Stage 6: Identifying OVC | 13 |
| Stage 7: Identifying Home Visitors | 15 |
| Stage 8: Training Home Visitors | 16 |
| Stage 9: Supporting Home Visitors | 17 |
| Stage 10: Monitoring and Reporting | 19 |
| Stage 11: Mobilising Resources | 22 |

Introduction

Unit 1 describes a process that a mobiliser can follow to help a community start or strengthen care for orphans and other children made vulnerable by HIV/AIDS. Community care coalitions (CCCs) are groups or committees of individuals and organisations that are already taking responsibility for assisting OVC and other vulnerable community members, or who are interested in doing so.

World Vision and many other organisations have recognised that short-term relief and service provision strategies are not fully appropriate or viable to address the large-scale, long-term, multi-sectoral OVC crisis generated by the HIV/AIDS pandemic. Thus the CCC strategy for OVC care is fundamentally developmental, allowing for the delivery of emergency assistance as needed within community-led initiatives that build on local resilience and assets; and especially to strengthen community capacities to co-ordinate support efforts and mobilise resources for the care of vulnerable children.

CCCs should represent a broad spectrum of stakeholders, including the participation of OVC themselves, in order to operate effectively within a community. A coalition of diverse community stakeholders engenders co-operation towards a common response to OVC. A coalition structure also improves referrals between service providers and the management and mobilisation of resources; and strengthens project planning, accountability and advocacy.

World Vision recognises that community coalitions require both capacity building and training to achieve their potential. This guide outlines a process for mobilising a community care coalition that covers these important aspects. It recommends the following stages to mobilising a community care coalition, as outlined in this module:

- 1 Preliminary institutional mapping
- 2 Community stakeholders' meetings
- 3 Forming a community care coalition
- 4 Action planning
- 5 Training community care coalitions
- 6 Identifying OVC
- 7 Identifying home visitors
- 8 Training home visitors
- 9 Supporting home visitors
- 10 Monitoring and reporting
- 11 Mobilising resources.

In the course of describing these stages, this guide shares some of the experience World Vision has gained and the lessons it has learned in working with community care coalitions.

STAGE 1 Preliminary Institutional Mapping

The first thing the mobiliser needs to do is to learn as much as possible about the ways that HIV/AIDS has impacted the community, the kinds of responses that a community has undertaken, and who the key stakeholders are. This analysis of the situation may be formal or informal. If the mobilising agency is already active in the community, it may involve simply gathering information from field staff. A more elaborate mapping exercise could involve conducting key informant interviews, focus group discussions, or participatory learning and action exercises. In any case, this preliminary mapping should be seen as the first step in building good relationships with community members and leaders.

This institutional mapping is described as 'preliminary' because the community members themselves will carry out further situation analyses.

Case Study

In the World Vision Kasangombe Area Development Programme (ADP) in Luwero district in Uganda, the following steps were taken for institutional mapping:

1. Problem identification

Through the activities of the Area Development Programmes (since the early 1990s) it was realised that the numbers of OVC continued to increase and, while there were creative initiatives by the community to respond to the problem, they were limited in scale and fragmented. Often OVC would be referred to the ADP for assistance but the ADP could not address all the needs of OVC. The ADP conducted village-level exploratory meetings of selected categories of individuals such as local councils, religious leaders, opinion leaders, teachers, caregivers and OVC themselves. In this way, OVC issues were brought to the attention of stakeholders in the community.

2. Training of staff

Prior to conducting the community mobilisation meetings, the staff had a two-day orientation workshop aimed at sharing the community-led OVC care approach with all staff of the ADP. The reference materials used for the training were mainly derived from the World Vision *ADP Toolkit for HIV/AIDS Programming* (2003).

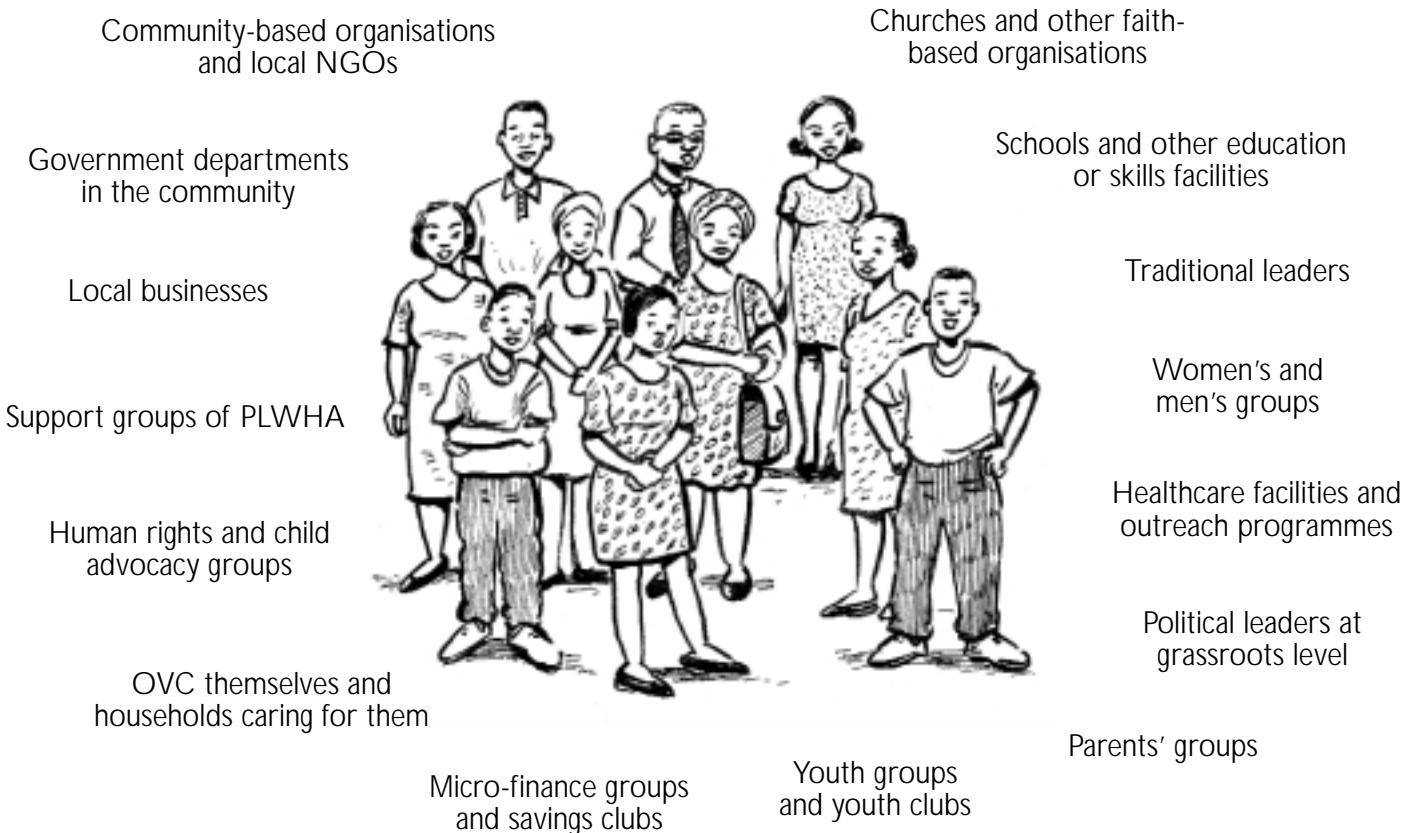
Some of the topics covered under this training included:

- The situation of OVC at global, national and district level
- The philosophy of the community-led OVC care approach
- Assessment of current OVC initiatives carried out by communities
- Key players in the community addressing OVC needs
- Gaps and challenges in community OVC care
- A roll-out plan of action to mobilise and strengthen community-led care for OVC.

STAGE 2 Community Stakeholders' Meeting

Once the mobiliser has gained a sense of how HIV/AIDS has impacted the community, what responses have been undertaken, and who the key stakeholders are, WV helps convene a two to three day meeting of the community stakeholders. Such stakeholders are concerned community members who are already taking responsibility for assisting OVC or other vulnerable community members, or are interested in doing so.

These community members typically come from:



At the meeting, WV facilitates a process through which the range of stakeholders:

- ◆ Identify problems that have emerged in the community in the last three to five years (usually more people ill and dying; more children orphaned)
- ◆ Identify links between these problems and HIV/AIDS
- ◆ Identify responses already underway to assist vulnerable children and households
- ◆ Identify gaps and unmet needs
- ◆ Decide on the next steps for expanding care for vulnerable children in the community, building on existing strengths.

Participatory tools such as social and resource mapping, activity profiles, and focus group discussions may be used to help elicit the community members' experiences and ideas.

Case Study

In the World Vision Kasangombe ADP in Luwero district in Uganda, village-level stakeholder mobilisation meetings were held.

These meetings explored the need to scale up local initiatives to support and protect OVC and their families. It was during such meetings that existing care groups were identified and OVC were defined. The target group for these meetings were all members of the community, including:

- Local council members
- OVC guardians
- Members of churches and other FBOs
- Opinion leaders
- Development and other committees existing in the community
- School teachers (both primary and secondary)
- Healthcare workers
- CBOs.

The agenda of the community meetings included:

- Definition of OVC (categories of OVC as understood by the community)
- Relation of OVC and HIV/AIDS
- On-going initiatives and the groups and institutions involved in providing care to the OVC in the community
- Challenges faced in the work of providing effective care to OVC
- Possible strategies and plans to overcome some of the challenges faced by the community in the care of OVC.

These meetings concentrated on identifying any on-going OVC interventions being carried out by people or groups at community level. All institutions that had any on-going interventions for OVC at village or parish level were designated as community care groups. Hence, community care groups were identified as churches, schools, mosques, CBOs, LCs and development committees. For example, Nakaseeta Parish in Kasangombe ADP has a total of 20 community care groups.

The ADP staff worked with local council leaders at village level, particularly officials responsible for children's affairs, to invite members of the community to the meetings. The leaders and ADP staff agreed on the schedules, venues and times for the meetings convenient for both men and women.

Case Study

Outcomes of the stakeholder meetings in Kaswa Area Development Programme, Uganda:

In Kaswa ADP the following were the outcomes of the two-day community stakeholder meetings held at each of the 12 parishes in the ADP in 2003:

Day 1

- HIV/AIDS and its effects on the community were discussed
- Categories of OVC were defined by the community
- The needs of OVC were discussed
- Ongoing interventions for the care of OVC were identified
- Achievements, numbers of OVC reached, unmet needs and gaps were identified
- Ways for strengthening or scaling up community responses to care for OVC were identified
- Community OVC care coalitions were formed
- Roles of community care coalitions were generated.

Day 2

- Monitoring and reporting of OVC were discussed
- Roles and tasks of home visitors were defined
- Selection criteria for home visitors were generated
- Registration and monitoring report format for OVC was generated
- Community care coalition leadership was discussed and leaders selected
- Training programme for community care coalitions was developed
- A follow-up meeting involving all ADP field staff was held at the ADP.

At the first community stakeholders' meeting, the mobilising team should clearly outline the rationale for the CCC within the community. This will improve the reach and effectiveness of all the CCC's interventions to support and care for vulnerable children

STAGE 3 Forming a Community Care Coalition (CCC)

At the end of the workshop, the way forward that most communities choose is to form a broad-based community care coalition (CCC) for OVC. The CCC model is intended to be highly flexible and responsive to local realities. 'CCC' is an umbrella term intended to describe a widely inclusive community structure. This may also be called a Mutual Aid Society, a Village AIDS Committee, community OVC committee, or preferably a term in a local language.

This coalition can grow out of support groups that have already been formed, such as church groups, support groups for PLWHA or women's groups. The coalition should be as broad-based as possible, including representatives from all the local organisations working to help OVC, men and women currently visiting or caring for OVC, and also OVC themselves.

Members of the coalition may be elected, volunteer, or be nominated by the community, depending on community members' preferences. The following qualities for CCC members and leaders have been recommended by existing CCCs:

- ◆ A commitment to caring for others, ideally demonstrated by the person already working voluntarily to visit, care for and protect OVC
- ◆ A willingness to put the benefit of others above his or her own benefit
- ◆ A strong sense of responsibility and high level of integrity
- ◆ A willingness to listen to other people's points of view
- ◆ The ability to commit time and energy to the coalition.

When the CCC has been formed, the mobiliser may wish to facilitate the coalition's election of a leadership team. This is likely to include a chairperson, a vice-chairperson, a secretary and treasurer. The leadership can then facilitate the development of an action plan for the CCC.

Key Roles of the CCC may include:

- ◆ Mobilise the community to form community OVC care committees
- ◆ Develop OVC assessment criteria
- ◆ Identify OVC based on these criteria
- ◆ Develop criteria for identifying home visitors
- ◆ Identify home visitors and select candidates for home visitor training
- ◆ Conduct local-level advocacy for policy, practices and resources to benefit the OVC and their guardians
- ◆ Mobilise resources to support OVC, their guardians and home visitors.

STAGE 4 Action Planning

The coalition members should plan to meet at an agreed time, date and place to develop an action plan for scaling up care, support and protection of OVC in the community. Some issues that the action plan will cover include the following:

- ◆ Roles and responsibilities of the CCC, perhaps drafting a code of conduct for members
- ◆ Identifying the resources and capacity of the CCC; and identifying capacity training needs
- ◆ Agreeing upon vulnerability assessment criteria to identify OVC within the community
- ◆ Agreeing upon criteria for identifying, training and supporting home visitors for OVC care.

It is important for the mobiliser to be clear about what assistance that the agency (for example, a government body or an NGO) that she or he represents is able to provide to support the CCC's future steps. This will avoid unrealistic expectations, misunderstandings and disappointments.

Some of the ways World Vision may support the CCC are indicated below.

World Vision's support to CCCs may include:

- ◆ Formation of Community Care Coalitions
- ◆ Training of community care coalitions in such fields as:
 - OVC protection, care and support
 - Psychosocial counselling
 - Caring for the chronically ill parents
 - Participatory rural appraisal and project planning, designing and facilitating
 - Training in proposal writing and concept papers to possible sources of funds
 - Leadership skills
 - Other key organisational development skills that would enable the CCC to access resources to address critical needs of OVC.
- ◆ Formation of links from CCCs to referral systems and other relevant institutions (for technical, financial and other support) at district and national levels, for example, access to government disability support structures.
- ◆ Training of CCCs in child protection and linking them to human rights organisations, healthcare facilities and counsellors skilled at identifying child abuse and neglect.
- ◆ Resource mobilisation. Advocacy at local and national levels for allocation of additional resources for local groups caring for OVC; from both within and outside World Vision.
- ◆ Formation of links of CCC with existing relevant institutions at district and national levels.
- ◆ Community exchange visits of CCC members to successful programmes being run in other communities.
- ◆ Providing bicycles for CCC members to reach out to more OVC and to monitor the programme effectively.
- ◆ Production of IEC materials that are related to HIV prevention, OVC care and support and child protection (T-shirts, posters, pamphlets, videos, radio programmes and dramas).
- ◆ Quarterly CCC review and planning meetings.
- ◆ Financial and/or material support for the care, support and protection of OVC in the community.

STAGE 5 Training Community Care Coalition Members

During the workshop for the formation of the community care coalition, the capacity needs of the coalition members are established. It is critical that members of the community care coalition have the necessary knowledge and skills for supporting and protecting OVC at community level. The members will likely need to go through a training course to equip them with such skills and knowledge for providing appropriate integrated care for OVC.

The course content in Unit 2 for the training may include the following:

- ◆ Information on HIV/AIDS and the situation of OVC, including child rights and protection issues
- ◆ Psychosocial and spiritual support for OVC and their carers
- ◆ Addressing the physical needs of OVC including food, healthcare, shelter and clothing
- ◆ Equipping OVC for the future through succession planning, education support and life skills training
- ◆ Community OVC needs assessment and action planning.

The mobiliser may need to utilise other people with the necessary technical expertise in the different dimensions of OVC care to facilitate the training – using the training guide in Unit 2. Such technical persons may be found within the community, district, World Vision or other organisations.



STAGE 6 Identifying OVC

The CCC, in consultation with the community, needs to define criteria for assessing vulnerability within the community, and for identifying OVC. The community must take the lead in the process of deciding which children are most in need of care, based on these agreed criteria. For example, there should be a common understanding of what qualifies a family to be classified as very poor. It may also be necessary for the mobiliser to sensitise the community on issues of children with mental and physical disabilities, as these children are often stigmatised and hidden but are also vulnerable and in need of support.

In World Vision's experience, giving children a voice in the CCC enables them to advocate for their own needs and concerns in an emotionally direct way that is difficult for a community to ignore, thus strengthening community mobilisation. Their participation will help the local CCC to define their criteria for vulnerability. The criteria recommended by World Vision for defining OVC are outlined below.

World Vision's Definition of OVC:

Orphans: Children below 18 years of age who have lost either a mother, a father or both parents to any cause.

Vulnerable children include:

Children whose parents are chronically ill. These children are often even more vulnerable than orphans because they are coping with the psychosocial burden of watching parents become increasingly ill and the economic burdens of reduced household productivity and income and increased healthcare expenses.

Children living in households that have taken in orphans. When a household absorbs orphans, existing household resources are spread more thinly among all children in the household.

Children with physical or intellectual disabilities, whether they are orphans or not.

Through discrimination, fear and lack of understanding, children with disabilities are often under-valued, and face neglect and malnutrition. These children are often hidden and rarely attend school. They are often more likely to suffer sexual abuse and violence and are least likely to have access to information about HIV and how to avoid infection.

Any other children the community identifies as most vulnerable, using criteria developed by the community. One of these critical criteria may be the poverty level of the household.

At the community level, defining OVC is complex and should not be dictated by others. Not all orphans may be vulnerable, and some of the most vulnerable children may not fall into the categories that have been defined here. The term 'AIDS orphans' should not be used because parents rarely know their HIV status. The term may lead to stigmatisation and discrimination against the orphans.

Once the criteria have been standardised, CCC members can initiate the process of selecting and registering children for their programme at village level according to a prioritisation of needs. This is one of the most crucial phases as it requires selflessness, honesty and integrity on the part of all those concerned.

The case study below shows an example of a participatory process for generating criteria for the identification of vulnerable children.

Case Study

In the World Vision Kasangombe ADP in Uganda, criteria for the identification of OVC were developed jointly through widespread community consultations. The following steps were taken to generate criteria for identifying OVC:

Discussions at village-level meetings

During community mobilisation meetings at village level, participants generated characteristics of OVC in the community.

Ranking during stakeholders meeting at parish level

Communities were able to narrow down the OVC identification criteria generated in different villages through a process of ranking and prioritisation conducted by a cross-section of stakeholders at the parish level.

Analysis by CCC at ADP level

The OVC criteria generated from different parishes were analysed further by members of the CCC at the ADP level meeting. Six criteria were chosen to be applied throughout each ADP to assist in the selection process. These criteria were:

1. Single/double orphans
2. Children living with HIV/AIDS
3. Children with chronically illparents
4. Children from extremely poor families
5. Children from families of elderly parents of 65 years of age and above
6. Children living with HIV/AIDS
6. Disability (of children or parents/guardians).

STAGE 7 Identifying Home Visitors

Home visitors are individuals living in the same community as OVC who make regular visits to OVC and their households to provide care and support. These visitors partially fulfil some of the roles of a parent, giving the children the psychosocial support of someone who cares about their well-being, assisting with household chores or responsibilities beyond the skills or strength of the children, and providing adult wisdom and counsel to help address problems, fears or issues the children may be facing. The home visitor can help fill these roles even while parents are alive.

Most home visitors will likely be women and men who are already visiting vulnerable family members and neighbours either on their own or as a member of a local community body. These home visitors, who volunteer their time to support OVC and affected households, form the backbone of a strategy for the care and support of OVC.

The home visitors help vulnerable children and the households caring for them to solve their own problems and to ensure that their needs are met. If there are problems or needs that cannot be addressed by the household and home visitor, the home visitor can refer the problem to the CCC for additional guidance and support.

Along with supporting community members who are already providing care to OVC, coalition members may wish to develop criteria to identify and recruit additional home visitors.

Possible qualifications for home visitors include:

- ◆ Being chosen by a child or children
- ◆ Previous involvement in OVC issues in the community and a demonstrated commitment to addressing and following up on these issues
- ◆ Living in the vicinity of OVC and therefore a familiar figure to the children
- ◆ Commitment to children's rights and to protecting children from exploitation and abuse
- ◆ Commitment to behaving ethically and acting as a role model in the community
- ◆ Good communication skills and a willingness to listen
- ◆ Strong interpersonal skills, in order to establish good relationships with both guardians and children
- ◆ The ability to maintain the confidentiality of the children, households, guardians and CCC members they work with
- ◆ A willingness to work on a voluntary basis.



Home visitors are the eyes, ears, arms and legs of the CCC. They will visit vulnerable children regularly. One home visitor may be responsible for visiting five to 10 children, up to once a week. Home visitors will receive training in how to carry out the visit, assess and record the status of the family members in a household, and record the assistance provided. Training for home visitors is covered in Unit 2 of this guide.

STAGE 8 Training Home Visitors

An important role of the CCC is to equip home visitors with the skills and knowledge that will enable them to provide care to OVC effectively. Home visitors should be trained to provide some or all of the following services:

- ◆ Continuous monitoring and recording of the childrens' well-being (including health, nutrition, education, safety and psychosocial status).
- ◆ Ensuring that OVC have adequate nutrition, shelter, access to health services and schooling, according to standards established by the CCC. This entails facilitating access to services and resolving problems according to protocols established by the community. For example, a register of children needing food aid; advocating for school fee exemptions, if needed; community assistance with household repairs or enrolling families in community garden projects.
- ◆ Assistance with basic household tasks (such as fetching water or tending crops).
- ◆ Protection against abuse and neglect (through prevention, negotiation, advocacy and referrals).
- ◆ Spiritual and psychosocial support for OVC and their guardians (through counselling and support groups among OVC, including children's clubs and peer groups; and among guardians).
- ◆ Succession planning (preparing for the loss of a parent or guardian):
 - Development of memory books or memory boxes
 - Identification of standby guardians
 - Advocating for the protection of inheritance rights
 - Assisting ill parents to disclose their HIV status to children and other family members, where desired and appropriate.
- ◆ Providing information on HIV/AIDS prevention and awareness.
- ◆ Care for chronically ill adults and children in the household (valuable on its own, and because it relieves the psychosocial and labour burdens on the children of chronically ill parents or guardians). Healthcare assistance may include:
 - Palliative care – simple assistance to reduce physical suffering, including basic medicines and/or traditional remedies that are safe, effective and easily available
 - Nutrition – providing training on good nutrition practices and the provision of supplements
 - Hygiene training – protection from HIV transmission and information on how to avoid the spread of common illnesses, such as diarrhoea
 - Referrals to healthcare facilities when necessary.
- ◆ Training in life-sustaining skills (for example, household management skills, negotiation skills, basic agricultural skills or home repair skills).
- ◆ Linking vulnerable households to income-generating projects.
- ◆ Supervising recreation activities for **all** local children (sports, games, singing, dancing, drawing and other activities that promote integration and healthy socialisation; and overcome stigma and isolation); promotion of the formation of youth clubs.
- ◆ Local-level advocacy for policies, practices and resources to benefit vulnerable children and their families.

CCCs will have identified the needs that the vulnerable children in their community have in order to guide appropriate home visitor training. Unit 2 of this guide provides facilitator's instructions, reference materials and handouts developed by World Vision for training home visitors in most of the competencies listed above.

STAGE 9 Supporting Home Visitors

The CCC and mobiliser need to find ways to support home visitors in their important and challenging work. This support may take the following forms:

- ◆ Fostering mutual emotional and spiritual support among caregivers through facilitating support groups in which home visitors can share experiences, work through difficulties they are encountering, and receive empathy and care from other group members.
- ◆ Organising community exchanges to give home visitors and other CCC members the opportunity to learn from other communities' efforts, to share successful practices, to motivate each other and to develop joint action plans, thus scaling up a regional OVC response. Community exchanges are a positive way to affirm the work that is already being done and encourage and challenge communities to do more, especially if the process is enhanced by the inclusion of vulnerable children and others testifying to the care and support they are receiving from within their community.

There is debate as to whether or not to provide other support, such as material or financial incentives, to home visitors. There are concerns that providing material support (such as hats or food) will draw people to be involved out of a desire for personal gain rather than genuine concern for children and families. Such incentives may also undermine community ownership and the sustainability of these initiatives – when incentives end, assistance to the children might also end.

The CCC, in consultation with the community, could recommend incentives that they believe are appropriate and sustainable. The community may recommend ways to publicly recognise, appreciate and encourage caregivers. For example, in some areas community members assist home visitors with household chores to help free their time for OVC care and support. Alternatively, home visitors could be provided with tools that enable them to provide care to OVC more effectively, for example:

- ◆ Bicycles that enable them to visit children easily
- ◆ Basic palliative healthcare kits to treat ill children and adults
- ◆ Raincoats, umbrellas and rain boots
- ◆ Carrier bags for their handbook and records.

Factors for commitment in Home Visitors:

In World Vision's experience, the most powerful incentive for home visitors is knowing that they have helped neighbours in need and have contributed to the development of their community. When asked what keeps them committed to CCC goals, community members from Kenya, Uganda and Malawi listed the following factors:

1. Recognising that their own children could be orphaned or vulnerable one day and that in such a situation they would want others in the community to help
2. Personal fulfillment and satisfaction in assisting OVC
3. Following instructions to care for orphans and widows according to Christianity, Islam and other faiths
4. Love for orphans and children
5. Concern for the rate at which the number of orphans is growing
6. Seeing the effects of their work – for example, an increased number of children healthy and more children attending school
7. Recognition by community members as a role model and leader
8. Affirmation from visitors on the CCC's achievements.

STAGE 10 Monitoring and Reporting

When the CCC has determined the criteria for identifying OVC and home visitors have been trained, the next step is to register the orphans and vulnerable children whom their interventions will assist. Registration will be an ongoing activity for the CCC, as children may fall into vulnerability at different rates and stages of the programme. Children in the community should thus be continuously assessed for their vulnerability status according to the CCC's criteria.

The registration of OVC will capture details such as each child's name, sex, age, school status (in or out of school, grade level), village, parental situation (paternal, maternal, or double orphan, or other kind of vulnerability), and head of household (for example, whether single, female, male, child, grandparent, neighbour, uncle, aunt). This information is important because interventions to support OVC will vary according to how a household is headed. For example, OVC in grandparent-headed households may require more direct material support, while an OVC in middle aged female- and male-headed houses may require minimal material support but need long term, sustainable, production-oriented activities. The information in the registration forms will inform the CCC on the number of vulnerable children and households and what their needs are. This will help to determine the type of interventions and the resources required for effective and sustainable OVC care in the community.

note

An example of an OVC Registration Form is in Module 2 on page 56

When the OVC have been registered and linked to a home visitor, home visitors should keep a record of each visit using a simple home visit form developed by the CCC (see an example on page 57). This will record the status of family members, services required and assistance rendered. The reports on OVC status should be handed to the designated person in the CCC during the CCC's monthly meeting with home visitors. In these meetings, home visitors will discuss their reports and clients in order to obtain advice and assistance with problems and to share ideas about how to help the children.

Periodic feedback meetings involving the CCC, all home visitors and the wider community are very important. These meetings will help the community review what has happened since the last meeting, including why activities have failed or succeeded, lessons learned and issues that need further resolution. They will also maintain the focus on the community's own responsibility to care for and support OVC.

Case Study 1

In the World Vision Kasangombe ADP in Uganda, the CCC ensures that OVC problems are the concern and responsibility of the community themselves:

The community must take on the responsibility of addressing these problems, rather than waiting for external assistance. For example, in Karonera Sub-county (Kaswa ADP), 32 750 OVC have been identified, registered and are assisted, and of these World Vision only assists 2 000 orphans. Hence, according to the FGD in Bukoto, '*the community must boldly come up and take on the problem of OVC since external assistance will not suffice to reach all of them*'.

Home visitors may meet every month with the CCC, while CCCs may meet as a body every quarter. In the home visitor meetings, home visitors will discuss their reports and clients in order to obtain advice and assistance with problems and to share ideas about how to help the children. The meetings are a platform for joint problem solving and mutual support, as well as an opportunity for affirmation and celebration of achievement.

Another important function of the monthly home visitor meeting with the CCC is the handing over of the home visitors' OVC visit records. These reports on OVC status should be handed to the designated person in the CCC, who will assess the information and use it to monitor the OVC programme. This is primarily to enable the CCC to monitor performance and adjust as necessary. It will also indicate whether the programme is successfully reaching those OVC in need of support. An important additional purpose is accountability – both to the community as a whole and to donors that support the CCC.

Possible indicators that CCCs can use for monitoring include:

- ◆ Existence of child registers
- ◆ Number of home visitors trained
- ◆ Amount of resources generated internally by communities for the care of OVC (examples of such resources may include funds, assets, commodities or labour)
- ◆ Amount of resources mobilised externally by communities for the care of OVC
- ◆ Retention or turnover rate of home visitors
- ◆ Number of OVC registered
- ◆ Percentage of OVC registered who are visited regularly
- ◆ Number or percentage of registered OVC and their households receiving support
- ◆ Number or percentage of OVC that are either in school or in appropriate vocational training
- ◆ Number or percentage of OVC that have at least as much nutrition as is the norm for children in the community, as defined by the community (for example, three meals per day).
- ◆ Number or percentage of OVC accessing specific services (such as healthcare, home-based care and psychosocial counselling).

Case Study 2

In Kasangombe ADP in Uganda, the CCC conducts regular meetings to discuss OVC care:

The CCC conducts regular meetings held at three levels – at village level (for home visitors); parish level and ADP level. The CCCs from all parishes meet quarterly at the ADP to discuss progress and the way forward. Opinion leaders in the community such as politicians, businessmen and women and students are also invited to attend the meetings for support and advocacy. The CCC leadership arranges the meetings. The ADP facilitates resources such as transport, meals and stationery.

The CCC quarterly co-ordination meetings take the following format:

- ◆ Refresher session on the critical areas in OVC care (including new developments in the care of OVC at the district, national and other levels).
- ◆ CCCs make presentations in the following areas:
 - Number of OVC registered by the CCC in the previous quarter
 - Number of OVC who received care in the previous quarter by the CCC
 - Major achievements of the CCC
 - Main challenges and constraints for the CCC
 - Suggested strategies to overcome the constraints
 - Next plans and objectives.
- ◆ Members discuss the following:
 - What have you learned from each other's CCC?
 - What are the strengths of the responses and how can they be improved?
 - What solutions to the challenges mentioned above can be found within the community?
 - What support can be obtained from outside the community – for example, at district level, private sector or through politicians?
 - What lessons can be taken back to your CCC?
- ◆ Agenda for the next meeting.

STAGE 11 Mobilising Resources

A CCC needs to mobilise resources in order to address critical needs the home visitors identify when visiting the homes of OVC, as well as to undertake projects that are determined to be of benefit to OVC in the community. Depending on its activities, a CCC may need to access material or financial resources on a regular basis. Resources needed may include food, school uniforms and other clothing, cash for school fees and play /learning toys.

While there are sometimes resources available from multilateral, government and NGO sources, the most reliable and sustainable resources come from within the community itself.

Methods for communities to generate resources

Communities have been very creative in developing ways to generate resources to support OVC. Successful methods include:

- ◆ Income-generating activities like maize milling, brick making and basket weaving
- ◆ Vegetable and maize gardens, which provide food for the children and their households
- ◆ Fishponds, poultry and pig-rearing projects
- ◆ Choir festivals, arranged by youth groups and churches, which charge a small entry fee to raise funds
- ◆ Collections of used clothing, food and cash (for example, in church services) to be distributed to OVC households
- ◆ Piece-work or casual labour done by CCC members, with the earnings donated to CCC funds
- ◆ Monthly membership contributions by CCC members (usually less than US\$1 a month) to create a regular influx of cash.

The mobiliser can assist in resource mobilisation by providing financial and material assistance to supplement the resources raised internally. It is important not to undermine or overwhelm a community's commitment and capacity to raise its own resources. Thus external assistance is often provided in limited amounts to enable a CCC to gain experience of managing external resources and develop a track record that can help it access additional funding from other sources.

To help CCCs access other external resources, the mobiliser can provide or link the CCC with training in writing proposals and grant applications for assistance from government agencies or international NGOs and aid agencies. In addition to capacity building, the mobiliser should work to link coalitions with other sources of support (technical, financial and material) available at district and national levels. The mobiliser may also advocate at district and national levels for the allocation of additional resources for local groups caring for OVC.

Module 2

Detailed Instructions for the Mobiliser

| | |
|---|-----------|
| Introduction | 23 |
| Step 1: Preliminary Institutional Mapping | 24 |
| Step 2: First Community Stakeholders' Meeting: Assessing the OVC Situation | 29 |
| Step 3: Second Community Stakeholders' Meeting: Forming a Community Care Coalition (CCC) | 37 |
| Step 4: Action Planning | 44 |
| Step 5: Monitoring and Reporting | 53 |

Introduction

This part of Unit 1 provides the detailed instructions that a mobiliser can follow to help a community start or strengthen care for orphans and other children made vulnerable by HIV/AIDS.

This guide recommends the following process to mobilise a community care coalition, as discussed in Module 1:

- 1 Preliminary institutional mapping
- 2 Community stakeholders' meetings
- 3 Forming a community care coalition
- 4 Action planning
- 5 Training community care coalitions
- 6 Identifying OVC
- 7 Identifying home visitors
- 8 Training home visitors
- 9 Supporting home visitors
- 10 Monitoring and reporting
- 11 Mobilising resources.

In Module 2, the following steps are recommended to be taken towards mobilising community-led care coalitions in the support of orphans and vulnerable children:

- ◆ Step 1 - Preliminary institutional mapping
- ◆ Step 2 - Holding a first community stakeholders' meeting to assess the community's OVC situation
- ◆ Step 3 - Holding a second community stakeholders' meeting to form a community care coalition (CCC)
- ◆ Step 4 - Action planning
- ◆ Step 5 - Training community care coalition members.

Each step describes a number of actions to be taken to achieve the process outlined in Module 1. These actions are described in detail in this module and include many reference information sheets and reference forms that mobilisers can use to record their assessments, analyses and planning towards initiating community-led care to support orphans and vulnerable children. The information and reference sheets may be used as they are in this guide, or they may be adapted by a CCC to suit their own requirements.

STEP 1 Preliminary Institutional Mapping

The purpose of conducting an institutional mapping exercise in the community is to identify the main stakeholders involved in OVC activities, or those with the potential to become involved. You will later hold a stakeholder meeting in order to mobilise a broad-based community response to OVC issues. This preliminary mapping activity will help you to identify whom to invite to this meeting.

The following actions will help you identify potential stakeholders in the community:

◎ Action 1: Own knowledge

The first step in this exercise is to record what you already know about the community you are assessing. Use the forms from *Mobiliser Reference 1* to record what you know about the current situation in the community. There are two forms to fill in:

- one for recording all institutions and organisations in the community (see page 27),
- one for recording key individuals in the community (see page 28).

Fill in as much as you can, even if your information is not complete.

Remember to include all possible organisations and individuals. You may use the *List of Potential Stakeholders* (see page 26) to help you to think of as many stakeholders as possible.

note

Make as many copies of the Mobiliser Reference sheets as you need

◎ Action 2: Consult with WV field workers

The next step is to fill in any information gaps that you may have in your situation analysis forms. If World Vision or other agencies already have programmes in the community, staff members may be able to give additional information. Consult with your colleagues in order to fill in your tables as completely as possible.

◎ Action 3: Meet with local authorities

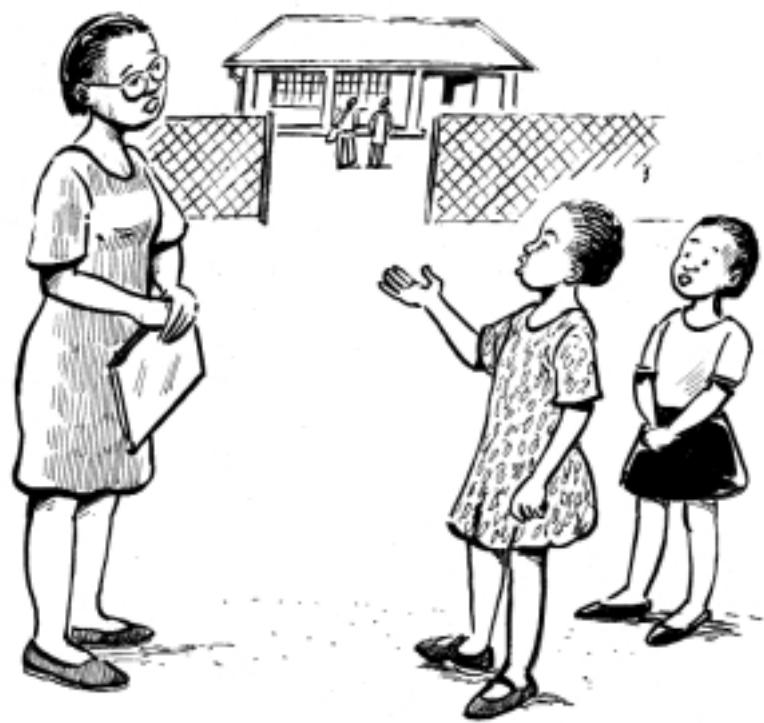
To complete your analysis, you may need to consult further. You should set up a meeting with the relevant local authorities, whether they are administrators or local leaders (depending on the structure in your community). Use this meeting to present the OVC programme, and to ask for additional information in order to complete your forms. In this way, you will be sure that you are not excluding any important figures from your stakeholders' meeting.

This meeting should take place prior to community mobilisation and before you call for a first stakeholders' meeting. This meeting is also important as the local authorities will appreciate your consulting them and informing them of your planned activities, and this will help to ensure good relationships throughout the community mobilisation process. The support of local authorities and leadership will strengthen the CCC's efforts to support and care for OVC.

◎ Action 4: Community walkabout with children

When planning activities that will impact on the lives of children, it is a good idea to include children themselves in the planning process. Explain your intentions to the local authorities, and then identify a number of both boys and girls to accompany you on a tour of their community.

Use this opportunity to talk to the children about their daily activities, and about the community services that are important to them. As you pass different areas or buildings in the village, ask the children to tell you about them in their own words. For example, you may explore issues of protection by asking them which areas they consider safe, and which they think are unsafe.



Based on the childrens' own perspectives, you may come up with further relevant information regarding potential stakeholders. Use this information to complete your forms. The participation of children in the all stages of planning the OVC programme will help to ensure its effectiveness in addressing the needs of orphans and vulnerable children in the community.

◎ Action 5: Contact stakeholders

You should then contact each of the stakeholders that you have included in your *Mobiliser Reference* tables, and invite them to the stakeholder meeting. You should provide them with a brief description of the purpose of the meeting, and you may ask them to look at your table to make sure you have not forgotten anybody. You may make additions to your table if the stakeholders you contact have more information.

You may check the column 'When Contacted' once you have invited a stakeholder, and record any observations that may have come out of this contact.

Once all the stakeholders have been contacted and a date, time and venue has been set for the meeting, you can prepare for the first stakeholders' meeting, as detailed in Step 2.

List of Potential Stakeholders

Institutions / organisations

- Local government departments
- Community radio stations
- NGOs
- CBOs
- International agencies
- Youth groups
- Police
- Special AIDS programmes
- Midwives' groups
- Human rights groups
- Women's clubs
- Arts and cultural groups
- Schools
- Clinics and health facilities
- Churches, mosques, temples and other faith-based organisations
- Sports clubs

Key individuals

- OVC themselves
- Head officials / administrators
- Faith leaders
- Traditional leaders
- Traditional healers
- Business leaders
- Farmers' leaders
- Factory or business owners
- Social workers
- Health professionals
- Teachers
- Other influential individuals

Mobiliser Reference 1
Institutional Mapping
Table of key organisations / institutions in the community

| Name of Organisation / Institution | Name of Key Contact Person | Type of Institution / Sector | When contacted | Observations |
|------------------------------------|----------------------------|------------------------------|----------------|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Mobiliser Reference 1
Institutional Mapping
Table of key individuals in the community

| Name of Key Individual | Title / Responsibility | When contacted | Observations |
|------------------------|------------------------|----------------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

STEP 2**First Community Stakeholders' Meeting:
Assessing the OVC Situation****The first stakeholders' meeting**

The purpose of this meeting is to gather all stakeholders in the community to discuss the trends of HIV/AIDS in that community and how it impacts on children. This assessment of the current situation of OVC in the community will also help to indicate existing responses in the community. In a subsequent phase, the stakeholders will decide on the type of response they would like to undertake, as described in Steps 3 and 4. For this first meeting, though, you should focus the group on the assessment itself.

Once you have welcomed everyone to the meeting, introduced yourself and explained the purpose of the meeting, you will take the group through the activities outlined below.

◎ **Activity 1: Tracking trends of HIV/AIDS in the community**

For this activity, divide the participants into four groups. Give each group a piece of flipchart paper and one of the following four topics:

- ◆ Illnesses/deaths
- ◆ Orphans and other children made vulnerable by HIV/AIDS
- ◆ Existing community responses
- ◆ HIV awareness.

(If you have different or additional ideas for relevant topics, you may instruct the groups accordingly.)

Ask the participants to think about the trends in the community over the past five to ten years with respect to their topic. Some examples of questions are:

- Have illnesses and deaths increased or decreased?
- Have the numbers of orphans increased or decreased?
- What has been the response to HIV/AIDS in the community? Has it increased?
- How do they perceive HIV awareness among community members?

Participants should come up with a **trend graph** (as illustrated in *Mobiliser Reference 2* on page 33). This will help them to see how the situation has changed over time.

Optional Activity: Time line

If it helps the participants, prior to doing the trend graph, they may draw a **time line** showing significant occurrences in the community in the past five to ten years. This may help them to begin to think about the history of the community, and the ways in which the community has changed in recent years. (See the example time line in *Mobiliser Reference 2* on page 34.)

When each group has completed their trend graph (and time lines, if included), participants will present results in plenary, explaining their observations with respect to their respective topics. You should facilitate a discussion regarding the degree of seriousness of HIV/AIDS in the community and how it has affected children in the community.

◎ Activity 2: The needs of OVC

Now that the participants have discussed the general trends related to HIV/AIDS in the community, you can focus the assessment on the current situation of OVC. In plenary, ask the group to brainstorm the various needs that vulnerable children have. List these on flipchart paper. It is important to allow the group to decide on this list – so that they can identify needs based on their own perceptions of the community situation, and from information given by children themselves to stakeholders prior to this meeting. Nonetheless, you may suggest others, as per the list below, and ask the group if they feel these (additional) needs are relevant for their situation.

- ◆ Healthcare/nutrition
- ◆ Education
- ◆ Psychosocial support
- ◆ Protection from abuse and exploitation
- ◆ Birth registration (in order to access additional services).

This list reflects the suggestions from the *UNICEF Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, which recommends that efforts to be made to improve OVC access to these identified services.

◎ Activity 3: The situation of OVC

Divide the participants into groups once again, and assign one topic from the list developed in the previous step to each group. Each group should discuss the current situation of OVC with respect to the assigned topic or need. For example, questions related to healthcare may include:

- ◆ To what extent do OVC in the community have access to healthcare?
- ◆ What is the general nutrition status of OVC?
- ◆ Are births generally registered in the community? Does this differ for OVC?

Allow time for discussion, and then ask each group to record their observations on flipchart paper and present to plenary.

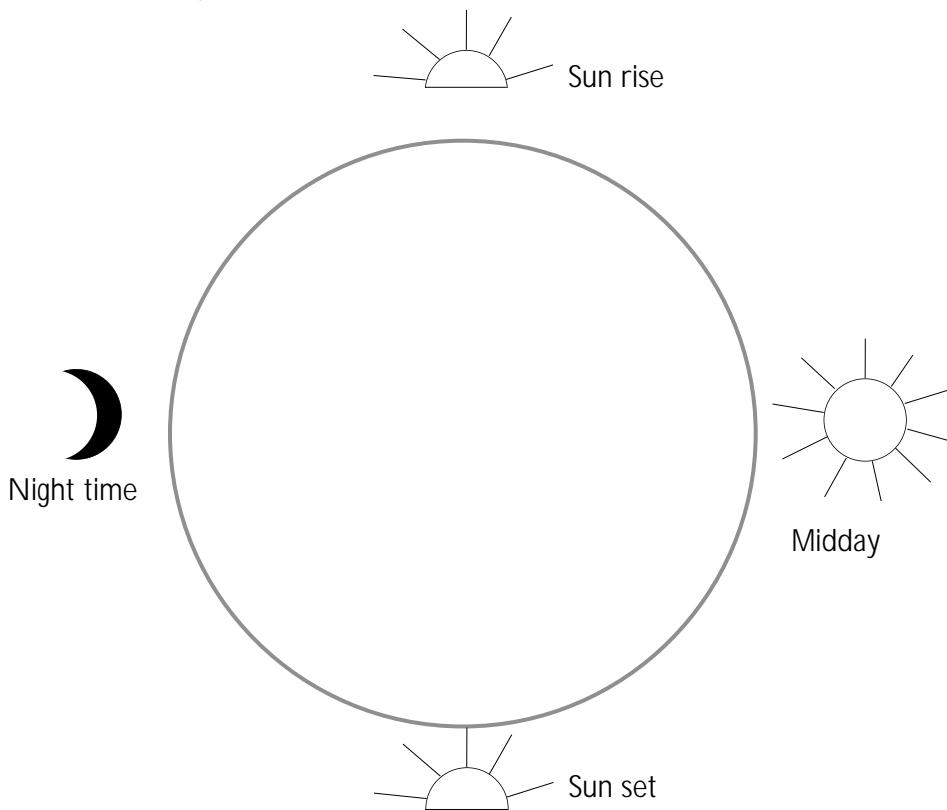
◎ Supplementary activities: Child participation

While the previous brainstorming activity helps to understand the participants' ideas about the situation of OVC in the community, the assessment would be strengthened if the participants could supplement their ideas with some practical research. The following three activities can be carried out with community children. In all cases, the activity is aimed at participants understanding the situation of the children more fully and allowing the children to give insights and ideas to inform the assessment process. It is not necessary for participants to undertake all three of these activities. After completing any of the activities, the participants should fill out an *Assessment Summary Sheet* (see *Mobiliser Reference 2* on page 35) with their observations. If the activities are carried out thoughtfully and if the participants probe sensitively for information, much may be learned from the children themselves.

i Child Activity Wheels

Have a child draw a large circle on a piece of paper, and draw symbols at each quarter-turn of the circle of: a sun rising, a full midday sun, a sun setting, and a moon for night time, to represent a full 24-hour day. From the centre of the circle, she or he can then draw a line to the approximate time of waking, and another line to the approximate time of sleeping. The area inside the circle will then be segmented to describe activities for each part of the day, until the activity wheel is complete. For example, one segment could represent the hours when the child is sleeping.

Activity wheels may be done to discover children's daily routines, with respect to schooling, work loads, food preparation, and so on. By asking probing questions, participants can gain a better understanding of the children's situations. Fill in the *Assessment Summary Sheet* on page 35 when the activity is complete.



ii Community walkabout with children

As in Step 1, participants may choose to organise a walk around the community with a small group of children to gain insight into their perceptions. It may be useful to tour with both orphans and non-orphans to understand their differences in perception. The idea is to facilitate a discussion. Issues could include:

- What are the features of the community from the children's perspective?
- Where do children spend their time?
- Are there any places they especially like, or are afraid to go?

Following the community walk, the participants should complete the *Assessment Summary Sheet* on page 35.

iii 'Key Informant' interviews

The key informants in this case are children. If the participants feel that the previous two activities are too time-consuming or too indirect, they may choose to talk directly with children to learn about their situations and their needs. They may use the *Assessment Summary Sheet* on page 35 as a guide. In this case, the mobiliser should coach the participants on sensitive questioning techniques so as not to probe too deeply into issues that the child is not ready to address.

(Home visitors will later be trained in appropriate psychosocial support to children, and ways of talking to children about sensitive issues.)

Assessment summary

Following these supplementary activities, the group should reconvene and review each of the previously-identified topic or needs. On large pieces of flipchart paper (one for each topic) they should summarise their observations in terms of Healthcare, Education, Child Safety and Protection, Psychosocial Support, Birth Registration and any other category they have identified, based on the information they gathered through talking to the children. This information would have been recorded on the *Assessment Summary Sheets* they filled in for each activity.

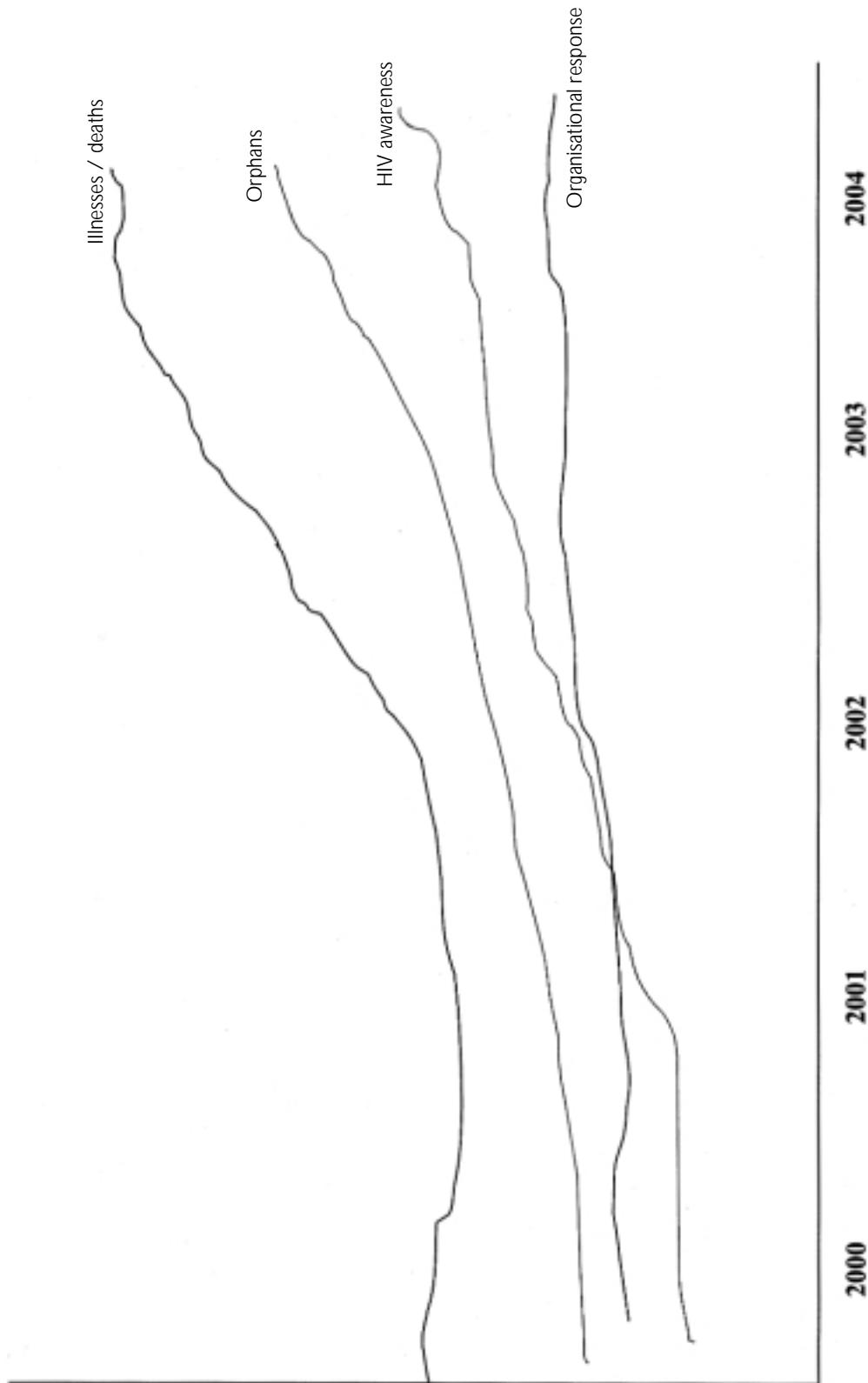
At this point, the participants should have a good picture of the most pressing needs faced by OVC in the community, and the current situation with respect to those needs.

◎ Activity 4: Current response

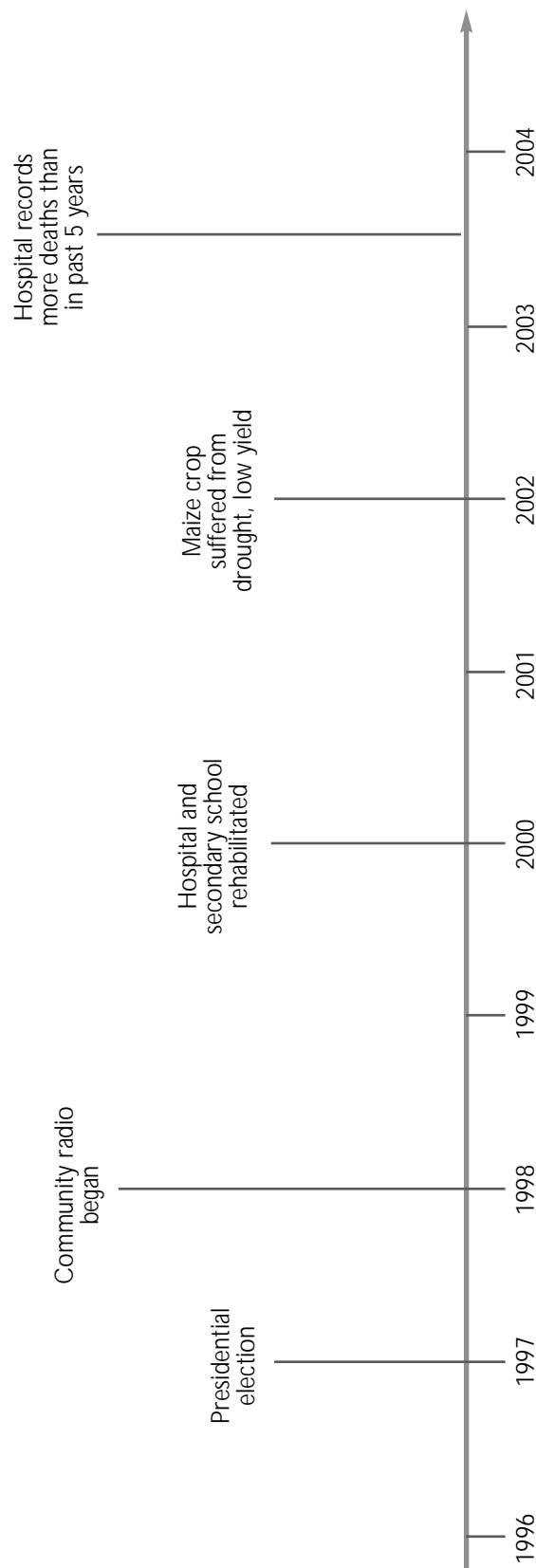
The *Current Response Matrix* (see *Mobiliser Reference 2* on page 36) should be copied onto one or more large pieces of flipchart paper, with enough space to record each organisation and each key individual. Each representative should fill in his or her name or the name of his or her organisation, and indicate area(s) of response. You may choose to include categories of response beyond those identified in the initial listing of OVC needs. The *Matrix* provides a simple visual picture of current activities and gaps in response in the community.

Explain to the participants that you will be holding a second community stakeholders' meeting (see Step 3) in which all those interested in organising a community response to the OVC situation are welcome to attend. Explain that participation is entirely voluntary, but that all stakeholders are welcome. In the second stakeholders' meeting, you will be discussing possible community care structures that the stakeholders can choose to form and coming up with a plan for the way forward. Set a date, time and venue for the second meeting in consultation with stakeholders.

Example HIV Trend Graph



Example Time Line



Mobiliser Reference 2
Community Stakeholders' Meeting
OVC Assessment Summary Sheet

| | Identified Strengths | Identified Gaps | Other Observations |
|----------------------------------|----------------------|-----------------|--------------------|
| Education | | | |
| Nutrition / Food Security | | | |
| Healthcare | | | |
| Psychosocial Support | | | |
| Protection | | | |
| Birth Registration | | | |
| | | | |
| | | | |

Mobiliser Reference 2
Community Current Response
Example of a Current Response Matrix

| Name of Organisation / Institution | Type of Response / Activity | | | | | |
|--|-----------------------------|--------------------------|-----------|--------------|------------|---------------|
| | Health | Nutrition/ food security | Education | Psychosocial | Protection | Birth / legal |
| Schools / teachers | | | | | | |
| Youth groups | | | | | | |
| Churches and faith-based organisations | | | | | | |
| Police | | | | | | |
| Traditional leaders | | | | | | |
| Local government / local authorities | | | | | | |
| AIDS organisations | | | | | | |
| Clinics / healthcare facilities | | | | | | |
| Men's / women's groups | | | | | | |
| NGOs / CBOs | | | | | | |
| World Vision | | | | | | |

STEP 3**Second Community Stakeholders' Meeting:
Forming a Community Care Coalition (CCC)****The second stakeholders' meeting**

By the end of the first community stakeholders' meeting, the participants had described the current situation of OVC in the community and identified both current responses and gaps in responding to OVC needs. Participants then returned home (or returned to their respective organisations) and had time to reflect and decide if they wanted to continue to participate in strengthening a community response to the identified OVC needs. Those participants appearing at this second meeting, then, are assumed to be those who are interested in moving forward.

◎ Activity 1: Choosing a CCC model

Remind the participants of the topics discussed in the first meeting. Review the needs of OVC, the current response, and the identified gaps in meeting these needs. Ask the participants if they have thought of how they would like to organise themselves to address the identified gaps. If the participants already have their own ideas, ask them to explain these. In most cases *you should accept whatever community structure the participants decide to form*. As it is likely that they will speak of some type of collaborative effort where many organisations and individuals come together for the purpose of assisting vulnerable children, their own structure will probably not be too different from the CCC model(s) that you, as a mobiliser, have been introduced to. You should allow for debate among the members until they reach agreement on the structure that they want.

If the members are quite clear about the type of structure they wish to form, you can ask them to draw a visual representation of how they see the different stakeholders coming together. If this drawing more or less matches one of the two models you have in *Mobiliser Reference 3*, you may help them to clarify the details of their model. If the group is uncertain about the type of structure they wish to form, you may present the two models in *Mobiliser Reference 3* as possibilities. Explain the difference between the two models, as outlined on the next page.

You should explain to the participants that the choice of models depends on the extent to which they feel that the response to OVC needs in their community is weak, and a new structure is needed to carry out activities to fill this gap, or, conversely, the extent to which they feel existing stakeholders are already responding adequately to the OVC crisis, with only small gaps, and that what is needed is simply more co-ordination.

Show the two visual representations of the models to the participants, emphasising the difference between the two, and allow time for the participants to discuss and decide which model is most appropriate to their situation. They may wish to refer to the *Current Response Matrix* that they filled out in the previous meeting to review the current situation and the identified gaps in response.

Once the participants have decided on the model they wish to use, they may draw the appropriate community care coalition model on a large sheet of flipchart paper.

CCC Model 1 - An implementing structure (see page 42)

In the first model, the various organisations and individuals come together to form a *new organisation*: one that has as its mission to respond to the needs of OVC in the community. Together they will come up with an action plan and decide how to implement the plan. This work is in addition to the regular work the members are already doing within their own organisations. The CCC will be a new organisation, formed for the purpose of responding to the OVC crisis.

This model may be a better option if stakeholders or participants feel there is very little current activity with respect to vulnerable children; and that a new structure should be created to fill this gap and implement new activities.

CCC Model 2 - A co-ordinating structure (see page 43)

In the second model, the various organisations and individuals come together, but this time more for purposes of carrying out a *co-ordinating function*, rather than an implementing function.

In this case, each member organisation continues to work in accordance with its own internal mission, in recognition of the fact that many organisations are already working with OVC and that an effective response can be carried out by these organisations without needing to form a new implementing structure.

In this model, the CCC exists more to understand what each stakeholder is doing to respond to OVC, and to help to co-ordinate the response.

The member organisations can come together in the CCC to share experiences, to identify lessons learned and to share information about their activities so that complementarities may be gained. In some cases, if the CCC feels that there is an obvious gap that no member organisation is filling, the CCC may choose to implement certain OVC-related activities itself.

This model may be followed if there are already many stakeholders responding to the OVC situation and the participants feel that what is needed is more co-ordination, with limited CCC direct implementation.

◎ Optional Activity 2: Individual and collective response

The following activity may also help the participants in deciding on the structure they wish to form.

Ask each organisation, institution or individual to write one brief statement that sums up their mission. (If some do not have a defined mission statement, ask them to write down simply what it is that their organisation wants to achieve.)

Ask each organisation or individual to write down what it sees as the OVC priorities for its community. Ask each organisation or individual to then draw a picture of their mission and how it relates to work in the community. For example, an organisation with a mission to improve food security might draw a picture of a child picking tomatoes to indicate a means of improving the nutrition of OVC.

Now pair two organisations or individuals together. Ask them to read their missions and show their drawings to each other, and to then make another drawing, together, showing how a partnership between the two of them would manifest itself, with respect to work in the community. a question to ask is: *How do the two missions combined together relate to work in the community?*

Following this, pair this pair with another pair (to make a group of four organisations or individuals) and repeat the exercise. The four must come up with a new drawing to show what their community response would look like, if they were all partnered together.

Continue in this fashion, 'pairing pairs', until the group is working as one undivided whole. Ask the group as a whole, finally, to make a drawing, showing what their collective response in the community would look like.

You may wrap up by comparing this final drawing with the individual drawings that each organisation drafted in the first step of the activity. This may assist the members in deciding how they can best structure their response. There is no right or wrong outcome to this activity. The participants may decide that they can achieve more working collectively; or they may decide that the mixing of missions creates too much confusion and things worked better when each organisation worked individually. Their conclusion will impact on which CCC model they decide to choose.

◎ Activity Three: Leader selection

Once the group has decided on the type of structure it would like to form, they may wish to elect leaders for the CCC (both CCC Model 1 and Model 2 can benefit from good leadership). Leadership could typically include a chairperson, a vice chairperson, a secretary (who performs administrative duties) and a treasurer (who looks after the finances of the CCC). Each of these roles will need to be filled by a candidate selected by the group. Emphasise that candidate selection should be based on who can best fill the role, irrespective of gender. The voting may be open (nomination of a candidate and a show of hands) or secret (written down on paper or stones placed in a pile). The voting method should be decided by the group.

Before the group chooses their leaders, however, you may want to take them through the following exercise to discuss leadership qualities and styles.

To start, get the group to suggest qualities of a good leader. Write these up on flipchart paper.

Examples of good leadership qualities could be:

- the ability to unite a group and provide a stable base
- the ability to inspire group members to take action
- the ability to speak out if things go wrong
- being open to new ideas and ready to listen
- the ability to make decisions based on group consensus.

People who are popular, strong-willed and influential may not always be good leaders. Good leaders are often quieter people who are good listeners, are respected by the group and are able to maintain and support the group.

After the group has suggested a list of good leadership qualities, go through the list and ask the group to think about these qualities in relation to a community member who could be the CCC leader.

Next, discuss general leadership styles with the group:

- Leaders who command (they make decisions on behalf of the group with little discussion with other group members).
- Leaders who consult (they encourage discussion about situations and goals and then make a decision on behalf of the group).
- Leaders who enable (they set certain limits but within these limits encourage and enable the group to discuss and analyse their situation in order to make their own decisions).

Encourage the group to try and identify the leadership style that would be most fitting for the CCC model they have chosen.

Next, discuss the roles of individual leader positions in the CCC. For example, a **chairperson** in meetings, needs to:

- Be able to manage a group discussion within a time framework
- Clarify issues under discussion and regularly review where the discussion has reached
- Be able to inspire and motivate others during meetings
- Be able to hold back their own feelings and concentrate on the needs of the group
- Encourage participation so everyone gets a chance to share their opinions, views and knowledge
- Keep control of a debate, making sure people stay on the subject and don't speak too long
- Allow decisions to be made through group consensus
- Allow discussions from all sides but make sure that disagreements and arguments do not interfere with the group discussion
- Make good judgements on the group's behalf share out responsibilities and work
- Be approachable and encourage openness.

Discuss these with the group and get them to volunteer any other responsibilities or qualities that they think a chairperson should have; and how a vice chairperson can share and support the chairperson in these responsibilities.

A **secretary** should provide support to the chairperson and perform administrative duties for the CCC.

A secretary needs to be:

- Literate so that a record (minutes) can be made of all the important points discussed and decisions made at each meeting
- Able to write letters and reports on behalf of the group
- Able to arrange the time and venue for meetings and make sure all CCC members have this information and details of matters to be discussed
- Able to organise any information resources and notes for CCC.

Discuss these responsibilities with the group and get them to volunteer any other responsibilities or qualities that they think a secretary should have. Emphasise the importance of record keeping for the CCC, so that the group is shown to be accountable to all its members, its donors and the community it represents.

A **treasurer** has the very responsible role of keeping all the financial records of the CCC. A treasurer should be:

- Skilled in handling finances, perhaps with proven experience in the role
- Trustworthy and accountable
- Able to keep good financial records of contributions, fees or sale of produce, and of all money paid out – as loans, or expenses
- Able to look after the group's money wisely
- Able to manage a bank account on behalf of the CCC
- Able to provide updated written financial reports to the group at each meeting
- Able to advise the group on the best ways to use their funds.

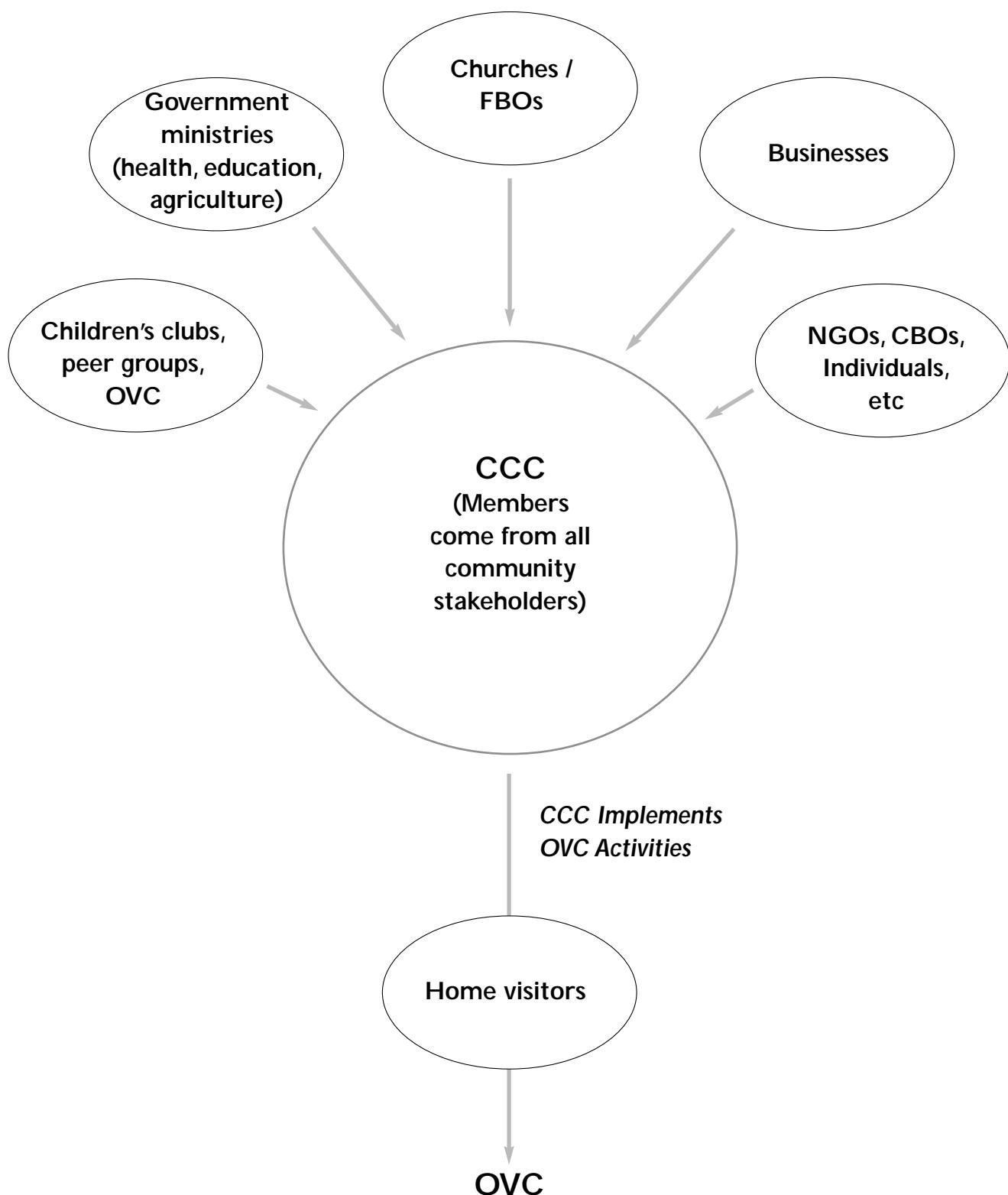
Briefly discuss these responsibilities with the group and get them to volunteer any other responsibilities or qualities that they think a treasurer should have. Emphasise that financial management is a critical component of the CCC, as financial accountability is most important for the effective running of the programme.

These discussions on aspects of leadership will help the group to make more informed choices when they come to select their leadership team. To select the leaders, get members to volunteer or nominate candidates for each role. They will then vote for the candidate of their choice through the selection or voting process that the group has agreed upon.

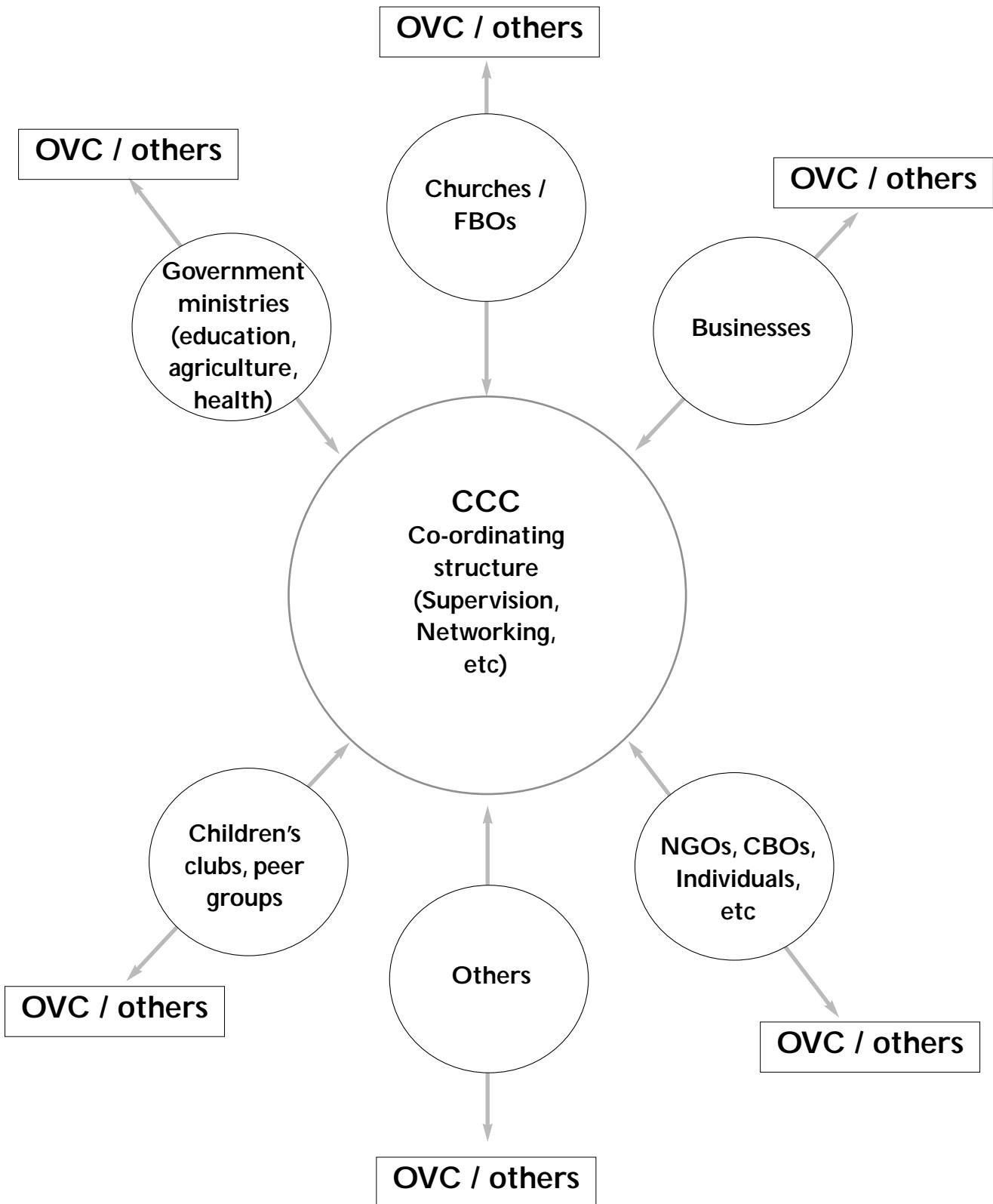
Mobiliser Reference 3

Community Care Coalition Models

Model 1: CCC as an Implementing Structure



Model 2: CCC as a Co-ordinating Structure



STEP 4 Action Planning

◎ Activity 1: General planning

Based on the first three steps already carried out, the CCC should have some ideas about the types of actions they would like to implement. As a mobiliser, you should allow them to make their own decisions about what it is they want to do. If they ask for guidance, you can share ideas, but the process should be theirs.

The CCC may choose to focus on an array of activities with relation to OVC, and all of their ideas should be welcomed and considered. Your contribution at this point is to explain that WV is available to help the CCC to train home visitors to visit and support vulnerable children in the community using Unit 2 of this guide. For **one** of their ideas, however, you may offer World Vision's training for OVC home visitors.

If the CCC decides that they do want to undertake a programme of home visits to OVC, you may then proceed to the next activity.

◎ Activity 2: Identify community OVC

In order for the CCC to identify who the vulnerable children are in the community, they should agree on a definition of what constitutes vulnerability. The community must take the lead in deciding which children are most in need of care. However, the guidelines used by World Vision (see *Mobiliser Reference 4* on page 50) may be useful as an example. Once the CCC has agreed upon a definition of OVC, they may begin to identify OVC in the community.

◎ Optional activity - Defining vulnerability

Divide the CCC members into small groups and give each group eight or ten blank cards. On these cards they should write characteristics of vulnerability. You may give one or two examples so that they understand the exercise. (For example, a child is vulnerable if his mother is chronically ill; or a child is vulnerable if her family has taken in two or more orphans). In their groups, they should try to arrange their cards in order of increasing seriousness of vulnerability. Once each group has completed the exercise, they should present and explain their answers in plenary. The CCC as a whole should then debate the inputs until they arrive at agreed-upon criteria for judging the vulnerability of a child. These criteria should then be listed on a sheet of flipchart paper.

◎ Optional activity - Mapping vulnerability

As an optional activity, you may assist the CCC members in carrying out a **mapping** exercise, where groups draw a map of their community on pieces of flipchart paper. They may divide the community into different areas (if the community covers a large area) with small groups taking responsibility for different portions. CCC members can draw houses on the maps which highlight vulnerable households (based on previously-defined criteria) that need to be prioritised and reached with CCC home visits.

◎ Activity 3: Identify home visitors

Before looking at the qualities that a CCC should look for in an individual home visitor, it is important to explore the role of the home visitor in the wider community context. The broad aims of home visitor identification and training follows a transformational agenda, that is, they seek to empower communities with the capacity to cope with, support and sustain themselves in the face of adversity and trauma; and to help re-establish and strengthen the social networks and support structures that will enable communities to do this.

This transformational agenda aims to:

- Empower community members with the knowledge and skills to care and support OVC and their families at community level.
- Empower and equip households and communities caring for OVC to:
 - Ensure the survival of orphans and other highly vulnerable children.
 - Enhance access to healthcare and basic education for OVC.
 - Provide psychosocial, spiritual and emotional nurturing for OVC.
 - Ensure sustainable household livelihoods and enhance the capacity of OVC to earn a future livelihood.
 - Protect OVC from abuse and exploitation.
- Empower and equip orphans and other highly vulnerable children to:
 - Care for themselves, their siblings, their aged guardians, and other vulnerable members of their household and community.
 - Protect themselves and others from HIV infection.
 - Serve as agents of transformation in the present and the future.

The home visitor is the key transformational agent in this process and should understand the full responsibility of their position. Some broad qualities that a home visitor should have include:

- ◆ Commitment to the care and support of orphans and vulnerable children
- ◆ Commitment to children's rights and to protecting children from exploitation and abuse
- ◆ Commitment to behaving ethically and acting as a role model within the community they serve
- ◆ Being trusted by the children, perhaps being chosen by a child
- ◆ Approachable, with good interpersonal communication skills and a willingness to listen
- ◆ Ability to maintain the confidentiality of the children, households, guardians and CCC members they work with
- ◆ Willingness to work on a voluntary basis.

Give a copy of *Mobiliser Reference 4: Identifying Home Visitors* (see page 51) to the chairperson of the CCC and ask him or her to facilitate a discussion with the CCC so that they may decide on the necessary qualifications of a home visitor. The questions in this reference sheet should help the CCC to think through many of the issues that will impact on the effectiveness of the home visitor programme.

◎ Activity 4: Support to home visitors

Refer the CCC back to the questions (from *Mobiliser Reference 4: Identifying Home Visitors*) that ask:

- What kind of compensation, if any, will home visitors receive?
- What forms of encouragement can be given if there is no compensation, i.e. entirely voluntary?
- How can we help the volunteers to stay motivated?

Use three sheets of flipchart paper. On one, write, 'World Vision Support'. On another write, 'Community Support', and on the third write, 'Home Visitor Internal Motivation'.

You may list, on the 'World Vision Support' sheet, any form of support that World Vision will be offering the home visitors. It is important that the home visitor programme does not rely solely on World Vision support in order to be successful, however, so the forms of support listed here should not be the over-riding focus of this exercise.

Nevertheless, you may point out the following benefits to the home visitor that may arise out of World Vision's involvement:

- ◆ Training (in some countries, the training that home visitors receive from WV may help them to upgrade their skills for eventual entry into the formal job market)
- ◆ Raincoats, rubber boots, umbrellas and other protective gear (if applicable)
- ◆ Exchange visits (if applicable)
- ◆ Access to support groups (if applicable).

Once you have filled in this sheet on World Vision's support to home visitors, ask the CCC to fill in the remaining two sheets. On the sheet on 'Community Support', they should think of the various ways that they – the CCC – and the community at large, can help to support home visitors.

This discussion should not be limited to material support, but also emotional support, appropriate forms of recognition; mentoring assistance and assistance with home visitor's household tasks. If you allow the CCC to brainstorm, they may come up with some creative ideas.



On the final sheet, 'Home Visitor Internal Motivation', the CCC should list the ways in which volunteering can be satisfying to an individual, apart from any forms of incentive.

These include such intangibles as:

- realising that one has protected and supported vulnerable children
- realising that one has contributed to the well-being of the community
- realising that others in the community think that home visitors are good and compassionate people
- realising that others in the community respect the skills that home visitors have gained
- fulfilling one's responsibilities according to one's faith.

If the CCC has difficulty with this exercise, ask them to imagine that they are the home visitors, or alternatively, to imagine that they are chronically-ill parents who are concerned about their children's welfare after they pass away. This will help the CCC focus on the expected roles and appropriate behaviour for a potential home visitor. It may be an idea for the CCC to brainstorm a home visitor code of conduct, which will help to outline ethical behaviour for home visitors.

At the end of the exercise, the CCC will have three categories of support to offer potential home visitors:

- ◆ World Vision's support
- ◆ any identified CCC/community support
- ◆ the internal rewards that come from volunteering for the good of someone else.

The CCC may use these to explain the role of the home visitor to the potential volunteers, so that there is clear understanding from the outset what they can expect.

Once the home visitors have been identified, you or one of your colleagues will carry out the OVC home visitor training, as detailed in Unit 2 of this guide.

◎ Activity 5: Analysing the situation in the community - the SWOT analysis

A CCC will need to make an analysis of the circumstances that exist in their present community environment before they can make strategic plans for supporting orphans and vulnerable children.

The SWOT analysis is a process that will help the CCC to identify the internal strengths and weaknesses of their group, in relation to the opportunities and resources that exist in the community and the possible threats to their plans to increase action to care, support and protect orphans and vulnerable children. SWOT stands for Strengths, Weaknesses, Opportunities, Threats.

For this activity, divide the CCC participants into groups, based on the community groups they represent (for example, church or FBO representatives, local government or women's groups). Explain to them what the SWOT analysis is, based on the introduction above.

Ask the groups to think about the following questions in relation to their work in supporting orphans and vulnerable children in their communities:

- What major external opportunities do we have?
- What major external threats do we face?
- What are our major internal strengths?
- What are our major internal weaknesses?

Allow time for groups to discuss these issues and offer guidance, if needed.

Hand out copies of *Mobiliser Reference 4: The SWOT Analysis* (see page 52) to each group and let them fill in the SWOT analysis sheet, based on the broad points raised in their discussions. Then get groups to give their ideas and experiences in plenary, and write up their main points on flipchart paper.

These points will be referred to in the next activity when the CCC will formulate recommendations for increased action for OVC support and care.

◎ Activity 6: Formulating recommendations to increase support to OVC

The points raised in the SWOT analysis exercise which will be used to help CCC formulate recommendations for increasing care, support and protection of OVC in their communities.

It may be useful to remind participants to be clear about their aims as they do this activity – they should have these aims in mind in order to set out their objectives. They need to identify their aims and objectives clearly in order to come up with recommendations for what they want to achieve.

Start the activity by reminding participants of the difference between *aims* (over-riding, general, guiding, long-term and open) and *objectives*, which should be specific, measurable, achievable, relevant and time bound. The acronym SMART helps people to remember these criteria.

Again divide the participants into groups according to the institutions or groups they represent. Groups should discuss and come up with a set of aims that they, as a group, want to achieve in supporting OVC. It is important to remind groups that these aims or recommendations should be do-able, because they will form the basis of their Action Plan. Refer them back to their SWOT sheets if they need further input on their aims.

Once each group has a set of aims written up, they should select a representative to present their group's aims to plenary. Once all the groups have presented their aims, summarise the discussion by highlighting the main points. These points will form the basis of the CCC's action plan to support and care for orphans and vulnerable children in their community.

◎ Activity 7: Action plans

Groups will use their lists of aims or recommendations to draw up an action plan for supporting OVC. The action plan will serve as an outline and guide for action for the CCC and all its members. All members of the CCC should have a copy of the Action Plan, so that they can act upon it.

Keep participants in the same groups according to their organisations or institutions, as appropriate. Ask each group to review their aims, for example:

- What are your aims and objectives as an organisation?
- What are the obstacles that will hinder you to achieve these aims and objectives?
- What factors can help you to achieve these aims and objectives?
- What can be done to decrease the obstacles and increase the positive factors?

This will help groups consider what actions they can take to make their aims become a reality.

Get groups to write up the actions or steps that they will take to achieve their aims and objectives. Remind the groups that their objectives should be SMART (specific, measurable, achievable, relevant and time bound). Emphasise that the action plans should be realistic and include how and when they will be implemented, for example, who will do a task and by when. The plans should be written up on flipchart paper.

When groups have completed their action plans, get each group put their list up and to present their action plan in plenary. Explain to the groups that by presenting their action plan to the whole group, they are also committing themselves to taking the actions they have stated on their lists.

World Vision's Definition of OVC:

Orphans: Children below 18 years of age who have lost either a mother, a father, or both parents to any cause.

Vulnerable children include:

Children whose parents are chronically ill. These children are often even more vulnerable than orphans because they are coping with the psychosocial burden of watching a parent become increasingly ill and frail; and the economic burdens of reduced household productivity and income and increased health care expenses.

Children living in households that have taken in orphans. When a household absorbs orphans, existing household resources must be spread more thinly among all children in the household.

Children with physical or intellectual disabilities, whether they are orphans or not. Through discrimination, fear and lack of understanding, children with disabilities are often undervalued, and face neglect and malnutrition. These children are often hidden and rarely attend school. They are often more likely to suffer sexual abuse and violence and are least likely to have access to information about HIV and how to avoid infection.

Other children the community identifies as most vulnerable, using criteria developed by the community. One of the critical criteria will be the poverty level of the household.

At the community level, defining OVC is complex and should not be dictated by others. Not all orphans may be vulnerable, and some of the most vulnerable children may not fall into the categories that have been defined here. The term 'AIDS orphans' should not be used because parents rarely know their HIV status. The term may lead to stigmatisation and discrimination against orphans.

Use these questions to help the CCC members identify volunteer home visitors.

If you can think of additional considerations, feel free to introduce them.

- ◆ Where should the home visitors come from?
- ◆ Does age matter or not? If so, what is the age range desired?
- ◆ Do we want home visitors with an affiliation, such as to a church or an NGO? Can regular community members with no affiliation also be home visitors?
- ◆ What kinds of personal qualities do we want home visitors to have?
- ◆ How will we attract potential home visitors? How will we spread information about the programme so that people are interested? How will we approach potential home visitors?
- ◆ How many hours per week will home visitors work? Should this be standard or flexible?
- ◆ What kind of compensation, if any, will home visitors receive? What forms of encouragement can be given if there is no compensation, i.e. entirely voluntary? How can we help the volunteers to stay motivated?
- ◆ Should potential home visitors be subject to some type of screening process? If so, how will this function?
- ◆ Should we ask potential home visitors to provide the names of persons to serve as community references?
- ◆ Should home visitors work singly or in pairs? What are the benefits and drawbacks of these two possibilities?
- ◆ Should home visitors announce their commitment, in some kind of ceremony, or in front of their church / fbo congregations?
- ◆ How will the CCC help home visitors when they have problems or difficulties?
- ◆ Who will home visitors report to? Will this be a formal or informal relationship? A mentor, a friend, a supervisor?
- ◆ What kinds of records will home visitors keep?

Other:

SWOT Analysis Chart

Strengths

Weaknesses

Opportunities

Threats

STEP 5 Monitoring and Reporting

Now that the CCC has come up with an action plan for responding to OVC needs in the community, you should help them to decide how they will monitor their activities and evaluate the results. The monitoring of the programme is essential and needs to be considered right at the beginning together with the aims and objectives of the programme.

There are a number of ways for a CCC to keep records that they can use to monitor the progress and effectiveness of their programme.

◎ Activity 1: OVC register

When the CCC has determined the criteria for identifying OVC and home visitors have been trained, the next step is to register the orphans and vulnerable children whom their interventions will assist.

Ask the CCC how they want to register OVC. Should they use separate cards for each child, one notebook, or something else? What sort of information should be included on the register? Ask the CCC members to draw on a large piece of flipchart paper the way that they want the register to look, and the information that the register should include. There will likely be a fair amount of debate and some crossing out of initial answers, until the group comes up with a format that they are satisfied with. A sample OVC Register Form is included in *Mobiliser Reference 5* (see page 56).

The CCC should then decide who should register the children: the CCC members themselves, or the home visitors.

◎ Activity 2: Home visitor record

When OVC have been registered and linked to a home visitor, home visitors should maintain a record of each visit by using a simple standardised form developed by the CCC.

Repeat the above exercise, this time having the CCC design the Home Visitor Record form on flipchart paper. They should debate among themselves the information that they want to see on the form, remembering that they should keep it simple so as not to burden the home visitors with too much paperwork. You may suggest that they include the following:

- ◆ Status of family members
- ◆ Services required
- ◆ Assistance rendered during visit
- ◆ Any other observations.

A sample Home Visitor Record form can be found in *Mobiliser Reference 5* (see page 57).

◎ Activity 3: Monitoring

Explain to the CCC that it is useful for them to monitor their activities so that they can later evaluate the extent to which they have been successful in achieving their purpose. For a simple understanding of monitoring and evaluation, you can explain to the CCC that they can track Primary, Secondary and Tertiary information.

Primary information relates to the CCC itself. Primary information helps to answer the question, *How well do we function as an organised CCC?* Ask the CCC what they need to keep track of, or to measure, in order to answer that question. You may need to help with one or two examples. Examples of primary (organisational-level) information include:

- ◆ Existence of OVC registers (yes/no)
- ◆ Existence of leadership structure (yes/no)
- ◆ Existence of activity plan (yes/no)
- ◆ Number of CCC meetings, or number of CCC meetings per month
- ◆ Amount of funds generated internally by communities
- ◆ Amount of funds mobilised externally by communities.

The CCC should choose those pieces of information, called *indicators*, that they feel are most useful for their own situation.

Secondary information refers to the things that the CCC does. Secondary information helps to answer the questions, *What, and how much, are we doing?* Ask the CCC what they think they need to count or to keep track of in order to answer these questions. Possibilities include:

- ◆ Number of OVC registered
- ◆ Number of OVC registered who are visited regularly
- ◆ Number of home visitors trained
- ◆ Retention or turnover rate of home visitors.

Again, the CCC should select those indicators they feel to be most important to their situation. (If the level of the CCC is high enough, you may go into further detail and explain that these can be considered as *output indicators*.)

Tertiary information helps to answer the question, *What is the result of what we are doing?* or *What is the impact of our interventions?* They should remember that the people they are most trying to help are the OVC themselves, and that therefore this information should be collected with respect to impact on OVC. Examples include:

- ◆ Number and percent of OVC in school
- ◆ Number and percent of OVC accessing healthcare services
- ◆ Number and percent of OVC accessing social services
- ◆ Number and percent of OVC with at least as much food as the norm for children in the community.

(If the level of the CCC is high enough, you may go into further detail and explain that these can be considered as *impact indicators*.)

Once the CCC has chosen the indicators that they wish to track, review each indicator one by one to determine where they will find the necessary information. For example, 'Number of OVC registered' comes from the amount of OVC Registers filled in. 'Number of OVC registered who are visited regularly' comes from the Home Visit Records. 'Number and percent of OVC in school' will also come from the Home Visit Record if the forms were drafted to include this information. If not, the CCC will have to decide if they want to revise the Home Visit Record, or if they want to develop a different way to track this information.

When each indicator has been reviewed, assist the CCC in drawing a simple monitoring form on flipchart paper, similar to the example given in *Mobiliser Reference 5* (see page 58). Each indicator should be listed, with the 'Source of Data' identified, and columns drawn for each month of the year.

Explain to the CCC that Primary and Secondary monitoring should be done monthly, while Tertiary monitoring/evaluation may be done less frequently, depending on the difficulty of information collection.

The CCC should decide who is to be responsible for collecting the data and filling out the monitoring form. This need not be one person, but may rather be a group.

As mobiliser, you should periodically assist the group to evaluate their results. Information collection is not an end in itself, but rather a means to an end of understanding how effective our work is. On a trimestral or semestral basis you should meet with the CCC to review their 'tertiary indicators' (impact indicators) and discuss with them the extent to which they feel their efforts have been successful in improving the lives of OVC in their community.



Register of Orphans and Vulnerable Children**Name of child:** _____**Sex:** _____ **Date of Birth:** _____**Approximate age as of (today's date)** _____**Parental status:** _____**Head of household (tick one)**

- Mother
- Father
- Other female adult
- Other male adult
- Grandparent or other elderly adult
- Sibling (over 18)
- Sibling (under 18)
- Self
- Other (explain) _____

Number of people living in home: _____**Number of children living in home:** _____**Child at school? Yes / No** _____ **Grade:** _____**General observations:****Name of Assigned Home Visitor:****Date of visit:**

Home Visit - Record Sheet**Name of Home Visitor:** _____**Date of visit:** _____
_____**Family name of household visited:** _____**Name and status of OVC visited (healthy, ill, etc)****Name** _____ **Status** _____**Name** _____ **Status** _____**Name** _____ **Status** _____**Name** _____ **Status** _____**Name** _____ **Status** _____**Services needed by OVC in household:****Assistance provided during visit:****Description of visit:****Signature of Home Visitor:** _____

Mobiliser Reference 5 Information Monitoring
Example of an Information Monitoring Form

| Indicator | Data source | Month monitored | | | | | | | | | | | |
|--|--------------------|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Primary | | | | | | | | | | | | | |
| Existence of OVC Registers: yes <input type="checkbox"/> / no <input type="checkbox"/> | OVC Register | | | | | | | | | | | | |
| Existence of leadership structure: yes <input type="checkbox"/> / no <input type="checkbox"/> | CCC Records | | | | | | | | | | | | |
| Number of meetings per month | CCC Records | | | | | | | | | | | | |
| Amount of funds raised during month | CCC Records | | | | | | | | | | | | |
| Secondary | | | | | | | | | | | | | |
| Number of OVC registered | OVC Register | | | | | | | | | | | | |
| Number of home visitors trained | CCC and WV Records | | | | | | | | | | | | |
| Number of OVC visited regularly | Home Visit Records | | | | | | | | | | | | |
| Tertiary | | | | | | | | | | | | | |
| Number and percent of OVC in school | Home Visit Records | | | | | | | | | | | | |
| Number and percent of OVC with birth record | Notary Records | | | | | | | | | | | | |
| Number and percent of OVC with home gardens | Home Visit Records | | | | | | | | | | | | |

UNIT 2

Training for Community-Led Care of Orphans and Vulnerable Children

A GUIDE FOR FACILITATORS

FACILITATOR'S GUIDELINES

| | |
|--|-----------|
| Background information | 51 |
| The impact of HIV/AIDS | |
| Who are Orphans and Vulnerable Children? | |
| What are Community Care Coalitions (CCC)? | |
| | |
| Part 1 | |
| The Key Issues of Training | 53 |
| Introduction | |
| Why train Community Care Coalitions? | |
| What is the desired outcome of CCC training? | |
| Preparing for successful CCC home visitor training | |
| Adult training and learning | |
| | |
| Part 2 | |
| The Seven Steps of Planning | 59 |
| Step 1: Why? The aims and objectives of the training | |
| Step 2: Who? Those involved in the training process | |
| Step 3: When? The training schedule | |
| Step 4: When? The training venue | |
| Step 5: What for? The learning needs assessment | |
| Step 6: What? The content of the training course | |
| Step 7: How? Training methods | |
| | |
| Part 3 | |
| Running the Training Programme | 71 |
| Introduction | |
| Climate setting | |
| The facilitator's role in running the session | |
| Training methods | |
| | |
| Part 4 | |
| Sample Training Agenda | 83 |

Background information

The impact of HIV/AIDS

An estimated three million children were living with HIV/AIDS by 2002, and about 13 million children were orphaned by AIDS. The number of children infected and affected by HIV/AIDS is expected to top 25 million by the year 2010, given the prevailing poverty and HIV/AIDS pandemic situations in most countries in sub-Saharan Africa (UNAIDS, 2002).

The number of orphans and other vulnerable children (OVC) and the negative impact of HIV/AIDS on children is continuing to increase in many WV ADP communities. A large and growing number of children are experiencing the trauma and distress of losing their parents; and are being forced to fend for themselves. In the absence of adult protection, love and support, these children have been made even more vulnerable by illness, exploitation and abuse, and by HIV infection. Illness, malnutrition and death among young children are on the rise, school attendance is declining and the numbers of street children are growing. The Christian and humanitarian imperative, which underpins everything World Vision does, compels us to respond in the face of such pain and suffering.

Based on records from a number of WV's programme reports, existing support for this large population of children orphaned or made vulnerable by HIV/AIDS has been limited and fragmented, even in the communities where WV works. The coverage, reach and impact of OVC responses have remained limited in scale.

World Vision recognises that no single organisation can comprehensively respond to all the needs of all OVC; and that the family and the community are the first line of defence and are ultimately responsible for their children. World Vision thus seeks to mobilise and strengthen the existing community care systems for vulnerable children as the key strategy in helping communities to support, care and protect their children. By doing so, World Vision envisages working with communities in partnership or in coalition with their care systems, hence this training programme on Community Care Coalitions (CCC).

Who are Orphans and Vulnerable Children?

The process for generating a community definition of who OVC are is outlined in this guide. The selection of OVC, as well as OVC households, needs to be guided by community members, local government officials, WV and other non-governmental organisations working in partnership. In each community, it is important to use criteria that are simple to implement and that are community friendly.

However, it is important to set criteria that are as objective as possible, to be consistent in the criteria used, to be regular in the identification of the neediest in the community (as this may change over time), and to reflect more broadly on the impact on the OVC and families assisted.

World Vision Definitions used in this Guide

The World Vision definitions of orphans and vulnerable children outlined below are to be used consistently in all training:

- ◆ **Orphans** – Children less than 18 years, who have lost either one or both biological or foster/adoptive parents.
- ◆ **Vulnerable Children** – Children who are assessed by an agreed set of objective criteria to be in need of external assistance. Vulnerable children may be:

Children whose parents are chronically ill – These children are often even more vulnerable than orphans, because they are coping with the psychosocial burden of watching a parent become increasingly ill and frail; and the economic burdens of reduced income and increased healthcare expenses.

Children living in households that have taken in orphans – When a household absorbs orphans, existing household resources are spread more thinly among all children in the household, making them more vulnerable.

Children with physical or intellectual disabilities – whether they are orphans or not. Through discrimination, fear and lack of understanding, children with disabilities are often undervalued, and face neglect and malnutrition. These children are often hidden and rarely attend school. They are often more likely to suffer sexual abuse and violence and are least likely to have access to information about HIV and how to avoid infection.

Any other children the community identifies as most vulnerable – using criteria developed jointly by the community and World Vision staff. For example, one of the critical criteria may be the poverty level of the household.

What are Community Care Coalitions (CCC)?

The term *Community Care Coalitions* is used to refer to groups or committees of individuals, representing different institutions or groups that exist in the community and are providing support to the OVC directly or indirectly.

Examples of members of such committees may include support groups of PLWHA, church groups and other FBOs, traditional leaders, women's and men's groups, parents and teachers associations (PTAs), co-operative groups, political leaders at grassroot level, youth groups, households caring for OVC, OVC themselves, government departments in the community and local authorities at district level.

Part 1

The Key Issues of Training

Introduction

These guidelines are for you – the facilitator or trainer. Please read them before selecting the activities you want to use for training.

Even if you are an experienced facilitator, there are particular issues to consider in planning your training with this guide.

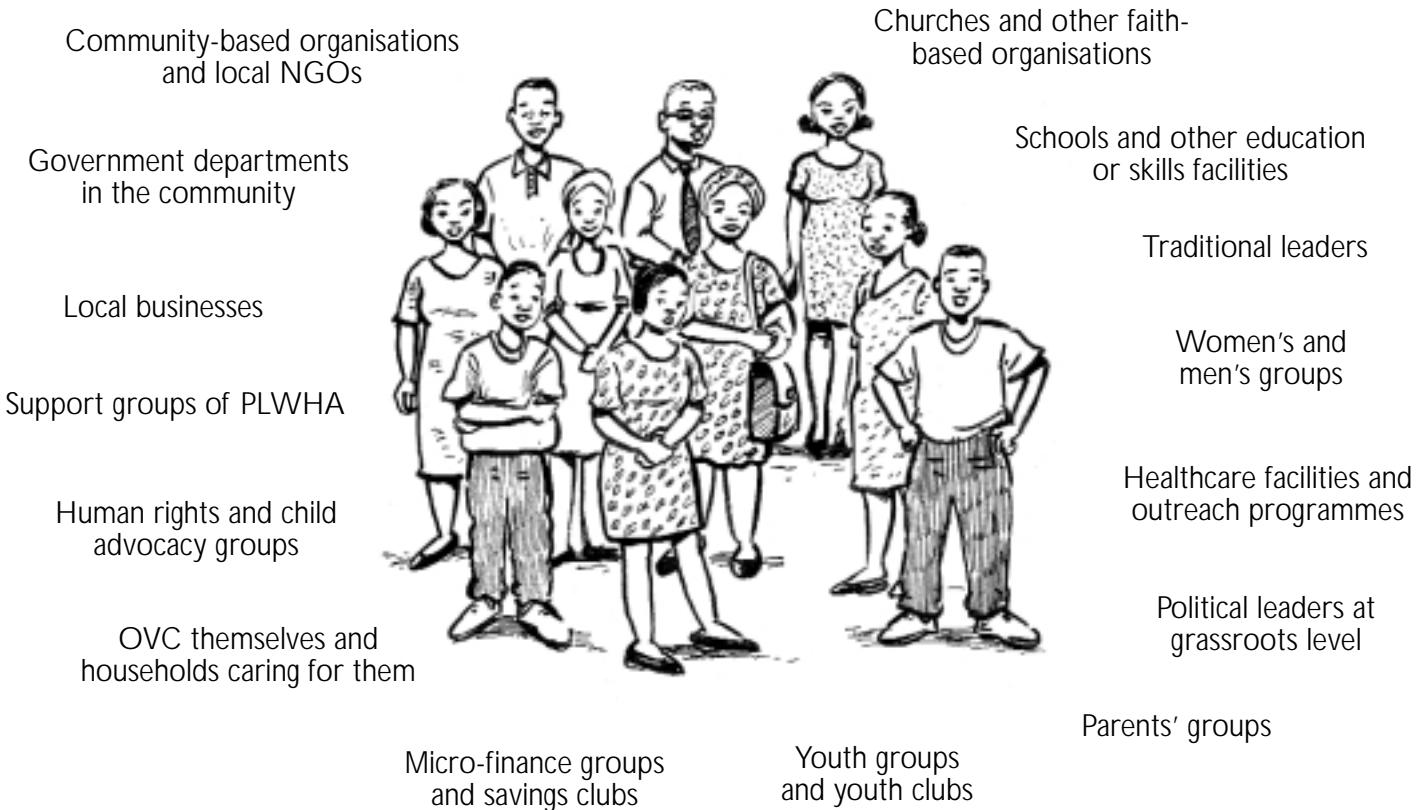
The key issues in training are the following:

- ◆ Why train Community Care Coalitions?
- ◆ What is the desired outcome of CCC training?
- ◆ Preparing for successful CCC home visitor training
- ◆ Adult training and learning

Why train Community Care Coalitions?

The term *Community Care Coalitions* shall be used to refer to groups or committees of individuals, representing different institutions that exist in the community and are providing support to vulnerable children directly or indirectly.

Examples of members of such community care committees may include:



Families and communities are most often the first line of support for children. Unfortunately, these communities and family members may lack the necessary knowledge, skills and awareness to provide appropriate care, support and protection of the orphans and other vulnerable children in the community. Acknowledging the central role of the family in the culture of communities, this training builds on the strengths, experiences and knowledge of family and community members in order to increase their intent and ability to provide for children.

The training of CCC promotes scaling-up actions already underway, which will impact on large numbers of vulnerable children through a multi-sectoral, comprehensive approach. A united and co-operative community coalition (as opposed to a single organisation or individual) has a greater capacity to mobilise resources, advocate for OVC needs and establish working relationships with relevant government ministries and other community coalitions. This will broaden the effectiveness of the intervention to support and care for vulnerable children.

What is the desired outcome of CCC training?

The CCC training aims at achieving impacts articulated through the transformational Development Dialogue for All of World Vision's work, adapted for use in areas heavily affected by HIV/AIDS.

This transformational agenda aims to:

- ◆ **Empower community members** with knowledge and skills to care, support and protect OVC and their families at community level.
- ◆ **Empower and equip households** and communities caring for OVC to:
 - Ensure the survival of orphans and other highly vulnerable children.
 - Enhance access to healthcare and basic education for OVC.
 - Provide spiritual and emotional nurturing for OVC.
 - Ensure sustainable household livelihoods and enhance the capacity of OVC to earn a future livelihood.
 - Protect OVC from abuse and exploitation.
- ◆ **Empower and equip orphans and other highly vulnerable children** to:
 - Care for themselves, their siblings, their aged guardians, and other vulnerable members of their household and community.
 - Protect themselves and others from HIV infection.
 - Serve as agents of transformation in the present and the future.

The Home Visitor



The home visitor is the transformational development agent, working within the CCC.

In order to become active home visitors, they undergo World Vision's training course for the community-led care for OVC.

Home visitors acquire the necessary information, counselling and communication skills through the training, in order to monitor and give care and support to vulnerable children in their community.

Preparing for successful CCC home visitor training

The success of the CCC home visitor practical training course depends largely on the quality of the planning – the selection of appropriate trainees or course participants, quality of trainers, length of the training, venue and sufficient time of invitation for trainees, involvement of some of the target trainees in planning the training, simplicity of language of training materials, use of audio visual materials, etc.

This training should be part of an overall ADP/Project Annual Operational Plan, aimed at achieving long-term objectives. This will ensure the integration of OVC programming within the ADP/Project. Participatory planning with the community is also important and will help to inform your training procedures. For example, it may change the way OVC beneficiaries are identified in the community. Successful CCC training requires preparation to be done even before the first training course is planned.

Key programme issues that need to be addressed to ensure successful training are:

1. The purpose of the training and the desired outcomes must be made clear to the community and ADP staff. These objectives must be based on the needs and interests of the CCC members. This may involve carrying out a simple training needs assessment among CCC members.
2. Training is a learning process and requires sufficient time for effectiveness. For example, a series of short training courses may be more effective than a long course, as this will give participants time to incorporate what has been learnt into their work practices.
3. CCC training must be managed and supported by strong, qualified professionals whose experience is respected within the community.
4. The training facilitator or trainer should ideally be someone from within the ADP who has a full-time responsibility for OVC programming. External consultants may be used to do the training, but they need to work with someone from within the ADP to co-ordinate logistics, and provide information on participants to the trainers.
5. Training is more effective and efficient when key ADP staff, or at least the main facilitator, attends prior training or orientation on this guide. Training of trainers (TOT) is a critical element for achieving a long-term integration of capacity building issues for the community care of OVC.
6. Budgeting for a training programme must be comprehensive. Facilitators will require adequate resources and support personnel in order to train effectively. Administrative and logistical support personnel must budget accurately and timeously for these requirements.
7. No single training strategy will fit all communities. Each training strategy must take into account the particular nature of the community; and the social and economic context in which it is located.
8. Finally, it is important that the CCC training is supported and not contradicted by other training or major functions in the ADP and community.

Adult training and learning

Aim to make adult training and learning as learner-centred or participatory as possible. The main function of adult training is to equip learners or participants with the skills and knowledge to transform their own social circumstances to meet their needs. The trainer should facilitate, rather than dictate, this process. In CCC home visitor training, the facilitator should aim to use participatory training methods in order to equip participants with the necessary practise in thinking and speaking skills, and to boost their confidence as agents of information.

A *participatory training programme* has the following characteristics:

- ◆ Learners or participants are partners in the training process
- ◆ The trainer is a facilitator, rather than controller, of the learning process
- ◆ The trainer is a guide, helping the group in a supportive way to manage their situation
- ◆ The learning experience is an open dialogue involving all group members. This implies that everyone's views should be heard and valued, whether the trainer or other participants agree with them or not
- ◆ All group members actively take part and contribute
- ◆ The trainer does not lecture at the group. It must be assumed that learners have experience and knowledge; and that solutions involve the sharing of ideas.

In training adults, the following points need to be assumed:

- ◆ A readiness to learn in adults occurs when they perceive a need to know. For example, among CCC members this may occur when they feel a gap between where they are in providing care to vulnerable children, and where they would want to be.
- ◆ Adults are more motivated to learn when they have experienced a need in their own life situation and when gaining knowledge is relevant to their immediate needs.
- ◆ Adults are often motivated to learn for internal factors, such as self-esteem, recognition, a better quality of life, greater self-confidence or the opportunity to self-actualise.



Part 2

The Seven Steps of Planning

Introduction

It is essential that any training should be well planned. Every training course needs preparation time. This should normally be between three and eight days for each day's training. You may reduce this to a minimum of one day's preparation for one day's training if the same team are conducting the same training with different groups. However, you should still allow time for adapting materials and structures to the specific context and needs of the participants.

The methods and the content of this training, often the first to be considered, should be chosen only after full consideration of the aims and objectives of the training, and the learning needs of the target group. One way to ensure that all aspects have been considered is to check the seven steps of planning: Why? Who? When? Where? What for? What? How? The steps are best done roughly in this order, but some steps will also need to be considered together.

The seven steps in planning for training are the following:

- ◆ **Why?** **The aims and objectives of the training**
- ◆ **Who?** **Those involved in the training process**
 - The learning group or participants
 - The facilitators or trainers
 - Support staff
- ◆ **When?** **The training schedule**
- ◆ **Where?** **The training venue**
- ◆ **What for?** **The learning needs assessment**
- ◆ **What?** **The content of the training course**
- ◆ **How?** **Training methods**

STEP 1 Why? The aims and objectives of the training

Training aims are broad general statements of the overall intention for a training activity. Ask yourself: *Why am I planning this session, course or workshop?* Your aims say what you as the facilitator are going to do! It is useful to write your aims and objectives down. In this way, you will always be able to remind yourself of them as you plan your training.

Objectives are specific and short term. Training objectives are generally:

- ◆ **Short term:** precise statements of actions undertaken in the training process
- ◆ **Measurable:** able to be assessed, for example, skills and knowledge transfer in explaining the facts about HIV/AIDS
- ◆ **Achievable:** can be accomplished, are do-able
- ◆ **Realistic:** are possible or can be done given time or resource constraints
- ◆ **Time bound:** have specific duration boundaries, for example an activity to explain children's rights could take two hours to get through with a group.

The aims and objectives need to be realistic in terms of what training can achieve, and what is needed to support the aims. One way of deriving objectives is through a *learning needs assessment*.

It is wise to begin to think about how the training will be evaluated even at this stage, because the achievements of your training should always be measured against your original aims and objectives.

STEP 2 Who? Those involved in the training process

The learning group or participants

Consider this step together with Step 1 – *Why? The aims and objectives of the training*, and Step 5 – *What for? The learning needs assessment*. The selection of participants is crucial to a successful training course or programme. Who should attend, who they represent, and what will encourage them to keep attending is an important part in the whole training strategy.

Training is easier if the group is as homogenous (that is, if a group contains people of a similar kind) as possible. In some cases, a group may be made up of very different kinds of people who will require training together in order to build collective responsibility and unity. In this case, the training should be designed to take into account the very different needs, responses and receptivity of people with different abilities and experiences. As in any other project, disaggregated data (information indicating the differences between people in the group, for example, the range of ages) should be obtained to indicate the different needs of men and women and how these may be affected by age, class and ethnicity.

Training aims
for a group must
match the needs
of its members

As much as possible should be found out about the group beforehand so that the training matches the needs of its members. The composition of the group will affect group dynamics, and you will need to consider whether you want to specify an equal balance of men and women, or CCC members who are of equal status, in order to avoid a minority feeling isolated and intimidated.

Existing skills, interests and capabilities, such as language and literacy levels of the participants (for both men and women) need to be assessed. It is also important to find out people's previous levels of knowledge on the components of this training and any previous relevant training or experience.

Generally, people learn best in small groups, particularly where they are asked to participate. However, given that the number of CCCs or home visitors in the ADP may be large, and the objective is to engage as many members of the community as possible, it may be inevitable to have groups of 30 to 45 people. Such large groups will require more trainers and more rigorous planning.

The facilitators or trainers

Ideally, there should be at least two facilitators or trainers for every session. This should ideally be the lead person from the ADP and a resource person from within or outside the ADP or community.

Having more than one facilitator (**co-facilitating**) training together is useful because:

- ◆ Facilitating a big group can be extremely challenging and tiring.
- ◆ Co-facilitators can give each other support. This helps the group dynamics and breaks the monotony of having only one facilitator.
- ◆ It is important for at least one facilitator to come from the same area and ethnic group as the majority of the participants. This will provide relevant local knowledge.
- ◆ Having at least one facilitator with knowledge of local languages enables small-group discussion to be held in people's first language. This may be particularly important to prevent women or the less articulate groups from being disadvantaged in discussions.

You need to consider all the above points when choosing your co-facilitator(s). Facilitators need to work together as a team and to be seen to be doing so, because:

- ◆ The reactions of the participants will vary according to their perceptions of the facilitators in terms of their sex, ethnicity, age, class and many other factors.
- ◆ The group may cast them in different roles, for example 'expert' / 'non-expert', 'one of us' / 'outsider', and try to play one facilitator off against the other.
- ◆ The same message will be interpreted differently depending on which facilitator it comes from.

In order to work effectively as a **team**, facilitators should:

- ◆ Discuss and agree on training styles and methods, and how to tackle specific issues in the guide.
- ◆ Discuss their strengths and weaknesses and use these constructively as a basis for planning.
- ◆ Agree on fees, responsibilities and schedule time required for planning and training.
- ◆ Make arrangements in good time – remember that good technical resource people tend to have full diaries, so contact them well in advance.

During the planning time, co-facilitators should spend time getting to know each other if they have not worked together before. During workshops, one person should be elected to run the session, while the other gives support. Facilitators should not interrupt each other during training, but invite comments at the end. Each should ask the other for support, and be prepared to give it.

After the workshop, facilitators should review the session and record what each facilitator felt worked well and why. They should explore what each found easy, difficult and valuable about working with their co-facilitator; and what changes they would make if running the workshop again. Facilitators need to be prepared to listen and learn as well as to lead and teach.

Facilitation skills

It is assumed that people using this manual will have some experience of facilitating groups and/or running training workshops. Part of the purpose of this section is to provide some of the basic guidelines for planning and running your training.

Some basic facilitation skills are:

- ◆ Facilitators do not need formal educational qualifications which could even be a barrier if participants are alienated by the implied superiority of the trainer. However, the credibility of facilitators with participants is important.
- ◆ Facilitators need good communication and listening skills, an understanding of group dynamics and the ability to encourage mutual respect and understanding amongst the group.
- ◆ Facilitators need to be creative in their use of learning styles. For example, an activity that is writing based may need to be adapted to a visual presentation for a less literate group.
- ◆ The behaviour and language of the facilitator, both in and out of the training sessions, should always be congruent with the aims, values and principles of child care, support and protection. For example, facilitators should be very careful not to use stigmatising terms such as 'AIDS orphans', discriminate deliberately or unwittingly against people with disabilities, illiterate people, or any other group.
- ◆ Facilitators should assure participants that everything that takes place during the training session will remain confidential.

note

In Appendix 2 there are expanded notes on facilitation skills and techniques (page XX), and a Trainer Evaluation Sheet (page XX)



Support staff

In planning your training, you also need to consider administrative and logistical support. Apart from the training, this is important when planning the report of the workshop. It is much easier to write up the report straight after each training session, rather than trying to get it done later. You may also want someone to take photographs for the report. If possible, have a non-facilitator in charge of all practical arrangements including the venue, accommodation, refreshments, transport, childcare facilities, translators, access and special needs.

Some tasks may be carried out by some of the participants, for example, liaising with the staff of the venue, time-keeping and security. This will encourage a sense of responsibility in the group and enable the facilitators to give full attention to the task of training.

Participants may also be asked to lead sessions. In these cases you should be clear about what you expect of them, and whether they are part of the facilitation team planning the whole event, or just leading specific sessions. Outside resource people may also be asked to come and give inputs and lead discussions on particular topics. This can give fresh perspectives, but such people need to be fully briefed on the aims and objectives of the workshop and the expectations of their sessions. The same issues also need to be considered when arranging for support people to be co-facilitators.

Part of the role of the facilitation support staff is to make sure that all budgeting, logistical and resource requirements have been taken care of. For example, if you need flipcharts and markers or projector equipment, you will need to include this in your planning and alert support staff about this timeously.

STEP 3 When? The training schedule

You may want to consider a variety of different ways of scheduling training: training workshops, evening courses, or phased training. Choose the type of training which best suits the group and their needs within the community context. In setting the dates for the workshops or training courses, consider the other plans and responsibilities which women and men have at different times of the year (such as work schedules, daily and seasonal routines, participation in religious festivals). In deciding times for the sessions, remember women's and men's different situations (such as busy times, family responsibilities and social constraints on women going out at night). Obtaining this information will in itself be an exercise in obtaining gender disaggregated data!

Allow enough time for the facilitation team to meet to plan the training in detail. A minimum would be one day's planning for one day's training, if the facilitators are experienced, have done some pre-planning and have full administrative back up. Include extra time for study visits, writing or adapting and testing materials. Plan for at least one day's rest between planning and training – otherwise you will be exhausted before you start! In calculating the amount of time you need for the actual training, remember to allow time for rest, exercise, socialising, meals, visits to projects or groups, and any personal study. Participants must be committed to attending all sessions, so you will also need to pace your sessions so that they are not over-stretched as well.

Another important part of planning and scheduling for training sessions is to decide how much time you will spend on each of the activities you have chosen to facilitate. The activities in this guide each have a suggested timeframe, but you should feel free to change these timeframes to suit your training programme.

STEP 4 Where? The training venue

You will need to consider the availability, convenience and cost of the venue. You also need to check whether the place is accessible to all those who wish to come. You need to consider:

- ◆ Safety
- ◆ Access for people with disabilities
- ◆ Access to public transport
- ◆ Ability to care for special dietary needs or other special needs.

Special thought needs to be given to women with young children otherwise they may be excluded indirectly. A venue with childcare facilities, a creche or accommodation for a child minder may need to be provided and budgeted for.

Consider the possible advantages of having training workshops in cities; although participants may be intimidated or distracted. Residential courses often allow for a more intense experience, where participants can give their full attention to the topic, but some people may find them more difficult to attend. You may want to hold the training near a place that is suitable for a study visit, such as a particular project location.

STEP 5 ➤ What for? The learning needs assessment

You need to identify the learning needs of the group, so that you can set specific objectives for the training, as well as general aims (see *Step 1 – Why? The aims and objectives of the training*). It may be that the learning needs of a group are too diverse to be covered in one training session.

Learning needs are identified by looking at the gap between what someone already knows, and what they need to know. This can be done by:

- ◆ Asking people about their successes and difficulties
- ◆ Asking people what they want to and need to know about
- ◆ Asking people what the key issues for care, support and protection of children in their families and communities are
- ◆ Filling in a pre-course questionnaire with course participants (see the example below)
- ◆ Observing people's activities, skills and competencies
- ◆ Studying results of surveys, project documents, minutes of meetings and other documents.

It is important that you gather information about a group's learning needs in good time so that you can supplement the information contained in this guide to meet the specific needs of your group.

EXAMPLE: Pre-course Questionnaire

1. Name
2. Address (for example, village and district)
3. Occupation
4. Have you attended any child care and protection training courses? (please give brief details)

5. Have you attended any training courses of any kind? (please give brief details)

6. What do you hope to get out the training for OVC care?

7. What are the major problems affecting OVC in your community?

8. Do you have any requirements to enable you to participate fully in the training?
Special diet - specify
Facilities, for example, a wheel chair
Help with childcare
Other - specify

9. Please add any other information or comments you feel are relevant.

STEP 6 What? The content of the training course

The course content consists of the topic areas outlined in Modules 1 to 5; and is based on the objectives derived from the learning needs of the participant group. It can include:

- ◆ **Awareness** (for example, understanding the situation and awareness of HIV, AIDS and orphans and vulnerable children).
- ◆ **Knowledge** (for example, information about various forms of child abuse, rights and needs of OVC).
- ◆ **Skills** (for example, in counselling and communicating with children, assessing needs of a child).
- ◆ **Behaviour** (for example, changes in knowledge and skills will affect how we communicate and counsel).

It is important to include the awareness of OVC issues and problems at a personal as well as theoretical level in all training, to provide a firm basis for skill acquisition and behaviour change. It is also important to include needs assessment and planning skills as well as awareness-raising, so that the training has real impact.

When planning, put the content in a logical order, and always start with introductions and activities to encourage trust and cohesion within the group, and end with practical forward planning and evaluation of the course. Calculate the approximate times needed.

Example of a training programme:

Once you have the content worked out, you can fill in the particular activities which you will use, taking into account all of the above points.

You may want to look at the example of a two week (10 day) training programme that was used in Uganda. This was quite a tight programme and in some cases we ran over time and changed the programme. Ideally, three weeks would be ideal for this training programme.

In designing a programme, you need to include enough flexibility to make changes if necessary. For example, there is no point in just going ahead with activities if the group has not understood the previous session.

note

See page XX for an example of a training course run in Uganda.

Breaks

When planning your training programme, remember to schedule time for breaks, tea times and lunch times into the timeframe of your course.

STEP 7 How? Training methods

Whichever type of training you use, whether workshops or evening courses, participatory methods are the most appropriate for adult learning. They are the most effective and enjoyable. Participatory training is characterised by a respect for the participants, who are active in their own and others' learning.

Once you have decided on a workshop and worked through the first six steps of planning, you are at last ready to choose the activities! Choose activities for a purpose, based on the needs of your group. Within participatory training, there are a number of different methods and techniques which should be chosen to meet the specific objectives and content of the training sessions. Learning skills is best done through practice; games and songs are most useful for awareness-raising; while factual information can be given through videos, quizzes, and lectures. All these aspects are inter-related, and different methods can be used for many different purposes.

Individuals have different learning styles, and this should be catered for. For example, men and women often have different learning styles. Many women find it easier to talk in pairs or smaller groups and in single-sex groups – and these activities should be included. Men may have more difficulty in discussing personal feelings in groups, and may deride such discussion as 'gossip'. In these situations, you will need to go slowly, with respect for the participants. Accept people's comments without defensiveness – no method is perfect. Through mutual trust, you will enable people to learn from a variety of methods. A mix of different methods within any one training event is best, and keeps people interested. Try to use people's knowledge and creativity to come up with ideas that are particularly relevant for them.

Refer to Part 3 – *Running the Training Programme* for further descriptions of training methods recommended for this training.

You will also need to give inputs or presentations. They should be clear and brief, especially where the facilitator is not very conversant with the first language of some participants. Recommendations from learning theory about presentations include:

- ◆ Limit any segment of speaking to a maximum of 20 minutes – after that people will not be able to concentrate.
- ◆ Condense what you want to say to the bare essentials that people absolutely have to know (for example, 'the five key points'; 'the four guiding principles'). You can expand or give brief illustrations of other points, but people must go away remembering the main points. Few people are able to memorise long lists of points.
- ◆ Use visual aids to back up what you are saying (flipcharts or handouts).

Handouts



Many activities in the guide are based on Handouts – either as information pages or as activity sheets that participants will fill in.

Workshop materials

Prepare your materials and workshop aids well in advance. Each activity has an indication of materials needed. However, some common requirements are:

- ◆ Flipcharts, newsprint or other very large sheets of paper.
- ◆ Markers, pens, coloured pencils or crayons.
- ◆ 'Blu-tak' or prestik, masking tape to stick flipchart sheets of paper to the wall.
- ◆ Copies of handouts: Make sure these are chosen, written or adapted in good time and that you have enough copies for all participants and facilitators. If you have written new materials such as case studies, work through them to make sure they are clear and contain relevant information.
- ◆ Small sheets of paper, index cards or post-its.
- ◆ A good supply of A4 paper for individual work.

You may also need:

- ◆ An overhead projector and videos; slides and a slide projector. These will make your training more interesting, but are not indispensable. No activities in this guide advocate such elaborate resources, but if you do want use them, make certain you know how to use them and that they are in proper working order. Have a trial run to check beforehand.
- ◆ Other materials specific to an activity, for example, materials for role-plays, photos or print resources such as brochures or pamphlets, as specified in a particular activity.

Some tips on choosing activities

Use activities which fit the educational abilities of the group – they should be easily understood by everyone. You may need to adapt some of the materials to make them relevant to your particular group or context, so that misunderstandings don't occur.

The activities in this manual have been field-tested, particularly in Uganda and Zambia and other countries, but you need to check and develop situations, for example, case studies or role-plays that occur in the experience of your participants.

- ◆ **Read the activities carefully and plan accordingly.**

Some of the activities require preparation weeks ahead, for example, case studies.

For some activities you may need to generate other, more appropriate, alternatives.

Remember that training is a process and the activities should have a coherent order.

Later activities should build on earlier ones.

- ◆ **Pace the course content to suit your participants and to stimulate and sustain motivation and interest.**

This is best done by varying the type and length of activity, the size of the group and the skills and involvement each activity requires.

Where an activity demands intense concentration, you can start with a brief energiser or game.

Training is a process and training activities should build on each other in a coherent order

- ◆ **Keep the length of each session to less than two hours.**

Include enough refreshment and exercise breaks.

Consider the time of day. For example, try not to plan theoretical inputs immediately after a heavy lunch as you may find people falling asleep!

Include times for enjoyment and local cultural activities such as songs and dances.

- ◆ **Choose activities to meet your specific training objectives.**

In this guide we have included a variety of training methods, but please do not choose an activity because of the method. Choose it because it will meet your specific objectives for that session and will be suitable for the group. If necessary, adapt the activity so that it meets your objectives. For example, a simple case study can be turned into a drama, if you feel the group would understand it better if it were acted out, rather than read.

Part 3

Running the Training Programme

Introduction

This part of the guidelines for facilitation looks at practical training methods for running your sessions. This section will cover the following aspects of training:

- ◆ **Climate setting**

- Welcome, introductions and ground rules
- Ice breaking
- Expectations, aims and objectives

- ◆ **The facilitator's role in running the session**

- Facilitating activities and tasks
- Maintaining the group

- ◆ **Training methods**

- Lectures
- Brainstorming
- Demonstrations
- Questions and answers
- Role-plays
- Field visits
- Storytelling
- Games and energisers
- Other methods

Climate setting

Climate setting is the creation of a conducive environment favourable for learning to take place. From the start of the course, you and the facilitation team should aim to get participants to interact and participate as a group, rather than as isolated individuals. This section outlines some ideas for getting participants, no matter what their background, to acknowledge one another as team members rather than as strangers.

Welcome, introductions and ground rules

Be prepared! Before the participants arrive, make sure that you have planned the appropriate seating arrangements for the group, depending on the number of participants. An optimal seating arrangement would be semi-circular, so that participants can see more of each other than if they were seated in rows.

Also make sure that you have all the materials you need and have seen to the planning around participants' needs such as refreshments, meals and accommodation requirements.



At the start of the training session when everyone is seated, welcome everybody and introduce yourself by name. Introduce your co-facilitators and any other staff, such as monitors, who may be working with you. Also tell participants what each member of the training team's role is in the training process.

Give participants a brief summary of the purpose of the training course and its duration. Outline how the training is structured – sessions times and when there will be breaks for tea and meals.

It is useful to agree on some **ground rules** for the duration of the training, especially if the course is a long one. These are basic guidelines for behaviour that everyone collectively agrees to uphold while the training is taking place. You may get participants to help with a list which you can write up on the flipchart. For example, everyone could agree to:

- ◆ Respect and accept one another.
- ◆ Tolerate differences in one another (ethnicity or gender).
- ◆ Show compassion towards and help one another.
- ◆ Endorse a spirit of sharing and participation.
- ◆ Be non-judgemental towards others.
- ◆ Abide by the course framework, such as timeframes, and not undermine the process by going to tea early, for example.
- ◆ Have cell phones switched off while the course is in progress.

Once you have a complete list, put it up on the wall for the duration of the whole course.

Ice breaking

Depending on the size of the group and how well they know each other already, you could go around the group and get participants to stand up, give their names, say where they are from and what work they do. Alternatively, in a very large group, participants could introduce themselves to the person sitting to the left and right of them.

Expectations, aims and objectives

In your introduction, you will have given an indication of the general purpose of the training course. Before you give the participants clearer aims and objectives of the course, do the following activity with the group. The activity will act as an ice-breaker, as well as giving you the opportunity to assess whether the participants share the course aims and objectives.

Activity: Assessing that training aims and objectives are shared



For this activity you will need:

- ◆ Flipchart and markers
- ◆ Copies of *Pre-course Questionnaires* (see example on page 77)
- ◆ *Course Aims and Objectives* on flipchart paper (prepared beforehand)

To facilitate this activity:

- 1 You would have sent out and received *Pre-course Questionnaires* back from participants. These responses were used in planning the training course, to make it as relevant to the participants needs as possible. Ask participants the following two questions from the questionnaire:
 - *What are the main issues concerning OVC in your community?* and
 - *What do you hope to get out of the training?*

As an activity, this will:

- ◆ Give participants an opportunity to participate in their first group discussion.
- ◆ Give participants an opportunity to review their expectations for the training course.
- ◆ Give the facilitation team the opportunity to either endorse their course objectives, or to adapt them, if they have the flexibility and time.
- ◆ Give the facilitator a chance to level expectations and make sure that course objectives and aims are shared, and agreed upon, by all the participants in the group.

- 2 Ask participants to form groups of three or four and to discuss their expectations of the workshop, and to list them on paper. Explain that participants do not have to agree with one another.

Expectations should be listed under the following headings:

- (a) **Hopes:** what they hope to get out of the training. The groups can amend or add to the hopes they expressed in the pre-course questionnaires.
- (b) **Fears:** what they hope will not happen, or what they fear may happen. Encourage participants to share their fears openly – this will help them to be more tolerant of one another.
- (c) **Contributions:** what each person brings to the group – a special experience (e.g. taking care of vulnerable children), certain skills (e.g. listening skills), and aptitudes (e.g. a willingness to learn and change thinking and behaviour).



- 3 You should encourage responses from as many participants as possible, as this activity also serves as an icebreaker.

Get each group to report back and write up their responses on the flipchart. Review each group's hopes, their fears and their contributions with the group after everyone has responded. This will give you the opportunity to align participants' expectations of the training with your objectives for the training. If there are any expectations which are unrealistic, explain why they may not be met. This activity will also help you assess that your training course matches their needs concerning OVC in their community.

- 4 Lastly, pin up and go through the list of course aims and objectives that you have prepared beforehand on flipchart paper. Group consensus may cause you to adapt or change these objectives slightly. You should aim to get collective agreement on each point, as these will be the guiding principles of the course. Once you have a set of principles that everyone agrees with, put them on the wall for the duration of the course.

The facilitator's role in running the session

Once the workshop starts, you, as the facilitator, are responsible for ensuring that the group accomplishes the activities set, and maintains itself as a group.

In order to maintain the group, you will need to observe, listen and be aware of the way individuals are reacting to one another (the group dynamics); enabling each person to feel accepted as part of the group and able to participate equally; enabling participants to listen and learn from each other; drawing common threads and pointing out differences of opinion. You need to be aware of possible difficulties, such as 'scapegoating' of individuals, or individual members dominating the group. You need to find ways of working with them constructively.

note

In Appendix 2 there are expanded notes on facilitation skills and techniques (page XX), and a Trainer Evaluation Sheet (page XX)

Encouraging balanced group participation

People learn better and feel better if they are in a group with balanced participation. As a facilitator you need to be very aware who is speaking and who is not. For those people who find it difficult to speak out in a group, the facilitator can:

- ◆ Build confidence and trust within the group – for example, get participants to work in small groups and use introductory activities.
- ◆ Make explicit the principles of participatory training and help the group to establish relevant ground rules (for example, you may tell the group that men usually talk more than women in groups and that you would like to encourage more equal participation).
- ◆ Make everyone feel valued and that their experiences are relevant.
- ◆ Draw people out by using specific questions or rounds.
- ◆ Do a round of 'something I've been wanting to say all morning'.
- ◆ Divide participants into separate-sex groups, if the women are being quieter than the men.
- ◆ Remember that people should not be forced to participate in an activity if they do not want to.

Some individuals speak too much and dominate the group. In these cases the facilitator can:

- ◆ Use the 'talking stick' method where people only speak when they hold the stick; and no interruptions are allowed.
- ◆ Divide people into small groups, with the quiet ones together and the talkative ones together.
- ◆ Speak privately to the individual/s 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.

Training methods

Training methods are the various methodologies you use in training to help participants to achieve their learning objectives. They include lectures, brainstorming, demonstrations, discussions, question and answer sessions, role-plays, field visits, storytelling, drama, and others.

Selecting the type of training method to use will depend on:

- ◆ The participants' background and learning styles
- ◆ Participants' existing knowledge on the subject
- ◆ The number of participants in the course
- ◆ Equipment available for training
- ◆ The training environment venue
- ◆ Time available for training
- ◆ Budget available for conducting the training session
- ◆ Amount of participation you want from the group.

Successful training methods are those that enable participants to acquire the knowledge, skills and attitudes required for their work in the targeted community. Participants are more likely to retain new ideas and new skills when they can relate to the cultural context in which they will be performing their services. Taking these factors into consideration will enable you to select the most suitable training method.

◎ Lectures

The lecture method is a verbal presentation where the trainer or facilitator does most of the talking, although lectures may be modified to allow for more group participation.

But remember, telling is not training and listening is not learning! Lecturing is the least effective training method and, if used, should be used with other methods. Lectures are best for:

- Establishing the relevance of a topic and its objectives.
- Providing direction for participant activities.
- Imparting information only.

Advantages

- Provides a large amount of information in a short time
- Can reach a large group in one shot
- Limited cost

Disadvantages

- Participants may not be able to learn if facilitator does not have good speaking skills
- Doesn't change attitudes
- Difficult to assess participants' understanding of information

Tips for improving the use of lectures:

- Limit lecture time to less than 20 minutes, if the lecture is not participatory
- Encourage participant input
- Use other methods to accompany the lecture
- Provide summaries at the beginning and end of lectures.

◎ Brainstorming

Brainstorming is aimed at gathering a large number of uncensored ideas from participants. It stimulates them to generate ideas without criticism. These ideas are often more representative of participants' real feelings and thoughts. Brainstorming is appropriate when:

- Beginning a session.
- Trying to solve a difficult problem.
- Participants need to change focus
- A group trust has been established.
- The facilitator is skilled in managing the brainstorming process.

Advantages

- Stimulates creative thinking
- Generates many ideas
- Encourages free communication
- Enables group problem solving

Disadvantages

- If rules are not clear, it can create confusion
- Time is wasted if the process is not controlled
- Needs responses to be written down quickly

Tips for improving the use of brainstorms:

- Be sure to welcome all ideas
- Do not allow other participants to criticise or support ideas as they are raised
- Select the best ideas offered on an issue with the participants.

◎ Demonstrations / Discussions

Demonstration is a training method in which participants do more talking than the facilitator but with support from the facilitator whenever appropriate. Discussions, if conducted properly, allow for maximum participation in the training session. Ensure that there is always a three-way communication (that is, the facilitator should always be in the middle of a discussion between participants, guiding the discussion).

◎ Questions and Answers

Question and answer sessions are a quick way of assessing the training situation; and for getting everyone to participate which can enhance learning. The main purpose is to help participants, not to embarrass them. They should feel free to participate and should not feel threatened if their answers are wrong.

If you, as the facilitator, happen not to know the answer, admit it, find the answer and share it with participants later. Or you can use this as an opportunity to get them to do some research themselves. Questions and answers are appropriate when:

- Wanting to make a quick review of participants' understanding.
- Starting a discussion.
- Alerting or getting participants' attention.
- Wanting to get insights into participants' attitudes and practices.
- Encouraging participants to study further.

Disadvantages

- Slow or insecure participants may withdraw
- Unclear questions frustrate both participants and facilitators
- May encourage guessing instead of critical thinking

Tips for improving the use of question and answer techniques:

- Use random questioning patterns to keep participants alert – question, pause and call a name
- Be patient and wait for participants to answer
- Use positive feedback – find something good or useful about the answer, praise good effort
- Build on questions, moving from what participants know to what they are expected to know.

◎ Role-plays

Role-playing is a training method in which problems are outlined, acted out and discussed.

In this method, participants act out a situation and, by doing so, may find creative solutions to problems raised. In a role-play, the facilitator may stop the action at appropriate stages to get the audience to give input on what is being acted out. It is appropriate to use role-plays when:

- Security exists within the group.
- Presenting subjects which are difficult to connect with through discussions or lectures.
- Participants need to be engaged emotionally as well as intellectually.
- Examining participants' attitudes.
- Participants need to practise new skills and behaviours.

Advantages

- Provides insights into attitudes, values and perceptions
- Emotional connection occurs
- Allows for practise in new skills
- Can maintain participants' interest
- Makes use of imagination



Disadvantages

- If participants flounder, they may withdraw
- May be seen as entertainment and not taken seriously
- Takes lots of time
- May not allow full participation
- If not carefully processed, lessons can be lost

Tips for improving the use of role-play:

- Give clear instructions; make sure participants understand the purpose of the role-play
- Participants should be volunteers
- Tell the players what to do; tell the observers what to look for
- Control the role-play – stop the role-play as soon as problems are seen
- Allow sufficient time for preparation
- Get and provide feedback at the end and review learning points.

◎ Field visits

Field visits enable participants to gain experience from real live situations and promote constructive interaction with relevant players in the field. Field visits should be relevant to the community in which the participants will be expected to work as home visitors. The facilitator must be available to control the participation and correct mistakes quickly.

Field visits can be particularly useful in a long training course, to break up the routine and to enable people to put theory into practice. Study visits require a lot of careful preparation by the core group to set them up before the training. A briefing session is necessary, so that participants know why they are going and what questions they will be researching on the visit; also a de-briefing session after the visit, so that full use can be made of the experience.

Advantages

- Active learning so expands experience
- Enhances better understanding of community
- Helps participants understand community problems
- Motivates and stimulates interest in course

Disadvantages

- Opportunities may be difficult to find
- Logistically it can take a lot of time and resources
- Hosts may present problems and ideas which do not reflect the priorities of the course
- Could generate high expectations within the host community

Tips for improving the use of field visits:

- Arrange for field visits far in advance
- Communicate clear objectives of the field visit to both the participants and the host
- Assist participants in formulating questions for the visit
- Review the field visit by relating the experiences of the participants to the learning objectives.

◎ Storytelling and drama

Storytelling and drama are long-standing traditions in African communities. Stories often have a moral and teach what is acceptable behaviour. Stories are usually created around some important and common situations people face in their community. When using storytelling as a teaching tool, give the topic first, tell the story and then get participants to dramatise it. Allow the participants to relate the impact of the story on their lives. Use local stories to make the lesson more meaningful.

Advantages

- It encourages critical thinking
- It addresses attitudes and exposes values
- It integrates culture and learning
- Participants can assess cultural practices
- Develops creativity

Disadvantages

- Requires a lot of imagination on the part of the facilitator
- Requires a lot of preparation
- May be confusing if not thought out - i.e. unrelated topic may be dramatised instead or topics not adequately addressed

Tips for improving the use of storytelling:

- Prepare the drama or story skilfully in order for it to relate to the topic under discussion
- Allow adequate time for rehearsals
- Participants should be able to follow the sequence of the drama correctly
- Choose participants who can bring out the issues of the drama.

Other training methods

Buzz groups: Participants form pairs or threes to quickly discuss ('buzz') some aspect of what the speaker has been saying. It helps to break up the monotony of the input and is a good way to get discussion going in a large group. Buzz groups can report back to the large group; or 'snowball' by each buzz group talking to another pair, and then the four talking to another four, until the group is back together.



Statement ranking: An example of this is when participants rank a list of criteria for selecting OVC in the community. They are asked to rank the criteria or statements against each other, so that they can identify the most important statements relevant to their situation.

Questionnaires: These are usually used to test knowledge, but can examine attitudes too. Questionnaires can also be used to assess the impact of the training.

Case studies: These may be based on real cases or be designed as hypothetical situations but based on real issues. They provide the material on which participants practise using analytical tools they have learned. They also stimulate participants' critical faculties by presenting successes and failures in child care and support work. Case studies should always be carefully designed with specific objectives in mind, and tailored to fit the concepts or problems they are intended to address. Case studies need careful preparation and prior testing.

Creative work: This may include collage, drawing, painting, modelling, composing songs, poems, stories or plays. These can be done individually or as a group effort to enable expression of issues in a different way. It is important to stress that these activities are a vehicle for ideas, not a test of a person's talent or creative ability.

Debates: These can help to clarify thinking on controversial issues, and allow different perspectives to be heard.

Rounds: A round is an exercise in which each participant has the opportunity to say something quickly, in turn, in answer to a question or to report an opinion or feeling. Rounds are a useful quick monitoring exercise to give a sense of individual and group mood and learning. It is particularly useful if you have very uneven participation in the group. However, some people may not want to reveal their true thoughts on certain topics to the group. In this case, you can use index cards or slips of paper and ask each person to write a question or opinion on a card. The cards are then collected in, shuffled, and each person takes one card, which they read out. Thus everyone's feelings are obtained, anonymously. This technique is also known as the 'Ballot Box'.

Games and energisers

These are useful for breaking up monotony, raising energy levels and generally getting people to enjoy themselves. They can also raise sensitive topics in a light-hearted way.

Energisers

Energisers can be used at any time in the training when energy or attention is flagging: after lunch or a session on theory. They also can be used to encourage group feeling – which is useful at the beginning of the training, or where there have been sharp differences of opinion. They are also great fun. You may have some or may ask your group if they have any games or songs – this also encourages the feeling of group participation. Each energiser should take no more than 10 to 15 minutes, depending on the group size.

Facilitators should join in too – you need to be revived at times! Some examples of energisers are:

Opening the day

Stand in a circle. Each person takes a turn to make a sound and a gesture to show how he or she is feeling. This is a good one to do at the start of a day, for people to express their feelings. A variation is for people to imitate the sounds and actions of others.

Word and deed

The first person in the circle does one action, while describing another. For example, she says 'I'm scratching my nose' while pretending to cook. This then continues round the circle. This game can have hilarious consequences – but it may not be for people who want to retain their dignity at all costs!

Stretching and breathing

If you see that participants are looking tired after sitting for a long session, you could have them leave their seats and find a place on the floor. Standing on the floor with their feet about 30 centimetres apart, have them stretch their arms up above their heads as they breathe in, and bring their arms down to their sides in a wide arc as they breathe out. This exercise can also be done sitting down, for those who may be disabled or unable to stand. A few of these stretches will help the group feel more energised.

Part 4

Sample Training Agenda

Introduction

This part of the guidelines for facilitation looks at a practical example of a training course, which facilitator's can adapt to suit their own training requirements. The training course outlined here was run over two weeks (10 days) in Uganda. It was a tight schedule and the facilitation team recognised that it could have been adapted to comfortably run over three weeks.

When planning your training, consider different options for scheduling. These may be training workshops, evening courses or phased training depending on the needs of the group and the community context. The planning and scheduling for training sessions will help you decide which activities to choose for the training and how much time you will spend on each of the activities you have chosen to facilitate.

Example 10 Day Training Course

| Module | Topic | Session / Activity | Time |
|---|---|--|--|
| DAY 1: Module 1 HIV/AIDS and the situation of OVC | Training Orientation | 1 Introduction to the workshop 2 Getting to know each other 3 Expectations | 45 min 1.5 hours 1 hour |
| | Topic 1 - Basic information on HIV/AIDS | 1.1 Introduction/objectives 1.2 The meaning of HIV and AIDS 1.3 Modes of transmission 1.4 Prevention Strategies 1.5 HIV/AIDS Risk Assessment 1.6 General Trend of HIV/AIDS 1.7 Preparing for home visits Evening Video: HIV transmission | 20 min 30 min 30 min 30 min 45 min 45 min 30 min 30 min |
| DAY 2: Module 1 (cont) | Topic 2 - The Impact of HIV/AIDS | 2.1 Introduction/objectives 2.2 Social economic impacts of HIV/AIDS 2.3 End of Day 1 evaluation | 20 min 2 hours 10 min |
| | Topic 3 - Framework for OVC Support | 3.1 Introduction/objectives 3.2 National OVC Policy 3.3 Government responsibilities 3.4 Other stakeholders responsibilities 3.5 Seven components of OVC support 3.6 Our CCC and OVC support 3.7 Preparing for home visits | 20 min 20 min 30 min 45 min 1 hour 1 hour 30 min |
| DAY 3: Module 1 (cont) | Topic 4 - Rights of OVC | 4.1 Introduction/objectives 4.2 Meaning of rights 4.3 Main categories of rights 4.4 Discussing sexual abuse 4.5 Factors affecting implementation of OVC rights 4.6 Strategies to promote children's rights 4.7 Recognising forms and signs of child abuse | 20 min 15 min 1.5 hours 1 hour 45 min 30 min 45 min |
| | Topic 5 - Gender considerations | 5.1 Introduction/objectives 5.2 Describing roles of girls and boys 5.3 Advantages and disadvantages of gender roles 5.4 What we can do 5.5 Preparing for home visits 5.6 Review of home visitor manual | 20 min 30 min 30 min 30 min 30 min 30 min |
| DAY 4: Module 2 Addressing the Pyschosocial and Spiritual Needs of OVC | Topic 1 - Stages of development in children | 1.1 Introduction/objectives 1.2 What is psychosocial support? 1.3 Growth and development in children 1.4 Indicators of growth 1.5 Theories of age and understanding in children 1.6 Environmental factors 1.7 Role of the community 1.8 Preparing for home visits | 20 min 15 min 45 min 30 min 45 min 1 hour 45 min 30 min |
| | Topic 2 - Counselling and communicating with children | 2.1 Introduction/objectives 2.2 Characteristics of children 2.3 How children communicate 2.4 Effective methods of communicating with children 2.5 Dos and don'ts of communicating with children 2.6 Practice | 20 min 45 min 45 min 45 min 45 min 45 min |

| Module | Topic | Session / Activity | Time |
|---|---|---|--|
| DAY 5: Module 2 (cont) | Topic 3 - Accompanying OVC through Grief | 3.1 Introduction/objectives 3.2 Grief and loss 3.3 Signs and symptoms of grief in children 3.4 Age and understanding of death 3.5 Preparing children for death 3.6 Support strategies 3.7 Preparing for home visits | 20 min 45 min 45 min 1 hour 1 hour 45 min 30 min |
| | Topic 4 - Spiritual care and support for OVC | 4.1 Introduction/objectives 4.2 Signs of spiritual problems 4.3 Signs of spiritual health 4.4 Strategies for spiritual care and support of OVC 4.5 End of workshop evaluation | 25 min 45 min 45 min 1 hour 20 min |
| DAY 6: Module 3 Addressing physical needs of OVC | Topic 1 - Assessing needs of OVC | 1.1 Introduction/objectives 1.2 Needs of OVC 1.3 Reaction to unmet needs 1.4 Problems of OVC in the community 1.5 Preparing for home visits | 20 min 45 min 45 min 1 hour 20 min |
| | Topic 2 - Enhancing food security for OVC households | 2.1 Introduction/objectives 2.2 Meaning of food security 2.3 Threats to food security 2.4 Community initiatives to enhance food security for OVC households 2.5 What a home visitor can do to enhance food security for a OVC household | 20 min 20 min 1 hour 1 hour 1.5 hours |
| DAY 7: Module 3 (cont) | Topic 3 - Nutritional care and support of OVC | 3.1 Introduction/objectives 3.2 Meaning of nutrition 3.3 Identifying important foods 3.4 Nutritional care for caregivers with HIV/AIDS 3.5 Nutritional care for pregnant and lactating mothers 3.6 Nutritional care for children with HIV/AIDS 3.7 Poor nutrition - problems and causes 3.8 Steps to take with malnourished OVC 3.9 Preparing for home visits | 20 min 15 min 1 hour 1 hour 45 min 1 hour 45 min 45 min 30 min |
| DAY 8: Module 3 (cont) | Topic 4 - Monitoring the health of OVC | 4.1 Introduction/objectives 4.2 Health needs of OVC 4.3 Basic health information 4.4 Preparing for home visits | 20 min 1 hour 1.5 hours 30 min |
| | Topic 5 - Hygiene precautions | 5.1 Introduction/objectives 5.2 Basic hygiene precautions 5.3 Preparing for home visits 5.4 Review of home visitor manual | 20 min 1 hour 30 min 45 min |
| Module 4 Equipping OVC for the future | Topic 1 - Access to education and vocational training | 1.1 Introduction/objectives 1.2 Importance of education for OVC 1.3 Barriers to access to education 1.4 Community initiatives to ensure access, participation and achievement of OVC in education | 20 min 45 min 45 min 1 hour |

| Module | Topic | Session / Activity | Time |
|--|---|---|---|
| DAY 9: Module 4 (cont) | Topic 2 - Life skills for OVC | 2.1 Introduction/objectives 2.2 Meaning and importance of life skills 2.3 Types of life skills 2.4 Strategies for passing on life skills | 20 min 25 min 1 hour 1 hour |
| | Topic 3 - Behaviour formation for OVC | 3.1 Introduction/objectives 3.2 The meaning of behavioural change 3.3 Factors influencing behavioural change 3.4 Behavioural change process 3.5 Helping OVC change behaviour | 20 min 20 min 1 hour 45 min 1 hour |
| DAY 10: Module 4 (cont) | Topic 4 - Memory book | 4.1 Introduction/objectives 4.2 What is a memory book? 4.3 Content of a memory book 4.4 Making a memory book 4.5 Review of home visitor manual | 20 min 20 min 1 hour 1.5 hours 1 hour |
| | Topic 5 - Will making | 5.1 Introduction/objectives 5.2 Meaning and importance of a will 5.3 Example of a will 5.4 Consequences of failing to write a will 5.5 Drawing an action plan 5.6 End of workshop evaluation 5.7 Closure and graduation | 20 min 30 min 1.5 hours 1 hour 1 hour 15 min 45 min |

Module 1

HIV/AIDS and the Situation of OVC

Topic 1

Basic Information on HIV/AIDS

97

Topic 2

The Impact of HIV/AIDS

107

Topic 3

National Frameworks for Supporting OVC

113

Topic 4

Children's Rights and How They Apply to the Care of OVC

125

Topic 5

The Implications of Gender-Based Roles for OVC

137

Topic 1

Basic Information on HIV/AIDS

| | |
|---|------------|
| Introduction and Objectives for Topic 1 | 98 |
| | |
| Activity 1: What are HIV and AIDS? | 99 |
| | |
| Activity 2: Modes of HIV Transmission - Facts and Misconceptions | 100 |
| | |
| Activity 3: Preventing HIV Infection | 102 |
| | |
| Activity 4: HIV Self-Risk Assessment Quiz | 103 |
| | |
| Activity 5: General Trends in HIV/AIDS Infection | 104 |
| | |
| Activity 6: Preparing for Home Visits: Information on HIV/AIDS | 105 |

Introduction and Objectives for Topic 1

There has been a great deal of sensitisation carried out with regard to HIV/AIDS, but there are still many misconceptions concerning modes of transmission and how to prevent it. Within this topic, participants will be equipped with basic information about HIV/AIDS, its transmission and prevention strategies. They will be able to use this information while offering care and support to vulnerable children, their families, and their guardians or caregivers.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain what HIV and AIDS are.
- ◆ Describe the relationship between HIV and AIDS.
- ◆ Discuss the modes of HIV transmission.
- ◆ Discuss common misconceptions regarding HIV transmission.
- ◆ Describe the measures that can be used to prevent HIV infection.
- ◆ Understand their individual risk status through use of a self-risk assessment tool.
- ◆ Discuss the general trends of HIV/AIDS in their community.
- ◆ Provide basic HIV/AIDS information to families and children during home visits.

The Activities

For each of the activities that follow, facilitators will need to prepare by reading through the facilitator notes before doing the activity with participants. These are guidelines to help you plan the activity. There is also an indication of materials required and a timeframe for each activity.

Participants should be reminded to keep all handouts given to them during activities, as these will be used to make up an information handbook for them to use when making home visits. At the end of each training topic they will select pages, or make pages themselves, to include in their handbook. By the end of the complete training course, their handbooks will contain information they can use as reference material during home visits.

For more information

Further detailed information for facilitating this topic on HIV and AIDS information can be obtained from the church's **Channels of Hope Training Manual** by Christo Greyling (2003) obtainable from World Vision (see references on page 363).

note on language

Although this training is conducted in English, there is often enough space on the handouts for information to be translated. Participants can translate the information into the language of their choice while on the training course, or they can do so later when they are home visitors.

Activity 1 What are HIV and AIDS?



In this activity, you will:

- Define what HIV and AIDS are
- Explain the relationship between HIV and AIDS

Facilitator's notes:

HIV stands for **Human Immunodeficiency Virus**.

HIV is a virus that causes AIDS. A virus is a very small organism that cannot be seen with the naked human eye. The only way to be certain that a person is infected with HIV, is for them to be tested for the virus. The HIV virus is spread through contact with an infected person's body fluids, such as semen, vaginal secretions and blood. Once inside the body, the virus attacks white blood cells. White blood cells are responsible for defending an individual against infections in the body. If these blood cells are attacked by the virus over a period of time, a person's body will become weak and they will become sick often. When a person's immune or infection defence system becomes too weak to fight off sicknesses because of the HIV, we say that the person has AIDS.

AIDS stands for **Acquired Immune Deficiency Syndrome**.

A person with AIDS has a very weak immune system so they get sick easily. They may suffer from a number of different sicknesses, such as tuberculosis (TB), pneumonia, weight loss with diarrhoea and vomiting, skin sores and infections.



For this activity you will need:

- Copies of Handout 1
- Flipchart and markers



To facilitate this activity:

- 1 Distribute Handout 1 to participants.
- 2 Explain to participants what HIV stands for, as outlined on the handout. Give them a simplified explanation about the role of white blood cells in defending the body from infection. Explain that the HIV virus attacks white blood cells, reducing their ability to defend against infection, which means that people infected with HIV are more prone to infection.
- 3 Use the picture on the handout to explain how the HIV virus attacks the white blood cells, and that over time, the white blood cells become weak and the HIV virus spreads in the body.
- 4 Then explain what AIDS stands for, using the handout. Explain that the HIV virus causes AIDS and that AIDS is the second stage of the disease, with a number of symptoms.

Handout 1 - Module 1 Topic 1
What are HIV and AIDS?

| | | |
|---|--------------------|-----------------------------------|
| HIV - Human Immunodeficiency Virus | | |
| H | - Human | |
| I | - Immunodeficiency | |
| V | - Virus | |
| AIDS - Acquired Immune Deficiency Syndrome | | |
| A | - Acquired | - Been given (not born with) |
| I | - Immune | - The body's defence system |
| D | - Deficiency | - Lack |
| S | - Syndrome | - Group of symptoms of a sickness |

HIV virus attacking white blood cells in the body

Activity 2 ➤ Modes of HIV Transmission - Facts and Misconceptions



In this activity, you will:

- Discuss the modes of HIV transmission
- Discuss common misconceptions regarding HIV transmission

Facilitator's notes:

The HIV virus is spread by a person coming into direct contact with the body fluids (semen, vaginal secretions or blood) of a person who is already infected with HIV.

HIV IS transmitted by:

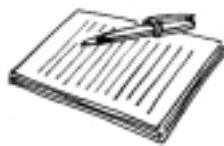
- Having unprotected sex (sex without a condom) with an infected person
- Coming into contact with infected blood
- Skin piercing or other practices where exchange of blood is likely (through the use of infected needles or razors)
- An infected mother infecting her unborn baby, either during pregnancy or at delivery, or while breastfeeding.

There are many common misconceptions about the transmission of HIV.

Many of these myths are generated by fear and ignorance of the facts about the virus.

HIV IS NOT transmitted by:

- Mosquito bites
- Sharing cups, plates and utensils
- Living with a relative who has HIV or AIDS
- Shaking hands or touching an infected person
- Having your hair cut
- Sharing food and drinks
- Wearing second-hand clothes
- Sitting next to an infected person
- Using the same toilet or bath as an infected person
- Coughing and sneezing
- Swimming.



For this activity you will need:

- Flashcards (cut out from Handouts 2 and 3)
- Copies of Handouts 2 and 3



30 minutes

To facilitate this activity:

- 1 For this activity, hand out the flashcards listing the ways HIV is and is not transmitted. (You will need to prepare this beforehand.) Hand out a card to each participant (or group of participants if there are more participants than cards).
- 2 Introduce the activity by explaining that HIV is transmitted from person to person in various ways, but that there are also many beliefs about the way the virus is transmitted that are not true. Participants must decide if the card they have received represents a means of transmission, or not.
- 3 Before beginning the activity, review the meaning of each word or sentence on the cards so that participants understand them clearly.
- 4 Get participants to arrange themselves into two groups, according to their cards. One group will represent the correct modes of transmission and the other group will represent transmission misconceptions. When groups are assembled, review the answers and make corrections as needed. Allow time for discussion and questions.
- 5 Hand out Handouts 2 and 3 to participants. They could write a sentence to clarify each description on the handouts, if necessary.



Activity 3 Preventing HIV Infection



In this activity, you will:

- Describe the measures that can be used to prevent HIV infection

Facilitator's notes:

The most common strategies for preventing HIV transmission and infection are:

- Abstain from sex
- Be faithful to your partner
- Use condoms (practise safe sex)
- Avoid sharing sharp instruments such as razors or needles (where you may come into contact with infected blood)
- Prevent mother-to-child transmission of HIV (join a PMTCT programme).



For this activity you will need:

- Copies of Handout 4
- Flipchart and markers

To facilitate this activity:

- 1 Brainstorm with the group ways that they think they can prevent becoming infected with HIV. Write their ideas up on flipchart paper.

Discuss participants' answers together with the group and correct any wrong or inaccurate answers.

- 2 Based on the list on your facilitator's notes above, you may want to expand on the points further in a discussion with the group. For example, the point '*Be faithful to your partner*' implies that both partners are HIV negative and that neither partner is having sex outside the partnership. If one partner is not faithful, it could put both partners at risk of becoming infected with HIV.
- 3 Distribute Handout 4 to participants. Carefully review each item on the handout to ensure understanding.



Activity 4 HIV Self-Risk Assessment Quiz



In this activity, you will:

- Help participants understand their individual HIV risk status



30 minutes

Facilitator's notes:

The quiz in this activity is designed to make participants aware that their own actions, behaviour and choices may put them at risk of becoming infected with HIV. For example, a person who does not practise safe sex is at greater risk of infection than a person who uses a condom whenever they have sex.

To facilitate this activity:

- Before you begin reading the questions out, make sure the participants understand the rules of the quiz and how to score. This quiz is for participants to assess their own risk status, so do not ask them to share their scores at the end. Assure participants that their answers will remain strictly confidential. If time permits, follow the quiz with a discussion.

Are you at risk of HIV infection?

Rules: If you know you are HIV positive, then this test is not for you.

If you were tested for HIV, work from the day you were tested.

If you have not been tested, work from the year when HIV came to your country.

Points: For Questions 1 to 8: Yes = 10 No = 0

For Questions 9 to 11: Yes = 0 No = 10

Questions:

- Have you or your sexual partner ever had a blood transfusion?
- Have you ever had injections from a non-professional practitioner who may not have taken care to use sterile equipment?
- Have you ever shared skin piercing equipment?
- Have you ever had sex?
- Have you ever had sex with someone who already had sex with someone else? (if uncertain, score 10)
- Have you had sex with more than one sexual partner?
- Have you ever separated from your sexual partner and then resumed the sexual relationship after some time?
- Have you ever had a sexually transmitted disease?
- Were you a virgin when you married? If not married: Are you a virgin now?
- Do you use condoms correctly and consistently every time you have sex?
- Was your husband/wife a virgin when you married? If not married: Are you sure your partner is a virgin?

Scores: 0 = Low risk; 10 to 40 = At risk; 40 to 80 = High risk; 80 to 110 = Very high risk

Source: Rev. Canon Gideon Byamugisha, 2002

Activity 5 General Trends in HIV/AIDS Infection



In this activity, you will:

- Discuss the general trends of HIV/AIDS infection rates

Facilitator's notes:

Available information and statistics indicate the following general trends in HIV/AIDS infection:

- HIV/AIDS is spreading very rapidly.
- The numbers of orphans and other vulnerable children are increasing.
- More and more women and children are being infected.
- Between four and five girls and young women are infected with HIV for every one young man infected.
- Persons with poor health and / or living in poverty are more vulnerable to HIV infection.

Remember: There is still no cure for AIDS, but HIV is preventable.



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- 1 Divide the participants into two groups.
- 2 Ask each group to think about what is happening with HIV/AIDS in their community and their country. For example, you may want them to consider the following questions:
 - Is the rate of infection increasing or decreasing in their community?
 - Who do they think is most vulnerable to infection?
 - What are some of the consequences of HIV infection and AIDS that they see in their community?

Allow about ten minutes for groups to discuss, then have each group briefly present their ideas. You can write these up on the flipchart.

- 3 Then read out the points from the list in your facilitator's notes above. You may want to write them up on the flipchart as you speak. Use these points to generate a discussion on the issues raised.

Activity 6 Preparing for Home Visits: Information on HIV/AIDS



In this activity, you will:

- Assist participants to put together basic HIV/AIDS information for their home visitor's handbook which they can use for reference on home visits

Facilitator's notes:

Home visitors will now have some basic information about what HIV/AIDS is; how it is transmitted and how transmission can be prevented. With the handouts given to participants during these activities, they will be able to start compiling a home visitor's handbook. They can use this for their own records and to give information to families during home visits. In the first part of this activity, you will help participants put their handbooks together. In the second part of the activity, participants will practise using the information they have appropriately. For example, some information they have may not be appropriate for children.



For this activity you will need:

- Copies of Handouts 1 to 4 (Participants should bring their handouts from previous activities)
- Extra sheets of blank paper



1 - 2 hours

To facilitate this activity:

- Explain to the participants that they will be compiling a home visitor's handbook to assist them when they make home visits to families and children. For this topic, participants should arrange Handouts 1 to 4 to form the first section of their handbook. If they want to include an introductory page titled "Basic Information on HIV/AIDS", this will help them to organise their handbook.
- Explain to participants that they can use the information in the handouts to help families and children understand what HIV/AIDS is, how it is transmitted, and how they can prevent becoming infected themselves. Correct information about HIV/AIDS is important for people to share, as there is much stigma, distrust and fear associated with this disease.
- Participants may want to translate some of the concepts in order to communicate them more effectively. For example, there are often local names for HIV/AIDS that are used in a community. They can do this on the handout (where space permits) or on separate sheets of paper that they can include in their handbooks.
- Use this session to review participants' understanding of the topic, so that they are clear about the facts around HIV/AIDS; and especially about HIV transmission routes.



5 In the second part of the activity, participants can practise giving information using their handouts by doing a role-play.

To do this, divide them into pairs and ask them to imagine that one of them is a home visitor wanting to explain HIV/AIDS to a family member. Each participant should get an opportunity to play at being the home visitor. Ask them to think of the different things they will say when talking to a child, as opposed to talking to an adult. For example, is all the information presented on the handouts appropriate for young children?

note

There is more information on role-plays on page 86 of this guide.

6 Finally, ask the participants to label a new sheet of paper: **Referral Information**.

This will serve as a resource information directory that they will include in the back of their handbooks. On this page (or pages) they will include information about organisations such as clinics that can give practical assistance to community members. For example, someone may be concerned about their HIV status; or may need assistance and advice about caring for someone with AIDS. In such cases, you will need to know where people can go to take an HIV test; or find information for caregivers. The types of possible referrals will depend on the types of facilities available in the community, and/or on the types of services that the CCC is prepared to provide.

Examples of referral information might be:

- Pregnant woman: Provide information and refer to primary health clinic for PMTCT advice and services
- Sexually active teenager: Provide information and refer to a Voluntary Counselling and Testing centre
- Under-15 child: Refer to life skills training courses run in churches or at community centres.

Referral information may include telephone numbers of services such as local clinics, healthcare centres and AIDS advice centres. It is important that home visitors have the basic information (such as addresses and telephone numbers) included in their information on available services. You should help participants to complete this page, based on any information you have. Information can be updated later if it is not immediately available.

The referral information directory will be filled in as an on-going process throughout the training course, so that by the end of the home visitor training, participants will have listed information on a range of services covering a variety of needs.

7 Continue to work with the participants until they feel they are ready and able to provide basic information on HIV/AIDS to families as part of their home visits.

Topic 2

The Impact of HIV/AIDS

Introduction and Objectives for Topic 2 108

Activity 1: *The Definition of Psychological and Socio-economic* 109

Activity 2: *The Psychological and Socio-economic Impact
of HIV/AIDS on Children, Families and
Communities* 110

Introduction and Objectives for Topic 2

HIV/AIDS has had devastating effects on children, rendering them vulnerable by forcing them to experience their parents or guardians illness and death, by leaving them orphaned, and by causing them to live in families that have taken in orphans.

The social impact of HIV/AIDS on children and families includes discrimination, vulnerability, decline in physical and emotional well-being, loss of access to education and increased poverty. Families become poorer and economically vulnerable when breadwinners become too ill to earn, while family healthcare costs rise. The death of a breadwinner may cause widows and orphans to lose their inheritance, their possessions and property, and to be left with nothing.

Fieldworkers working with communities which have been ravaged by HIV/AIDS, have noted that mental and emotional depression is a significant factor in further increasing the vulnerability of OVC, guardians and communities as a whole. People who have been in a state of depression over a long period of time can lose their ability to cope with their everyday lives and often lose interest in life in general. Children in families or part of communities that are depressed, can become increasingly vulnerable as adults neglect their own needs and the needs of children.

This topic will explore the various ways in which HIV/AIDS affects all aspects of a child's life.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Define what psychological and socio-economic mean.
- ◆ Explain the psychological impact of HIV/AIDS on children, their families and communities.
- ◆ Explain the socio-economic impact of HIV/AIDS on children, their families and communities.



Activity 1 The Definition of *Psychological* and *Socio-economic*



► **In this activity, you will:**

- Define what *psychological* and *socio-economic* mean

Facilitator's notes:

This activity will ensure that participants fully understand what *psychological* and *socio-economic* mean:

Psychological = relating to the mind. In this context, it would mean the effects of mental anguish, stress, grief and depression that a person suffers.

Socio-economic = relating to social and economic factors.



For this activity you will need:

- Copies of Handout 1
- Flipchart and marker



To facilitate this activity:

- 1 Hand out copies of Handout 1 to participants.
- 2 Explain to the participants the objectives of this topic and ask them to list what they think *psychological* and *socio-economic* mean. Give them a few minutes to write up some ideas under the headings on their handouts.
- 3 Ask for responses from the group. You may write up responses on the flipchart. Clarify answers if necessary. It is important that participants have a clear understanding of these terms, as the rest of Topic 2 builds on this understanding; as do many of the further sections on the care and counselling of vulnerable children.
- 4 Participants will include Handout 1 in their home visitor's handbook at the end of the activity.



Activity 2**The Psychological and Socio-economic Impact of HIV/AIDS on Children, Families and Communities****In this activity, you will:**

- Discuss the psychological and socio-economic impact of HIV/AIDS on children, families and communities

Facilitator's notes:**The following are key points to a discussion on the impact of HIV/AIDS:**

- The cost of HIV/AIDS is very high physically, emotionally and psychologically.
- HIV/AIDS has resulted in the loss of the most productive individuals in society
- The medical costs of HIV/AIDS have put a great strain on healthcare delivery.
- The extended family's capacity to care for orphans has been stretched to breaking point, and has created a group of vulnerable children who are disadvantaged in all aspects of their lives: socially, economically, psychologically and physically.

Some impacts of HIV/AIDS on children:

- Loss of family, loss of identity
- Psychological distress and depression
- Self-rejection
- Increased malnutrition
- Loss of healthcare, including immunisations
- Increased workload
- Loss of shelter and clothing
- Low self-esteem and confidence
- Fewer opportunities for schooling and education (many children drop out of school)
- Loss of inheritance
- Increased risk of abuse and exploitation.

**Some impacts of HIV/AIDS on families:**

- Loss of family members (through death, fostering or adoption); family dissolution
- Changes in household and family structure
- Unemployment due to ill health
- Selling of household property to raise money for healthcare costs
- Stigma and discrimination experienced by family, especially women and children
- Possession and property grabbing
- Guilt suffered by individuals who are infected with HIV/AIDS
- Turning to witchcraft and witch doctors to help cure ill health
- Lost income and impoverishment
- Forced migration
- Grief
- Stress and depression
- Increased stress may lead to increased neglect, abuse and exploitation of children
- Reduced ability to care for children and elderly household members.

Some impacts of HIV/AIDS on communities:

- The labour pool is reduced, especially for agricultural and skilled labour
- Poverty increases
- Community infrastructure deteriorates
- Access to healthcare, adequate nutrition and education is reduced
- Mortality rates rise
- The community has fewer resources to marshal for mutual aid
- Communities suffer depression and a general loss of resilience
- Communities are less productive because members are spending most of their time in hospitals and caring for dying members of the community or family
- There is poor health among family and community members
- There are high poverty levels among families and communities due to spending all the resources trying to care for dying family members.



For this activity you will need:

- Copies of Handouts 2a, 2b and 2c
- Flipchart and marker



To facilitate this activity:



- 1 In this activity, participants will imagine or think of a scenario in which many adults in their community become sick with HIV/AIDS and eventually die. (Explain that this is a very realistic scenario, given the trends of HIV/AIDS, as discussed in the previous topic.)
- 2 Divide participants into three groups. Ask them to think about the impact that this will have on children, families and the community as a whole. They should think of 'impact' in terms of economic effects, emotional effects and needs, physical, spiritual and social effects and needs, and any other types of impacts.
- 3 One group will be assigned to discuss the effects of HIV/AIDS on children, the second group the effects of HIV/AIDS on families, and the third group the effects of HIV/AIDS on the community as a whole. Give them about 15 minutes for this discussion.

4 If the groups show reasonable levels of literacy you may distribute Handouts 2a, 2b and 2c accordingly – one handout per group – and ask the group to choose someone to record answers on the handouts from the group. Circulate between groups and help them get started by giving a few examples from your facilitator notes, if necessary.

Note that this activity can also be done as a discussion that does not involve writing.

5 After the group work period, each group will report back to plenary on the three areas of impacts they discussed. Follow up with a discussion and question and answer session. Write up each group's responses on the flipchart under the three headings and review the answers, if necessary. (These can be pinned up for the duration of the course.) Add any additional points from your facilitator's notes if the groups have not come up with them themselves.

Take time to understand ideas and points of view put forward and remember that people are free to agree or disagree with any ideas put forward.

6 Lastly, read out to the group the four key points from the box in your facilitator's notes on page 100. They offer a brief summary of the devastating impact of HIV/AIDS.

Handout 2a - Module 1 Topic 2
The Impact of HIV/AIDS on Children

Examples of Impacts of HIV/AIDS on Children



Handout 2b - Module 1 Topic 2
The Impact of HIV/AIDS on Families

Examples of Impacts of HIV/AIDS on Families:



Handout 2c - Module 1 Topic 2
The Impact of HIV/AIDS on Communities

Examples of Impacts of HIV/AIDS on Communities:



Topic 3

National Frameworks for Supporting Orphans and Vulnerable Children

| | |
|---|------------|
| Introduction and Objectives for Topic 3 | 104 |
| | |
| Activity 1: National OVC Policy | 105 |
| | |
| Activity 2: Government Strategies and Responsibilities | 106 |
| | |
| Activity 3: Other Stakeholder Responsibilities | 108 |
| | |
| Activity 4: The Seven Components of OVC Support | 111 |
| | |
| Activity 5: CCCs and OVC Support | 113 |
| | |
| Activity 6: Preparing for Home Visits: Elements of OVC Support | 114 |

Introduction and Objectives for Topic 3

HIV is the leading cause of orphans and vulnerable children in many countries in Africa, for example, in Uganda. The number of orphans in most African countries is expected to remain high over the next decade and beyond 2010.

Many governments in Africa are concerned about the plight of OVC and they have adopted and are implementing both national and international legal and policy instruments that concern children. In this topic, you'll look at OVC policies at a national level; and how they may support and supplement CCC efforts to care for vulnerable children at a community level.

Further criteria for vulnerability may include children with disabilities, those suffering from extreme poverty and lack of basic food, care and shelter. In this topic, it may be useful to link national government policies on OVC together with general policies on child rights, care and protection.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Discuss government strategies and policy guidelines for the care of OVC in their country.
- ◆ Explain what is being done for OVC in their country by various stakeholders.
- ◆ Describe ways of strengthening care and support for OVC in their country.

The Activities

For each of the activities that follow, facilitators will need to prepare by reading through the facilitator notes before doing the activity with participants. These are guidelines to help you plan the activity, and include an indication of materials required and a timeframe for each activity.

note on policy

Many examples in this section are from Uganda. Facilitators conducting training in other countries should substitute the national and local policies for OVC in their own country context.

This will require some prior research and planning.

Activity 1 National OVC Policy



In this activity, you will:

- Explore what it means to have a national OVC policy

Facilitator's notes:

The definition of a National Policy on OVC:

A policy on OVC is a set of broad guidelines (preferably legal) for action that is intended to eliminate the unfavourable conditions of orphans and other vulnerable children in society, so as to mainstream them into society and to enhance their social and economic progress. These guidelines provide a general framework within which relevant interventions by both governmental and non-governmental bodies can be implemented.



For this activity you will need:

- Flipchart and markers



15 minutes

To facilitate this activity:

- Ask participants what they understand by a national OVC policy. Listen to their ideas and then clarify based on the information in your definition.

Note that you will not read the description from your facilitator notes, since the language is sophisticated. You could explain in your own words what it means. For example: *A National Policy is a set of guidelines that the government and other stakeholder organisations or individuals have agreed upon and will follow to improve the situation of orphans and vulnerable children in their country.*



- If time permits, lead the question of policy into a general discussion on a government's duty and responsibility to respond appropriately to the needs of the population. Remind participants of the definitions for orphans and vulnerable children, for example, disabled children are generally considered vulnerable, whether they are orphans or not.

In Activity 2, you will expand on this further by getting participants to review what their own government is doing in response to the challenge of the HIV/AIDS epidemic, particularly in relation to the plight of vulnerable children.

Activity 2 ➤ Government Strategies and Responsibilities



In this activity, you will:

- Explore what Government's OVC strategies and responsibilities are

Facilitator's notes:

The rights of orphans and vulnerable children encompass both children's rights and general human rights. This activity will help to outline what is being done in your country around children's rights.

What has your government done to give children their rights?

For inputs here, you will need to research your country's child rights policies.

In Uganda, for example:

- ◆ The rights of the child have been put in the Constitution.
- ◆ The Children Statute was accepted by parliament in 1997. There is now a secretary for children in the Local Council system who is tasked to protect children's rights.
- ◆ More children can now go to school because of Universal Primary Education (UPE).
- ◆ There is immunisation of children against the six killer diseases.
- ◆ The government raises awareness in the community about children's rights.
- ◆ The National Council for Children was established to make sure that everything is done to enable children to enjoy their rights.

What more does a government need to do for children? It needs to:

- ◆ Listen to children and take their views and opinions seriously.
- ◆ Provide more money for the needs of children.
- ◆ Make sure that more children enjoy their right to life. At present, there are many children who die before they reach one year; and many more die before they reach five years old.
- ◆ Make sure that children and adults know the rights of the child and put them into practise, for example ensuring the care and protection of children.
- ◆ Help families to get out of poverty, since poor families are unable to provide sufficiently for the needs of their children.

Although there are many policies and programmes aimed at improving the general well-being of children, a significant number are still not able to fully access, participate in and benefit from these initiatives on a sustainable basis. There are high levels of orphanhood, abuse, exploitation, discrimination, displacement and conflicts that leave many children vulnerable.

In this activity, you will get participants to view government's record on children's rights in the following eight government service areas (as outlined on Handout 1): Child Welfare (care and support), Child Safety and Protection, Education, Health, Psychosocial Support, Socio-economic Support (child-care grants), Legal Aid and Representation; and Social Development (vocational or life skills training).



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1
- Information on your country's policies and legislation on OVC



45 minutes

To facilitate this activity:

- 1 Write the following heading on a sheet of flipchart paper: *What the Government has done to help Children*. On another sheet, write: *What more does the Government still need to do for Children?*
- 2 Ask participants to brainstorm and list ideas under each question. Facilitate a discussion based on their answers, and based on the information provided in your facilitator's notes. This part of the activity should take about half an hour.
- 3 Then hand out copies of Handout 1 to participants.
- 4 Keep the two flipchart pages up to use as references. Using the handout, go through each of the eight categories on the handout where Government has or could intervene to endorse both children's rights and to support orphans and vulnerable children. The eight categories are:
 - Child Welfare
 - Child Safety and Protection
 - Education
 - Health
 - Psychosocial Support
 - Socio-economic Support
 - Legal Aid and Representation
 - Social Development.
- 5 If the group (yourself included) cannot list any government interventions in a particular category, these can be researched and filled in later.

Handout 1 - Module 1 - Topic 2

Government Strategies on Children's Rights

What Government has done or needs to do for children's rights in the following service areas:

| | |
|------------------------------|-----------------------------|
| Child Welfare | Child Safety and Protection |
| Education | Health |
| Psychosocial Support | Socio-economic Support |
| Legal Aid and Representation | Social Development |

Activity 3 Other Stakeholder Responsibilities



In this activity, you will:

- Explore what other sectors and stakeholders are doing towards OVC support

Facilitator's notes:

Government ministries are key to the formulation of policies on OVC, but there are many other institutions and individuals at various levels of society who have a role to play in caring for, supporting and protecting OVC.

Roles undertaken by other stakeholders in the care of vulnerable children

◆ Parents, guardians and other caregivers

Some roles they undertake are to:

- identify OVC
- provide care and support
- offering psychosocial counselling and guidance
- plan for the welfare of children
- participate in policy development and review
- ensure birth and death registration in every household
- identify resourceful persons within the community to support OVC
- manage conflicts
- protect children from abuse and exploitation.



◆ Local authorities

They can undertake to:

- incorporate OVC concerns in the local government plans and budgets
- mobilise, allocate and use funds for implementing programmes
- ensure data on OVC is collected, collated and disseminated for improved targeting and OVC service delivery
- co-ordinate activities of OVC stakeholders at local and community levels
- ensure the protection of children from abuse and exploitation by making sure that child protection laws are upheld.

◆ **Civil society organisations (including FBOs, CBOs, NGOs)** can:

- lobby and advocate for OVC issues and concerns
- implement OVC interventions and develop programmes
- undertake resource mobilisation and allocation
- build the capacity of existing community groups and individuals
- build partnerships with government and other agencies in support of OVC
- mobilise the community for needs assessments
- advocate for child support and protection and create child-safe mechanisms for the reporting of abuse and exploitation
- provide psychosocial support and counselling
- support supervision, monitoring and evaluation
- promote OVC-friendly policies
- promote and facilitate networking and co-ordination among OVC service providers
- create awareness and promote the writing of wills.

◆ **The community (local community groups, traditional, cultural and religious leaders)** can:

- identify OVC and OVC households
- engage in conflict resolution
- provide care and psychosocial support
- organise and strengthen social support networks for OVC and their families
- participate in programme implementation and identify appropriate strategies
- link service providers with OVC
- lobby relevant bodies for OVC support
- advocate for child support and protection, by forming child protection committees
- protect property rights of OVC and widows
- facilitate succession planning and will writing
- create awareness of the plight of vulnerable children
- advocate for birth and death registration
- facilitate the process of identifying and changing cultural and religious norms and practices that negatively affect OVC, especially girls and disabled children.

◆ **The private sector (businesses)** can:

- contribute resources and job opportunities
- participate in initiatives for improved protection and care
- develop work policies that protect vulnerable children from exploitation and abuse
- provide social insurance and social security schemes for workers
- provide health insurance for workers and their families
- collaborate with government and CSOs to deliver social services
- publicise and popularise OVC policies.

note

See Appendix 2 on page 350
for a further breakdown of
national and local government
OVC support responsibilities.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2



40 minutes

To facilitate this activity:

- 1 Distribute Handout 2 to participants. Explain to the group that there are many institutions and individuals at various levels of society who have a role to play in caring for and supporting OVC. Review the examples on the handout and clarify what each one means. For example, you can clarify *Civil Society Organisations* or *Private Sector* by giving some examples.
- 2 Then divide the participants into groups. Give each group one or two categories to work with and ask them to brainstorm what they think the roles and responsibilities of each one are in caring for, supporting and protecting OVC. This should take about ten minutes.
- 3 Back in plenary, summarise the roles and responsibilities of each stakeholder category by writing the feedback from the groups up on the flipchart.

You may add additional information based on your facilitator's notes. Allow time for questions and answers.

Handout 2 - Module 1 - Topic 2

Stakeholder's Roles in the Support of OVC

There are many stakeholders in society that have roles and responsibilities to protect children's rights and support OVC.

| | |
|--------------------------------|-------------------|
| Parents, guardians, caregivers | Local authorities |
| <hr/> <hr/> <hr/> | |
| Civil society organisations | Community groups |
| <hr/> <hr/> <hr/> | |
| The private sector | |
| <hr/> <hr/> <hr/> | |

Activity 4 The Seven Components of OVC Support



In this activity, you will:

- Look at seven key components of support for orphans and vulnerable children

Facilitator's notes:

Both the government and other advocacy groups involved in setting policy for OVC support, have identified seven broad categories of the types of support that OVC, and their caregivers, need.

The Seven Components of OVC Support:

1 Welfare (Care and Support)

- Provision of basic needs (food, water, shelter, clothing, bedding)
- Community support to households that care for OVC
- Support to OVC who are mothers
- Awareness of benefits of family planning

2 Child Protection

- Fostering, guardianship and adoption
- Protection from child labour
- Succession planning and inheritance issues
- Protection from sexual abuse and other forms of abuse and exploitation

3 Education

- Formal and informal education
- Life skills training
- Vocational training
- Caregiver education (and adult literacy)
- Special needs education

4 Health

- Access to healthcare
- Immunisations
- Nutrition
- Treatment of HIV/AIDS, including ARVs
- Caregiver health

5 Psychosocial Support

- Community-based (and institutional) psychosocial support
- Child-friendly health and education services
- Recreation activities for children and youth
- Mentoring
- Peer groups

6 Socio-Economic Security

- Income generating activities
- Financial and entrepreneurial initiatives
- Job development in formal and informal sector
- Internships and apprenticeships
- Social security benefits (for orphans, for elderly caregivers)

7 Legal Advice and Representation

- Rights, including gender advocacy
- Inheritance rights
- Policy formulation and implementation



For this activity you will need:

- Flipchart and different coloured markers
- Copies of Handouts 1 and 2 (from previous activities)
- Copies of Handout 3



40 minutes

To facilitate this activity:

- 1 Give out Handout 3 to participants. Explain that not only the government, but also advocacy groups involved in setting policy for OVC support, have identified seven broad categories of the types of support that OVC need. Refer the participants to their handout and ask them to explain what they understand about each category.
- 2 There is space on their handout for the participants to write in more detailed information and/or examples beneath each category, if they wish. You can refer to your facilitator's notes to help the participants complete the information.
- 3 Allow for questions and answers until you are satisfied that they understand the seven categories.
- 4 Then return to the flipchart pages where the responsibilities of the various stakeholders from Activities 2 and 3 were listed, and next to each responsibility listed, have the participants try to identify the category or categories of support they represent. Use a different coloured marker or crayon for each category.

Handout 3 - Module 1 - Topic 2

The Seven Components of OVC Support

| | |
|---|---|
| 1 Welfare (Care and Support) | 2 Child Protection |
| <ul style="list-style-type: none"> - Provision of basic needs (food, water, shelter, clothing, heating) - Community support to households that care for OVC - Support to OVC who are victims - Awareness of benefits of family planning | <ul style="list-style-type: none"> - Training, guardianship and adoption - Protection from child labour - Succession planning and inheritance issues - Protection from sexual abuse and other forms of abuse and exploitation |
| 3 Education | 4 Health |
| <ul style="list-style-type: none"> - Formal and informal education - Life skills training - Vocational training - Caregiver education (and adult literacy) - Special needs education | <ul style="list-style-type: none"> - Access to healthcare - Immunisation - Nutrition - Treatment of HIV/AIDS, including ARVs - Caregiver health |
| 5 Psychological Support | 6 Socio-economic Security |
| <ul style="list-style-type: none"> - Community based (and institutional) psychological support - Child friendly health and education services - Recreational activities for children and youth - Mentoring - Peer groups | <ul style="list-style-type: none"> - Income-generating activities - Financial and entrepreneurial initiatives - Job-development in formal and informal sector - Internships and apprenticeships - Social security benefits (for orphans, for elderly caregivers) |
| 7 Legal Aid and Representation | |
| <ul style="list-style-type: none"> - Rights, including gender advocacy - Inheritance rights - Policy formulation and implementation | |

Activity 5 CCCs and OVC Support



In this activity, you will:

- Review CCC roles and responsibilities for OVC support

Facilitator's notes:

It is assumed that the World Vision mobiliser has already mobilised a CCC in the community where this home visitor training is taking place. In this activity, participants will list their own CCC's responsibilities towards the care and support of orphans and vulnerable children.

At the end of this activity, you should highlight the vital importance of community ownership and action with respect to OVC care and support services. The problem is too large for government and any one outside organisation or intervention to handle without the front-line efforts of communities themselves.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- 1 Tell participants that the aim of this activity is to review the activities of the CCC, so that all home visitors are clear as to the types of support that the CCC can provide, and the types of referrals that they may make to the CCC or to CCC members.
- 2 Ask for responses and list the activities and/or responsibilities of the CCC on a piece of flipchart paper. Remind participants of the seven categories of OVC support and identify the category or categories of support that each response represents.
- 3 Explain to participants the vital importance of community ownership and action with respect to OVC care and support services. Explain to the group that the problem is too large for government and other outside organisations to handle without the front-line efforts of communities. Ask participants if they agree with this view and discuss this further if time permits.

Activity 6 Preparing for Home Visits: Elements of OVC Support



In this activity, you will:

- Assist participants to generate their own checklist of OVC support elements to include in their home visitor's handbooks

Facilitator's notes:

Handout 3, *The seven elements of OVC support*, from Activity 4 is useful to the participants as an introduction to the various needs of orphans and vulnerable children. In this activity, participants will revisit this information, but will also work on their own list of OVC support elements. For example, they may know of different needs that are not reflected on the handout, and want to include them. Participants will make up a checklist of questions to ask when making home visits. These checklists will help them to assess or determine the needs of vulnerable children in their own CCC.

They will be included in their home visitor's handbooks.



For this activity you will need:

- Copies of Handout 3 - *The seven elements of OVC support*
- Extra sheets of blank paper

To facilitate this activity:



- Have participants look again at Handout 3. Explain to them that they will be looking in greater detail at four of the seven categories (child protection, education, health, psychosocial support) from the handout in later modules; and that most of what they will need to learn will be covered in those modules. Participants need to think about the kinds of information they will want to collect when making home visits, based on the seven categories on the handout. This will help them to determine any areas of support that may be lacking for any one particular category.
- Give participants sheets of blank paper for them to make up their checklists of OVC support needs. These will be included in their home visitor's handbooks.

An example of a checklist of questions based on the category on *Health* could include questions such as:

- Has the child received all his or her basic immunisations?
- What does the child get to eat?

Questions in other categories could be:

- Who is the primary guardian or caregiver of the child?
- Is the child in school? (yes/no)
- Is the child required to work beyond normal simple household duties?

- Work with the participants until they feel confident that they are ready to ask the right questions when making home visits. These questions will help to identify the needs of the children they visit.

Topic 4

Children's Rights and How They Apply to the Care of OVC

| | |
|---|-----|
| Introduction and Objectives for Topic 4 | 126 |
| Activity 1: What are <i>Children's Rights</i> ? | 127 |
| Activity 2: Categories of Children's Rights | 128 |
| Activity 3: Abuse of Children's Rights: Forms, Causes and Consequences | 130 |
| Activity 4: The Sexual Abuse of Children | 133 |
| Activity 5: Protecting Children | 135 |
| Activity 6: Home Visits: Monitoring for Signs of Child Abuse | 136 |

Introduction and Objectives for Topic 4

Both international and national laws provide legal rights for all children. Specific laws have been put in place to protect the rights of children. The *United Nations Convention on the Rights of the Child* identifies four categories of the rights of a child. These are:

- ◆ Survival rights
- ◆ Protection rights
- ◆ Development rights
- ◆ Participation rights.

Although these instruments are in place, most adults, communities, families and children themselves may not be aware of these rights and corresponding responsibilities. In fact, many people may be uncomfortable with the idea of children having rights. In cases where participants have difficulty with the notion, facilitators can argue that a society's commitment to applying children's rights is similar to a government's obligation to govern its citizens by applying the country's laws. All parents have dreams for their children, and children's rights outline how children can best grow up as their parents wished.

Children's rights should be a fundamental principle within a CCC, which should include a child protection structure within the coalition. Ideally, a child protection mediator or counsellor should be appointed in every CCC. The person in this role should have experience in psychosocial child support, should be trusted by OVC in the CCC programme and be able to mediate on behalf of a child. The mediator can also act as a support for home visitors who suspect child abuse in a household that they visit. Such a person would also have relevant referral information for taking action in the case of suspected child abuse or exploitation.

Unfortunately, even in countries where children's rights are enshrined in law, these rights may not be adequately implemented and protected. Part of the facilitator's role in this section is to advocate for best practice with regard to child support and protection, and to instill this idea into potential home visitors. In this section, you will take participants through what children's rights are and the ways in which children's rights are violated. Home visitors will also need to know what actions to take when they come across signs of child abuse while on home visits.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain what children's rights are.
- ◆ Describe the main categories of children's rights.
- ◆ Describe the forms and causes of child abuse that may exist in the community.
- ◆ Describe the effects or consequences of child abuse on children.
- ◆ Discuss sexual abuse as a violation of children's rights.
- ◆ Plan strategies for monitoring and taking action if OVC show signs of abuse.

Activity 1 What are Children's Rights?



In this activity, you will:

- Define what *rights* mean and what *children's rights* mean

Facilitator's notes:

In this activity you will help to define, with participants, what **rights** and **children's rights** are. These definitions will be used to underpin all further sections on the support and protection of orphans and vulnerable children.

The following are definitions of children and rights:

- A **child** is defined as a human, male or female, aged 18 or under.
- A **right** is what any person, child or adult, is entitled to legally and morally.
- The rights of **all** children are enshrined in law and must not be violated. When there is violation of the rights of children, legal action can and should be taken.
- Nobody, not even parents, can violate the rights of a child.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



20 minutes

To facilitate this activity:

- Ask participants to give their ideas as to the meaning of a *right* and a *child* and allow some discussion on this. You can write up responses on the flipchart.
- Give out copies of Handout 1 and review all the points on the list. Allow for some discussion on these points. For example, you can ask participants if they agree that children have certain rights that not even parents can violate.
- Ask participants to give some examples of the rights that children have, as a warm-up for the next activity.

Handout 1 - Module 1 - Topic 4
The Meaning of Children's Rights

Definitions of children and children's rights:

- A **child** is defined as a human, male or female, aged 18 or under.
- A **right** is what any person, child or adult, is entitled to legally and morally.
- The rights of **all** children are enshrined in law and must not be violated. When there is violation of the rights of children, legal action can and should be taken.
- Nobody, not even parents, can violate the rights of a child.

Activity 2 Categories of Children's Rights



In this activity, you will:

- Explore different kinds or categories of children's rights with participants

Facilitator's notes:

This activity elaborates what children's rights are and gives categories of rights that **all** children, including orphans and vulnerable children, are legally and morally entitled to. These categories are based on the definitions from the *United Nations Convention on the Rights of the Child*.

The four categories of children's rights are:

◆ Survival Rights

- The right to a name and a nationality
- The right to grow peacefully in a caring and secure environment
- The right to the basic necessities of life; for example food, shelter and clothing
- The right to one's parents or guardian.

◆ Protection Rights

- The right to have one's health protected through immunisation and appropriate healthcare
- The right to protection from abuse and exploitation
- The right to be treated fairly and humanely
- The right not to be employed or engaged in activities that harm one's health, education, mental, physical and functional development.

◆ Developmental Rights

- The right to a basic education
- The right to leisure and to socialise in an environment that is not morally harmful.

◆ Participation Rights

- The right to express one's opinion
- The right to be listened to
- The right to be consulted according to one's understanding.

Before you start this activity, do the following preparations: Attach four sheets of flipchart paper to the wall where participants can see them clearly. Label the top of each paper with one of the category headings: *Survival Rights*, *Protection Rights*, *Development Rights* and *Participation Rights*.

Then copy each right from the categories (see your notes above) on a separate strip of paper.

For example, *The right to a name and nationality* which comes from the *Survival Rights*.

Make sure that your writing is large enough for all the participants to read easily. In the activity, you will get participants to attach these strips to the correct category pages you have pinned up.



For this activity you will need:

- The flipchart pages and strips you have prepared
- Copies of Handout 2



40 minutes

To facilitate this activity:

- 1 Tell the group that you will be talking about categories of children's rights.
Go through the four categories of children's rights written on the flipchart pages you have put up on the wall.
- 2 Have a volunteer come and select one of the strips of paper you previously prepared.
Have the volunteer read the right to the group. Discuss and clarify as needed, and then have the group decide under which category the right should be posted.
For example: *The right to a name and nationality* should be posted on the *Survival* page.
Have the volunteer attach the strip of paper to the appropriate page using blue-tac or prestik.
- 3 Continue with all remaining strips of paper with rights written on them, asking for a different volunteer each time. Clarify the examples as needed.
- 4 When all the rights have been stuck to the appropriate category sheet, open a discussion with participants about whether they agree with each example being a children's right.
If there is any disagreement, clarify and explain that these rights are, in fact, enshrined in law.
It is important that participants understand that children's rights are human rights.
- 5 If the group comes up with additional examples of rights, add them to the appropriate categories.



Handout 2 - Module 1 - Topic 4
Categories of Children's Rights

There are four categories of children's rights:

- **Survival Rights:**
 - The right to a name and a nationality
 - The right to grow physically in a caring and secure environment
 - The right to the basic necessities of life: food, shelter and clothing
 - The right to one's parents
- **Protection Rights:**
 - The right to have one's health protected through immunisation and appropriate healthcare
 - The right to protection from abuse and exploitation
 - The right to be treated fairly and humanely
 - The right not to be employed or engaged in activities that harm one's health, education, mental, physical and functional development
- **Developmental Rights:**
 - The right to a basic education
 - The right to leisure and to socialise in an environment that is not physically and morally harmful
- **Participation Rights:**
 - The right to express one's opinion
 - The right to be listened to
 - The right to be consulted according to one's understanding

Activity 3 ➤ Abuse of Children's Rights: Forms, Causes and Consequences



In this activity, you will:

- Hold a discussion on the abuse of children's rights with your group

Facilitator's notes:

For this activity, you will need to have read all the background information on child abuse in order to engage in a general discussion with the group. You will not read out all the background information to them, but will need to understand it so as to explain the concepts to participants.

- ◆ **A definition of child abuse:** Broadly speaking, child abuse involves an adult harming a child. Child abuse occurs when someone does something hurtful to a child or by someone not doing something to provide for or to protect a child.

Child abuse is not new. For centuries children have been abused. In recent years, the media has made us more aware of cases of child abuse. Studies in child development have indicated that what happens in our childhood has a great impact on our adult lives. Therefore, children should be viewed as people who have the right to be protected.

- ◆ **Who abuses children?** Child abusers include a wide range of people. They do not have anything about them that makes them look different from anybody else. They can be parents, grandparents, older brothers and sisters, uncles, aunties, neighbours, teachers, leaders in organisations and churches, childcare workers and baby sitters. There are many people who harm children, sometimes without even deliberately setting out to do so. Whatever the reasons adults give for harming children, there is never any valid excuse for abusing children. The abuse of children violates the rights of the child.

- ◆ **Factors that contribute to increased child abuse or exploitation:**

- Poverty
- Death of parents
- Lack of good parenting skills
- Marriage break-ups
- HIV/AIDS in families
- Alcohol or drug-induced violence
- Lack of social support networks
- Conflicts and wars.

- ◆ **The consequences of child abuse:**

- Mental and emotional suffering
- Street children
- Children getting infected with HIV/AIDS
- Substance abuse
- Self-rejection
- Depression
- Poor performance at school
- Dropping out of school
- Suicidal tendencies
- Early marriages
- Low self-esteem in children
- Early parenting.



Forms of child abuse:



Physical abuse - when a child's body is injured through punching, hitting, beating, shaking, biting, child sacrifice, burning or any other harmful actions. Physical abuse often manifests as bruises, swellings and broken bones.

Is physical punishment child abuse? This is a common question without an easy answer. WV does not condone physical punishment. Sometimes physical punishment goes too far and results in a child's body being injured. This may be anything from mild bruising to death. To answer this question for yourself, ask yourself: *Would I like someone to do this to me?*



Emotional abuse - when a child's self-esteem, confidence and sense of worth is destroyed by someone's behaviour towards the child. It includes constant criticism, belittling, blaming, 'put-downs', withdrawals of affection, ignoring, excessive teasing and nicknaming children who are infected with HIV/AIDS.



Neglect - Failure to provide a child with basic needs such as food, shelter, clothing, hygiene, education, adequate supervision, medical and dental care, love and affection, and other necessities of life.



Child labour - Refers to work which is hazardous by its nature and the circumstances under which it is performed; and which jeopardises the health, safety and morals of a child. This is not acceptable. Examples of work which are dangerous to children include:

- Domestic service by children
- Commercial sex exploitation
- Children in self-employment on the streets
- Children in commercial agriculture.

This is in contrast to child-appropriate work, which includes a child helping with such activities as cooking, washing and fetching firewood or water. Children learn by observation and supervision, and child work prepares children for the roles they are expected to take on during their adulthood and is therefore acceptable. A child should not, however, be forced to do all the manual labour of the family, at the expense of their attending school. Any forced labour that negatively affects the health and well-being of a child, constitutes abuse.



Sexual abuse - Refers to an adult involving a child in sexual activity. Sexual abuse includes sexual suggestions, exhibitionism, inappropriate touching and penetration of the private parts (genital or anal areas) of a child, masturbation, oral sex and rape. Examples of sexual abuse include rape, incest, sexual harassment and forced early marriages. It is not uncommon for a person who sexually harms one sibling in the house, to do the same to the other children.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 3



To facilitate this activity:

- 1 Explain to the group that although children do have rights that are enshrined in law, these rights are often violated. We may speak of certain violations of children's rights as child abuse.
- 2 Part 1 of this activity will deal with the different forms of child abuse. Label the top of a sheet of flipchart paper: *Forms of Child Abuse*. Go through the five forms of abuse one by one, explaining each to the group. Begin with *Physical Abuse*. Give some examples (for example, kicking, hitting, or burning). Ask the group if they agree that these are examples of abuse, and thus are examples of the violation of children's rights. Ask them if they think these forms of abuse exist in their community.
- 3 You may then ask for two volunteers to come up and dramatise or act out *Physical Abuse*. One will play the role of the abuser and one will play the role of the child. The 'abuser' will not actually hit or kick, but will only pretend to. The volunteer playing the role of the child should act out the effect that this has on the child, for example sadness, fear or anger. The important point here is that participants get a sense of what it's like to be in a child's shoes.
- 4 Repeat for the remaining four types of child abuse, i.e. *Emotional Abuse*, *Neglect*, *Child Labour* and *Sexual Abuse*. You may ask for volunteers to role-play each example (with the exception of sexual abuse). In each instance, ask the participants if they agree that these are examples of the violation of children's rights, and if they believe such violations occur in their community.
- 5 Distribute Handout 3 so that the participants have a copy of the five forms of abuse.
- 6 For Part 2 of this activity, divide the participants into groups. Ask them: *Why do adults abuse children?* Groups should brainstorm the **causes** of, or factors that contribute to, child abuse. They should write their ideas on flipchart paper, or on Handout 3. Allow ten minutes for this.
- 7 Then groups should brainstorm the **consequences** of child abuse: that is, the effects that abuse has on the child. The groups should then present their ideas in plenary. Review and amend responses according to your facilitator's notes.

Note:

You may conduct this as a discussion activity only, if that suits your timeframes and the literacy level of the group.



Activity 4 The Sexual Abuse of Children



In this activity, you will:

- Hold a group discussion on the sexual abuse of children

Facilitator's notes:

Prior to carrying out this activity, please read the handouts on sexual abuse that accompany this activity. They contain a great deal of information on different aspects of child sexual abuse. You will not read this paper to the group, but you should understand the information.

Some topics covered in the handouts on sexual abuse as a violation of children's rights are:

- ◆ Steps to take to help children against sexual abuse in the community
- ◆ The forms of child sexual abuse
- ◆ How sexual abuse harms children
- ◆ The signs of child sexual abuse
 - physical signs
 - emotional signs
- ◆ Keeping children safe
 - what parents can do
 - what can be done to protect OVC in particular
- ◆ How to handle cases of the sexual abuse of children.



For this activity you will need:

- Flipchart and markers
- Copies of Handouts 3, 4, 5 and 6

To facilitate this activity:



- 1 For this activity, you will hold a group discussion about the sexual abuse of children. Use the handouts as a guide to introducing this sensitive topic. You can use the points from your facilitator's notes above to help you guide the discussion. Write these up on the flipchart as you discuss them.
- 2 Encourage participant questions which you should be able to answer based on your reading of the handouts. You will also be giving participants information for their home visitor's handbook, so they will be equipped to deal with this sensitive topic.

3 Hand out copies of Handouts 4, 5 and 6 to participants.

These handouts deal with:

- ◆ Handout 4 - *The signs of sexual abuse in children* (physical, psychological and behavioural)
- ◆ Handout 5 - *Guidelines for parents and guardians to help prevent sexual abuse*
- ◆ Handout 6 - *Steps to take when child sexual abuse is suspected.*

These handouts are information pages that participants will read and keep as reference guides for inclusion in their home visitor's handbooks.

Handout 4 - Module I - Topic 4
Sexual Abuse of Children

Possible signs of sexual abuse in children

The following list of possible signs of sexual abuse do not mean that sexual abuse has absolutely occurred, but such signs must not be ignored. If a home visitor or guardian thinks that a child displays the signs of possible sexual abuse, they should contact the CCDC who should have a mechanism in place for child protection, psychological and medical support, and referrals. Under no circumstances should home visitors try to determine sexual abuse on their own. If they do so, this could be considered further abuse of a child's rights and dignity and may be against the law. Only a person qualified to physically examine a child, should be allowed to do so.

Physical Signs (girls):

- Tearing, unusual bleeding and discharge (pus) from the vagina
- Pain in the area of the vagina
- Need for frequent urination (which could indicate an infection).

Physical Signs (boys and girls):

- Tearing of and bleeding from the maz (child's bottom)
- Pain in area of the penis.

Behavioural changes in boys and girls:

- Depression, withdrawing and loss of interest in life
- Difficulty in sleeping and nightmares
- Over- and under-eating and sudden weight gain or loss
- Clinging to other people
- Frequent crying for no obvious reason
- Doing less well at school or avoiding school
- Staying away from people or not trusting people
- Washing too often or not at all
- Seeking attention
- Self-destructive behaviour
- Sexual knowledge and sexual behaviour not normal in a child.

Handout 5 - Module I - Topic 4
Sexual Abuse of Children

Guidelines for caregivers to help prevent sexual abuse

Parents / guardians / caregivers:

- Show affection and attention to your child. Children who do not feel loved are more likely to be sexually abused because they seek attention from others.
- Talk to children about child sexual abuse. Ask them if they are worried or uncomfortable about anything that someone said or did to them. This is the responsibility of both male and female parents or caregivers.
- Be cautious about who looks after your children.
- Do not send them to stay with other people, if possible.
- Do not send your children out alone, especially after dark.
- Teach your children self-defence and life skills.
- Treat children well.
- If children are in your care, behave like a good parent. Think about the dangers of sexual abuse and teach the child how to protect him or herself.

Tell your children:

- To be careful of being alone with anyone who could abuse them.
- That if someone frightens them, they must run away and shout loudly for help.
- To avoid dark or lonely places like isolated well-sides and empty buildings (even shacks).
- To avoid walking around on their own and to stay in a group, if possible.
- To avoid other people's bedrooms and bathrooms.
- Not to go to public toilets or latrines on their own.
- To think about what they wear.
- That even friends can sexually abuse them.
- To report anyone who tells them to do anything that makes them feel uncomfortable and may lead to sexual abuse.
- Not to accept a present or money from a stranger or someone who they wouldn't normally expect it from.
- Not to enter the vehicle of an unknown adult, even if that adult seems friendly.
- Not to go into the houses of neighbours, teachers, religious leaders or other adults on their own.

Handout 6 - Module I - Topic 4
Sexual Abuse of Children

Steps to take when sexual abuse of a child is suspected

With the child:
Listen calmly to the child's story – it is very difficult for a child to talk about sexual abuse. The child may have been threatened with harm or even death by the abuser if they tell what happened. You should help them report the incident to the nearest authorities. There are often specially trained police at police stations that a child can speak to.

Child sexual abuse can also be reported to local council leaders, probation officers, teachers, community development officers, or child rights services. Your CCDC and/or your home visitor trainer should have explained the correct channels for you to follow if you suspect that one of the children you are visiting has been abused. In the space below, record the authority in your community where you can report suspected cases of child abuse to.

Report to: _____

Medical assistance:
If the child has been sexually assaulted, he or she will need medical attention. If possible, two healthcare workers should examine the child, ideally those appointed by the police. This must be done within 24 hours and before the child bathes or washes his/her clothes, especially underwear. Keep the clothes in a plastic bag and give them to the police to preserve the evidence of the crime.

Review of steps to take:

- Comfort and reassure the child, provide the child with loving care and a safe place to talk.
- Inform the parent or guardian.
- Do not tamper with evidence: clothes, blood stains and bruises should not be washed.
- The child should not wash or bathe before a medical examination.
- Torn dresses or pants should not be washed before reporting to the police or other authority – they will be used as evidence.
- Take action: report the case of abuse to the authority you have identified during your training.

Activity 5 Protecting Children



In this activity, you will:

- Engage the group in an exercise which will highlight child protection issues

Facilitator's notes:

In this topic, there is much information about children's rights and child abuse. Many adults will understand the importance of protecting children on an intellectual level, but this activity will help participants to focus on child protection issues by engaging them emotionally. Children differ from adults in many ways. They have unique needs and they need protection and care. In this exercise, participants will experience the sense of a child's feelings of helplessness, powerlessness, fear and being vulnerable in an adult world. The balloon game will help adults to relate to the children's emotions and help them to empathise with the children more directly.



For this activity you will need:

- Inflated balloons attached to pieces of string about 30 cm long



40 minutes

To facilitate this activity:

- Divide participants into four groups. Each group will be given separate instructions, which the other groups should not hear. Participants in group 1 will tie balloons to their ankles. Participants in group 2 will each find a person with a balloon to protect so that their balloon is not popped. They are instructed not to speak. Group 3 are instructed to pop all the balloons as quickly as possible. Group 4 should simply observe the action.
- When the groups are ready, start the game on your shout of 'Go!'. It should only take a couple of minutes before all the balloons are popped.
- To debrief the game, get the participants back into their groups and ask the first three groups in turn what they felt; and ask the fourth group what they saw. The first two groups probably felt under attack from the third group, who most likely seemed more organised as a group. Ask the groups what they needed to know so that they could have been more prepared. Likely responses from group 1 are that they needed to know what they would be facing so that they could prepare themselves. Likewise, group 2 probably felt that they needed to work together more.
- Then tell the participants that group 1 represented children; group 2 represented the adults who try to protect children; and group 3 represented adults who disregard the rights of children, and abuse or exploit them. Group 4 represented the observers in a community who know and see that children are being abused, but choose not to say or do anything about it out of fear or ignorance. In the light of this information, let the participants discuss issues of child protection. Focus the discussion on ways that the barriers of fear, guilt or ignorance can be broken so that the 'observers' in a community can also begin to engage in the process of protecting children.

Activity 6**Preparing for Home Visits: Monitoring for Signs of Child Abuse****In this activity, you will:**

- Discuss monitoring for signs of child abuse when making home visits

Facilitator's notes:

It is often the case that OVC are more vulnerable to abuse and exploitation and have their rights violated more often than other children. These children may be infected with HIV themselves, or they may be children who have sick parents. They may be mentally or physically disabled children who are denied access to schooling or adequate care and who may be hidden from the community. Orphans and vulnerable children need to be protected, but it is often these children who suffer the most discrimination and abuse in the community.

In this activity, you will review the handouts dealing with signs of abuse with participants. The handouts will form part of their home visitor's handbooks and they will use them as references to monitor any signs of child abuse when making a home visit. Participants will also plan a course of action to be taken (with appropriate referrals) if they do encounter any signs of abuse, in accordance with the services available in the community and the prior decisions of the CCC.

**For this activity you will need:**

- Copies of Handouts 1 to 6 (from Activities 1 to 4)

**To facilitate this activity:**

- 1 Explain to participants that OVC have their rights violated more often than other children. Orphans and vulnerable children need to be protected, but it is often these children who suffer the most discrimination and abuse in the community. For this reason, when making home visits to OVC, participants will be monitoring for signs of abuse.
- 2 Participants have learned to identify the different forms of abuse, and have paid close attention to the signs of sexual and physical abuse. Discuss with the participants the steps that they should take when they suspect or have evidence of any form of abuse in the households they are visiting.
- 3 Decide on a course of action (with appropriate referrals) in accordance with the services available in the community and the prior decisions of the CCC. Work with the participants until they are confident that they can successfully monitor OVC for abuse and take the necessary steps if abuse is suspected. The referral information should be listed on their referral sheet in their handbooks.

Have the participants include Handouts 1 to 6 in their home visitor's handbooks for reference.

Topic 5

The Implications of Gender-based Roles for OVC

| | |
|---|------------|
| Introduction and Objectives for Topic 5 | 138 |
| | |
| Activity 1: The Gender Roles of Girls and Boys | 139 |
| | |
| Activity 2: The Advantages and Disadvantages of Gender-based Roles | 141 |
| | |
| Activity 3: Strategies to Overcome Gender-based Discrimination | 143 |
| | |
| Activity 4: Preparing for Home Visits: Gender Awareness | 145 |
| | |
| Activity 5: Review of the Home Visitor's Handbook | 146 |

Introduction and Objectives for Topic 5

Children are often labeled by virtue of their gender (as either boys or girls). Gender refers to the roles and behaviours associated with being male and female, and is a socially and culturally constructed concept. Gender norms are not universal and change over time and across cultures.

Gender is associated with privileges, opportunities and access to various services. Gender roles are acquired through a process of socialisation and through the culture of a particular society. For example, often boys are encouraged in behaviour considered to display male traits and girls encouraged in behaviour considered to display female traits. Gender roles are enforced through toys given to children (guns for boys, dolls for girls), the kind of discipline meted out, the education they receive, jobs they have to do in the household, the careers to which they might aspire, and the portrayal of men and women in the media. These social and cultural practices usually discriminate against female children.

Although they are discriminated against more and thus have reason to question gender stereotyping, women and girls are not the only ones who should be involved in issues of gender. Men and boys need to understand that attitudes that condone male domination over women and girls are the cause of many social problems in communities, and are not necessarily valid gauges of manhood. They would gain more self-esteem and respect from others by supporting the equal development and education of girls so that they can fulfill their potential in society. Parents and guardians also need to appreciate the equality of all children regardless of gender, especially the advantages of educating, supporting and protecting girl children.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Define what gender means.
- ◆ Describe the roles that are socially ascribed to girls and boys.
- ◆ Discuss the advantages and disadvantages of gender-based roles for the future development of children and communities.
- ◆ Discuss possible strategies for overcoming gender-based discrimination against children, especially girl children.



Activity 1 The Gender Roles of Girls and Boys



In this activity, you will:

- Define what gender means and what gender roles are

Facilitator's notes:

In this activity you will define what gender means, and then discuss gender roles with your group.

Definition of gender:

Gender refers to the roles and behaviours associated with being female and male; and is a socially and culturally constructed concept. Gender norms are not universal and change over time and across cultures. Gender is associated with privileges and opportunities. A useful way to describe gender to participants is to compare it with the concept of a person's sex – sex is a person's biological make-up; while gender is a person's cultural and social make-up, based on whether they are male or female. Gender roles are thus acquired through a process of socialisation through the culture of a particular society.

Examples of gender roles are boys being encouraged to behave in ways that are considered male; and girls encouraged in behaviour considered to display female traits. Gender roles are enforced through toys given to children (guns for boys, dolls for girls), what education they receive, the careers to which they might aspire, and the portrayal of men and women in the media. Many social and cultural practices discriminate against girl children.

Roles usually undertaken by boys and girls (you may add others):



Some roles usually assigned to boys:

- Farming / tending crops
- Hunting
- Playing football
- Tending to goats and cattle
- Building.



Some roles usually assigned to girls:

- Baby-sitting
- Cooking and serving food
- Sweeping and cleaning the house
- Nursing/caring for the sick and children
- Grinding grain
- Attending to visitors
- Cleaning utensils
- Making mats and baskets for home use
- Washing clothes.

Examples of activities usually ascribed to both girls and boys (you may add others):

- Digging or tending gardens
- Going to school
- Shopping
- Fetching firewood
- Fetching water.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:



- 1 Start the activity by defining to the group what *gender* is. Explain the difference between sex and gender; and how gender is socially and culturally constructed. Use your facilitator notes to discuss gender roles and, importantly, explain that gender roles and responsibilities often place girl children at a disadvantage.
- 2 Divide the participants into groups. Explain that each group should think about the common roles – or common jobs, tasks or functions – that are generally assigned to girls, and others that are generally assigned to boys. Give them some time to discuss and brainstorm this in their groups and come up with a list of roles for girls and a list of roles for boys.
- 3 Volunteers from each group should then select one example that he or she will role-play in plenary. For example: a role-play of a girl grinding millet, or a boy tending to goats. Note that a woman can role-play a boy's role, or vice-versa. The other participants will try to guess the activity being demonstrated, and will guess whether they think it is a boy or a girl carrying out the activity. You can write up on the flipchart the roles that are acted out by participants.
- 4 Distribute Handout 1 to participants and summarise gender roles and responsibilities by going through the lists with the group. Get them to add any other examples that are not listed on the handout.
- 5 Discuss with participants whether they think there is an imbalance of roles between girls and boys; and whether this has any effect on their development. For example, do girls and boys have the same education and recreation opportunities? These questions are dealt with in the next activities.

Handout 1 - Module 1 - Topic 2
Gender Roles of Boys and Girls

| Examples of gender-based roles | Examples of roles usually assigned to boys: |
|--------------------------------|---|
| | |
| | |
| | |
| | |

Examples of roles usually assigned to girls:

| | |
|--|--|
| | |
| | |
| | |
| | |

Examples of roles usually assigned to both girls and boys:

| | |
|--|--|
| | |
| | |
| | |
| | |

Activity 2 The Advantages and Disadvantages of Gender-based Roles



In this activity, you will:

- Discuss the advantages and disadvantages of gender roles, especially for girls

Facilitator's notes:

This activity expands on the last activity and looks at the advantages and, especially, the disadvantages of gender roles. Given that gender roles would usually be accepted within a cultural group, you will need to conduct the discussion in a loaded way, so as to stimulate more critical responses from participants. Be especially aware of this when discussing the disadvantages of ascribed gender roles and emphasise how gender roles commonly discriminate against women.

In discussing this sensitive topic, you may find it useful to highlight the difference between social behaviours and cultural norms. Social behaviour, such as men's violence against women, may not be a cultural norm in a society. Similarly, discrimination against girl children getting an adequate education may have no real foundation in a society's norms.

General disadvantages of gender roles, especially for girls:

- Lack of access to information and schooling, because of the nature and long hours of girls' work
- Low levels of education and life skills because girls are often withdrawn from school to look after siblings and sick parents
- Early marriages due to lack of education and economic independence
- Girls become commercial sex workers due to economic vulnerability
- Violence against women
- Risk of unprotected sex because girls lack adequate knowledge and information
- Rape and difficulty in negotiating for safer sex for many girls, exposing them to high risk of HIV infection
- Male drunkenness and drug abuse impacting on the physical safety of girls.



Cultural and social considerations:

Often married and unmarried men have multiple partners, including sex workers, and this behaviour is socially accepted. Cultural attitudes condone or even encourage male sexual freedom and repress female sexuality. The practice of multiple partners and commercial sex services places girls and women at risk. It is a significant factor in promoting the spread of HIV/AIDS, thus fuelling the problems that further lead to orphans and vulnerable children. In many other cases, women are expected to have relations with, or marry, older men who are more experienced and more likely to be infected with HIV. Men may also seek younger partners in order to avoid infection; and in the unfounded belief that sex with a virgin cures AIDS and other diseases.

The consequences of discrimination against women - major issues to highlight:

- Violence against women, including all forms of coerced or forced sex
- Harmful traditional practices
- Stigma and discrimination associated with AIDS – violence, abandonment and neglect
- Lack of access to HIV/AIDS education, prevention and services for adolescents
- Sexual abuse of girls, lack of control over sexuality and sexual relationships
- Poor reproductive and sexual health
- Neglect of health needs, nutrition and medical care
- Issues of partners not disclosing HIV status (partner notification vs. total confidentiality) and thus the practise of unsafe sex.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2

To facilitate this activity:



45 minutes

- 1 Start the activity by asking the group to first brainstorm the advantages of dividing roles according to gender. Write these responses up on the flipchart.
- 2 Then ask them to brainstorm the disadvantages of dividing roles. Spend more time discussing the disadvantages. Introduce this in a loaded way, in order to elicit some of the discrimination commonly directed towards women. For example, ask questions such as:
 - Do you think there are disadvantages for women in this way of dividing things?
 - Do you think these gender roles are fair and equal; or unfair and unequal?
 - What are some of the negative effects on women of the way society views and treats boys and girls, or men and women?
 These are loaded questions and they should stimulate a good debate on the disadvantages of ascribed gender roles. Write participants' responses up on the flipchart.
- 3 Give out Handout 2 and go through the list of disadvantages of gender roles for girls and women. Discuss gender roles in the light of cultural considerations. Point out that cultural customs and norms may differ from accepted social behaviours and that negative social behaviour (such as men's drinking or the abuse of women) are not usually culturally endorsed, and so should not be automatically socially condoned. Highlight the negative effects that gender roles can have on a community, especially how these place girls and women at risk, thus promoting the spread of HIV and further fuelling the problems that lead to the vulnerability of children.
- 4 Conclude the session by leaving participants with the following two thoughts:
 - ◆ Girls, especially, are discriminated against on the basis of gender. They are socialised to be 'servants' of boys or men. This increases their risk of HIV infection. While gender-based discrimination affects individual children, it also affects the entire family and society as a whole.
 - ◆ Everything God made is good; and we are God-made and well-made. We are special not because we are girls or boys, but because we are all human beings created in God's image.

Activity 3 Strategies to Overcome Gender-based Discrimination



In this activity, you will:

- Discuss strategies to overcome gender-based discrimination

Facilitator's notes:

In this activity, you will lead the discussion on from the disadvantages of gender-based roles to exploring strategies to overcome gender-based discrimination against girls and women, and also orphans and vulnerable children, so that they may reach their full potential in life.

Key strategies in overcoming gender-based discrimination:

- Creating community gender awareness
- Facilitating access to education, information and services for women and girls
- Sensitising and mobilising men and boys to stop discriminating against girls and women
- Sensitising and mobilising men and boys to stop exploiting girls and women
- Creating a supportive and enabling environment for girls and women
- Providing gender-sensitive services
- Combating violence against women.

Examples of interventions and approaches that build gender awareness and self-esteem among girls:

- Using drama and visual arts to help women 'discover' their abilities and talents
- Role-plays that enhance life skills, self-esteem and a sense of worth
- Youth groups where both girls and boys challenge gender stereotyping
- Vocational training in productive, communication and management skills
- Peer education programmes
- Enhancing the development of girl children, as attitude changes begin in childhood
- Supporting boys to change their attitudes about girls' roles.



Remember: girls can be scientists and boys can be chefs!

Parents and guardians can play a primary role in overcoming gender-based discrimination by talking to children about sexuality and related issues. The approaches below are some community interventions that are needed help to inform children and parents about sexuality and gender issues. These are critical steps to help combat discrimination against women and girls which will help to stop the spread of HIV/AIDS:

- Media campaigns can help challenge discrimination against women and girls.
- NGOs and schools can offer courses and activities for school children and out-of-school youth that explore gender relations, values, sexuality and related issues. Stressing the effects of positive, as well as negative, peer pressure is an important component of such programmes.
- Teachers and youth workers can be trained in gender education.
- Training of youth peer educators (both girls and boys) in gender education.
- Advocacy work must be done to change customary and written laws so women have legal recourse in cases of abuse, loss of maintenance and discrimination over inheritance. (Many women are unaware of their rights and don't know that they are legally protected against certain abuses. More can be done to make the law accessible to women and to promote their capacity to understand and assert their rights.)

Developing gender-sensitive services will involve addressing the specific needs of girls and boys regarding schooling, protection, access to food and health services, psychosocial support and sexual education and life skills. These are dealt with further in later modules.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- 1 To start the activity, divide participants again into groups. Ask them to brainstorm strategies for overcoming gender-based discrimination in their community. Groups will then report back in plenary. Summarise their ideas on flipchart paper.
- 2 Facilitate a discussion based on the results of the report-back, drawing from the information in your facilitator's notes.
- 3 If time permits, you can lead a further discussion on community resources and structures that could help to overcome discrimination against girls, women and OVC in particular. These could be researched by participants and used as reference in their home visitor's handbook. Examples could be clinics which hand out information on sexual health and HIV, or local community centres that offer vocational or career training for older youth.

Activity 4 Preparing for Home Visits: Gender Awareness



In this activity, you will:

- Review the topics dealt with so far in the light of gender considerations and discuss recommendations on how to support girl OVC, in particular

Facilitator's notes:

In this activity, you will explain to the participants that when they make home visits they need to give equal attention to both girl and boy OVC. The things they have learned so far in this module – how to explain basic information about HIV/AIDS, how to assess the types of support that the OVC might need, how to recognise the signs of abuse and what steps to take, for example – are equally applicable to girls as they are to boys.

Nevertheless, it is true that girls, in general and on average, are usually more disadvantaged and vulnerable than boys. Recognising this, participants should think of some ways in which they can specifically focus their efforts on improving the situation of the girl OVC that they will be visiting. Part of this activity will be for participants to create a new page for their home visitor's handbooks, entitled: *Actions to Support Girl OVC during Home Visits*. This page will consist of participants' own ideas, either as individuals or in groups. This page can then serve as a reference guide to be included in their handbooks.



For this activity you will need:

- Flipchart and markers
- Sheets of blank paper for participants to write on

To facilitate this activity:



- Start the activity by quickly summarising the topics discussed earlier in this module. Then explain that, although all OVC are vulnerable, girl OVC, in general and on average, are usually more disadvantaged and vulnerable than boys. Participants should think of some ways in which they can specifically focus their efforts on improving the situation of the girl OVC that they will be visiting. The participants should come up with their own ideas, either as individuals or in groups. Since it is often male attitudes that endorse gender stereotyping to the disadvantage of girls, participants should be encouraged to think of ways of engaging men and boys to help improve the situation of girls in their community.
- Hand out sheets of paper for participants to write on. You will write up responses on the flipchart and participants can record these ideas on paper, under the heading *Actions to Support Girl OVC during Home Visits*.
- Tell participants that this page can then serve as a reference guide to be included in their home visitor's handbooks.



Activity 5 ➤ Review of the Home Visitor's Handbook



In this activity, you will:

- Review the home visitor's handbooks with participants

Facilitator's notes:

You have now finished your first module of the home visitor training. At this point it is a good idea to review the home visitor's handbooks with the participants to ensure that each participant has compiled all the necessary pages. The home visitor's handbook should now include the following reference pages from the five topics discussed in this module:



Home Visitor's Handbook – Module One

Topic 1: Basic Information on HIV/AIDS

- What are HIV and AIDS?
- How is HIV Transmitted?
- Ways of Preventing HIV Infection
- Referral Information (participants' own worksheet)

Topic 2: The Impact of HIV/AIDS

- Defining *Psychological* and *Socio-economic*
- The Impact of HIV/AIDS on Children, Families and Communities

Topic 3: National Frameworks for Supporting OVC

- Government Strategies on Children's Rights
- Stakeholders' Roles in the Support of OVC
- The Seven Components of OVC Support
- Elements of OVC Support (participants' own checklist of questions)

Topic 4: Children's Rights and how they apply to the Support of OVC

- The Meaning of Children's Rights
- Categories of Children's Rights
- The Abuse of Children
- Sexual Abuse of Children (three handouts)

Topic 5: The Implications of Gender-based Roles for OVC

- Gender Roles of Boys and Girls (two handouts)
- Actions to Support Girl OVC during Home Visits (participants' own worksheet)

MODULE 2

Addressing the Psychosocial and Spiritual Needs of OVC and Their Caregivers

| | | |
|----------------|--|------------|
| Topic 1 | The Different Needs of OVC | 147 |
| Topic 2 | Psychosocial Support for OVC | 155 |
| Topic 3 | The Stages of Development and Understanding in Children | 159 |
| Topic 4 | Counselling and Communicating with OVC | 173 |
| Topic 5 | Accompanying OVC through Grief and Bereavement | 185 |
| Topic 6 | Using Play in Counselling OVC | 195 |
| Topic 7 | Spiritual Care for OVC | 201 |
| Topic 8 | Support for Caregivers | 207 |

Topic 1

The Different Needs of OVC

| | |
|---|------------|
| Introduction and Objectives for Topic 1 | 148 |
| | |
| Activity 1: The Different Needs of Children | 149 |
| | |
| Activity 2: How Children React to Unmet Needs | 151 |
| | |
| Activity 3: Problems Experienced by OVC in the Community | 152 |
| | |
| Activity 4: Preparing for Home Visits: OVC Needs | 154 |

Introduction and Objectives for Topic 1

Orphans and vulnerable children often find themselves in difficult situations in which their basic needs are neglected. They may also have special needs because of their vulnerable status. They will likely have suffered the sickness and eventual death of one or more caregiver and associated economic hardships. They may face malnutrition, lack of basic care and protection, a lack of practical life skills, and more. The stresses to which they are subjected may result in emotional instability, guilt, depression and psychosocial trauma. All of these problems will affect these children's future well-being. It is therefore important to attend to the various needs of these children to ensure that they live meaningful lives; and that they are supported with psychosocial, nutritional and healthcare requirements to ensure their healthy development and growth.

Some of the needs and problems that vulnerable children face have been discussed in Module 1, and are again reviewed in this topic. This topic also serves as an introduction to further topics on the needs of children in general, and vulnerable children in particular.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Discuss the different needs of children, and of vulnerable children in particular.
- ◆ Explain the different needs of children in relation to their age, and what signs they display when needs are not met.
- ◆ Describe the problems faced by orphans and vulnerable children in their communities.
- ◆ Explain the effects of these problems.
- ◆ Discuss indicators of problems in children.



Activity 1 The Different Needs of Children



In this activity, you will:

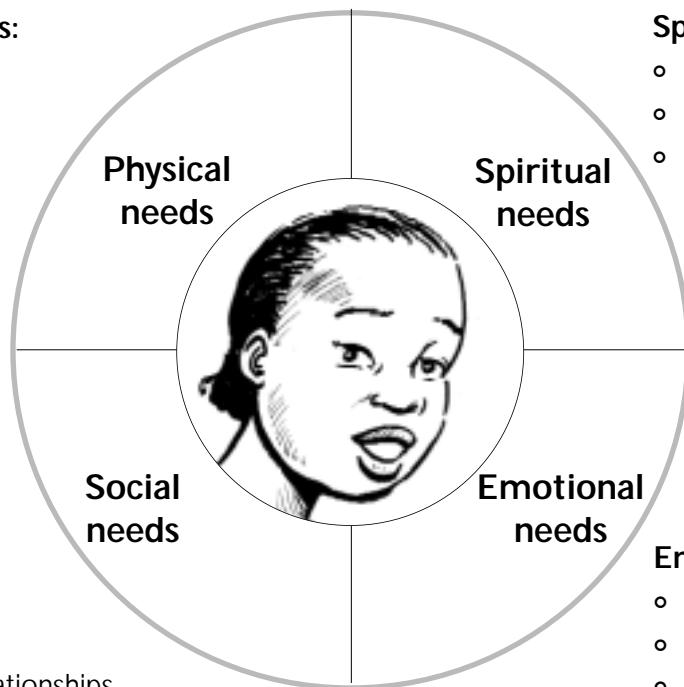
- Discuss the different kinds of needs that children have

Facilitator's notes:

Children have many different needs as they grow up and develop. In this topic, participants will be given a wholistic view of children's needs, as outlined below. The different areas of a child's needs will be elaborated on further as the training course proceeds.

Physical needs:

- Clothing
- Food
- Shelter
- Medical care
- Protection



Spiritual needs:

- Faith and prayer
- Sense of hope for future
- Sense of moral life

Social needs:

- Schooling
- Play / leisure
- Friends / relationships

Emotional needs:

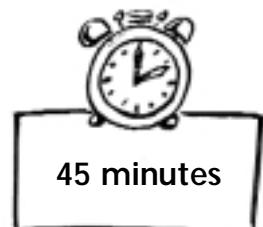
- Love
- Acceptance
- Care
- Being appreciated



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:

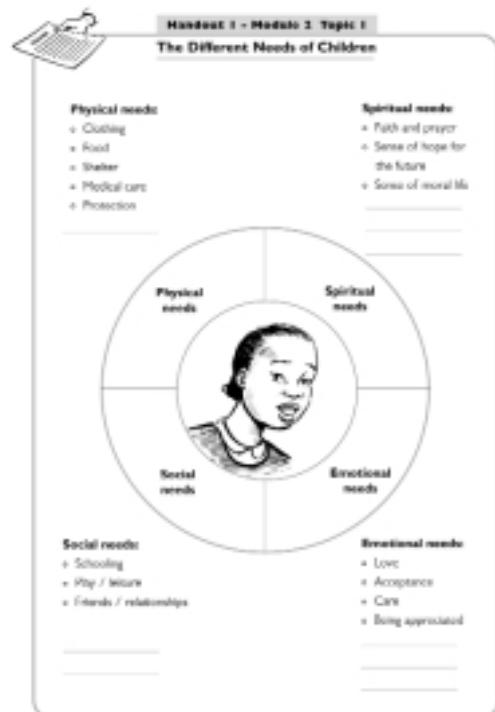


- 1 Divide the participants into four groups – one group representing *physical needs*, one group *social needs*, one group *emotional needs* and the last group the *spiritual needs* of a child. Ask each group to come up with a list of needs that all children have, in their particular category.
- 2 Once they have come up with ideas, each group should select one idea for a role-play. Allow a few minutes for participants to practise their roles.

- 3 The four groups then come together again in plenary. Each group will carry out their various role-plays. The rest of the participants should try to guess the need being demonstrated (for example, a role-play of a child eating demonstrates the physical need for food).
- 4 At the end of the activity you should have four lists – you may ask for a volunteer to transcribe these on to flipchart paper if literacy levels permit. Add any remaining ideas from your facilitator's notes. Discuss with the participants and summarise.
- 5 Hand out Handout 1 to participants for their reference.
- 6 Explain to participants that the next topics in this module will focus on physical needs. Ask participants to revisit the list of physical needs and explain that the next topics will focus on food security, nutrition and healthcare for vulnerable children, while the next module on equipping these children for the future will focus mainly on their social needs.

Note:

If, in the course of listing *physical needs*, participants strongly want to have a separate session on issues such as shelter and clothing, provide extra time for that. For example, you may get participants to talk about shelter by having a round in which each participant gives one suggestion on what is required for a good shelter in the community; and what happens when these requirements are not met. List the points up on the flipchart and discuss them with the group.



Similarly, you can use the same method to talk about other issues, such as the clothing needs of boys and girls. You may want to get the group to brainstorm ways in which home visitors can access clothing supplies for children in need.

Activity 2 How Children React to Unmet Needs



In this activity, you will:

- Understand children's behaviour in relation to unmet needs, according to their age and development

Facilitator's notes:

In this activity, you will discuss with participants how children react to unmet needs, according to their age and stage of development, as indicated in the table below.

| Age | Needs | Deeds (if needs not met) | Worst fear |
|---------------|--|---|---|
| 0 -1 year | Love Security Physical contact Bonding | Soiling Crying Irritability | 'I will starve' Abandonment |
| 1 -5 years | Approval Attention | Temper tantrums / disobedience Fear of dark Hyperactivity Bed wetting Eating problems | 'My parents will leave me' |
| 6 -12 years | Mastery of skills Recognition | Competition Fighting with friends and siblings Perseverance | 'I will never be good at anything' |
| 13 - 18 years | More freedom Sense of direction for future life Finding own values | Rebellion Rejection of parents' values. Experimentation in sex and in drug abuse | 'I won't be a success in life' 'I will repeat my parents' mistakes' 'Peers won't accept me' |



For this activity you will need:

- Flipchart and markers (optional)



45 minutes

To facilitate this activity:

- For this activity, you can once again make use of role-play. Explain that children have different priority needs at different ages. You may review these different needs with the participants.
- Then explain that children will react in different ways, again according to their age, when these needs are not met. You may ask for volunteers to act out each of the examples (i.e. crying, irritability, temper tantrums, fighting with friends and siblings or rejection of parents' values).
- Following the role-plays, explain that such behaviours are often the result of hidden fears and give examples based on your notes. Ask participants to suggest other fears that children may have, and how they might express those fears.

Activity 3 ➤ Problems Experienced by OVC in the Community



In this activity, you will:

- Discuss how aspects of community life affect OVC

Facilitator's notes:

In the last module, you discussed how children's environments affect their development and how they understand their world. In this activity, participants will explore how a community's lack of support and care for orphans and vulnerable children affects them.

Problems experienced by OVC in the community:

- Child labour and exploitation
- Sexual and physical abuse and rape
- Illness, including HIV/AIDS
- Lack of parental guidance and support
- Lack of food, shelter and clothing
- Dropping out from school
- Children heading their own families
- Caring for dying parents.

Effects of these problems on OVC:

- Children living on the streets
- Early marriages or pregnancy
- Self blame and self-rejection
- Depression
- Poor health and stunted growth
- Loss of concentration
- Violence
- Lack of care in physical appearance
- Engaging in substance abuse.

Indicators of Children's Problems

1. Sadness and irritability

Children who are unhappy will look sad, cry a lot and will not want to play. They may be depressed and withdrawn and may not react to what happens around them. Feelings may also be expressed as irritability or getting upset very easily.

2. Suspicion and lack of trust

Vulnerable children living on their own, in child-headed households or in other difficult circumstances, often have good reasons to be suspicious of people. They feel vulnerable and may be afraid that adults will take advantage of them or exploit them.

3. Anger and hostility

Some children may be hostile towards adults because they have been treated badly by adults and not cared for properly; or they may fear physical abuse or punishment.

4. Guilt, self-blame and shame

Children may be ashamed of what has happened to them, especially if they have been victims of rape or humiliation, or are disabled and bear the brunt of stigmatisation. They may blame themselves for not protecting their family or for surviving when others have died.

5. Loss of interest and energy

Usually children enjoy playing and display a lot of energy in doing so. A child who is miserable, worried or frightened may be depressed and will show no interest in doing anything and seems to lose her or his energy and appetite.

6. Poor concentration and restlessness

Children who are worried or unhappy often find it difficult to concentrate. They may be very tense and restless. They may find it impossible to sit still and behave.

7. Aggression and destructiveness

Some children, especially young ones, become aggressive or destructive when they are experiencing strong emotions. Because they cannot put feelings into words, they may hit other people in the family or school friends when they feel tense, upset or frightened.

8. Isolation

If a child is on her or his own most of the time and never plays with other children or is rejected by them, she or he becomes isolated, loses trust in other children and experiences loneliness.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2



45 minutes

To facilitate this activity:

- 1 Remind the participants that negative behaviour usually stems from unmet needs and hidden fears. Divide the participants in groups and ask them to discuss the types of problems that OVC in the community are experiencing. Ask them, at the same time, to think of what the effects of these problems will be, if they continue to go unaddressed. Come together again in plenary and review the results. Add ideas from your facilitator's notes if needed.
- 2 Explain to the participants that there are certain signs that we can look for to discover whether a child is experiencing problems. Ask the participants first for their ideas, then review the indicators in your facilitator's notes with the participants. It is possible that some of these indicators were not recognised as a sign of trouble by the participants. For example, that if a child is unable to concentrate at school, this may be a sign of a problem.
- 3 Hand out Handout 2 and make sure the participants understand the various signs and indicators of children's problems.

Handout 3 - Module 3 - Topic 1
Indicators of Children's Problems

- 1. Mauless and irritability**
Children who are unhappy will look sad, very tired and will not want to play. They may be depressed and withdrawn and may not react to what happens around them. Feelings may also come out as irritability or getting upset very easily.
- 2. Suspicion and lack of trust**
Vulnerable children living on their own, in child-headed households or in other difficult circumstances, often have good reasons to be suspicious of people. They feel vulnerable and may be afraid that adults will take advantage of them or exploit them.
- 3. Anger and hostility**
Some children may feel hostile towards adults because they have been treated badly by adults and not cared for properly, or they may fear physical abuse or punishment.
- 4. Guilt, self-blame and shame**
OVC are often ashamed of what has happened to them, especially if they have been victims of rape or humiliation, or are disabled and bear the brunt of discrimination. They may blame themselves for not protecting their family or for something which seems fear-inducing.
- 5. Loss of interest and energy**
Usually children enjoy playing and display a lot of energy in doing so. A child who is miserable, worried or frightened may be depressed and will show no interest in doing anything and seems to lose her or his energy and appetite.
- 6. Poor concentration and restlessness**
Children who are worried or unhappy often find it difficult to concentrate. They may be very tense and restless. They may find it impossible to sit still and behave.
- 7. Aggression and destructiveness**
Some children, especially young ones, become aggressive or destructive when they are experiencing strong emotions. Because they cannot put feelings into words, they may hit other people in the family or school friends when they feel tense, upset or frightened.
- 8. Isolation**
If a child is on her or his own most of the time and never plays with other children or is rejected by them, she or he becomes isolated, loses trust in other children and experiences loneliness.

Activity 4 Preparing for Home Visits: OVC Needs



In this activity, you will:

- Review the information discussed in Topic 1, emphasising how it can be useful for participants making home visits to OVC

Facilitator's notes:

Explain to the participants that they should be attentive to all the different needs of the children they will be visiting. They should keep in mind the problems experienced by OVC and their effect on them. Refer the participants again to their home visitor's handbooks.



For this activity you will need:

- Flipchart and markers
- Handout 2 - *Indicators of Child Problems* from the last activity
- Extra sheets of blank paper



45 minutes

To facilitate this activity:

- Organise role-plays with pairs of participants. In each pair, one participant will act the role of a child (demonstrating the different indicators of problems); the other will play the role of a home visitor responding to the child. Circulate and give guidance to participants as they do their role-plays.
- Explain to the participants that they should be attentive to the indications of problems in the OVC they will be visiting in the community. Participants should include Handout 2 in their home visitor's handbooks and to refer both to this page and Handout 1 when determining whether children are having their needs met or not.
- Remind participants that many of the signs of a child's distress may not be immediately obvious during a home visit to OVC. For example, behaviours that indicate emotional stress may need to be viewed over time. One way to get information is to ask questions of caregivers or siblings about the children. Hand out sheets of paper so that participants can write up their own checklist of questions based on information in this topic, to get information about the children, such as:
 - Is the child attending school?
 - Does this child have friends?
 - Is the child happy, or depressed?
- These checklists will be included in their home visitor's handbook.
- Based on the outcome of their questions and the conclusions they reach when monitoring a child, a home visitor may need to refer a child in distress to a community service or the child protection mediator within the CCC, if there is one. Discuss with participants the possible steps to take when helping a child who is in distress. Participants should list services (such as counselling or health services) on their *Referral Information* page in their handbooks for future reference.

Topic 2

Psychosocial Support for OVC

Introduction and Objectives for Topic 2 156

Activity 1: What is *Psychosocial Support*? 157

Activity 2: What Psychosocial Support is Being Provided to OVC? 158

Introduction and Objectives for Topic 2

Many orphans and vulnerable children experience great distress and trauma. In this topic, you'll be exploring how mental or psychological stress and depression affects children and the impact it has on their emotional and mental development and well-being. Home visitors need to understand how children function psychologically and emotionally, in order to help them overcome their mental and spiritual anguish.

There is more emphasis placed by care organisations on the material or physical needs of OVC, but mental and spiritual support is also crucial to OVC's development and ability to live well-balanced lives in the future. Participants in the training course will learn counselling skills and work on strategies that will help OVC to cope with the many challenges that they face by strengthening their inner resources.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Define *Psychosocial Support* (PSS)
- ◆ Understand why psychosocial support is important in caring for vulnerable children.
- ◆ Identify the types of PSS being offered to OVC in their communities.



Activity 1 What is *Psychosocial Support*?



In this activity, you will:

- Define what is meant by *psychosocial support*

Facilitator's notes:

Psychosocial support (PSS) has been defined as an ongoing process of meeting children's physical, emotional, psychological, social, mental and spiritual needs. All of these are considered to be important elements in the growth and development of the children. Psychosocial support goes beyond meeting just the physical or material needs of the children.

Why do OVC need psychosocial support?

Many orphans and vulnerable children experience great distress, trauma and depression. Mental or psychological stress affects children and has a negative impact on their emotional and mental development and well-being. Mental and spiritual support is as important as material support to OVC's development and ability to live well-balanced lives in the future. Psychosocial support will enable OVC to strengthen their inner resources in order to cope with and overcome the many challenges they face.

Psychosocial support aims to :

- ◆ Strengthen the inner resources of the OVC
- ◆ Reduce and prevent the psychological impacts of HIV/AIDS on children
- ◆ Build resilience of OVC and enhance their coping capacities
- ◆ Build up the capacity of support systems for OVC
- ◆ Prepare children for the challenges and problems that they may encounter in their lives.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- 1 Explain to participants what *psychosocial* and what *psychosocial support* mean, as outlined in your facilitator's notes above. Write up the definitions on the flipchart.
- 2 Then discuss children's needs with the group. Take participants through the different aims of psychosocial support for OVC from your notes.
- 3 Divide the participants into groups. Ask them to discuss psychosocial support for orphans and vulnerable children further. They should come up with any other reasons that they think psychosocial support is especially important in OVC care. You should tell participants that they should also think about how the lack of psychosocial support will affect a child in need.
- 4 Back in plenary, get groups to volunteer any new points they may have come up with that can be added to your original list of aims for psychosocial support.

Activity 2 ➤ What Psychosocial Support is Being Provided to OVC?



In this activity, you will:

- Help participants identify what psychosocial support is being provided to OVC

Facilitator's notes:

In this activity, you will lead participants through a process to research and identify what different groups or bodies are doing to provide psychosocial support to orphans and vulnerable children in their community. Once they have done this, they will explore how existing structures that help OVC in material support in their community could be encouraged to take on this more comprehensive role if they potentially have the resources.



For this activity you will need:

- Flipchart and markers



To facilitate this activity:

- Divide the participants into groups. Ask them to brainstorm all the psychosocial support avenues that orphans and vulnerable children may have in their local communities. For example, these may be existing caregiver and guardian structures who give counselling to distressed children.
- After a few minutes, get groups to share their lists of existing psychosocial support providers in the community. You can write these points up on the flipchart.
- Then ask groups to consider whether these support providers are adequate for the needs of the orphans and vulnerable children in their community and CCC. If not, groups should think about what other existing structures in their community could help to take on this important role. For example, there may be potential services at a local clinic, or teachers who understand children well.
- When groups are ready, get them to share their lists of potential psychosocial support providers in the community. You can also write these points up on the flipchart. Then discuss with the participants that much of this module will deal with home visitors gaining the understanding and skills to be able to offer psychosocial support to vulnerable children themselves.

Topic 3

The Stages of Development and Understanding in Children

| | |
|---|-----|
| Introduction and Objectives for Topic 3 | 160 |
| Activity 1: Growth, Development and Change in Children | 161 |
| Activity 2: Indicators of Development in Children | 163 |
| Activity 3: Theories of Age and Understanding in Children | 165 |
| Activity 4: Environmental Factors in Children's Development | 167 |
| Activity 5: The Community's Role in Child Development | 169 |
| Activity 6: Preparing for Home Visits: Child Development | 170 |

Introduction and Objectives for Topic 3

Children below the age of 18 are growing mentally, emotionally and socially as they progress towards adulthood. What happens during this time of development and what a child experiences, greatly influences that child's future well-being. Growth and development are largely influenced by the environmental and psychosocial support, or lack of support, a child may experience.

In this section, participants will learn about how children develop physically, mentally and emotionally; and why it is important for children to have their developmental needs addressed adequately, so that they can grow up to be well-adjusted adults.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of growth and development in children.
- ◆ Discuss the changes that occur when a child is growing.
- ◆ Discuss indicators that show that a child is developing and functioning well.
- ◆ Discuss factors that influence how a child experiences and understands the world.
- ◆ Explain the role of communities in ensuring proper growth and development in children.



Activity 1 Growth, Development and Change in Children



In this activity, you will:

- Define growth, development and change in children

Facilitator's notes:

Definition of Growth and Development:

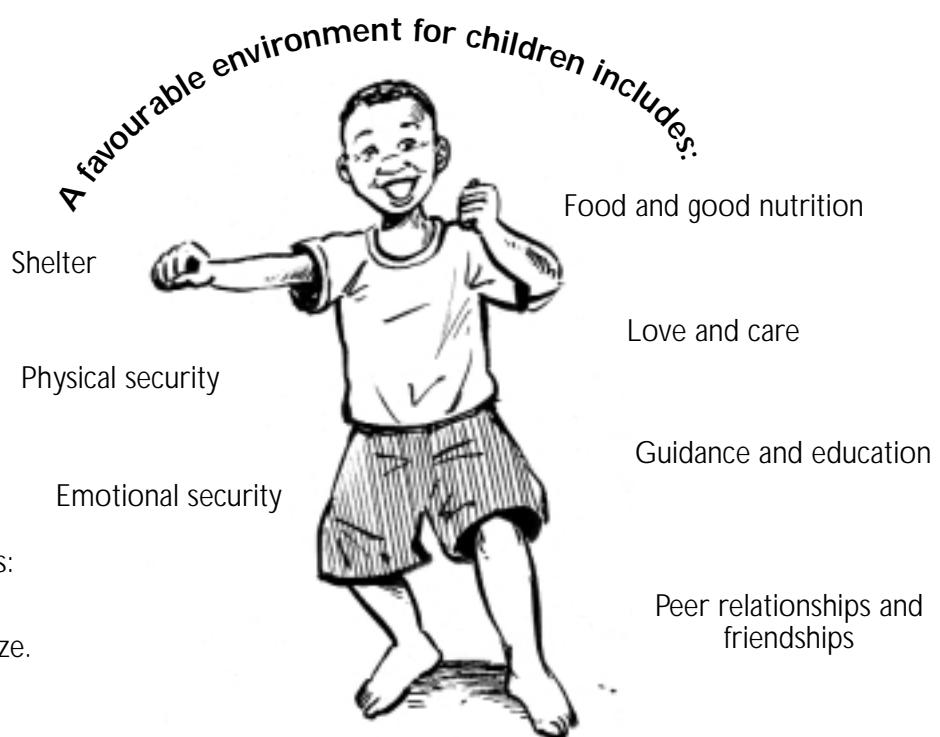
Growth refers to physical changes in the body, with special focus on the growth of the skeletal system (bones), muscles and the brain.

Physiological growth starts at conception and continues through to 25 years of age.

Development accompanies growth. At each stage of physical growth, we also expect social, psychological, cognitive (intellectual), emotional and moral development. (Cole and Cole, 2001)

Changes accompanying growth:

The changes that occur when a child is growing include physical, psychological/emotional, social and intellectual changes. For all these changes to take place at the right stage, the child's environment has to be favourable.



Examples of physical changes:

- Weight gain
- Increase in body size.

Examples of social changes:

- Formation of friendships
- Independent thinking.

Examples of intellectual changes:

- Taking independent decisions
- Becoming inquisitive
- Increased sensitivity to the environment around them.

**For this activity you will need:**

- Flipchart and markers

**30 minutes****To facilitate this activity:**

- 1 Start the activity by asking the participants what definitions they can come up with for *growth* (physiological changes) and *development* (psychosocial, cognitive and moral changes) in relation to a child growing up. Write up their definitions on the flipchart.
- 2 Once you have a list of definitions, review the answers based on the definitions in your facilitator's notes.
- 3 Then divide participants into four groups.
Ask each group to brainstorm different changes a child experiences, as follows:
 - Group 1: Brainstorm the physical changes a growing child undergoes
 - Group 2: Brainstorm the social changes a child undergoes
 - Group 3: Brainstorm the intellectual changes a child undergoes
 - Group 4: Brainstorm the moral and spiritual changes a child undergoes.
- 4 Have the groups come back together and present their conclusions to the plenary.
You can write each group's answers on the flipchart. Finally, review and summarise each group's conclusions.

Activity 2 Indicators of Development in Children



In this activity, you will:

- Discuss indicators or signs of either healthy development or poor development in children

Facilitator's notes:

This activity builds on the last one. You may want to briefly remind participants of the definitions for growth and development in children from the last activity. While a person may notice whether a child's body is growing properly or not, it is not always obvious whether a child is developing well emotionally, intellectually and spiritually.

Indicators are **outward signs**, usually displays of social behaviour and personal habits, that help to indicate a child's well-being. Explain to participants that, as home visitors, they should be aware of these signs in the children they visit. Signs of poor development in children will often be the result of deep distress and grief, and can be overcome through appropriate care and counselling.

In fact, they are often signals that a child needs help.

Indicators of healthy development in children:

- Playing, especially with other children
- Forming friendships
- Participating in decision-making
- Good appetite
- Peaceful sleep
- School attendance
- Good performance in school
- Participating in spiritual activities.

Indicators of possible problems in children:

- Lack of interest and energy in playing
- Isolation
- Inarticulate
- Displays of anger and hostility
- Sadness and depression
- Poor concentration and tiredness
- Aggressive behaviour.





For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



To facilitate this activity:

- 1 Ask participants to form two groups and ask them to do the following:

Group 1: To discuss and list the characteristics of a child who is developing well.

Group 2: To discuss and list the characteristics of a child who may not be developing well.

Explain that these characteristics are known as *indicators* or outward signs, usually displays of behaviour, of a child's well-being. When groups are ready, record their answers on the flipchart.

- 2 Hand out copies of Handout 1 and briefly go through these indicators with participants as they may not have been included on their group lists.
- 3 If time permits, have one or more volunteers from one group to act out the characteristics or indicators of a child who is developing well; and then get one or more volunteers from the other group to role-play the characteristics of a child who is developing poorly. Keep these role-plays short so that there is time for discussion, if necessary.

Handout 1 - Module 2 - Topic 3
Development in Children

Indicators of healthy development in children

- Playing, especially with other children
- Forming friendships
- Participating in decision-making
- Good appetite
- Peaceful sleep
- School attendance
- Good performance in school
- Participating in spiritual activities

Indicators of possible problems in children

- Lack of interest and energy in playing
- Isolation
- Inertitude
- Displays of anger and hostility
- Sadness and depression
- Poor concentration and distractibility
- Aggressive behaviour

Activity 3 Theories of Age and Understanding in Children



In this activity, you will:

- Discuss the stages of childhood development at different ages

Facilitator's notes:

Sociologists and behavioural psychologists who study the development of children over time have identified patterns in their behaviour based on their age. This, of course, may be intuitive to any parent, who has also observed first hand the stages of development of his or her children.

Here are two well-known theories of child development:

ERICKSON'S THEORY:

Infancy (0-1 years): Child entirely dependent. During this phase the child develops a sense of trust.

Early Childhood (1-3 years): Child becomes aware of being a separate being from the parent and of having his/her own will. (Possible behaviour includes temper tantrums and crying when separated from mother.)

Nursery School Age (3-5 years): Child begins to play in groups and show increased sense of responsibility for him/herself.

Primary School Age (5-11 years): Child develops a desire to achieve, especially in social relationships.

Adolescence: Child acquires a sense of own identity, independence and goals in life.

PIAGET'S THEORY:

Sensori-motor stage (0-2 years): Child acquires a permanent image of him/herself and the practical world around him/her.

Infantile realism (3-7 years): Child sees him/herself as the centre of the universe. Bad events are seen as a punishment for what he/she has done.

Concrete operations (8-11 years): Child acquires the ability to think systematically about logical relations within a problem. There is abstract thinking, e.g. planned activities.

It is useful to know what children understand at a particular age or stage in order to know how children view themselves and the world, and what influences their behaviour. However, the fact that these two theorists have different views on what a child understands at a particular age, shows that generalisations may not be enough to explain a child's development. There are many factors that influence how an individual child sees and understands his or her world. Those who wish to help children should listen to and observe them carefully to understand what stage of development they may be at in relation to their culture and life experience.



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- 1 Explain to the group that sociologists and behavioural psychologists who study the development of children over a period of time have identified patterns in their behaviour based on their age. In this activity, participants will describe the characteristics and behaviour of a child at different ages.

Start by asking the group to think about a baby, less than one year of age, and to describe the characteristics and behaviour of this child. Write up responses on the flipchart. When you have a few listed, briefly present the theory that Erickson and Piaget had for a baby of less than a year old. Use your facilitator's notes for this.

- 2 Do the same for a child aged:

- 1 to 3 years
- 3 to 5 years
- 5 to 11 years, and
- adolescents up to 18 years.



Throughout this exercise, you should ask the participants if they agree with the theories of the psychologists, or not. Generate some discussion around child development by asking the group if they have had different experiences with their own children or children that they know.

- 3 If time permits, you could ask for a volunteer or a number of volunteers to role-play the different behaviours of the child as he or she progresses in age and in development (for example, crying, throwing a temper tantrum or playing in a group). This will help to lighten the subject and stop it from becoming too theoretically based!

Activity 4 Environmental Factors in Children's Development



In this activity, you will:

- Discuss how environmental factors can affect a child's development

Facilitator's notes:

A child's environment is the world he or she lives in.

Some factors that affect how a child sees and understands his/her world are:

- ♦ Nutrition, material security and physical security
- ♦ Relationship with parents and sisters/brothers
- ♦ Opportunities to play and share with other children
- ♦ Culture, for example, children may not be allowed to ask adults questions
- ♦ Traditional beliefs
- ♦ Religion
- ♦ Experience, for example, a child who has seen his or her parent die will understand what death means at an early age
- ♦ Education.

Although in the last activity we looked at general patterns of childhood development, what an individual child experiences and understands is influenced by many particular factors. Home visitors need to know that, when dealing with children, it is important to:

- ♦ Assess each child as an individual, not as a general case or group
- ♦ Accept different development and understanding levels
- ♦ Involve parents and guardians in their assessment, where possible.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- 1 Explain to participants that, although there are psychological explanations for the behaviour of children and that children do, in general, follow stages of growth and development, there is also great variation among children based on their own individuality, and based also on the environment that they grow up in. Children should thus be assessed as individuals, rather than as general cases.
- 2 Ask the group to think of the many factors that can affect how children see and understand the world they live in. You may need to give one or two examples to start the activity, for example, relationship with parents, or education level. Write responses up on the flipchart. Once you are satisfied that the group has given an adequate number of responses, you can review their list and add to it from the list in your facilitator's notes.

- 3 Once the participants have come up with a list of ideas, you could ask volunteers to role-play the effects on children growing up in different environments. For example, one volunteer can role-play a child living with loving and caring parents; while another role-plays a child living with parents who scream and insult each other. Different scenarios may be acted out, based on the list of factors that the participants have come up with. The important thing to emphasise to participants about these role-plays is the effect that situations have on a child.
- 4 To end the activity, ask whether the participants believe that the environmental factors in which a child grows up will have long-lasting consequences for the child's well-being. In the discussion, highlight the fact that what happens to a child early in life is very important, and will have lasting consequences not only for that child's development, but also on his or her future adulthood.

It is important that vulnerable children who are adversely affected by their experiences are supported in the community or environment they live in, so that they get the chance to reach their full potential as healthy, well-balanced adults.



Activity 5 The Community's Role in Child Development



In this activity, you will:

- Discuss how aspects of the community affect a child's development

Facilitator's notes:

In the last activity, you discussed how children's environments affect their development and their understanding of the world. In this activity, participants will explore how the community itself affects the environment that children grow up in.

Some examples of aspects of a community that have a **positive effect** on a child's development are:

- ◆ Schools
- ◆ Churches
- ◆ Caring adults who support vulnerable children by visiting child-headed households.

Some aspects of a community that have a **negative effect** on a child's development, for example:

- ◆ HIV/AIDS
- ◆ the abuse and exploitation of children.

In the activity, get participants to add to these two categories (i.e. positive effects and negative effects).



For this activity you will need:

- Flipchart sheets headed *Physical, Social, Intellectual and Moral/Spiritual* and markers
- Copies of Handout 2



45 minutes

To facilitate this activity:

- 1 Ask participants to think of ways that the community can help ensure proper growth and development in children. While they are thinking about this, put up the four sheets of flipchart paper you have prepared.
- 2 Ask participants to volunteer their ideas about how a community can help a child's development. Write each response under the appropriate heading – make this part of the activity and get participants to guide under which heading responses are placed. Review the responses. Ask participants to look at the four categories on the flipchart paper and see if there is anything they would like to add. For example, if most of the suggestions have been relevant to the child's physical and social development, add more points to the *Intellectual* and *Moral/Spiritual* categories.
- 3 Hand out copies of Handout 2. Participants can fill in their handouts as you review the lists.

| Handout 3 - Module 3 Topic 3 | |
|---|----------------------|
| The Community's Role in Child Development | |
| Positive developments: | Negative influences: |
| Physical | Physical |
| Physical | Physical |
| Social | Social |
| Social | Social |
| Intellectual | Intellectual |
| Intellectual | Intellectual |
| Moral / Spiritual | Moral / Spiritual |
| Moral / Spiritual | Moral / Spiritual |

Activity 6 Preparing for Home Visits: Child Development



In this activity, you will:

- Review the information discussed in Topic 3 on child development

Facilitator's notes:

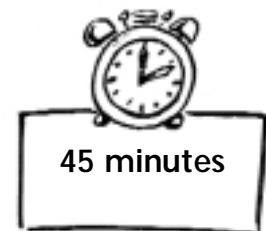
Participants should be attentive to the stages of development of the OVC they will be visiting. They should keep in mind the *Indicators of Development* and observe whether or not the children demonstrate these indicators. They should also look at *Indicators of Children's Problems* from Activity 3 in Topic 1.

In this activity, participants should read these two handouts and decide how they will use the indicators listed as an assessment tool to determine whether children are developing well or not. This will require them to come up with a set of questions to ask, which will help them in their assessment of the children.



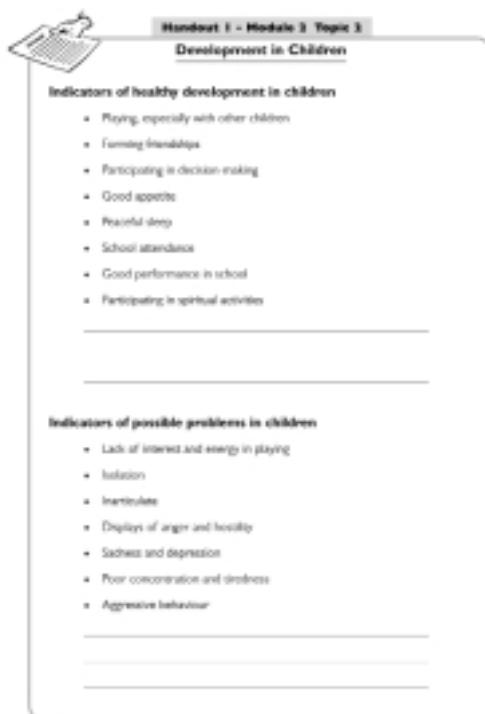
For this activity you will need:

- Flipchart and markers
- Handout 1 - *Indicators of Development* and *Indicators of Children's Problems* (from Activity 3, Topic 1)
- Extra sheets of blank paper



To facilitate this activity:

- Hand out the relevant handout to participants. They should include these handouts in their home visitor handbooks and be able to use these pages when determining whether children are developing well or not.



- 2 Remind participants that many of the signs of a child's distress may not be immediately obvious during a home visit to OVC. For example, behaviours that indicate emotional stress may need to be viewed over time. One way to get information is to ask questions of caregivers or siblings about the OVC.

- 3 With the group, go through the indicators of possible problems from the two handouts. Then hand out sheets of blank paper and ask participants to write up their own checklist of questions to ask when making home visits, based on the indicators. The questions they ask caregivers or siblings of a vulnerable child (or the children themselves, if they are old enough) will help to determine how well the child is coping and developing. These will help them to assess the children in their own CCC.

Some examples of questions, based on information in this topic, could be:

- ◆ Does this child have friends that he or she plays with?
- ◆ Does this child sleep well at night?
- ◆ Is this child often sad and depressed?
- ◆ Does the child bully other children and act aggressively?

- 4 Get the group to share their ideas. You could write them up on the flipchart, and participants can add questions to their own lists. They will put these into their home visitor's handbooks and refer to them when preparing to make home visits.



Topic 4

Counselling and Communicating with Orphans and Vulnerable Children

| | |
|---|------------|
| Introduction and Objectives for Topic 4 | 174 |
| Activity 1: The Characteristics of a Child | 175 |
| Activity 2: How Children Communicate | 176 |
| Activity 3: Effective Methods for Communicating with Children | 178 |
| Activity 4: The Do's and Don'ts of Communicating with Children | 181 |
| Activity 5: Practising Effective Communication | 183 |

Introduction and Objectives for Topic 4

Counselling and communicating with troubled children is recognised by childcare professionals as a major need and component of these children's development. Vulnerable children need therapeutic support to help them to understand and cope with their difficult circumstances. Vulnerable children face social, emotional, psychological, as well as material hardships, which are beyond their ability to control.

Currently, little attempt is made by care organisations and individuals to listen to children themselves and to understand their fears and concerns about the situations they are in. Decisions are often made without consulting the children affected by the decision.

Vulnerable children need emotional support and positive adult role models to enable them cope with their situation. They need to be listened to and accepted, and this can only be achieved if community care members and home visitors are equipped with skills to counsel and communicate effectively with children.

In Topic 4, participants will work through activities that will provide them with an understanding of effective ways to communicate with children; and assist with developing their own skills for effective communication.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Describe the characteristics of a child.
- ◆ Explain methods of communicating with children.
- ◆ Discuss the knowledge and skills used in counselling and communicating with children.
- ◆ Discuss the do's and don'ts of communicating with children.
- ◆ Demonstrate skills in communicating with and counselling vulnerable children.



Activity 1 The Characteristics of a Child

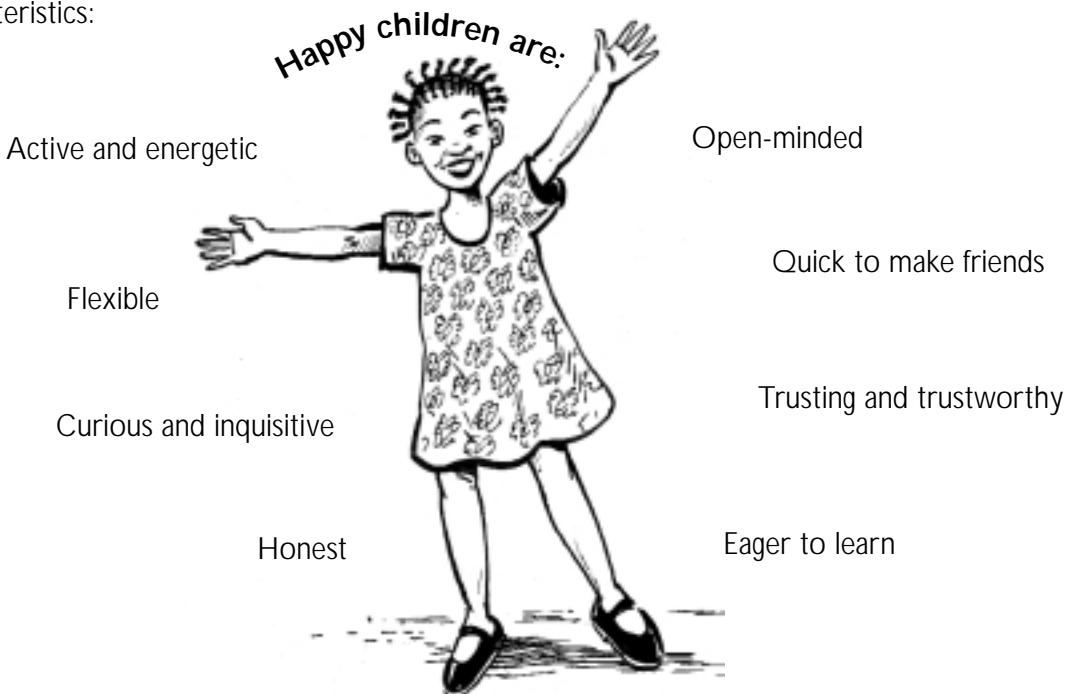


In this activity, you will:

- Discuss and define the characteristics of childhood

Facilitator's notes:

In this activity, you will be discussing the characteristics that define what a child is, as opposed to an adult. For example, apart from obvious physical size differences, happy children generally display the following characteristics:



Children's experiences and their environment also influence everything that they do, say and know. Counsellors should thus assess the personality of a child on an individual basis.



For this activity you will need:

- Flipchart and markers
- Handout 1 - *Characteristics of a Child*

To facilitate this activity:



- Divide the participants into groups and let them discuss the questions below:
 - What are the characteristics of children? In what ways are children different from adults?
 - How do children communicate? Is this different from adult communication?
- Discuss the group's answers in plenary. Write responses up on the flipchart, adding points from your facilitator's notes. Discuss the implications of these characteristics for communicating with children. For example, the fact that children are inquisitive means that adult counsellors should be prepared to answer a wide range of questions from children!
- Hand out Handout 1. Participants can add any extra points to those listed on their handouts.

Activity 2 How Children Communicate



In this activity, you will:

- Discuss how children communicate; and methods to get them to express themselves

Facilitator's notes:

In this activity, you will be exploring how children communicate both verbally (through words) and non-verbally (through body language and social behaviour). You will also discuss with participants ways of communicating about sensitive issues with children.

Communicating with vulnerable children:

Communication is the foundation of the relationship between a counsellor and a child. For this reason, practical ways must be found to communicate: ways that are effective not only for you, the caregiver, but more importantly, for the child.

When communicating with children, counsellors should never force them to tell their 'story'. If a child has difficulty communicating about something, there will be good reasons why this is the case.

Children may hesitate to discuss their problems for a variety of reasons, such as:

- Children may feel embarrassed or ashamed talking about issues related to sex, HIV/AIDS, and death because these are perceived culturally as taboo subjects.
- Children may be too young to put their feelings or experiences into words.
- Some cultures forbid children to question or disagree with adults.
- Children fear hurting those they love. They might hide their feelings in order to protect their parents or teachers, and adults in general, particularly if these adults are unhappy.

It is the CCC members' and the home visitors' role to help children overcome these barriers and help them express their feelings freely. As a starting point, always try to meet the children on their level. This involves using creative and non-threatening methods to explore sensitive issues. Depending on the age of the child, verbal communication may not be a child's first choice to express himself or herself. To communicate with children you must be able to understand **their** ways of communicating.

Children use the following means to communicate:

- Body language
- The language of play
- Spoken / verbal language
- Silence – this could mean that the child feels too overwhelmed to communicate their experience.

Adults dealing with children should also be aware of their own body language and what it might be conveying to the child, because children are always watching what you **do**, as well as responding to what you **say**.

note

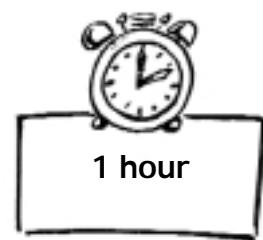
In Appendix 2 on page 351, there are notes on some fun and non-threatening activities that you can use to help children express their feelings indirectly. These are: drawing, storytelling, drama and playing games.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2 - *How Children Communicate*

To facilitate this activity:



1 Introduce this topic to participants by explaining that communicating with vulnerable children must be handled sensitively, because of the traumatic experiences they may have had and because of cultural taboos that prevent children from communicating directly with adults. Explain that it is sometimes more effective to get children to deal with sensitive topics by letting them communicate indirectly, rather than by bombarding the child with blunt, direct questions they may find difficulty in answering.

Explain that children not only communicate with spoken or verbal language, but also with:

- ◆ Body language
- ◆ The language of play
- ◆ Spoken / verbal language
- ◆ Silence – this could mean that the child feels too overwhelmed to communicate or articulate his or her experience.

2 Ask participants for their ideas about how children could express themselves other than answering questions. Write their responses up on the flipchart.

3 Distribute copies of Handout 2 to the group. Discuss some of the following methods that can be used to help children express their feelings. These are more indirect, but fun and non-threatening ways of helping a child to communicate:

- ◆ Drawing
- ◆ Storytelling
- ◆ Drama
- ◆ Playing games.

4 Use the facilitator reference notes in Appendix 2 on page 351 to help you in the discussion of the methods of getting a child to communicate, especially a young child who is not able to talk about his or her experience.

5 Stress to participants that these child-friendly methods of communicating, although they can be seen as play, are part of counselling the child. They will need to be sensitive to what the child is expressing in order to give the appropriate support and care. So, for example, in a child's drawing you will focus on what the content of the drawing is expressing, rather than on the drawing skills of the child. With older children, you can engage in more verbal forms of therapeutic counselling.

Handout 2 - Module 2 - Topic 2
How Children Communicate

Children use the following means to communicate:

- Body language
- The language of play
- Spoken / verbal language
- Silence – this could mean that the child feels too overwhelmed to communicate their experience.

Children may hesitate to discuss their problems for a variety of reasons, such as:

- Children may feel embarrassed or ashamed talking about issues related to sex, HIV/AIDS, and death because these are perceived culturally as taboo subjects.
- Children may be too young to put their feelings or experiences into words.
- Some cultures forbid children to question or disagree with adults.
- Children fear hurting those they love. They might hide their feelings in order to protect their parents or teachers, and adults in general, particularly if these adults are unhappy.

Some indirect, but fun and non-threatening ways of helping a child to communicate are:

- Drawing
- Storytelling
- Drama
- Playing games.

Activity 3 Effective Methods for Communicating with Children



In this activity, you will:

- Discuss and define the qualities, knowledge and skills that would make an adult a good counsellor for children in distress

Facilitator's notes:

The purpose of this activity is to encourage participants to think about the qualities, knowledge and skills that make adults good listeners and counsellors for children in difficult circumstances.

The qualities of effective communicators with children:

- Patience
- Good listening skills
- Empathy – the ability to imagine and understand another person's experiences
- An interest in children and a desire to protect them; trusted by children
- Openness, honesty and an approachable manner
- Caring and non-judgemental attitude
- The ability to maintain confidentiality.

note

This is a long activity. It is linked with Activity 4, where you will have the opportunity to review parts of this activity, so also look at that activity in your planning.

An important quality of someone who communicates well with children is someone with good **self-understanding**. It may be useful for a potential counsellor to undertake a self-critique before beginning counselling. This critique could involve:

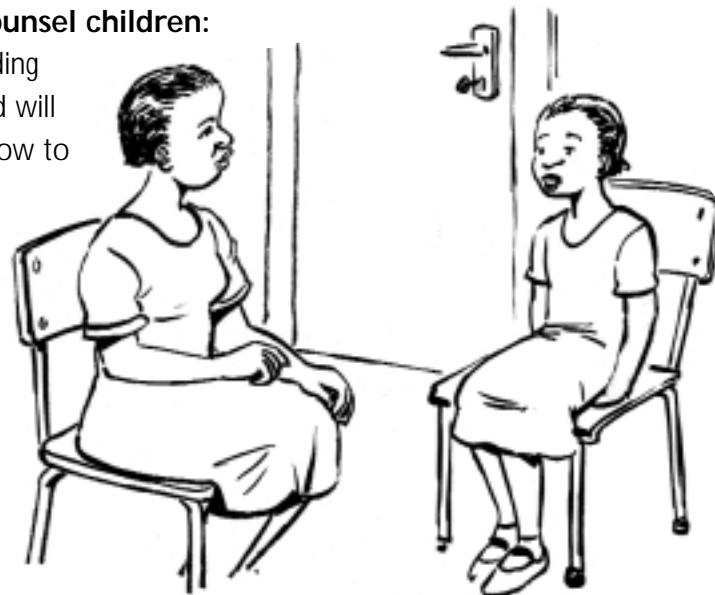
- Reflecting upon one's own abilities and character
- Reflecting upon whether one's own behaviour towards children is ethical and congruent with the values expressed in the home visitor training
- Reflecting upon one's own attitude and personal values
- Reflecting upon one's ability to communicate with and understand children
- Reflecting on one's own experiences and challenges as a child.

(For example, are there any unresolved personal issues that need to be dealt with?)

Knowledge needed to communicate with and counsel children:

- Knowing how to assess the child's understanding
- Knowing what the likely reactions from a child will be, the difficult questions they may ask and how to handle them
- Knowing how to handle your own feelings and reactions during the process of counselling.

It is important that a counsellor controls the urge to tell a child what to do when counselling. Listen to a child and try to assess his or her experience or problems, with the aim of considering options or actions to help and support the child.





For this activity you will need:

- Flipchart and markers

To facilitate this activity:



1 hour

- 1 This activity links directly with Activity 4, so you may want to introduce both topics together. In this activity, you will explore with the group what it means to be a good communicator with vulnerable children; in the next activity, you'll look more closely at the general do's and don'ts of communicating with children.
- 2 Ask participants: *What are the qualities of someone who communicates well with children?* List responses on flipchart paper, adding and clarifying based on your facilitator's notes. Explain to the group that reflecting on one's own personality, values, and communication skills is an important part of becoming an effective counsellor.

If you like, ask each participant to write a confidential self-assessment of his or her own strengths and weaknesses as a communicator as homework. Explain that this exercise is not a critical judgement of their abilities, but an opportunity to build on their strengths and address any areas that need attention. You can use the list in your facilitator's notes to indicate the kinds of questions participants can reflect on to gain some self-understanding.

- 3 Next, ask participants: *What knowledge does someone need to have in order to counsel OVC?* To help them answer this question, ask participants to brainstorm the kinds of questions that OVC may ask them. Make sure that participants are able to answer basic questions about HIV and AIDS, for example.

Review the responses as necessary. Emphasise that some difficult questions that may arise during discussions with children, such as those dealing with sexuality, illness and death. Go through different ways that home visitors in their role as counsellors, might approach answering them. Explain that developing good listening and communication skills will be especially helpful when difficult questions arise.

note

Issues of death and bereavement are covered more closely in Topic 5.

Some useful skills in communicating with and counselling children:

- ◆ **Take a 'one down position'**, which means showing a child that he or she knows more about certain things than you do, as an adult.
- ◆ **Develop good listening and attention skills.** This involves not interrupting a child, asking follow-up questions, and being willing to sit in silence and to listen.
- ◆ **Use minimal encouragers.** This means using brief words and gestures to encourage the child to go on talking without interrupting him or her.
- ◆ **Be as fully present as possible.** Giving the child your full attention; 'the whole of you should be there'.
- ◆ **Externalise problems.** This involves separating the problem from the child, for example, not labelling a child a truant, liar, bed wetter or orphan. Always call children by their names, without making any reference to their race, height, size or place of origin, and most importantly, by not labelling them in relation to bad behaviour.
- ◆ **Encourage enactment.** One way to help a child communicate is to ask him or her to act or show what happens when the problem arises. Children can be asked to act out both the problem and the solution. Enactment or role-playing is especially useful with children who may not have words to describe what happened in detail. Enactment may also be useful to any CCC members who are observing children to review the communication process and identify where the children's problems lie.
- ◆ **Summarise.** Summarising means repeating back to the child what you understand that he or she has told you, in order to affirm and validate the importance of what the child has said and to make sure you have understood correctly.
- ◆ **Reframe** (or re-label). Reframing involves restating the situation the child has described in a more positive way. For example, if a child says that a playmate has told him that his mother has AIDS because she is a sinner, the counsellor can explain that AIDS affects all kinds of people, and that AIDS is not God's punishment.
- ◆ **Clarify.** To understand what the child understands or means by any given information or situation, a counsellor can ask open-ended or specific questions, such as, 'When you said this, did you mean...?'

Activity 4 The Do's and Don'ts of Communicating with Children



In this activity, you will:

- Look at what to do and what not to do when communicating with children

Facilitator's notes:

When you start this activity, briefly review the lists of qualities, knowledge, and skills of good communicators that were developed in Activity 3. In this activity you will develop a list of *do's* and *don'ts* for communicating with children.

Examples for Do's when communicating with children:

- Do be patient. Children will tell or show you what they are ready to show or tell you. Try to move at their pace.
- Do show interest in the child. Children will feel valued if you show interest in their lives.
- Do be open and honest with facts. If you give information, be accurate and precise.
- Do maintain a non-judgemental attitude. CCC members are not trained to be judges of vulnerable child's situation, but to offer badly-needed emotional support.
- Do be empathetic. Put yourself in the shoes of a child and try to understand what they feel.
- Do maintain confidentiality and privacy. Don't share sensitive information except when necessary to help the child.
- Do maintain a calm and approachable manner.
- Do maintain a caring attitude.
- Do show acceptance of the child and what he or she is telling you.
- Do practise individualisation. This involves treating each child as an individual rather than comparing them or seeing them as case studies.
- Do plan ahead for difficult questions, the child's emotional responses, and ways to help.
- Do factor in differing perceptions, especially if the child and counsellor have different backgrounds, knowledge and experience.
- Do use the local language, so that children and their families can understand.
- Do understand and maintain control of your own emotions. Refer the child to someone else if you feel your emotional involvement is endangering your ability to help him or her.
- Do network with other CCC members for personal support and guidance.
- Do know your limits and strengths.
- Do try to develop good listening skills. Use 'ROLES':
 - R — Relax
 - O — Open
 - L — Lean forward
 - E — Eye contact
 - S — Sit at the same level as the child.
- Do develop good question and answer techniques. For example, use open-ended questions. Make sure you understand a child's question and what he/she already knows or understands before answering.
- Do summarise and clarify what a child has told you.

Examples of Don'ts when communicating with children:

- Don't have a judgemental attitude
- Don't speak in a commanding manner
- Don't impose adult values on a child
- Don't compare children
- Don't make empty promises
- Don't talk too much
- Don't interrupt when a child is talking
- Don't blame the child as he or she tries to express his or her feelings
- Don't look down upon the child
- Don't ignore the child or the importance of what he or she is saying
- Don't allow your emotions like anger, jealousy and fear to develop
- Don't form a sexual relationship with the child you are helping
- Don't use negative body language, such as negative facial expressions or sitting postures
- Don't evaluate the situation too quickly
- Don't give the child too much information all at once.



For this activity you will need:

- Flipchart and markers



To facilitate this activity:

- 1 Briefly review the lists of qualities, knowledge, and skills of good communicators that were developed in Activity 3. Then get the group to think of the do's and don'ts of communicating with children. Ask each participant to contribute one *do* and one *don't* to the list. Write the responses up on the flipchart. Add to and clarify the do's and don'ts based on your facilitator's notes.
- 2 Next, ask for volunteers to act out the do's and don'ts of their choice. Have one participant play the role of the child and another play the role of the counsellor. After each role-play, ask the participant playing the role of the child to explain how the counsellor's actions affected him or her.

For example, you could have the participants act out the 'do' of *separating the problem from the child*, and then the participant playing the role of the child could explain how the counsellor's action affected him or her in a positive way.

Alternatively, you could have the participants act out the 'don't' of *interrupting when a child is talking*, and then have the participant playing the role of the child explain how the counsellor's action affected him or her in a negative way.

Activity 5 Practising Effective Communication



In this activity, you will:

- Get the group to practise their communication and counselling skills

Facilitator's notes:

In this activity, you will present the group with a series of scenarios which they will use to practise their communication and counselling skills.

Before you facilitate this activity, you will need to make copies of the scenarios, and then cut out the instructions for the child and the instructions for the counsellor for each scenario.

note

The ten scenarios for this activity are in Appendix 2 on page 352

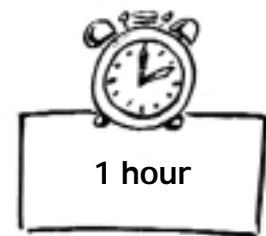
Participants will work in pairs for this activity – one will role-play the child (and receive the appropriate instructions); the other will role-play the counsellor (and receive their instructions). Alternatively, you can verbally tell each participant what role he or she will play. This activity will work best if partners are not aware of each other's instructions in the scenario. The emphasis of the activity should focus on the communication and counselling skills displayed by the person playing the role of the counsellor.



For this activity you will need:

- Copies of the ten scenarios, cut out according to child and counsellor instructions

To facilitate this activity:



- Divide the participants up into pairs, explaining that each pair will be working on a scenario based on an interaction between a child and a counsellor. Let the pairs decide who plays each role.
- Give each member of the pair the copy of the appropriate instructions for their role. Alternatively, you may verbally give the participants the appropriate instructions. Remember that this activity will work best if pairs are not aware of their partner's instructions. The purpose of the activity is for partners who are playing the counselor to 'think on their feet', and respond appropriately, as they would need to do in a real life situation.
- Allow the participants a few moments to study their roles and plan how they will act and what they will say. Then have each pair act out their scenario in front of the group. After each scenario, allow time for the other participants to ask questions and make suggestions.
- As the facilitator, you should use the opportunity when reviewing the scenarios to link the role-plays to the information on communication and counselling skills from the last few activities. For example, point out or highlight an example from a role-play that displays good listening skills from a counsellor.

Topic 5

Accompanying Orphans and Vulnerable Children Through Grief and Bereavement

| | |
|---|------------|
| Introduction and Objectives for Topic 5 | 186 |
| | |
| Activity 1: Grief and Loss | 187 |
| | |
| Activity 2: The Signs and Symptoms of Grief | 189 |
| | |
| Activity 3: The Understanding of Death at Different Ages | 190 |
| | |
| Activity 4: Preparing Children for Death in the Family | 191 |
| | |
| Activity 5: Support Strategies to Help Grieving Children | 193 |

Introduction and Objectives for Topic 5

Once children know that they or a member of their family is HIV positive and will die, they are emotionally affected. Guardians, teachers and relatives often witness a range of strong emotional reactions in children, including grief, anger, denial and despair. It is important to understand these reactions and to be able to support children struggling with grief and bereavement, and their fear of an uncertain future.

The psychological and social effects of depression amongst children, families and communities should not be underestimated. Many people who have not been able to have the benefits of counselling after grieving for their loved ones, may become severely depressed to the point of not being able to function properly. They may lose interest in their own lives, neglect the children in their care, the general maintenance of homesteads and food crops, and their own basic hygiene. All these may be signs of general dysfunctionality due to depression.

As home visitors, participants should be aware of the signs of grieving and the signs of depression in both the children they visit and the guardians who look after them. Home visitors will monitor for grieving and depression in the communities that the work in, and this should be discussed within the CCC and strategies formulated to help people in the community who are suffering.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of grief.
- ◆ Discuss signs and symptoms of grief in children.
- ◆ Discuss children's understanding of death in relation to what age they are.
- ◆ Discuss ways of preparing children for the death of a loved one.
- ◆ Discuss different ways of supporting children through grief and bereavement.



Activity 1 Grief and Loss



In this activity, you will:

- Discuss grief and loss and how children are affected

Facilitator's notes:

In this activity, you will be describe what grief is, what it feels like and what effects it has on the person experiencing it.

Grief refers to strong feelings of sadness after the loss of someone or something dear.

Loss refers to being deprived of something or someone very important in one's life.

Types of grief

Anticipatory grief: Children begin to grieve long before their loved one dies. This is very common when parents or guardians have HIV/AIDS or any other serious illness.

Children grieve because they anticipate permanent separation from their loved ones.

Delayed grief: Some people may not grieve properly at a funeral because they were busy making funeral preparations; or children may have been moved and do not attend the funeral due to some beliefs. They grieve later after the loved one has been buried.

Reactionary grief: This is immediate grieving.

Blocked grief: Common in individuals who may be in denial. Feelings or thoughts related to death are blocked or unexpressed.

Aborted grief: Some may fail to grieve the loss of their loved ones. In children this may happen when they are told that their parents are in heaven or are in a far away place.

Children may not know how to articulate their emotions because they are unable to reconcile such information with the fact of their parent's death.

Complicated grief: This is when grief is not expressed directly, but later is characterised by physical symptoms, behavioural symptoms and disturbed thought patterns (such as nightmares) and feelings (such as lingering depression).

Many orphans and vulnerable children may experience emotions of fear, anger, guilt and sadness after the loss of their parents, regardless of what age they are. Grieving children may display withdrawal tendencies, sleeplessness and lack of concentration, as well as self-blame and, ultimately, depression.

Some common myths and beliefs about grieving:

- ◆ Children should not participate at funerals
- ◆ Orphans will be very difficult children
- ◆ The surviving spouse should be cleansed after or before the burial of their spouse otherwise ghosts or bad luck will haunt them.



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- 1 Ask participants to describe what grief is and the effect it has on the person experiencing it. Clarify and summarise their responses using the information in the facilitator's notes. Many participants may have some direct experience of loss and grief, so you will need to be sensitive to this. Remember that the main reason for this activity is to get participants to understand that there are many ways of grieving. Also that a good therapeutic technique for releasing grief is to share it and to talk about it. Adults are often not aware that children are grieving, because they may not be showing it directly.
- 2 Participants can be helped to share their experiences by completing the sentences in the box below. Read each sentence out to participants and let them volunteer a response before reading the next one out. Remind participants to keep their responses short, so that the activity does not end up as a storytelling session. The main focus should remain on grief, how people have experienced it and how they coped with it.

1. The most significant loss I have ever experienced was...
2. I was aged...
3. It was significant because...
4. I felt...
5. I thought...
6. I wanted to know...
7. I was worried that...
8. My greatest fear was...
9. I regretted that...
10. I needed...
11. I wished that...
12. I was able to...
13. I coped by...
14. It helped when...
15. It annoyed me when...
16. The person who helped me was... because he or she was...
17. The hardest part was...
18. I knew my grief was resolved when...
19. In retrospect I think that...
20. My greatest lesson as a grief counsellor was...

Adapted from REPSSI training manual, Woden (1991); and Lifeline Western Cape Counsellor's Training Manual

In the next activity, you will take participants through the less obvious signs and symptoms of grief in children, especially those who may be grieving but are unable to articulate their emotions directly.

Activity 2 The Signs and Symptoms of Grief



In this activity, you will:

- Discuss the signs and symptoms of grief and loss in children

Facilitator's notes:

The Signs and Symptoms of Grief in Children

Physical symptoms of grief:

- Loss of appetite
- Difficulty sleeping
- Tiredness
- Decreased energy level
- Slow movements
- Restlessness
- More likely to become ill or injured

Thought patterns of grief:

- "This isn't really happening."
- "He or she [the person who has died] will come back."
- "It's my fault."
- "I should have been able to save him/her."
- "I should have behaved differently while he/she was still alive."
- "I hate him/her for abandoning me."
- "I shouldn't be alive when he/she is dead."
- "No one understands what I am feeling."
- "I do not want to live."

Behavioural symptoms of grief:

- Lack of interest in people or activities once enjoyed
- Withdrawal and isolation
- Angry or aggressive behaviour, 'acting up'
- Short temper or tantrums
- Lack of concentration
- Forgetfulness
- Easily upset
- Violent and aggressive behaviour, rage
- Petty crime
- Harming themselves
- Clinging

Feelings associated with grief:

- Sadness
- Denial
- Anger
- Guilt
- Fear and anxiety
- Tension
- Confusion and depression
- Isolation and loneliness



For this activity you will need:

- Sheets of blank paper



30 minutes

To facilitate this activity:

- Divide the participants into four groups and assign each group one of the following categories:
 - ◆ Physical symptoms of grief
 - ◆ Behavioural symptoms of grief
 - ◆ Thought patterns associated with grieving
 - ◆ Feelings associated with grieving.
- Ask each group to brainstorm the signs and symptoms of grief according to their categories. In plenary, ask each group to present their ideas. Add and clarify based on the facilitator's notes.

Activity 3 The Understanding of Death at Different Ages



In this activity, you will:

- Discuss children's understanding of death at different stages of development

Facilitator's notes:

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

Below 5 Years

Children of this age tend to see death as reversible and temporary, as they do not understand its full meaning. They also do not see that death may happen to them, and they may believe that it is something that they can avoid. They may also have misconception about what causes death. Explanations about death to children of this age should be brief, simple and concrete. For example, you could say, 'When people die, they do not breathe any more, just as when dogs die they do not bark any more'.



From 5 - 10 Years

At this age, children gradually develop an understanding of death as irreversible. They come to understand that all living things die and that they too will die some day. Around the age of seven, children grasp that death is unavoidable and universal, even though they often resist the idea of death as a possibility for themselves. They sometimes exhibit 'magical thinking', such as thinking that the dead can see or hear the living, or thinking that their own thoughts or behaviours can cause death. Like young children, they need concrete explanations of what death means.



From 10 Years to Adolescence

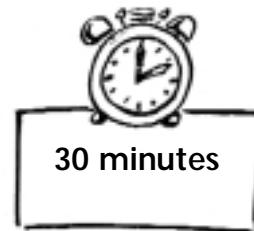
After the age of ten, children come to understand the long-term consequences of death. During adolescence, they begin to think about their lives and to hold their own views on the meaning of life. If children at this age experience a death in the family, they tend to be able to understand explanations about the facts surrounding the death.



For this activity you will need:

- Flipchart and markers

To facilitate this activity



- Ask the participants to share ideas about how children in the following age groups understand death: below five years old; five to 10 years old; 10 years old to adolescence. Supplement their ideas with the information provided on your facilitator's notes.
- Ask for volunteers to role-play children of various ages talking about death.

Activity 4 Preparing Children for Death in the Family



In this activity, you will:

- Discuss ways to prepare a child for the death of a parent, sibling or guardian

Facilitator's notes:

In this activity, you will be discussing ways to help participants deal with how to speak to children about death and dying.

You can help a child to prepare for the idea of death by:

- Remembering that children from 18 months to about five years have 'magical thinking'. They may fear that their thoughts or behaviour have caused themselves or others to get sick, for example by not doing well at school or not following a traditional custom.
- Communicating openly, honestly and factually. This involves giving information that is adjusted according to the child's age. Avoid using abstract or misleading explanations, such as 'your mother has gone to sleep'.
- Allowing the child to express anger or fear and helping the child to do so without harming himself, herself or anyone else.
- Acknowledging that a child's most natural reaction to death might be denial. Help the child to work through this by gently, but continually, discussing the facts about death and HIV/AIDS; and enabling the child to express fears and to ask questions.
- Ensuring that the child is not alone with worries and fears. For example, encourage family members to discuss issues of death and bereavement at home, as well as in counselling sessions. Also, where appropriate, consider involving others such as church leaders in counselling the child about what death and dying mean in the context of their own culture and religion.
- Allowing children to discuss how they would like themselves or their family members to be remembered. For example, they might like to prepare a 'memory book' of drawings, poems and photographs. Memory books will be discussed in a further section of this guide.

note

Memory books
are covered more
closely on page 273



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



45 minutes

To facilitate this activity

- 1 Ask for participants' ideas on how to prepare children for an impending death. If you like, ask participants if they have already had this experience with children, and how they handled it. Supplement their ideas with information from your facilitator's notes.
- 2 Divide participants into pairs and assign each member a child, stating the child's age, gender, and relationship to the person who is dying or has died (for example, a six year old boy whose father has died; a seven year old girl who has HIV/AIDS).
- 3 Have each member of the pair practise talking about an impending death to the child they have been assigned. The other member of the pair should then provide feedback and suggestions. The important point of this activity is that participants are able to practise talking about death and dying with a child who is scared and vulnerable. This is a difficult task and requires sensitivity and empathy on the part of the participants.
- 4 Afterwards, participants come together in plenary. Give them an opportunity to share what they learned in pairs, and allow time for discussion and questions, if time permits.
- 5 Give out copies of Handout 1.

Handout 1 - Module 2: Topic 4

Preparing Children for a Death in the Family

Whether a child or a child's family member has AIDS, you can help the child to prepare for the idea of death by:

- Reminiscing that children from 18 months to about five years have 'magical thinking'. They may fear that their thoughts or behaviour have caused themselves or others to get sick, for example by not doing well at school or not following a traditional custom.
- Communicating openly, honestly and clearly. This involves giving information that is adjusted according to the child's age. Avoid using clever or misleading explanations, such as 'your mother has gone to sleep'.
- Allowing the child to express anger or fear and helping the child to do so without harming himself, herself or anyone else.
- Acknowledging that a child's most natural reaction to death might be denial. I help the child to work through this by gently but continually discussing the basic about death and HIV/AIDS, and enabling the child to express fears and to ask questions.
- Ensuring that the child is not alone with worries and fears. For example, encourage family members to discuss issues of death and bereavement at home, as well as in counselling sessions. Also, where appropriate, consider involving others such as church leaders in counselling the child about what death and dying mean in the context of their own culture and region.
- Allowing children to discuss how they would like to remember, or how family members to be remembered. For example, they might like to prepare a 'memory book' of drawings, poems and photographs.

Activity 5 Support Strategies to Help Grieving Children



In this activity, you will:

- Get the group to practise their communication and counselling skills with grieving children

Facilitator's notes:

Children who are grieving can be supported through bereavement counselling.

Bereavement is the emotional reaction felt after the death of a loved one.

Timely support to bereaved children helps break the cycle of trauma. Support should be provided just before and after the death of a loved one. This will help to avoid complicated and extended grieving. During bereavement counselling, each child may respond differently. It is therefore important to accept and acknowledge each child's experience as unique.

Bereavement counselling for vulnerable children works well in groups because:

- Many children can be reached at the same time.
- Children realise that they are not the only ones who have lost parents. This helps to eliminate feelings of self pity, survivor guilt and blame.
- Children make friends and develop individual safety nets with other children.
- Children learn and share coping skills from each other.
- Children gain life skills, such as communication, trust and relationship-building.
- Children are more comfortable to share their problems and challenges with their peers who are in a similar situation.

Who should conduct bereavement counselling and where?

Trained counsellors are better placed to conduct bereavement counselling because this requires specialised skills. Counselling bereaved children requires sensitive and delicate handling, especially in communities where deaths are frequent. Counselling should be conducted where children feel most comfortable and safe.

Counselling should ensure that the child achieves the following:

- Accepts the reality of the loss
- Deals with intense feelings
- Adjusts to the environment in which the deceased is missing
- Emotionally relocates the deceased and moves on with life.

Participants who conduct home visits to bereaved children, should have referral information (through the CCC) about counselling services in their community, if they feel they cannot offer counselling to a child themselves.



During the process of bereavement counselling, the counsellor can:

- ◆ Give the child time to think about the death. Allow them to ask questions, but also accept their silences. It may be useful to look at photos, share memories and visit the grave together.
- ◆ Accept that the child may engage in behaviour, such as physically looking for the deceased. In a case like this, accompany the child and gently confirm the reality of the death.
- ◆ Allow the child to express anger or fears and enable the child to do so without harming himself, herself or anyone else.
- ◆ Without rejecting a child's feelings, provide simple and honest explanations of the facts about what has happened. For example, say, 'I know it's hard to believe that your mother has died, but her body was weak and tired and could not carry on'.
- ◆ Discuss questions relating to the child's religious or cultural beliefs. For example, the child might ask questions such as, 'Why has God taken my brother away?' Your response should never imply that AIDS or death is a form of punishment from God, 'the spirits' or another person.
- ◆ Help to make the loss real for the child. For example, allow the child to participate in a ritual, such as a burial ceremony or a funeral, and to keep reminders of the deceased person around.
- ◆ Never impose expectations on the child by saying, 'You will definitely feel much better in three months' time' or 'It is time you got on with your life'.
- ◆ Encourage coping within the whole family and local community. For example, try to ensure continuity in other areas of the child's life at home and at school. Also, avoid separating the child from other loved ones, such as siblings, and address any fears that the child might have about the future of the family.



For this activity you will need:

- Flipchart and markers



To facilitate this activity:

- 1 Ask participants to brainstorm ways to support children after the death of a loved one. Review the symptoms of grief listed in Activity 3. Ask participants to imagine how they would address each of these symptoms. You could ask volunteers to share personal experiences about how they comforted grieving children. Add ideas from the facilitator's notes. Give the participants the opportunity to discuss and ask questions.
- 2 Divide participants into groups. Ask each group to brainstorm the different strategies being used in their own communities to counsel bereaved orphans and vulnerable children. List all the strategies and discuss who provides them. In this exercise, participants should add details of any local counselling services to the *Referral Information* sheets in their home visitor's handbooks.

Topic 6

Using Play in Counselling Children

| | |
|---|------------|
| Introduction and Objectives for Topic 6 | 196 |
| | |
| Activity 1: Why is Playing Important for Children? | 197 |
| | |
| Activity 2: Play as an Indicator of a Child's Well-being | 198 |
| | |
| Activity 3: Methods for Using Play in Counselling Children | 200 |

Introduction and Objectives for Topic 6

This topic aims to discuss why playing is important in children, especially for orphans and vulnerable children. Counsellors need to understand the importance of play in children's development and communication. In this topic, participants will also discuss how they can use elements of play to both communicate with and counsel children in need.

Elements of play activities can be used by counsellors to get vulnerable children to express what has happened to them. Play can also be used strategically as a healing process to get children to work through their problems and feelings; and to project a more positive future.

Play also performs an important social function for children. Exercise is good for a child's physical development; and supervised sport and recreation activities, such as games, singing and dancing, promote social integration among children. This can help orphans and vulnerable children to overcome stigma and social isolation.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Understand why children play or what factors may inhibit their desire to play.
- ◆ Describe the functions of different types of play that children engage in.
- ◆ Explain the purpose of using play in counselling vulnerable children.



Activity 1 Why is Playing Important for Children?



In this activity, you will:

- Discuss with the group why play is important for children's development

Facilitator's notes:

Introduce this topic by explaining that recreation for children involves playing and other activities in which they can participate actively or passively. Play is one of the most effective ways in which children communicate. It helps children to develop their communication and social skills; and builds resilience in them. Recreational play is especially important for vulnerable children as it promotes social integration and helps them overcome stigma and isolation. It also keeps children active which is good for their physical and mental states.

note
Further notes on the importance of play are to be found in Appendix 2 on page 351

Explain that children communicate not only with spoken language, but also through body language, through play, and by other means of social behaviour.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



1 Divide participants into three groups and ask them to discuss the types of recreation activities boys and girls engage in. List the recreation activities for girls and for boys separately.

Group 1: Lists recreation activities for children 1 to 5 years

Group 2: Lists recreation activities for children 6 to 11 years

Group 3: Lists recreation activities for children 12 to 18 years.

In plenary, allow groups to give their lists and write these up on the flipchart.

2 Then discuss with the whole group how the participation of boys and girls differs in play activities. Discuss how recreational activities can help to support vulnerable children; and what activities home visitors can do with children.

Remind participants that these activities for children do not need many resources, except the creative imagination of the participants!



Activity 2 ➤ Play as an Indicator of a Child's Well-being



In this activity, you will:

- Discuss the psychological and developmental importance of playing in children

Facilitator's notes:

Play is an important part of a child's development. By playing, children learn the social, mental and creative skills that equip them to deal with life. In play, children use and develop their communication, relationship, negotiation and problem-solving skills with their peers. Play is thus a good indicator of a child's well-being.

Why children play:

- ◆ Play is one of the most effective ways in which children communicate, especially young children. Caregivers and counsellors can therefore utilise play activities to gauge how a child is coping. Supervised play can also be used to help children come to terms with and overcome difficult circumstances.
- ◆ Play is a way in which children practise social skills; and develop skills in communicating, relating with others, negotiating and problem-solving.
- ◆ Games such as solving puzzles, building things and drawing help to stimulate a child's mental, nervous and muscular systems; and aid the development of co-ordination.

Though not consciously aware of it, children engage in play for various reasons:

- ◆ To explore their environment
- ◆ For fun and recreation
- ◆ To learn from peers and their surroundings
- ◆ To develop personalities
- ◆ To build and maintain relationships
- ◆ To express their feelings
- ◆ To develop competencies and skills.

When children do not play:

Children may be reluctant to play for many reasons. If they do not take part in games and play activities, it should be of concern to the counsellor or home visitor and may need to be monitored. Some reasons for a child not taking part in play are:

- ◆ They are tired
- ◆ They are sick
- ◆ They are hungry
- ◆ They do not understand the language other children are using
- ◆ They are sad and depressed
- ◆ They are afraid of being bullied
- ◆ They are insecure and have low self-esteem
- ◆ They feel isolated and not part of a group.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



45 minutes

To facilitate this activity:

- 1 Explain to the group that play is an important part of a child's development. Get participants to brainstorm reasons why they think play activities are good for a child's development; then to give reasons why they think a child may withdraw from play. Write these up on the flipchart.
- 2 Give out Handout 1 to participants. With the group, read through the lists in your facilitator's notes (reflected on their handout), emphasising the points about the natural socialising and developmental effects of play on children. These will add to the points they have brainstormed. Highlight the fact that, when a child is seen to be withdrawing from play activities, there could be a problem that a counsellor or home visitor may need to monitor.
- 3 Divide the participants up into pairs, explaining that each pair will be working on a short scenario based on an interaction between a child and a counsellor. Let each pair decide who plays each role.

For this activity, it is assumed that a caregiver or home visitor has noticed that a child is sitting alone and is not participating in a game with other children. The person playing the role of the counsellor or home visitor will try to find out from the child what the problem is, and try to help the child. A home visitor who is supervising games for children will need to make sure that all the children are engaged in and integrated in the activity. If not, he or she should find ways to include the child in the game by, for example, teaming him or her up with another child.

- 4 In plenary, let pairs volunteer to act out their scenarios for the other participants. In each case, summarise the interaction between the pairs, emphasising the signs which indicate that the child may have a problem; and how the adult interpreted the signs and helped the child.

Handout 1 - Module 2: Topic 2

Reasons why Children Play

Why children play:

- Play is one of the most effective ways in which children communicate, especially young children. Caregivers and counsellors can therefore utilise play activities to gauge how a child is coping. Supervision play can also be used to help children come to terms with and overcome difficult circumstances.
- Play is a way in which children practise social skills, and develop skills in communicating, interacting with others, negotiating and problem-solving.
- Games such as solving puzzles, building things and drawing help to stimulate a child's internal, nervous and muscular systems, and aid the development of coordination.

Through most consciously aware of it, children engage in play due to various reasons:

- To explore their environment
- For fun and recreation
- To learn from peers and surroundings
- To develop personalities
- To build and maintain relationships
- To express their feelings
- To develop comprehension and skills

When children do not play:

Children may be reluctant to play for many reasons. If they do not take part in games and play activities, it should be of concern to the counsellor or home visitor and may need to be monitored. Some reasons for a child not taking part in play are:

- They are tired
- They are sick
- They are hungry
- They do not understand the language others are using
- They are sad and depressed
- They are afraid of being bullied
- They are insecure and have low self-esteem
- They feel isolated and miss parts of a group

Activity 3 Methods for Using Play in Counselling Children



In this activity, you will:

- Discuss ways in which play can be used to communicate with and counsel children

Facilitator's notes:

This activity builds on the last one where participants learnt about the importance of play and recreation activities in the general social, mental and emotional development of children. Healthy children naturally want to play; and when they show signs of not wanting to play, a caregiver may need to find out why. In this activity, you will get participants to explore the idea of using play as a controlled means of counselling a child. Elements of play can be used in counselling to communicate with the child, diagnose a problem and begin a healing process for the child.

Generally, a caregiver or home visitor can create a sense of belonging and integration in a group of children by introducing a round of singing and dancing (if the group is culturally homogenous); or by initiating group games like soccer or netball.

When individual children need personal counselling and have difficulty expressing themselves, however, less direct techniques can be used. These include using toys to help a child act out a problem they have; or getting a child to draw a picture to show what happened to them. These techniques are often more effective in getting a child to communicate their problem, as they are less intrusive than asking a child direct questions that they may find difficult to answer. Indirect counselling techniques such as these also help children to distance themselves from their problem, which makes it easier for them to express it. For example, a child may use a doll to show how a parent was very sick and died; or a drawing of a crying dog to show their sadness. The techniques may also be used to get a child to act out how their problems could be dealt with, but care should be taken so that the child still feels supported, and does not feel that they have to cope with their problems alone.



For this activity you will need:

- Sheets of blank paper



To facilitate this activity:

- Using your notes, explain to the group how elements of play can be used in counselling children. Then divide the group into smaller groups of about four people. Hand out pieces of blank paper and get participants to draw a picture of an incident that happened to them. Emphasise that they need not have good drawing skills to do this, as this is not an exercise in drawing technique, but a study of the drawing's content. They should spend no more than ten minutes on their drawings.
- In their groups, each participant in turn will show their drawing to the others who will try to interpret what the drawing expresses, rather than what it illustrates. For example, if someone draws themselves sitting on a chair, participants could ask questions such as: Why do you look so sad? Why is your body slumped? Were you feeling ill?

Topic 7

Spiritual Care for Orphans and Vulnerable Children

| | |
|--|------------|
| Introduction and Objectives for Topic 7 | 202 |
| | |
| Activity 1: Signs of Spiritual Problems in Children | 203 |
| | |
| Activity 2: Signs of Spiritual Health in Children | 204 |
| | |
| Activity 3: Strategies for the Spriritual Care of OVC | 205 |

Introduction and Objectives for Topic 7

As children grow up, they develop a sense of awareness about their moral and spiritual identity. Because this may not be nurtured in them and because of their distressing circumstances, many orphans and vulnerable children feel the lack of a moral or spiritual centre to their lives and so they may feel that their life has little meaning. When spiritual needs are not attended to, life becomes an endless challenge, devoid of hope. In this topic, spiritual counselling and support for vulnerable children is discussed as a means to helping them develop a sense of moral purpose in their lives; and develop a sense of hope for the future.

Instead of having hope and trust in God, and having a strong sense of a positive moral identity, children and youths may resort to negative survival strategies such as commercial sex, taking to the streets, crime, substance abuse and other risky behaviours.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Describe possible signs of spiritual problems among children.
- ◆ Describe signs of spiritual health among children.
- ◆ Discuss strategies for spiritual care and support among orphans and vulnerable children.



Activity 1 Signs of Spiritual Problems in OVC



In this activity, you will:

- Discuss indications of spiritual and moral distress in vulnerable children

Facilitator's notes:

In this activity, you will define what is meant by *spiritual* and by *moral*. You will also go through indicators of possible spiritual problems vulnerable children may have.

Spiritual - concerning the spirit rather than the external material world or body; dealing with a sense of the sacred or religious.

Moral - having a sense of right and wrong; living according to an accepted code of behaviour.

Some signs of spiritual distress

◆ Lack of meaning and purpose in life, expressed as:

- Wanting to die
- Feelings of despair and helplessness
- Withdrawal from life – losing the desire to communicate or eat
- Exhibiting angry and disruptive behaviour.

◆ Lack of love, expressed as:

- Cautious about loving people
- Worry and depression
- Guilt
- Anger
- Not able to receive love
- Not trusting people.

◆ Lack of hope, creativity and independence, expressed as:

- Anxiety about the future
- Displaying overly dependant behaviour or seeking attention
- Denial of the reality of the condition.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- 1 Ask participants to define what is meant by *spiritual* and by *moral*. Review their answers by using the definitions you have in your notes.
- 2 Then ask participants to describe signs of possible spiritual problems in children. They may want to give examples from their own experience and community. Add ideas from the list in your facilitator's notes. Tell participants that spiritual needs are just one aspect of the general needs of the child and that children's needs are explored further in Module 3.

Activity 2 Signs of Spiritual Health in Children



In this activity, you will:

- Discuss the signs of spiritual and moral health in children

Facilitator's notes:

This activity is linked to Activity 1 and outlines a set of signs that may indicate a positive sense of spiritual and moral health in a child.

Some signs of spiritual and moral health

- Has meaning and purpose in life, expressed as:
 - A desire to participate in religious activities according to faith
 - Hope for the future
 - Contentment in life.
- Needs to and is able to receive love, expressed as:
 - Confidence in caregivers
 - Feeling forgiven by God and other people; shows freedom from guilt feelings
 - Trust in God / others with situations which he or she has no control over.
- Needs to give love, expressed as:
 - Love for others through actions
 - Seeking the good for others.
- Expresses hope, creativity and independence, expressed as:
 - Asking questions about his condition
 - Learning to value his or her inner self, besides his or her physical self
 - Setting goals and having a sense of a future
 - Having hope in life and wanting to achieve positive things.



For this activity you will need:

- Copies of Handout 1

To facilitate this activity:

- Ask the participants to describe the signs of spiritual and moral health in children. Encourage them to give examples from their own experience and community. Add ideas from the list in your facilitator's notes.
- Distribute copies of Handout 1 to participants. They should add this to their home visitor's handbook for reference. Repeat that spirituality and morality are just two of the needs of a child.

Handout 2 - Module 2, Topic E

Spiritual Health in Children

Spiritual concerning the spirit rather than the external material world or body; dealing with a sense of the sacred or religious.

Moral having a sense of right and wrong; living according to an accepted code of behaviour.

Some signs of spiritual distress

- Lack of meaning and purpose in life, expressed as:
 - Feelings of despair, helplessness, loneliness and not needing to live
 - Withdrawal from life - ideas of the desire to communicate or talk
 - Exhibiting angry and disruptive behaviour.
- Lack of love, expressed as:
 - Causing stress among people
 - Worry and depression
 - Grief
 - Anger
 - Not able to receive love
 - Not trusting people.
- Lack of hope, creativity and independence, expressed as:
 - Anxiety about the future
 - Displaying anxiety, depression, behaviour or seeking attention
 - Denial of the reality of the condition.

Some signs of spiritual and moral health

- Has meaning and purpose in life, expressed as:
 - A desire to participate in religious activities according to faith
 - Hope for the future
 - Contentment in life.
- Needs to and is able to receive love, expressed as:
 - Confidence in caregivers
 - Feeling forgiven by God and other people; shows freedom from guilt feelings
 - Trust in God / others with situations which he or she has no control over.
- Needs to give love, expressed as:
 - Love for others through actions
 - Seeking the good for others.
- Expresses hope, creativity and independence, expressed as:
 - Asking questions about his condition
 - Learning to value his or her inner self, besides his or her physical self
 - Setting goals and having a sense of a future
 - Having hope in life and wanting to achieve positive things.

Activity 3 Strategies for the Spiritual Care of OVC



In this activity, you will:

- Get the group to look at ways to help children spiritually

Facilitator's notes:

Apart from counselling the children in their care, home visitors can also support vulnerable children by encouraging them to take part in religious or spiritual practices, according to their culture. This has the advantage of creating a further support structure for children who may need it.

Some strategies for the spiritual care of children:

- Encouraging them to pray in their respective faiths
- Praying for and with them
- Sharing your own faith with them through words and actions
- Showing love and concern for them
- Caring for their souls as well as their physical needs
- Answering their questions about God, right and wrong, the meaning of life, etc.
- Encouraging them to get baptised, when appropriate
- Encouraging them to join Sunday school or other religious education classes
- Encouraging them to learn simple Bible study, when appropriate
- Encouraging them to have faith in God
- Encouraging them to go to church or other faith-based services.



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- 1 Divide the participants into small groups and ask each group to brainstorm strategies for the spiritual care of vulnerable children who may be in their care. Encourage them to think of strategies that would be relevant to, and feasible in, their own community.
- 2 Bring the groups back together and ask each group, in plenary, to present their ideas. You may want to write up their responses in the flipchart. Once you have all their input, review the responses and then go through the list in your facilitator's notes. Allow time for discussion and questions.

Topic 8

Support for Caregivers

| | |
|---|------------|
| Introduction and Objectives for Topic 8 | 208 |
| | |
| Activity 1: Enhancing Self-Awareness in Caregivers | 209 |
| | |
| Activity 2: The Tree of Life | 210 |
| | |
| Activity 3: Me Drawings | 211 |
| | |
| Activity 4: Me Boxes | 212 |
| | |
| Activity 5: Support Groups | 213 |
| | |
| Activity 6: Review of the Home Visitor's Handbook | 214 |

Introduction and Objectives for Topic 8

In this topic, participants will work on activities that will help caregivers to build up the resilience they need to help them cope with the care and support of orphans and vulnerable children.

It is important that caregivers and counsellors are self-aware and constantly assess themselves in relation to their responsibilities towards these children. It is also important that caregivers take adequate care of their own needs, physically, mentally and emotionally; and are in turn given support in this.

It is not uncommon for communities who have experienced the effects of the AIDS epidemic to suffer severe states of depression over a long period of time, causing the further dissolution of family structures within a community. The stigma, fear and discrimination associated with AIDS has also had the effect of isolating affected families, causing them to lose important social networks. Without the safeguards of community support, people who are severely depressed may get to a point where they no longer have coping mechanisms and they lose hope and hold no interest in life. They may neglect their own needs and those of the children in their care. Participants in the home visitor training course should be aware of the debilitating effects of trauma and depression and monitor for signs of this in the communities they work in. CCCs should devise strategies for helping people in their community who have been identified as severely depressed.

Depression may also take less severe forms. The guardians of OVC, as well as home visitors, will need support for the demanding role they play in caring for others. At times they too will feel depressed and overburdened by their responsibilities. It is thus important that home visitors create local support groups which meet regularly in order to share their problems, their experiences, lessons they have learnt and to offer advice and support to those whose work involves the caring and support of others.

The activities covered in this topic are also useful as general exercises in self awareness and self reflection for all participants who are training to become home visitors; and to support vulnerable children and other caregivers.

(Adapted from REPSSI training manual for PSS)

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Help caregivers understand themselves.
- ◆ Discuss methods to use to conduct self-awareness exercises.
- ◆ Help caregivers deal with their own issues and challenges.
- ◆ Encourage caregivers to share their experiences and lessons learnt.

Activity 1 Enhancing Self-Awareness in Caregivers



In this activity, you will:

- Get the group to practise some self-awareness exercises

Facilitator's notes:

Start by mentioning to the group that everyone needs some support and that caregivers who work with orphans and vulnerable children may go through difficult times as they channel their energy towards the children. They need to be helped to introspect and to determine what their own needs are; and to identify their challenges, their strengths and their weaknesses. To do this, caregivers need to go through a process of self-evaluation to find their strengths and inner resources.

Questionnaires can help caregivers understand who they are as individuals - what their strengths, skills, qualities and abilities are. Home visitors can come up with a list of questions to help caregivers reflect on their own lives. These questions may include:

- What do you enjoy the most about giving care?
- What are the main challenges you face as a caregiver?
- What do you enjoy doing during your spare time?
- How often do you take time off from your caregiving duties to pursue other interests?
- Do you have anyone to share feelings, thoughts and problems with?

In order to support caregivers in their demanding tasks, home visitors can also help them by making sure that they are able to:

- Relax and have time to do the things they enjoy (for example, a hobby such as sewing)
- Make sure they are eating properly and getting enough rest
- Share their experiences and problems with someone
- Get support with household chores, shopping and planting, etc.
- Get spiritual support when they need it
- Spend time with friends and people they like.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:



- Introduce this activity by telling the group that everyone needs support and time away from their daily routines when they can reflect on their own lives and regain their strength. Caregivers are no exception. Home visitors will also need to offer support to the caregivers in their community. One way they can do this is by making sure that caregivers are looking after themselves and getting adequate time to do this.
- Give out Handout 1 to participants. Go through the lists on the handout and get participants to fill in any extra points they would like to add. Get participants to share their ideas with the group. You may want to write any new ideas up on the flipchart.

Activity 2 The Tree of Life



In this activity, you will:

- Get participants to do a self-exploration exercise

Facilitator's notes:

The 'tree of life' helps the participants understand themselves better on a psychosocial level.

This exercise will help participants to answer the following question:

- Are you, as a caregiver, well equipped with PSS skills to care for orphans and vulnerable children?



For this activity you will need:

- Extra sheets of blank paper
- Coloured markers or crayons



To facilitate this activity:

- Give each participant a piece of paper and some coloured markers or crayons.
Ask each participant to draw a tree that they feel will best represent who they are.
The following parts of the tree represent the different aspects of each person's life:

Branches: The people, places and events that influence one's life



Fruit: Things you have achieved

The trunk: People, places and events that influenced one's life when growing up

Bug: Challenges in your life

The roots: Background, ancestry, cultural ethnic or tribal background



Leaves on the ground: Losses or traumas you have experienced or suffered in life

The soil: Place of origin; where you come from

- After drawing their 'tree of life', each participant should share his or her tree with the group members sitting closest to him or her.

Activity 3 Me Drawings



In this activity, you will:

- Do this activity to get participants to learn more about themselves

Facilitator's notes:

This activity expands on Activity 1. 'Me drawings' can be used to help caregivers to define what inner resources they have, in a fun and non-threatening way. This activity is also aimed at giving the participants a chance to relax and self-reflect.

You will get each participant to draw a drawing that depicts themselves and manages to capture the following ideas about their life:

- Important people in their life
- Their likes and dislikes
- Their strengths and weaknesses
- Their dreams and hopes for the future
- Their health.



For this activity you will need:

- Enough extra sheets of blank paper for all participants
- Enough coloured markers or crayons for all participants

To facilitate this activity:



- Give each participant a sheet of paper and some coloured crayons or markers to share. You will get each participant to draw a depiction of themselves that manages to capture the ideas about their life listed above.
- Remember that the focus of this activity is on participants' view of their own lives, and not on their drawing ability. They do not have to draw a self-portrait. Allow them to be creative about how they want to depict themselves. For example, they could show their strengths as budding flowers and their weaknesses as wilting flowers. Circulate amongst the participants as they work to ensure that they depict all the points on the list and don't get stuck on one aspect of their lives for too long.
- If time permits and participants are willing, volunteers can show and explain their drawings to the group. It is, though, not necessary for participants to do this, as this exercise was also intended to be one of deeply personal self-inquiry, even though it was fun to do.

Activity 4 Me Boxes



In this activity, you will:

- Get the group to reflect on their life experiences

Facilitator's notes:

This activity could replace Activity 3, if time doesn't permit you to do both, as it offers another way for participants to reflect on their own lives. 'Me Boxes' also give the caregivers an opportunity to think about their lives. The things they are happy about in their lives will be shown on the outside of the box. These indicate their strengths and their positive qualities, which they are happy for all to see. The things inside the boxes represent the difficult and painful issues and challenges that they face or have faced in their lives.

Caring for the caregiver is about helping them deal with those issues inside the boxes. The facilitator's role is to encourage caregivers to share these issues, if they choose to. It is a valid counselling technique to allow a person to talk about their painful experiences, and in sharing them, lessen their weight. This process can be a healing one for caregivers. It may help them to think through their challenges and move towards healing and the ability to cope. However, the emphasis of this activity should be on the participants' self-reflection, not necessarily on direct counselling to participants.



For this activity you will need:

- Enough cardboard boxes with lids for each participant
- Coloured crayons or markers

To facilitate this activity:



- 1 Hand out a box and some crayons to each participant. Tell them that the box represents their life's experiences. Explain that the things they are happy about in their lives will be shown on the outside of the box (for example, their achievements). The things inside the boxes represent the difficult issues and challenges that they face or have faced in their lives. They will decorate their boxes creatively to depict their life experiences. Both the inside and the outside of the box can be decorated with drawings, words, symbols, patterns, or in any other way participants choose.
- 2 When participants are finished with their boxes, ask for volunteers to explain their boxes, especially the insides (which represent their challenges). You should concentrate on giving participants the chance to volunteer to talk about their challenges, but do not force responses. The main emphasis of this activity should be on participants and caregivers giving expression to, and acknowledging to themselves, their own life experiences.

Note: It is not your role, as the facilitator, to offer advice or to counsel participants during this activity. You need to make it clear to participants that this activity is a self-reflection exercise in which they will look at their own lives, past and present.

Activity 5 Support Groups



In this activity, you will:

- Introduce the concept of support groups to participants

Facilitator's notes:

The guardians of OVC, as well as home visitors, will need support for the demanding role they play in caring for others. At times they too will feel depressed and overburdened by their work in a traumatised community. One action that home visitors can take to share the weight of their role, is to link with other home visitors and guardians in their community and create local support groups. These support groups meet regularly in order for everyone to share their problems, their experiences, lessons they have learnt and to offer advice and support to those whose work involves the caring and support of others.

Fieldworkers have noted that those societies where people are traumatised by the HIV/AIDS epidemic or by wars and conflict, whole communities can become gripped by clinical depression and become dysfunctional. Groups discussions where people talk about and share their troubles and, with the guidance of a psychosocial counsellor, are helped to take small steps away from their depression by making small plans to better their situation and to cope with their lives, can bring people back to functionality.

In this activity, you will introduce the idea of support groups to the participants, especially as a means to alleviate depression caused by a range of traumatic experiences. Participants will brainstorm traits displayed by people who are severely depressed; and then consider ways that they could help to support such people to cope with their lives.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



1 Divide participants into small groups of no more than six in a group.

In their groups, participants should come up with a list of signs that could show that someone is severely depressed. For example, they don't wash their clothes or they don't work in the fields. After about ten minutes, let groups give their answers which you can write up on the flipchart.

2 Then get the groups to discuss ways that a home visitor could mobilise others in a community to become aware of people who are severely depressed and to plan ways to help them. Remind participants that a support group is essentially a social structure, and that plans to help others should primarily be concerned with bringing such a people out of isolation and back into general community life. After a few minutes, let the groups to put forward their suggestions. Write these up on the flipchart and allow further discussion of time permits.

Activity 5 ➤ Review of the Home Visitor's Handbook



In this activity, you will:

- Review the home visitor's handbooks with participants

Facilitator's notes:

You have now finished your second module of the home visitor training. At this point it is a good idea to review the home visitor's handbooks with the participants to ensure that each participant has compiled all the necessary pages. The home visitor's handbook should now include the following reference pages from the eight topics discussed in this module:



Home Visitor's Handbook – Module Two

Topic 1: The Different Needs of OVC

- The Different Needs of Children
- Indicators of Children's Problems
- Question checklist and Referral Information (participants' own worksheet)

Topic 2: Psychosocial Support for OVC

Topic 3: The Stages of Development and Understanding in Children

- Development in Children
- The Community's Role in Child Development
- Question checklist (participants' own worksheet)

Topic 4: Counselling and Communicating with OVC

- Characteristics of a Child
- How Children Communicate

Topic 5: Accompanying OVC Through Grief and Bereavement

- Preparing Children for a Death in the Family

Topic 6: Using Play in Counselling Children

- Reasons Why Children Play

Topic 7: Spiritual Care for OVC

- Spiritual Health in Children

Topic 8: Support for Caregivers

- Enhancing Self-awareness in Caregivers

MODULE 3

Addressing the Physical Needs of Orphans and Vulnerable Children

Topic 1

Food Security for OVC

215

Topic 2

Improving the Nutrition of OVC and Those Affected by HIV/AIDS

223

Topic 3

Monitoring the Health of Orphans and Vulnerable Children

237

Topic 1

Food Security for OVC

| | |
|---|------------|
| Introduction and Objectives for Topic 1 | 216 |
| | |
| Activity 1: The Meaning of <i>Food Security</i> | 217 |
| | |
| Activity 2: Threats to the Food Security of OVC | 218 |
| | |
| Activity 3: Community Initiatives to Enhance Food Security for OVC | 219 |
| | |
| Activity 4: Preparing for Home Visits: Food Security and OVC | 220 |

Introduction and Objectives for Topic 1

One of the greatest challenges facing orphans, other vulnerable children and the households which care for them is making sure that the children receive adequate food and nutrition. When adults in a household fall ill or die, they are no longer able to tend to crops, cook meals, or generate income to purchase food. Households who have taken in orphans may find that there is not enough food to go around. If the community is suffering from other threats to food security, such as drought or famine, the impact may be especially harsh for OVC, the community's most vulnerable members.

Vulnerable children thus may face all the three components of food security: availability, accessibility and utilisation. Food security may lead both adults, and the children in their care, to adopt risky survival strategies such as, sex for food and money, child labour, crime and drug abuse. The purpose of this topic is to help community members think about some of the dimensions of food security for vulnerable children; and to generate ideas about how the safety net for these children can be strengthened.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of food security.
- ◆ List threats to OVC food security.
- ◆ Discuss possible community initiatives to enhance OVC food security.
- ◆ Discuss what home visitors can do to promote food security in OVC households.



Activity 1 The Meaning of Food Security



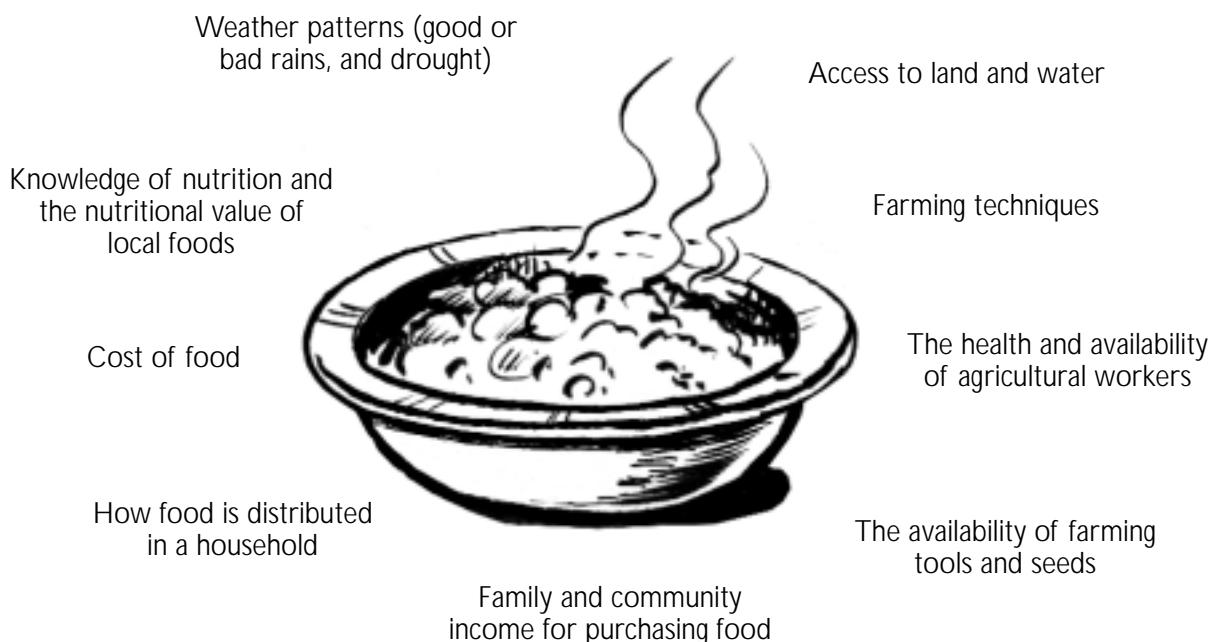
In this activity, you will:

- Define what *food security* means

Facilitator's notes:

Household food security refers to all people in the home including young children having access to adequate amounts and quality of food throughout the year. To achieve this, households must not only have the ability to produce, purchase or store food but must also have adequate knowledge on how to use the food.

Food security is influenced by a variety of factors, including:



For this activity you will need:

- Flipchart and markers

To facilitate this activity:

- 1 Introduce this topic by asking participants what they think is meant by *food security*.

Ask:

- Why is food security important for households with OVC?
- What needs to happen at the family and community level to ensure that vulnerable children have enough to eat?

Encourage participants not only to think of food security in terms of having enough food, but also to think about everything that influences whether or not a child has enough food. Supplement their ideas using your facilitator's notes.



Activity 2 Threats to the Food Security of OVC



In this activity, you will:

- Discuss the factors that may threaten food distribution to vulnerable children

Facilitator's notes:

Threats to OVC food security may include any or all of the following:

- Sickness or absence of household head to tend to crops
- Sickness or absence of household head to prepare food and cook
- Child- or elderly-headed household has difficulty attending to all the tasks required to grow or prepare food
- Time is spent on tending to the sick or attending funerals instead of farming or food preparation
- Money for food is spent on medicines or burial costs instead
- Livestock, farming equipment and tools may be sold to pay for medical or burial costs
- Knowledge about farming techniques is not passed down because parents have died
- Adults in the household no longer able to bring in income to buy food
- Lack of money to buy seeds, tools or food
- Community stores of grain and food are depleted because so many people are falling ill and dying
- OVC who have been brought into other households may not receive as much food as other family members
- Lack of understanding about good nutrition.



For this activity you will need:

- Flipchart and markers



20 minutes

To facilitate this activity:

- 1 Divide the participants into small groups. Ask each group to brainstorm as many threats to OVC food security as they can think of. Encourage them to think of threats at the family level, community level, and national level. Each group should discuss the threats to food security in three aspects: availability, utilisation and accessibility of food. Write responses up on the flipchart.
- 2 Once each group has made a list of threats, ask them to select the two or three items that most threaten the food security of OVC in their own community. Back in plenary, have each group present its ideas, which you can write up on the flipchart.
- 3 Then, based on these lists, ask whether the groups agree on the threats that are the greatest problems in their own community. If they do, ask them why; if they don't agree, ask them why not. Allow time for questions and discussion. You may supplement the participants' ideas using your facilitator's notes.

Activity 3 Community Initiatives to Enhance Food Security for OVC



In this activity, you will:

- Discuss ways in which communities can help OVC to secure food

Facilitator's notes:

This activity builds on the last one.

Some possible community-based initiatives to enhance the food security of OVC:

- Provide emergency rations to OVC who lack food
- Teach households caring for OVC more productive farming techniques
- Make sure OVC are taught skills such as how to farm or prepare food
- Provide OVC and their caregivers with resources such as seeds, tools or livestock
- Involve OVC and their caregivers in income-generating projects
- Provide OVC and their caregivers with nutritional information (see Topic 3)
- Help OVC establish vegetable gardens, either individually or collectively
- Help households headed by ill adults or children with farming and food preparation tasks
- Provide home-based care to ill adults, in order to free children from these responsibilities so that they can help with tending crops or food preparation
- Encourage households that have taken in OVC to treat these children the same as their own children and to feed them adequately.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



40 minutes

To facilitate this activity:

- Remind the groups of the threats to food security that they prioritised in the previous activity.
- Divide the participants into small groups, one group for each threat to food security. Each group should then discuss ways that the threat they have been assigned could be overcome in their community. Encourage them to think of solutions that would be feasible, without too many additional resources. Back in plenary, ask each group to present its ideas. Compile a list of all of the suggested interventions on flipchart paper, which the community can refer to in future planning. Add any ideas from your facilitator's notes, if relevant. Allow time for questions and discussion.
- Distribute Handout 1 to participants. It reviews local community-level initiatives for food security for OVC.

Handout 1 - Module 2 Topic 2
Community Initiatives to Enhance Food Security for OVC

Threats to OVC food security may include any or all of the following:

- Illness or absence of household head to tend to crops
- Illness or absence of household head to prepare food and care
- Child- or elderly-headed household has difficulty attending to all the tasks required to grow or prepare food
- Time is spent on tending to the sick or attending funerals instead of farming or food preparation
- Money for food is spent on medicines or burial costs instead
- Livestock, farming equipment, etc. are sold to pay for medical or burial costs
- Knowledge about farming techniques is not passed down because parents have died
- Adults in the household are longer able to bring in income to buy food
- Lack of healthy OVC food, tools or food
- Community stores of grain, food, etc. depleted because so many people are falling ill and dying
- OVC who have been brought into other households may not receive as much food as other family members
- Lack of understanding about good nutrition

Some community-based initiatives to enhance the food security of OVC:

- Provide emergency rations to OVC who lack food
- Teach households caring for OVC more productive farming techniques
- Make sure OVC and their caregivers are taught how to farm, grow vegetables, prepare food, etc.
- Provide OVC and their caregivers with seeds, tools, livestock, etc.
- Involve OVC and their caregivers in income-generating projects
- Provide OVC and their caregivers with nutritional information
- Help households headed by ill adults or children with farming and food preparation tasks
- Provide home-based care to ill adults, so children are free to tend crops, prepare food, etc.
- Encourage households that have taken in OVC to treat these children the same as their own children and to feed them adequately

Activity 4 Preparing for Home Visits: Food Security and OVC



In this activity, you will:

- Discuss how home visitors can address issues of food security for OVC with caregivers and other community stakeholders

Facilitator's notes:

In this activity, participants will explore the ways that home visitors can address OVC food security with caregivers and community stakeholders:

1 Home visitors need to assess each household in relation to OVC food security, for example:

- What is the HIV/AIDS burden on the household?
- What are the food production patterns in the community and in the households with OVC (types, quantities and seasonality of foods)?
- Do they have access to health, social and financial services?
- Who mainly does the work in the household?
- How is the available food used (prepared, preserved, stored, bought and sold)?
- Food consumption patterns (number and times of meals, distribution of meals among household members, and social cultural factors).
- Coping mechanisms for food insecurity (food for work, food aid or migration)
- Availability of food (ability to produce and purchase, donations, diversity of foods available and amount of food).
- Accessibility – does every member of the household get enough food in terms of quantity and variety?
- How are household constraints and challenges met in adopting recommended practices?

2 Based on their assessment, home visitors can support households with OVC to implement effective and sustainable food security strategies by:

- Encouraging households to improve food security by growing a variety of foods and rearing animals, such as chickens and rabbits.
- Getting information from local government and agricultural services on how to improve agricultural productivity using new crop breeds and new technologies to reduce labour requirements.
- Encouraging families to start income generating activities to enable the families to remain financially secure and conserve family integrity. Households may link up with micro-finance institutions to support production.
- Encouraging households to distribute food according to the different nutritional needs of family members.
- Giving households information on basic nutrition and the nutritional needs of children and those who are ill.

3 Home visitors can help to link households to food assistance services in the community, for example:

- Home visitors should have information about services which offer to strengthen food access and availability, especially among households affected by HIV/AIDS. (They should know what they offer, the criteria used to target beneficiaries and when they offer the services.)
- Home visitors should work with programme managers who operate food assistance services in the area and agree on the criteria for participation and establish formal links to avail referral.
- Home visitors should refer eligible OVC caregivers to these services that may provide food support to the children, the family and pregnant or breastfeeding mothers. (They need to give a referral note that is acknowledged by the programme.)
- Inform OVC households about food security social networks in the community, such as groups which assist households affected by HIV/AIDS to grow food; or those that collect food and distribute it to families affected by HIV/AIDS.



For this activity you will need:

- Flipchart and markers



45 minutes

To facilitate this activity:

- 1 Ask participants to brainstorm ways that a home visitor can improve food security in an OVC household in these three aspects: availability, utilisation and accessibility. Write up their suggestions on flipchart paper. When you have all their responses, try to link them with the community-based solutions to food security threats from Activity 3. In this way, participants will have a sense of both a household and a community-based strategy for food security. In this discussion, stress the role a home visitor can take in these strategies for food security. Add ideas from your facilitator's notes and allow time for questions.
- 2 Participants will insert these notes and the other handouts on food security into their home visitor's handbooks for reference.



Topic 2

Improving the Nutrition of OVC and Those Affected by HIV/AIDS

| | |
|---|-----|
| Introduction and Objectives for Topic 2 | 224 |
| Activity 1: The Meaning of <i>Nutrition</i> | 225 |
| Activity 2: Identifying Important Foods | 226 |
| Activity 3: Nutritional Support for Children with HIV or Those Born to HIV Positive Mothers | 228 |
| Activity 4: Nutritional Support for HIV Positive Pregnant Women and Breastfeeding Mothers | 231 |
| Activity 5: Nutritional Support for Adults Living with HIV/AIDS | 232 |
| Activity 6: The Causes and Effects of Poor Nutrition | 233 |
| Activity 7: Steps to Help Malnourished OVC | 234 |
| Activity 8: Preparing for Home Visits: Nutritional Information | 235 |

Introduction and Objectives for Topic 2

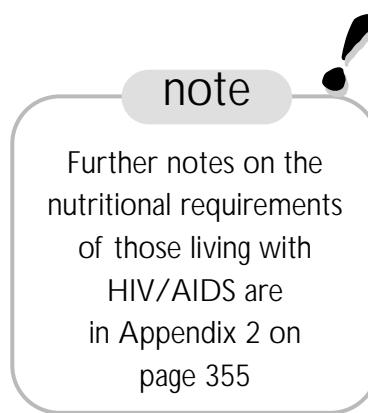
Many orphans and vulnerable children are malnourished, not getting enough food or the necessary nutritional requirements that they need for normal growth and development. This will consequently affect their growth and development rates. Children living with HIV/AIDS have even higher energy needs due to infections and changed metabolism.

An introduction to good nutrition is important for those who will be supporting OVC.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of nutrition and the signs of poor nutrition among OVC.
- ◆ Explain what foods are important to children's development.
- ◆ Describe the common nutrition problems among OVC and their causes.
- ◆ Explain important ways for providing nutritional care and support for adults with HIV/AIDS.
- ◆ Explain important ways to provide nutritional care for pregnant and breastfeeding women.
- ◆ Describe nutritional care and support for children with HIV or those born to HIV positive mothers.
- ◆ Discuss strategies for addressing poor nutrition among OVC.
- ◆ Discuss what a home visitor can do to promote good nutrition among OVC.



Activity 1 ➤ The Meaning of Nutrition



In this activity, you will:

- Discuss and define what *nutrition* means

Facilitator's notes:

Definition of nutrition:

Nutrition can be defined as the use of food by our bodies for growth, energy and protection from disease.

Good nutrition can be defined as the intake of sufficient nutrients and the efficient use of food by our bodies.

Poor nutrition means an insufficient or unbalanced intake of food substances, which generally results in malnutrition, which affects the proper functioning of the body.

An adequate diet requires consuming a variety of foods that will provide the body with the necessary energy, protein, fats and micro-nutrients (vitamins and minerals) it needs to function properly. These nutrients can be obtained from:

- Locally available foods grown in gardens, gathered or bought from markets that are naturally rich in nutrients
- Fortified foods that have been enriched with extra vitamins or minerals
- Micro-nutrient supplements, available as pills or tablets rich in vitamins and minerals.

All these sources of food contain nutrients that help the body to remain healthy and strong.



For this activity you will need:

- Flipchart and markers



20 minutes

Facilitator's notes:

- Introduce this topic to the group by asking participants to describe why they think food is important to the body. Write their responses up on the flipchart. Summarise and clarify their contributions by giving the definitions of nutrition and poor nutrition in your facilitator's notes.
- Explain that food has different uses: energy, the growth and repair of body tissues, and protection against diseases. Start making the link between sufficient quantities of different types of food and the health of the body. You will discuss these in more depth in the next activities.

Activity 2 Identifying Important Foods



In this activity, you will:

- Look at the different food groups and discuss why they are important

Facilitator's notes:

In this activity, you will discuss nutrition in relation to the main food groups.

Energy-giving foods:

Carbohydrates - The main source of carbohydrates in the diet is from staples and sugars.

- **Staples or starches** make up the biggest part of any meal for the majority of the population.

They include maize, matooke, Irish, potatoes, sweet potatoes, cassava, sorghum, millet, yams, rice and bread. Staples need to be eaten in combination with other foods to provide enough nutrients.

- **Sugars** are also rich sources of energy.

However, sugary foods are not very nutritious.

- **Fats and oils** are rich sources of energy,

but people only need fats in small quantities.

Vegetable oils and fats are obtained from corn, simsim, sunflower, cottonseed, shea butter, palm oil and margarine. Animal sources of oils and fats include lard, butter (including ghee), cheese, fatty meat and fish (including fish oil).



Body-building foods:

Proteins are body-building foods. They are essential for cell growth.

Proteins support the functioning and formation of the general structure of all tissues, including muscles, bones, teeth, skin and nails. There are two main types of proteins:

- **Plant proteins** include beans and peas of different varieties, green grams, groundnuts, soybeans and simsim.

- **Animal proteins** are meat, milk (including products like cheese, yoghurt and fermented milk) and eggs.



Protective Foods:

These foods keep the body working properly and protect against disease. **Fruits and vegetables** are known as protective foods because they provide vitamins and minerals that strengthen the immune system. Fruits and vegetables supply vitamins and minerals, which are substances required by the body in small amounts for its normal physiological functions.



- **Fruits** include avocados, mangoes, pawpaws, pumpkin, passion fruit, pineapple and jackfruit. Oranges, lemons and other citrus fruits are rich sources of vitamin C. Like vegetables, most fruits are seasonal.
- **Vegetables** include dodo, nnakati, spinach, pumpkin leaves, cowpea leaves, carrots, cassava and green peppers. Cabbage is a vegetable that is important mainly as roughage. Vegetables contain useful immune substances called beta-carotenes. In many cases, vegetables are seasonal in availability, quality and prices.
- **Vitamins** are vital for the body to function properly.
- **Minerals** are needed for the functioning of the immune system. Important minerals include iron, selenium, zinc, iodine, calcium and magnesium.

Note: Some foods fit in more than one category. For example, bananas give energy but they are also a good source of potassium, an important mineral. Milk and cheese are a good source of protein and also contain calcium. The healthiest foods often contain the most nutrients.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



45 minutes

To facilitate this activity:

- 1 Explain to the group that no single food contains all the nutrients the body needs in the right quantities and combinations. Explain that a balanced diet is made up of a variety of foods in adequate quantities and combinations to supply essential nutrients on a daily basis.

Then discuss the three main categories of foods:

- ◆ Energy-giving foods – carbohydrates, fats and oils, dietary fibre, sugars
- ◆ Body-building foods – foods for growth and repair
- ◆ Protective foods – vitamins, minerals, vegetables, fruits.

Add that water is also a very important component needed by the body and its functions.

- 2 Ask participants to give examples of foods from each category and what purpose they serve. Supplement their input with the information from your facilitator's notes.

If you like, you may use drawings or even bring examples of foods and ask participants to guess which purpose they serve.

- 3 Hand out copies of Handout 1 as reference for their home visitor's handbooks.

Handout 1 – Module 2 – Topic 2
Important Foods Group

Energy-giving foods:
Carbohydrates: - The main source of carbohydrates in the diet is from staples and sugars.
• **Staples and sugars:** make up the largest part of any meal for the majority of the population. They include maize, cassava, trift, posho, dried cassava, sorghum, millet, yams, rice and bread. Staples need to be eaten in combination with other foods to provide enough nutrients.
• **Sugars:** are also rich sources of energy, but are not very nutritious.
• **Fats and oils:** are rich sources of energy but people only need fats in small quantities.
Vegetable oils are obtained from coconuts, sunflower, cottonseed, olive, butter, palm oil and margarine. Animal sources of fat include lard, butter, cheese, meat and fish.

Body-building foods:
Proteins: are body-building foods. They are essential for cell growth and support the functioning and formation of the general structure of all tissues, including muscles, bones, muscle, skin and hair. Main types of proteins are:
• **Plant proteins:** include beans and peas, green grams, groundnuts, soybeans and beans.
• **Animal proteins:** are meat, milk (including products like cheese, yoghurt and fermented milk) and eggs.

Protective foods:
These foods keep the body working properly and protect against disease. **Fruits and vegetables** are known as protective foods because they provide vitamins and minerals that strengthen the immune system. They supply vitamins and minerals, which are required by the body for its normal physiological functions.
• **Fruits:** include avocados, mangoes, papayas, pumpkins, passion fruit, mangoes and papaya. Oranges, avocados and other citrus fruits are rich sources of vitamin C.
• **Vegetables:** contain useful immune substances called lutein carotenoids. In many cases, vegetables are seasonal in availability, quality and prices.
• **Vitamins:** are vital for the body to function properly.
• **Minerals:** are needed for the functioning of the immune system. Important minerals include iron, selenium, zinc, iodine, calcium and magnesium.

Activity 3**Nutritional Support for Children with HIV or Those Born to HIV Positive Mothers****In this activity, you will:**

- Look at the nutritional needs of HIV positive infants and children at risk

Facilitator's notes:

Children born to HIV positive mothers are more likely to be born with low birth weights compared to children born to HIV negative mothers. As they grow, they are more likely to experience growth failure and malnutrition and are at increased risk of death. In addition, factors related to inadequate care due to the deteriorating health of the mother may worsen the malnutrition. Therefore, children born to HIV positive mothers need special attention, feeding and support. This group includes infants and young children, HIV infected children and severely malnourished HIV infected children.

The role of a home visitor is to explain to mothers the importance of knowing their HIV status and to provide them with information so they can choose the most appropriate feeding option for their infants. This will help reduce the risk of HIV transmission and death from inappropriate feeding.

Nutrition for children under two years old who are born to HIV positive mothers:

Infants who are born to HIV positive mothers are at risk of becoming HIV positive themselves, through breastfeeding from the infected mother. In such cases, it is recommended that a mother choose one of two options to feed her child:

- ◆ *Exclusive breastfeeding* (with no other foods given, not even water)
- ◆ *Exclusive replacement feeding* (with all breastfeeding replaced with a food substitute, such as cow's milk).

It is important that a mother does not mix the two feeding options, as this will increase the risk of HIV transmission.

There are risks and benefits associated with each of the feeding options, so a mother will need to be aware of these so that she can make an informed choice. These have been outlined in Handout 2.



Nutrition for children over two years old who are HIV positive:

Children who are HIV positive will often not grow and develop properly, and are at greater risk of death. They are more susceptible to common childhood illnesses such as diarrhoea, acute respiratory infections (ARIs), malaria, neurological problems and general growth retardation. They are also at increased risk of malnutrition due to poor appetite, swallowing difficulties and nausea. As such, HIV infected children should be given special attention to ensure they receive adequate amounts of both macro- and micro-nutrients. They also need adequate care.

Children infected with HIV need nutritious diets to boost their immune systems so they can deal adequately with infections. Foodstuffs enriched with Vitamin A, in particular, can help to boost a child's immune system. Also, food for children with HIV must be prepared with extra hygienic care, as their bodies are vulnerable to infections from germs found in food that is not cooked adequately or prepared safely (for example, all dishes and cooking utensils must be clean).

Children infected with HIV need:

- ◆ Foods high in energy, proteins and micro-nutrients.
- ◆ To be fed more often, with smaller, frequent meals and snacks. This will aid the absorption of nutrients better.
- ◆ To be fed with a variety of fruit and vegetables, to ensure adequate nutritional intake.
- ◆ To be fed with foods that are fortified with added micro-nutrients, if possible.
- ◆ Adequate clean water to drink (preferably boiled water that has been left to cool).

Caregivers will also need to be aware of factors that result in the decreased food intake in these children. A child with HIV may experience difficulty in eating due to sores or ulcers in the mouth that make it hard to swallow food. Infections such as fevers and coughs cause increased energy needs in children. Diarrhoea can result in dehydration (water loss) and loss of nutrients, so increased energy requirements are needed. Children with HIV also have a poor absorption of nutrients, so if a child's diet is not adequate in meeting the increased nutritional needs, the child may be at risk of malnutrition. (Malnutrition is dealt with later in this topic.)

Some tips to aid the nutritional intake of children with HIV:

- ◆ Porridge can be enriched with milk, soya flour, groundnuts or simsim
- ◆ Add a small amount of uncooked vegetable oil to foods – this will aid digestion
- ◆ Vegetables and fruits such as bananas, pawpaws, pumpkins and avocados can be eaten mashed to make them easier to swallow
- ◆ Avoid fried and spicy foods – they are hard to digest, cause irritation in the stomach and can cause further diarrhoea
- ◆ Avoid sugary foods (sweets and colddrinks) – they encourage fungal infections
- ◆ Yoghurt or maas helps to stop fungal infections in the stomach and aids digestion
- ◆ Dried pumpkin seeds and garlic are good for stopping stomach parasites
- ◆ The older the child, the more food they need to eat.



For this activity you will need:

- Flipchart and markers
- Copies of Handouts 2 and 3

To facilitate this activity:



- 1 Introduce the activity by explaining that children living with HIV or those born to HIV positive mothers require special nutritional care and support.
- 2 Explain that people living with HIV/AIDS often lack some or all of the categories of food nutrients, because their immune systems are not strong. Get participants to discuss why they think children living with HIV/AIDS need good nutritional care and support. Write their responses up on the flipchart and then discuss and add any points you think are necessary from your facilitator's notes.
- 3 Ask participants to outline the different ways home visitors can ensure the nutritional intake of children living with HIV/AIDS. Summarise the responses into four to six strategies, using your facilitator's notes for guidance.
- 4 Divide participants into groups – so that there is a group for each strategy. Groups should consider and then describe activities that a home visitor can do to ensure such support is actually provided.
- 5 Groups report back to plenary and present their strategy outlines. Review their responses and add any points as necessary from your facilitator's notes.
- 6 Distribute copies of Handouts 2 and 3 to participants for reference.

note

Expanded notes on the nutritional requirements of adults and children living with HIV/AIDS are in Appendix 2 on page 355

Handout 3 - Module 3 Topic 3

Nutritional Support for Infants Born to HIV Positive Mothers

Infants who are born to HIV positive mothers are at risk of becoming HIV positive themselves, through transmission from the infected mother. In such cases, it is recommended that a mother choose one of two options to feed her child:

- **Exclusive breastfeeding:** (without other foods, given, not even water)
- **Exclusive replacement feeding:** (with all breastmilk replaced with a liquid substitute, such as cow's milk)

It is important that a mother does not mix the two feeding options, as this will increase the risk of HIV transmission. There are risks and benefits associated with each of the feeding options, so a mother will need to be aware of these so that she can make an informed choice.

Exclusive breastfeeding:

Benefits:

- Breast milk contains everything a baby needs, including more energy, protein and micro-nutrients.
- Breast milk is easy to provide to the child, it is always available and it is not costly.
- It gives emotional benefits to the mother and baby.
- It has immunological benefits for the mother.
- It is culturally appropriate.

Notes:

- Milk can be passed on the infant through breast milk.
- Breastfeeding can strengthen the strength of the mother and expose her to infections.

Replacement feeding:

Benefits:

- Replacement feeding reduces the risk of transmission of HIV from the mother to the infant.
- The mother's body resources are not depleted and this means the child is stronger.

Notes:

- There is a higher risk of other non-HIV infections for the infant.
- Other foods do not transfer mother's protective antibodies and enzymes.
- Foods are expensive, and hard for boiling the water and making the food also clean/ hygienic.
- If foods are not prepared properly, they can cause diseases that last to malnutrition.
- If the mother does not breastfeed, it may not be culturally acceptable and may increase stigma for the infected mother.

Handout 3 - Module 3 Topic 3

Nutritional Support for Children over Two Years who are HIV Positive

Children who are HIV positive will often not grow and develop properly and are at greater risk of death. They can easily get illnesses such as diarrhoea, acute respiratory infections (ARI), malnutrition, neurological problems and experience poor growth. They may also risk malnutrition due to poor appetite, swallowing difficulties and nausea. As such, HIV infected children should be given special attention to ensure they receive adequate nutrition and care.

Children infected with HIV need nutritional diets to boost their immune systems as their immune system is often compromised. Foods rich in Vitamin A, in particular, can help to boost a child's immune system. These foods for children with HIV must be prepared with extra hygiene care, as they bodies are vulnerable to infections from germs found in food that is not cooked adequately or prepared safely (for example, oil dishes and cooking utensils must be clean).

Children infected with HIV needs:

- Foods high in energy, protein and micro-nutrients.
- To be fed more often, with smaller, frequent meals and snacks. This will set the absorption of nutrients easier.
- To eat and drink a variety of fruits and vegetables, to ensure adequate nutritional intake.
- To be fed with foods that are fortified with added micro-nutrients, if possible.
- Adequate clean water to drink (preferably boiled water that has been left to cool).

A child with HIV may experience a diminished food intake because of difficulties in eating due to sores or ulcers in the mouth that make it hard to swallow food. Infections such as fevers and respiratory infections (cough) cause increased energy needs in children. Diarrhoea can result in dehydration (water loss) and loss of nutrients, so increased energy requirements are needed. Children with HIV also have a poor absorption of nutrients, so if a child's diet is not adequate in meeting the increased nutritional needs, the child may be at risk of malnutrition.

Some tips to aid nutritional intake for children with HIV:

- Porridge can be prepared with milks, soya flour, groundnuts or similar
- Add a small amount of uncooked vegetables oil to foods – this will aid digestion
- Vegetables and fruits such as bananas, pumpkins, carrots and cassava can be eaten mashed to make them easier to swallow
- Avoid fried and spicy foods – they are hard to digest, cause irritation in the stomach and can cause further diarrhoea
- Avoid sugary foods (sweets and biscuits) – they encourage fungal infections
- Yoghurt or maize helps to keep fungal infections in the stomach and oral cavity
- Dried pumpkin seeds and garlic are good for stopping stomach parasites
- The older the child, the more food they need to eat.

Activity 4**Nutritional Support for HIV Positive Pregnant Women and Breastfeeding Mothers****In this activity, you will:**

- Look at the nutritional needs of HIV positive pregnant women and breastfeeding mothers

Facilitator's notes:

Expectant women and breastfeeding mothers who are HIV positive have special nutritional requirements. Nutritional care for pregnant women is especially important so that:

- ◆ their bodies are strong enough to cope with delivering a baby (this also determines the risk of MTCT).
- ◆ their children survive and develop adequately.

Pregnant and breastfeeding mothers who are infected with HIV are at a higher risk of malnutrition and mortality. Due to the extra demands for energy and nutrients exerted by pregnancy, breastfeeding and HIV, they require additional food and energy intake. Unfortunately, many women become pregnant when they are already malnourished. They are often malnourished prior to HIV infection as well. If a woman is HIV positive, then the effects of malnutrition and HIV increase her vulnerability to further health dangers associated with pregnancy and childbirth.

As a home visitor, you can help pregnant women and breastfeeding mothers (some who may be OVC themselves), by encouraging them to test for HIV infection. You cannot force anyone to take a test; but knowing their status will allow them to take actions that will help them and their children to stay healthy for as long as possible. If mothers or pregnant women are diagnosed as being HIV positive, you can also encourage them to:

- ◆ Seek early antenatal and postnatal care and to use PMTCT services
- ◆ Have their general health checked (weight, blood); infections treated (for example, STIs, malaria); have regular deworming
- ◆ Monitor their nutritional status
- ◆ Practise reproductive health and safe sex.

**For this activity you will need:**

- Flipchart and markers

Facilitator's notes:

- 1 Get participants to brainstorm reasons why it is important that pregnant women and breastfeeding mothers need adequate nutrients in their diet. Write up their input and discuss this further using your facilitator's notes.
- 2 Then get the group to consider the additional requirements these women need if they are also HIV positive. For more information on this subject, you can consult Appendix 2.



Activity 5 Nutritional Support for Adults Living with HIV/AIDS



In this activity, you will:

- Discuss the nutritional needs of adults who are HIV positive

Facilitator's notes:

The mortality of parents and guardians due to HIV/AIDS poses a huge challenge to communities to accommodate and care for the resulting orphans and vulnerable children. However, it is important for home visitors to show adults who are living with HIV (and have not yet got full blown AIDS), that there is a lot they can do to ensure that their own health is maintained. One way is to make sure that they are eating properly and getting the nutritional requirements they need.

Adults with HIV may suffer from loss of appetite, difficulty eating and poor absorption of nutrients. This compromises their nutrition and results in deteriorating health. Good nutrition practices can contribute to the adoption of a positive attitude, which normally improves the quality of life for adults with HIV/AIDS.

To improve their nutritional status, an adult living with HIV needs:

- Between 10 - 30% more energy intake than an adult who is HIV negative.
- To do light exercise, to keep healthy and build up an appetite.
- To use anti-retrovirals (ARVs), if possible.
- To get treatment for symptoms or conditions that affect their appetite or ability to eat, such as mouth sores.
- To avoid eating foods that upset the stomach, such as sugary, acidic and spicy foods.

Home visitors can offer support to adults living with HIV by:

- Helping them to access dietary information on nutrition and HIV.
- Encouraging them to have regular check-ups, to monitor their weight and nutritional status.
- Encouraging them to get enough light exercise to prevent loss of muscle and strength.
- Supporting them to get treatment for illnesses that affect their health.



For this activity you will need:

- Flipchart and markers
- Reference notes on HIV/AIDS in Appendix 2 on page 355

Facilitator's notes:

- This activity links to the last one and gives participants a further chance to discuss how HIV affects the nutritional status of adults. As home visitors, participants may be required to help in households where adults and older youth are HIV positive and are in need of support. You may want to open the discussion by giving the information above and taking questions from the group. Use the reference notes to help you answer questions; or you can get participants to do research on the subject for homework.



Activity 6 The Causes and Effects of Poor Nutrition



In this activity, you will:

- Discuss the common signs of malnutrition in children and what the causes are

Facilitator's notes:

In this activity, you will discuss the causes and effects of malnutrition amongst children.

Causes of nutritional problems among children are:

- Insufficient food because of poor harvest, lack of money, famine
- Inadequate and infrequent meals
- Poorly balanced diet (too much of one food – usually carbohydrates, not enough protein, fruits and vegetables)
- Illness
- Worms and intestinal parasites
- Lack of knowledge or guidance
- Cultural beliefs and practices.

Common conditions of nutritional problems among young children are:

- Kwashikor
- Malasmus
- Underweight
- Small for age
- No energy, no strength, poor concentration and depression
- Weak body prone to disease
- Anaemia
- Oedema (swollen feet).



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- Ask participants to describe the appearance of a child who is suffering from poor nutrition. What problems is this child likely to have? Clarify and supplement based on the information in your facilitator's notes. Next, ask the participants to brainstorm the causes of poor nutrition. Ask them to think about the major causes of poor nutrition in their own community. Add ideas from the facilitator's notes and the references in Appendix 2. You may want to write the responses up on the flipchart.
- Ask participants to start thinking about what can be done in their own communities to help vulnerable children who are obviously not getting adequate food or having their nutritional requirements met. Community interventions will form the subject of the next activity.

Activity 7 Steps to Help Malnourished OVC



In this activity, you will:

- Discuss ways that the community can address poor nutrition in OVC

Facilitator's notes:

Some possible community-based strategies for addressing poor nutrition among OVC:

- Educate caregivers about proper nutrition and provide practical advice about improving nutrition in the household
- Train home visitors to provide nutrition information and advice
- Help households to start vegetable gardens (individually or communally)
- Train caregiver households in more effective farming practices
- Provide vulnerable households with seeds and tools to cultivate nutrient-rich foods
- Help households to start income-generating activities that can raise money for food
- Advocate for children to get treated for worms and other illnesses that cause poor nutrition
- Raise community awareness about good nutrition and advocate against cultural beliefs and practices that promote poor nutrition
- Help dangerously malnourished children to access food rations mobilised from within the community or from an NGO that provides food aid.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 4

To facilitate this activity:

- Divide the participants in groups and ask them to brainstorm the steps they can take to address poor nutrition in the children they visit. Participants may identify the following:
 - Educate OVC and their caregivers about proper nutrition, using the handouts provided in this module, together with drawings and/or examples of actual foods, and provide practical advice about improving nutrition in the household.
 - Help households to start vegetable and food gardens.
 - Help children to access treatment for worms and other conditions that cause poor nutrition.

The CCC may already have identified ways to assist malnourished children in the community. Discuss these and what further steps home visitors can take when they encounter malnourished children.

- Hand out copies of Handout 4 to participants.



45 minutes

Handout 4 - Module 2 - Topic 2

Steps to Help Malnourished Children

Some community-based strategies for addressing poor nutrition among OVC:

- Educate caregivers about proper nutrition and provide practical advice about improving nutrition in the household
- Train home visitors to provide nutrition information and advice
- Help households to start vegetable gardens (individually or communally)
- Train caregiver households in more effective farming practices
- Provide vulnerable households with seeds and tools to cultivate nutrient-rich foods
- Help households to start income-generating activities that can raise money for food
- Advocate for children to get treated for worms and other illnesses that cause poor nutrition
- Raise community awareness about good nutrition and advocate against cultural beliefs and practices that promote poor nutrition
- Help dangerously malnourished children to access food rations mobilised from within the community or from an NGO that provides food aid.



Activity 8 Preparing for Home Visits: Nutritional Information



In this activity, you will:

- Help participants put together their notes on nutrition and malnutrition for their home visitor's handbook

Facilitator's notes:

Nutritional information will be useful for home visitors when giving advice on the care and support of orphans and vulnerable children. The information in this topic will be expanded on in the next section on the general health of OVC.



For this activity you will need:

- Copies of the Handouts from this topic



30 minutes

To facilitate this activity:

- Get the participants to organise all the handouts on nutrition into their home visitor's handbooks. If you wish, you may get participants to design drawings to accompany their handouts in their own time.
- Then, in groups, have the participants practise in a role-play how they would explain good nutrition to children and families. Provide feedback and guidance as needed. Explain to them that this will be one of their important tasks during home visits: to monitor the nutritional status of the children they visit; and to provide basic nutrition information to caregivers and their families.
- Also use this time to answer any questions participants may have about diets and nutrition, especially the requirements of those living with HIV/AIDS. Encourage participants to research as much as they can about the subject.



Topic 3

Monitoring the Health of Orphans and Vulnerable Children

| | |
|--|------------|
| Introduction and Objectives for Topic 3 | 238 |
| | |
| Activity 1: Basic Healthcare and the Needs of OVC | 239 |
| | |
| Activity 2: Immunisation | 241 |
| | |
| Activity 3: Common Diseases that Affect Children | 243 |
| | |
| Activity 4: Barriers to Healthcare and Ways to Ensure Access | 245 |
| | |
| Activity 5: Basic Hygiene Practices | 246 |
| | |
| Activity 6: Access to Sanitation and Safe Water | 249 |
| | |
| Activity 7: Sexual and Reproductive Health | 250 |
| | |
| Activity 8: Preparing for Home Visits: Monitoring the Health of OVC | 251 |
| | |
| Activity 9: Review of the Home Visitor's Handbook | 252 |

Introduction and Objectives for Topic 3

Orphans and vulnerable children may suffer from poor health for a number of reasons:

- Their parents or guardians may be unable to take them to clinics
- They may lack money for transport and clinic fees
- Their guardians may lack knowledge about preventative healthcare
- Households and communities traumatised by HIV/AIDS or conflict situations may not recognise that the healthcare needs of a child are important and may neglect to care for children, including not giving them adequate food and treatment for illnesses.

These children will need healthcare support. However, a community-based programme cannot provide all the services of primary healthcare institutions, but it can ensure that vulnerable children are able to access the existing health facilities and resources to the same extent as other children.

Good health is defined as 'the complete physical, mental, social and spiritual well-being of the child, not merely the absence of disease' (WHO). However, general health knowledge is necessary so that an illness can be identified early and treated appropriately. Basic hygiene and sanitation practices in a household can also help to ensure that children's health is maintained.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Describe the healthcare needs of OVC.
- ◆ Describe what immunisation means and why it is necessary.
- ◆ Describe what malaria is and how it can be prevented.
- ◆ Describe some of the common illnesses that children get, such as diarrhoea and how to treat them.
- ◆ Describe good hygiene practices.
- ◆ Describe how good sanitation practices are important for health.
- ◆ Discuss safe drinking water.
- ◆ Discuss sexual and reproductive health.
- ◆ List barriers that prevent OVC from accessing healthcare.
- ◆ Discuss possible community-based initiatives to help OVC access healthcare.



Activity 1 Basic Healthcare and the Needs of OVC



In this activity, you will:

- Discuss the general healthcare needs of children

Facilitator's notes:

Good health is defined as 'the complete physical, mental, social and spiritual well-being of the child, not merely the absence of disease' (WHO). All children have the same healthcare needs, but vulnerable children may lack access to these basic needs to ensure their health. In this session, you will discuss some of these general requirements for the physical health of children.

All children have the same healthcare needs.

They need preventative healthcare, including:

- Regular medical check-ups done by a healthcare worker, to monitor whether they are developing properly (this includes children who are disabled or are HIV positive)
- Immunisation against serious diseases
- Insecticide-treated bed nets, or other means, to prevent malaria
- Good nutrition
- Age-appropriate information about preventing HIV infection.

They also need curative healthcare, including:

- The treatment of any illness or disease with appropriate medication
- Extra nutritional intake if they have been ill
- Regular deworming treatment.

In order for these needs to be met, children also need:

- Parents or guardians to understand the importance of preventative healthcare
- Parents or guardians to know where to seek medical help to treat a child's illness
- Parents or guardians to seek early medical help to treat a child's illness
- Access to immunisations through clinics or healthcare programmes
- Access to well-baby and well-child check-ups to make sure that the child does not have any developing health problems
- Access to clean water and proper sanitation
- Knowledge about basic good hygiene practices
- Age-appropriate information about universal precautions to prevent HIV infection when caring for a sick adult
- Access to healthcare workers, clinics and medicines when they are ill.

Regular health check-ups for children:

Regular check-ups done by a healthcare worker help to monitor the growth and development of children; and ensure that any infections are treated. For infants and young children up to five years old, check-ups will also involve immunisations against serious illnesses.

(This is dealt with further in Activity 2.)

Children should also be weighed regularly and this recorded on a clinic card. If a child is not gaining weight adequately, then they should be fed more regularly. If a child loses weight, he or she should be taken to a clinic as malnutrition may be indicated.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:



45 minutes

- 1 Explain to the participants that there are certain health precautions that we, as adults, can take to reduce the risk of illness. For example, practising good hygiene helps to stop the spread of germs that lead to disease. However, children may be unable to take these precautions themselves, so they may get ill unless their healthcare needs are monitored by caregivers.
- 2 Ask participants to list the general healthcare needs of children. Then ask them what the most urgent healthcare needs in their community are. Next, ask them to describe the healthcare needs that are particularly urgent for vulnerable children, who may not have adequate care and access to treatment. Add to participants' ideas by using your facilitator's notes.
- 3 Distribute Handout 1 and review each item with the group. Ask them if they understand why these practices are necessary. It is possible, for example, that they don't know about the transmission of germs due to poor hygiene practices. (Hygiene is discussed further in more detail in later activities.) Explain to the participants that they will be sharing this health and hygiene information during home visits and helping to ensure the health of those households that they visit.

Handout 1 - Module 2: Topic 2
Basic Healthcare Needs of Children

All children have the same healthcare needs.

They need **preventative healthcare**, including:

- Regular medical check-ups done by a healthcare worker, to monitor whether they are developing properly (including disabled children or those HIV positive)
- Immunisation against serious diseases
- Insecticide-treated bed nets, or other means, to prevent malaria
- Good nutrition
- Age-appropriate information about preventing HIV infection

They also need **curative healthcare**, including:

- The treatment of any illness or disease with appropriate medication
- Fresh nutritional intake if they have been ill
- Regular deworming treatment

In order for these needs to be met, children also need:

- Parents or guardians to understand the importance of preventative healthcare
- Parents or guardians to know where to seek medical help to treat a child's illness
- Parents or guardians to seek early medical help to treat a child's illness
- Access to immunisations through clinics or healthcare programmes
- Access to well-baby and well-child check-ups to make sure that the child does not have any developing health problems
- Access to clean water and proper sanitation
- Knowledge about basic good hygiene practices
- Access to healthcare workers, clinics and medicines when they are ill.

Activity 2 Immunisation



In this activity, you will:

- Discuss immunisation and the illnesses children need to be immunised against

Facilitator's notes:

Immunisation is when a child is given a vaccine that is either injected into the body or swallowed to protect against certain serious preventable diseases that can cause deaths in children.

The following are the immunisable diseases in most African countries: Measles, poliomyelitis, whooping cough, tetanus, tuberculosis, diphtheria, Hepatitis B, Haemophilus Influenzae type B, yellow fever.

The following are key messages about immunisation:

All children need to be immunised

- All children under one year need to be immunised. Half of the deaths from the nine diseases occur before the age of one year. Those children who are older and who are not fully immunised, should still be vaccinated.
- Infants must complete the full course of immunisation, or the vaccine may not work. The parent/guardian must take the child to be vaccinated at least four times to be able to complete the immunisation. A baby cannot be fully immunised against all the diseases in one visit to the clinic.
- Caregivers should not be afraid of having their children immunised. The vaccines are safe and effective.
- A child who is not immunised may get measles or tuberculosis. These diseases can kill children. Even if they survive them, they will be weakened and may not develop properly.
- A child who is not immunised could get the disease and infect other children.

note

There is an Immunisation Schedule in Appendix 2 on page 359



Even sick children should be immunised

- It is safe to immunise sick children. One of the main reasons why children are not brought for immunisation is that they have a fever or a cough, but this should not prevent them from receiving their immunisations.
- All children should be vaccinated, even when they are sick. The healthcare worker will check if there are any reasons why a child should not be vaccinated.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2



45 minutes

To facilitate this activity:

- 1 Introduce the topic by asking participants to brainstorm what *immunisation* means. Summarise the definition for the group. Then highlight the importance of immunisation for children. Discuss with participants the cultural myths and beliefs that hinder children from being taken to be immunised.
- 2 Ask volunteers to demonstrate through a role-play the different categories of people who are required to be immunised. For example, the different immunisations for children and pregnant mothers. Summarise and conclude by referring to your trainer reference for Activity 2.
- 3 Hand out copies of Handout 2 to participants. Divide participants into nine groups representing each of the immunisable diseases in children. Ask members of the groups to discuss the immunisation of a child for the particular disease assigned to the group. Describe the symptoms of that disease if not immunised – describing cases of children they have witnessed in their communities. You may need to do some research on these diseases first, before embarking on this part of the activity. It may be that some of these diseases are not commonly known in the area where this training is taking place.

Alternatively, you could ask participants to choose which diseases they want to discuss in their groups, based on the list in your facilitator's notes.

- 4 The groups present in plenary. Discuss the inputs and and ask volunteers from the whole group to supplement information where necessary. Ask participants to discuss what problems such effects have on a child, family and community. Summarise and conclude.
- 5 If time permits, ask participants to share what each of them can do to help families to complete their children's immunisation for one year. Again, ask volunteers to share their ideas with the group. Supplement as necessary with you facilitator's notes.

Handout 2 – Module 2 Topic 4

Immunisation

Immunisation is when a child is given a vaccine that is either injected into the body or swallowed to protect against certain serious preventable diseases that can cause death in children.

The following are the immunisable diseases in most African countries: Measles, poliomyelitis, whooping cough, tetanus, tuberculosis, diphtheria, Hepatitis B, Haemophilus influenzae type B, yellow fever.

All children need to be immunised

- All children under one year need to be immunised. Half of the deaths from the nine diseases occur before the age of one year. Those children who are older and who are not fully immunised, should still be vaccinated.
- Infants must complete the full course of immunisation, or the vaccine may not work. The parent/guardian must take the child to be vaccinated at least four times to be able to complete the immunisation. A baby cannot be fully immunised against all the diseases in one visit to the clinic.
- Caregivers should not be afraid of having their children immunised. The vaccines are safe and effective.
- A child who is not immunised may get measles or tuberculosis. These diseases can kill children. Even if they survive them, they will be weakened and may not develop properly.
- A child who is not immunised could get the disease and infect other children.

Even sick children should be immunised

- It is safe to immunise sick children. One of the main reasons why children are not brought for immunisation is that they have a fever or a cough, but this should not prevent them from receiving their immunisations.
- All children should be vaccinated, even when they are sick. The healthcare worker will check if there are any reasons why a child should not be vaccinated.

Activity 3 Common Diseases that Affect Children



In this activity, you will:

- Discuss some common diseases that affect children

Facilitator's notes:

In this activity, you will discuss some common diseases that children get and what their symptoms are.

Some common illnesses and conditions that affect children are:

◦ **Malaria**

Malaria is a life-threatening disease spread by the bite of a mosquito when it picks up malaria parasites from an infected person and passes them on to someone who is not infected. The first signs of malaria are usually body weakness, fever, aching body and headache. Malaria kills large numbers of children under five years old. Extra care should be taken to keep mosquitoes away from young children by ensuring that they sleep under mosquito nets. Another way to help stop malaria is to make sure that there are no stagnant pools, uncleared surroundings or containers of water left standing where mosquitoes can breed.



◦ **Diarrhoeal diseases**

Diarrhoea is defined as the passing of three or more stools a day, with more water in the stools than is normal for a child, making the child dehydrated (loss of fluid from the body). Diarrhoeal diseases are common and cause many deaths in young children, especially those under two years old. These diseases are often caused by poor water and sanitation; and by the consumption of infected food, especially meat. The most common way that children get diarrhoea is by not washing their hands after defecating, and then using their hands to eat food with. Children should be taught good hygiene practices.

Frequent attacks of diarrhoea can lead to the loss of essential nutrients, causing weight loss, undernourishment and poor growth. Children with diarrhoea need to drink more fluids than usual to replace the fluids they have lost, as well as frequent small meals to help them gain strength and weight.



◦ **Respiratory tract infections**

A child with a cough and a runny nose may have a mild cold. However, a child with a persistent cough and breathing difficulties may have pneumonia, asthma, Tuberculosis or another serious respiratory infection and should be taken for treatment. Other signs of lung infections are breathing that is very fast, wheezy or rasping. Children with breathing difficulties should be taken to a clinic for better assessment and treatment. These children should be kept warm at all times.

○ Intestinal worms

Intestinal worms are very common and are mainly passed on to humans through poor sanitation, rather than from food. Hygiene practices such as washing the hands after defecating; and before eating or preparing food, are vital to stop worm eggs from entering the mouth. Worms are parasites (they live off a person's body); and children with worms are robbed of their food and nutrients, causing weakness and poor growth.

There are many different types of worms that are dangerous, so children should be treated regularly with medicine to get rid of the worms. Most worms are spread from human and animal faeces. To prevent worm eggs (which are usually too small to see) from spreading, all faeces should be properly disposed of. Animals should be kept away from areas where children play, and children should be taught to wash their hands before eating.

○ Skin infections

Skin infections, such as scabies, are also caused by poor sanitation. They may be most common in areas where people do not have access to enough water to wash themselves and their clothes regularly. Scabies is a skin disease that is caused by a small parasite which lives in the skin and spreads easily from person to person. Scabies causes very itchy bumps on the skin and, because it is caused by parasites, it makes a child weak and not able to grow properly. Children with scabies should be treated and encouraged to wash often, if possible.



For this activity you will need:

- Copies of Handout 3
- Flipchart and markers



1 hour

To facilitate this activity:

- 1 Introduce this topic by asking participants to brainstorm the common diseases that affect children. Add any others to their list, based on your facilitator's notes.
- 2 Divide the participants into groups and assign one of these common diseases or conditions to each group. Ask the groups to discuss the following about the disease:
 - Causes and symptoms of the disease
 - Effects of the disease if it is not treated in time
 - When to seek treatment
 - Where to seek treatment in their communities
 - What caregivers can do to prevent the disease
 - Advice to caregivers on the actions they can take in the home when these health problems occur.
- 3 Groups will then report back in plenary. Write up their inputs on the flipchart, supplementing and correcting their ideas as you go. Finally, distribute Handout 3 for reference.

Handout 3 - Module 2 - Topic 2
Common Illnesses that Affect Children

• Malaria
Malaria is a life-threatening disease spread by disease-carrying mosquitoes. The first signs of malaria are body aches, fever, aching body and headaches. Malaria kills large numbers of children under five years old. Young children should sleep under treated mosquito nets to help stop malaria.

• Diarrhoeal diseases
A child with diarrhoea will pass stools or motions several times a day, with more water in the stools than is normal for the child, making the child dehydrated (loss of fluid from the body). Diarrhoeal diseases are common and cause many deaths in young children, especially those under five years old. These diseases are often caused by poor water and sanitation, and by the consumption of infected food, especially meat. A child with diarrhoea loses essential nutrients, loses weight, becomes malnourished and may not grow properly. These children need to drink more fluids than usual to replace the fluids they have lost, as well as frequent small meals to help them to gain strength and weight.

• Respiratory tract infections
A child with a persistent cough and breathing difficulties may have pneumonia, asthma, tuberculosis or another serious respiratory infection and should be taken for treatment. Other signs of lung infections are breathing that is very fast, wheezing or rasping. Children with breathing difficulties should be taken to a clinic for better assessment and treatment.

• Intestinal worms
Intestinal worms are mostly passed on to humans through poor sanitation, rather than from food. Hygiene practices such as washing the hands after defecating, and before eating or preparing food, are vital to stop worm eggs from entering the mouth. Worms are parasites (they live off a person's body); and children with worms are robbed of their food and nutrients, causing weakness and poor growth. There are many different types of worms that are dangerous, so children should be treated regularly with medicine to get rid of the worms. Most worms are spread from human and animal faeces. To prevent worm eggs (which are usually too small to see) from spreading, all faeces must be properly disposed of. Animals should be kept away from areas where children play.

• Skin infections
Skin infections, such as scabies, are also caused by poor sanitation or when people do not have access to enough water to wash themselves and their clothes regularly. Scabies is a skin disease that is caused by a small parasite which lives in the skin and spreads easily from person to person. Scabies causes very itchy bumps on the skin and, because it is caused by parasites, it makes a child weak and not able to grow properly. Children with scabies should be treated.

Activity 4 Barriers to Healthcare and Ways to Ensure Access



In this activity, you will:

- Discuss the barriers that stop OVC from accessing healthcare and how community-based initiatives can help

Facilitator's notes:

Barriers that prevent OVC from accessing healthcare:

- Lack of knowledge and information on the part of guardians, caregivers and the children themselves regarding the different diseases that afflict children
- Lack of knowledge and information on the part of guardians or caregivers on the causes, symptoms, prevention and treatment of these diseases
- Lack of healthcare services available in the community
- Lack of finances and resources in caregiver households to pay for transport, service fees and medication.

Community-based approaches to ensuring OVC have access to healthcare:

- Make sure that parents, guardians and home visitors of vulnerable children are informed about ways of preventing illnesses, including HIV/AIDS
- Make sure that parents, guardians and home visitors of OVC are aware of medical services available in the community, and assist them to access these services
- Provide OVC and their caregivers with transportation to clinics
- Provide money to pay for clinic fees and medicines
- Negotiate with clinics and healthcare providers to provide discounted or free health services to vulnerable children
- Provide insecticide-treated bed nets and other methods to prevent malaria
- Call for immunisations and child under-five medical services in the community
- Advocate for more healthcare workers, clinics and health services to be made available in the community.



For this activity you will need:

- Flipchart and markers



30 minutes

To facilitate this activity:

- 1 Ask participants to brainstorm the barriers that prevent vulnerable children from accessing healthcare services. Write responses up on the flipchart, reviewing from your facilitator's notes.
- 2 Then divide the participants into small groups of two to three each. Each group should come up with a few existing healthcare services, and some possible community-based initiatives to help OVC access healthcare. Groups will report back to plenary. Discuss their responses and remind participants that they, as home visitors, should help to put these community-based initiatives into practice in order to help the children whose health they will be monitoring.

Activity 5 Basic Hygiene Practices



In this activity, you will:

- Discuss good hygiene practices and how they can prevent the spread of disease

Facilitator's notes:

Good hygiene practices can prevent the spread of germs into our mouths through water and food contaminated by faecal matter. Most illness and deaths among children are a result of germs that get into the child's mouth. Preventing the spread of germs by disposing of faeces properly, and hand washing after defecation, can reduce illness. It is very difficult to prevent the spread of germs when there is no toilet, safe drinking water and no safe refuse disposal. However, there are some simple, but important, actions that people can take which will help to stop the spread of disease.

Some simple hygiene practices are:

◦ ***Clean hands with soap and water or ash***

Illness can be prevented by washing hands after going to the toilet or after contact with faeces. Hand washing helps to stop germs from getting onto food or into the mouth.

It is especially important to wash hands after defecating, before handling or eating food, and after cleaning the bottom of a baby who has defecated.

Children often put their hands into their mouths, so it is important to clean a child's hands often, especially before eating food and after going to the toilet. Ensure the availability of adequate water for hand washing, especially near the toilet if possible.



◦ ***Dispose of all faeces safely***

One important action that a household can take is to prevent the spread of germs by the safe disposal of all human and animal faeces. Many illnesses, including diarrhoea and worms, come from germs found in faeces which can get into water, food, onto the hands and onto cooking and eating utensils.

The faeces of all adults, children and babies should be disposed of in a toilet or latrine. If families or communities experience difficulties constructing toilets, then adults and children should defecate far away from the home, walking paths, water sources (such as rivers) and areas where children play. The faeces should be buried to stop germs and flies. Contrary to common belief, the faeces of children are even more dangerous than that of adults. So even small children's faeces should be put in a toilet or buried safely.

Animal faeces is a main breeding place for germs that cause disease, so animals should be kept away from areas where children play. Animals should also be fenced away from water supply points so that they do not contaminate the water supply.

○ **Food and water safety**

Illness can be prevented by taking care with the storage and preparation of food. The home and areas where food is stored or prepared should be kept clean. All cooking utensils should be kept clean.

Both food and water should be stored in clean containers with lids, so that flies and animals do not spread germs to them. Fly control is a positive way to prevent the spread of germs. When cooking, make sure that food is cooked properly before eating. This is especially true of meat, which should be cooked right through. Cooked food should not be eaten if it has been left unrefridgerated for more than six hours.

In areas where the safety of water is not guaranteed, water for drinking and cooking should be purified or boiled before use.

If babies' bottles are used, they should be scrubbed and boiled before being filled, as they are one of the main ways that diarrhoeal germs are spread to babies. Otherwise, babies should be fed with a cup and spoon, which are easier to keep clean.

○ **Other basic hygiene practices that help to stop the spread of disease:**

- Wash one's body regularly
- Wash clothes and bedding regularly
- Wash hands before preparing food and eating
- Wash hands before giving medicines
- Wash hands after changing soiled clothes or bedding of a sick person
- Avoid spitting as it spreads germs and can spread TB, for example
- Dispose of household waste in a pit latrine or by burying or burning
- Cover bleeding cuts or wounds and avoid direct contact with the blood of other people
- Wear latex gloves when helping a bleeding person.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 4

To facilitate this activity:



- 1 Ask participants to brainstorm a list of indicators of poor hygiene practices and then good hygiene practices for a household. Group the lists of indicators in appropriate categories, such as personal hygiene, water safety, use of latrines, clothing, housing and food preparation.
- 2 Then, based on the number of categories of good hygiene practices that were identified, divide the participants into groups. Each group will be assigned a good hygiene category.

- 3 Based on the category they have been assigned (for example, personal hygiene), groups will discuss the following points:
 - The characteristics of good practices for the category
 - What to advise OVC households to do to improve sanitation in their homes for that category
 - What communities can do to support OVC households to improve hygiene practices in that category.

- 4 Groups then report back to plenary on each category. Write up their responses on the flipchart. You can supplement and review their responses by referring to the information in your facilitator's notes.

- 5 Distribute Handout 4 to the participants for reference.

Handout 4 - Module 2 Topic 2

Basic Hygiene Practices



Clean hands with soap and water or ash

Illness can be prevented by washing hands after going to the toilet or after contact with faeces. Hand washing helps to stop germs from getting into food or into the mouth. It is especially important to wash hands after defecating, before handling or eating food, and after cleaning the bottom of a baby who has defecated. Children often put their hands into their mouths, so it is important to clean a child's hands often, especially before eating food and after going to the toilet.

Dispose of all faeces safely

Illness can be prevented by safely disposing of all human and animal faeces. Faeces, such as diarrhoea and worms, come from germs found in faeces which can get into water, food, reuse the hands and washing and eating uncooked. All faeces of adults, children and babies are dangerous and should be disposed of in a latrine or latrine. If there is no latrine, people should defecate away from the home, walking paths, water sources (such as rivers) and areas where children play. The faeces can also be buried in deep germs and tiles. Animal faeces is a main breeding place for germs that cause disease. So animals should be kept away from areas where children play. Animals should also be fenced away from water supply points so that they do not contaminate the water supply.

Food and water safety

Illness can be prevented by taking care with the storage and preparation of food. The home and areas where food is stored or prepared should be kept clean. All cooking utensils should be kept clean. Food and water should be stored in clean containers with lids, so that flies and animals do not spread germs to them. Hygiene is a positive way to prevent the spread of germs. When cooking, make sure that food is cooked properly before eating. Cooked food should not be eaten if it has been left unrefrigerated for more than six hours. If the safety of water is not guaranteed, water for drinking and washing can be purified or boiled before use. Babies' feeding utensils (bottles and spoons) should be kept especially clean, as they are one of the ways that dangerous germs are passed to babies.

Other basic hygiene practices that help to stop the spread of disease

- Wash body, clothes and bedding regularly
- Wash hands before preparing food, eating and giving medicines
- Wash hands after changing soiled clothes or bedding
- Wash spinning as it spreads germs and can spread TB, for example
- Dispose of household waste in a pit latrine or by burying or burning
- Cover bleeding cuts or wounds and avoid contact with the blood of other people
- Wear latex gloves when helping a bleeding person

Activity 6 Access to Sanitation and Safe Water



In this activity, you will:

- Discuss further issues around sanitation and water hygiene

Facilitator's notes:

In this activity, you will expand on the topics of sanitation and safe water from the last activity. The safe disposal of faeces; and the use of safe water for cooking and drinking are the two most important factors in stopping the spread of many diseases that are dangerous to children.

Some sanitation and water safety practices:

◎ Sanitation

Many people do not have access to healthy sanitation options, but the safe disposal of both human and animal faeces is one of the most important ways to stop disease from spreading in a household and a community. Where toilets or latrines are not available, adults and children should be encouraged to cover their faeces with soil. This will help to stop flies from breeding and spreading diseases.



Where pit latrines are used, they should be constructed so that they are private, comfortable and safe for all users, including women, children, the disabled and the elderly. Latrines should be constructed away from water supply points, but close enough to households so that they can be cleaned and maintained properly. A good latrine design will include vent pipes to reduce smells and fly-screens to stop flies from entering the pit.

◎ Water

Water is vital for all life, but contaminated water can cause illness in humans. A household uses water for many purposes, such as washing and watering food gardens. Water that is used for cooking and drinking needs to be of a higher quality, and may need to be purified or boiled before use. Drinking water should be stored in a clean container with a lid, to prevent contamination.

Water supply points should be fenced off from animals.



For this activity you will need:

- Extra sheets of blank paper and drawing materials

To facilitate this activity:

- 1 Hand out drawing materials to the group and ask them to draw the sanitation options in their community; then get them to draw the water sources. Discuss the advantages and disadvantages of each option in ensuring good health. Use your facilitator's notes for reference.

Activity 7 Sexual and Reproductive Health



In this activity, you will:

- Discuss sexual and reproductive health as an important personal health issue

Facilitator's notes:

Sexual and reproductive health practices can be considered hygiene practices that are important to help stop the spread of sexually transmitted illnesses, such as HIV/AIDS.

All humans are sexual beings, whether they acknowledge this or not. Discussing sexual health is a difficult subject because of the many taboos around speaking openly about sexual issues. One way to start a discussion about sexual health is to emphasise that sexual health is part of general health. It is part of taking care of ourselves, in the same way that we may take care of our emotional well-being. This activity focuses on participants having access to factual information about sexual health issues, based on the topics in the list below. You will need to collect pamphlets, brochures or other print materials on these topics, so as to share information with the group.

All adults need information on sexual and reproductive health, for example:

- sexual biology (how the male and female bodies work)
- conception, pregnancy and birth
- sexually transmitted infections (STIs), including HIV/AIDS
- check-ups and treatment for sexual infections
- contraception and safe sex practices
- educating children and youth on safe sex and sexual health, according to need and age.



For this activity you will need:

- Brocures, pamphlets and other information on sexual health
- Extra sheets of blank paper
- Flipchart and markers



40 minutes

To facilitate this activity:

- 1 Introduce this topic by acknowledging that it is a sensitive one. Using your facilitator's notes, discuss sexual health issues, emphasising the importance of having correct information. Access to facts will help people to make informed choices about how they conduct themselves sexually, and allow them to take action to maintain their sexual health. People who lack information are more vulnerable to becoming infected with sexually transmitted illnesses, including HIV/AIDS. Discuss with the group how reproductive health affects boys and girls differently.
- 2 Write up the list above on the flipchart and get the group to copy it. They will then be required to access the relevant information on these aspects of sexual health. Share any print materials you have collected with the group. They can use this information to fill in any gaps they have in their knowledge. If there are some areas where information is lacking, they should try to find this out themselves in their own time, by using resources from clinics or healthcare centres.

Activity 8 Preparing for Home Visits: Monitoring the Health of OVC



In this activity, you will:

- Help participants put together their notes on general health and hygiene for OVC for their home visitor's handbooks

Facilitator's notes:

In this activity, participants will review the healthcare information from this topic and arrange their handouts in their home visitor's handbooks. They will also receive two extra handouts:

- Handout 4 - *The Child Health Monitoring Sheet*
- Handout 5 - *Basic Health Information*.

They will use these sheets to help them monitor the children's health when making home visits.



For this activity you will need:

- Copies of all previous handouts from Topic 3
- Copies of Handouts 5 and 6



45 minutes

To facilitate this activity

- Explain to participants that they will be monitoring the health of the children they visit. In some cases, they can suggest home remedies, as explained on the handout, *Basic Health Information*. In other cases, they should refer the child on to other healthcare services. You should review the appropriate referral process for your community with the participants so that they all know what to do when they encounter a child in need of medical attention.
- A copy of *The Child Health Monitoring Sheet* should be filled out for each child that is visited and updated about every four months by home visitors, so that the children's health can be monitored effectively.

Handout 5 - Module 3 Topic 3
Child Health Monitoring Sheet
FOR QUARTERLY MONITORING

Child's Name: _____ ID/No: _____
 Male Female
 Community / Village: _____
 Parish / Location / Division: _____
 Guardian's Name: _____
 Guardian's Signature: _____
Child's Health Record:
 1. Height (in): _____ 2. Weight (kg): _____
 3. Age: _____ (in years, but if less than five years old, quote in months)
 4. Immunisation Status (for only children under 6 months):
 DPT+ BCG+ DPT1+ DPT3+
 OPV1 OPV2 OPV3 Measles
 5. Did the child fall sick in the last 2 months? (i.e. since the last WY health check-up)
 Yes No If yes, explain: _____
 (a) Type of sickness: _____
 (b) Action taken: _____
General Health Observations:
 Head (observe hair, teeth, eyes and nose):
 (a) Hair: Normal Abnormal If abnormal, explain: _____
 (b) Teeth: Normal Abnormal If abnormal, explain: _____
 (c) Eyes: Normal Abnormal If abnormal, explain: _____
 Body (observe arms, legs and feet for skin disorders, wounds etc.):
 Normal Abnormal If abnormal, explain: _____
 If child has diarrhoea or vomiting, write details: _____
 Date: _____ Form/Block in by: _____ Time: _____
 ACF Name: _____ ACF No: _____

Source: UNICEF/HNP/World Health Organization, 2004

Handout 5 - Module 3 Topic 3
Basic Health Information

Symptoms of illness: Look out for symptoms of illness, especially cough, fever, rapid or difficult breathing, loss of appetite, poor-weight gain, diarrhoea and vomiting. Seek treatment for as many of these symptoms as soon as possible.

Infections: Ensure that all children are immunised, but a child with HIV should never be given a BCG or yellow fever vaccine.

Diarrhoea: Give fluids containing potassium, such as bananas, spinach and coconut water. Give a child with diarrhoea more fluids to drink than usual, such as an oral rehydration solution, water, soups, yogurt drinks, coconut water and fruit juice. Feed the child regularly and seek help if the diarrhoea continues for more than three days, or if there is blood in the stool, the child vomits often, eats or drinks poorly, or has a fever.

Fever: Give plenty of fluids to a child with fever, and paracetamol to reduce the temperature. Take the child to a clinic if the fever lasts more than three days, and as soon as possible if the child also has convulsions, diarrhoea, stiff neck and a cough, or if there is malaria in the area.

Malaria: If possible, children should sleep under an insecticide-treated mosquito net.

Infectious disease: Take care to keep children away from people infected with TB, pneumonia and measles.

Mosquito: Give lemon juice in warm water or a ginger drink to reduce mosquitoes.

Vaginal thrush (itchiness in the vagina): A tampon dipped in plain yoghurt or a peeled clove of garlic can be inserted into the vagina. They should be removed and replaced twice a day and removed when the condition eases.

Oral thrush (white patches or fungus-like growth in mouth): Give unsweetened yoghurt or sour porridge.

Scabies: Give mashed foods such as bananas and sweet potatoes to children who are severely malnourished.

Preventing infections: Give herbs like garlic, ginger, turmeric and moringa leaf powder to prevent many infections.

Pain: Give paracetamol for pain.

Activity 9 Review of the Home Visitor's Handbook



In this activity, you will:

- Review the home visitor's handbooks with participants

Facilitator's notes:

You have now finished your third module of the home visitor training. At this point it is a good idea to review the home visitor's handbooks with the participants to ensure that each participant has compiled all the necessary handouts in their handbooks.

The home visitor's handbook should now include the following reference pages from the three topics discussed in this module:



Home Visitor's Handbook – Module Three

Topic 1: Food Security for OVC

- Community Initiatives to Enhance Food Security for OVC

Topic 2: Improving the Nutrition of OVC and Those Affected by HIV/AIDS

- Important Food Groups
- Nutritional Support for Infants Born to HIV Positive Mothers
- Nutritional Support for Children over Two Years who are HIV Positive
- Steps to Help Malnourished Children

Topic 3: Monitoring the Health of Orphans and Vulnerable Children

- Basic Healthcare Needs of Children
- Immunisation
- Common Childhood Illnesses
- Basic Hygiene Practices
- Child Health Monitoring Sheet
- Basic Health Information

MODULE 4

Equipping Orphans and Vulnerable Children for the Future

| | | |
|--------------------------------------|--|-----|
| Topic 1 | | |
| Ensuring Access to Education for OVC | | 253 |
| Topic 2 | | |
| Life Skills for OVC | | 259 |
| Topic 3 | | |
| Supporting Behaviour Change in OVC | | 267 |
| Topic 4 | | |
| Succession Planning | | 277 |

Topic 1

Ensuring Access to Education for OVC

| | |
|---|------------|
| Introduction and Objectives for Topic 1 | 254 |
| | |
| Activity 1: The Importance of Education for OVC | 255 |
| | |
| Activity 2: Barriers to Children's Access to Education | 256 |
| | |
| Activity 3: Community Action to Ensure OVC Access to Education | 257 |
| | |
| Activity 4: Preparing for Home Visits: OVC Access to Education | 258 |

Introduction and Objectives for Topic 1

Schooling is important to children, not only as a means of helping them to gain life skills, vocational skills and to prepare them to support themselves (an issue of particular importance to children affected by HIV/AIDS), but also because it is a principal mechanism for their social integration and psychological development. Going to school helps to make life normal for children.

But often vulnerable children are unable to go to school, either because of a lack of school fees or because of huge responsibilities at home. If a household is suffering the trauma of HIV/AIDS and is generally depressed which results in the children's needs being neglected, then often children drop out of school because they are not motivated and supported to keep going. Vulnerable children, such as those who are disabled and those who are HIV positive, may also be discriminated against and stigmatised in the community. These children may often be kept hidden and are denied access to schooling. The activities in this topic will help participants to understand the importance and the benefits of schooling for all children.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Discuss the importance of education for OVC.
- ◆ List the barriers to OVC access to education.
- ◆ Discuss possible community-led initiatives to overcome barriers to OVC access to education.

note on language

Although this training is conducted in English, there is enough space on the handouts for information to be translated. Participants can translate the information into the language of their choice while on the training course, or they can do so later when they are practising home visitors.



Activity 1 The Importance of Education for OVC



In this activity, you will:

- Discuss the importance of schooling and education for OVC

Facilitator's notes:

Reasons why it is important for OVC to receive an education:

- It prepares them to support themselves in the future
- It gives them the opportunity to form friendships and promotes social integration
- It gives them an opportunity to work with adults who care about them and wish to prepare them for their future
- It prevents isolation and marginalisation, and boosts self-esteem and sense of purpose
- It is good for their mental and psychological health and development
- It provides them with positive, meaningful activities
- It gives them the opportunity to learn life skills and gain information
- It helps prevent the spread of HIV/AIDS through information and awareness
- For girls, it helps prevent early pregnancies and marriages, and sexual exploitation and abuse, through both girls and boys learning to respect and understand one another.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



40 minutes

- 1 Introduce the topic by asking participants what kind of education vulnerable children need. Ask participants the following questions:

- Do you believe that it is important for OVC to go to school? If so, why?
- Does it depend upon whether the child is a girl or boy?
- What other types of education might be beneficial for these children?

Allow participants to express their views freely on the education of orphans and vulnerable children and encourage a lively discussion.

List the points raised in discussion on the flipchart, adding any from your facilitator's notes, if necessary.

- 2 End the session by suggesting that it is important for **all** children, including orphans and vulnerable children, both boys and girls, to go to school.



Activity 2 Barriers to Children's Access to Education



In this activity, you will:

- Discuss why orphans and vulnerable children may find it difficult to get schooling

Facilitator's notes:

Possible barriers to children's access to education:

- The child may be needed at home to care for a sick parent or to attend to other household tasks, such as looking after younger children.
- The child's parents or guardian may not understand the importance of educating the child, or there may be general neglect of a child's needs in a dysfunctional household.
- Parents or guardians may not think the school curriculum is relevant to the child's and family's needs.
- Children may not have the money for school fees, uniform costs or books.
- Children may suffer from stigma or discrimination at school because of HIV/AIDS in their family; or because of being disabled, or because of poverty.
- Female children may be discouraged from attending school because they are girls.
- The local school might not have adequate staff or facilities to cope with children with special needs, for example, physically or mentally disabled children.



For this activity you will need:

- Copies of Handout 1
- Flipchart and markers

To facilitate this activity:

- Divide the participants into small groups and ask each group to brainstorm as many possible barriers to children's access to education as they can think of. Once each group has made a list of barriers, ask them to select the two or three factors that are the biggest barriers to vulnerable children's education in their own community. Back in plenary, have each group present its ideas.
- In the discussion, find out if the groups agree on the barriers that are the greatest problems in their own community. If groups agree, find out why; if they don't agree, discuss why not. Allow time for questions and discussion. Supplement the participants' ideas using your facilitator's notes.
- Distribute Handout 1 to participants.



Handout 1 - Module 4: Topic 1
The Importance of Education and Barriers to OVC Access to Education

Reasons why it is important for OVC to receive an education:

- It empowers them to support themselves in the future.
- It gives them the opportunity to form friendships and promote social integration.
- It gives them an opportunity to work with adults who care about them and will help prepare them for their future.
- It prevents isolation and marginalisation, and boosts self-esteem and sense of purpose.
- It is good for their mental and psychological health and development.
- It provides them with positive, meaningful activities.
- It gives them the opportunity to learn life skills and gain information.
- It helps prevent the spread of HIV/AIDS through information and awareness.
- For girls, it helps prevent early pregnancies and marriages, and sexual exploitation and abuse, through both girls and boys learning to respect and understand one another.

Possible barriers to children's access to education:

- The child may be needed at home to care for a sick parent or to attend to other household tasks, such as looking after younger children.
- The child's parents or guardian may not understand the importance of educating the child, or there may be neglect of a child's needs in a dysfunctional household.
- Parents or guardians may not think the school curriculum is relevant to the child's and family's needs.
- Children may not have the money for school fees, uniform costs, books, etc.
- Children may suffer from stigma or discrimination at school because of HIV/AIDS in their family, or because of being disabled, or because of poverty.
- Female children may be discouraged from attending school because they are girls.
- The local school might not have adequate staff or facilities to cope with children with special needs, for example, physically or mentally disabled children.

Activity 3 ➤ Community Action to Ensure OVC Access to Education



In this activity, you will:

- Brainstorm with the group ways that the community can help OVC access education

Facilitator's notes:

Possible community-based initiatives to help children access education:

- Community members can visit parents or guardians who are keeping their children out of school and try to support them to send their children to school.
- Community members can share some of the children's household tasks so that they can go to school.
- Community members can work with schools to make the curriculum more relevant to the children's needs; for example, by adding life skills, business training, agricultural training or training in home-based care for ill parents.
- The community can provide children with school and uniform fees.
- The community can negotiate with schools to waive or subsidise children's school fees.
- The community can start a community school.
- The community can raise awareness about HIV/AIDS and disabilities in order to stop stigma and discrimination that often prevents children from attending school.
- Community members can act as tutors to children who are out of school.



For this activity you will need:

- Flipchart and markers



45 minutes

To facilitate this activity:

- 1 Start this activity by reminding participants of WV's definitions for orphans and vulnerable children. Then remind the group of the barriers to education for vulnerable children that they prioritised in the previous activity. If there were disagreements about which barriers to children's education were the most strong in their community, include all of the barriers that were mentioned as important.
- 2 Divide the participants into small groups, giving each group one barrier to discuss. Groups should discuss ways that the barrier they have been assigned could be overcome in their community. Encourage them to think of solutions that would be feasible without too many additional resources.
- 3 Come together in plenary and ask each group to present its ideas. Compile a list of all the suggested interventions on flipchart paper, to be referred to by the community in future planning. You may add ideas from your facilitator's notes, if the participants think they are relevant. Allow time for questions and discussion.

Activity 4 ➤ Preparing for Home Visits: OVC Access to Education



In this activity, you will:

- Assist participants to put together basic information on children's access to education for their home visitor's handbooks

Facilitator's notes:

In the previous activities, the participants talked about the barriers that often keep vulnerable children from attending school and the types of actions the community (the CCC) may take to minimise these difficulties. In this activity, they will compile this information into their home visitor's handbooks. They will also go through an exercise to help formulate steps to take when they come across cases where the children they visit are not attending school.



For this activity you will need:

- Flipchart and markers
- Extra sheets of blank paper

To facilitate this activity:



- Explain to the participants that, as home visitors, their role will be to monitor which vulnerable children they are visiting are not in school; and then to follow the steps identified by the CCC for reporting this information and working to assist the child to return to school.
- Hand out sheets of blank paper and ask the participants to label a page: *Steps to take when OVC are not in school*. You will help the participants to decide on what actions to take, based on what has been discussed in the previous activities. It will help home visitors to know what actions to take when they find a child not attending school, so it is best if they are prepared for this. For example, they may find that more girl children are not attending school because of household chores or caregiving responsibilities; or that physically disabled children are being denied schooling and are kept at home.
- Emphasise to participants that all children should be given the opportunity to attend school, and that home visitor's should be especially sensitive to this issue when monitoring households. It is important for a child's development to take part in schooling; as well as being a fundamental children's right.
- When the participants have completed the page, they should include it into their home visitor's handbooks.



Topic 2

Life Skills for Orphans and Vulnerable Children

| | |
|--|------------|
| Introduction and Objectives for Topic 2 | 260 |
| | |
| Activity 1: The Importance of Life Skills | 261 |
| | |
| Activity 2: Types of Life Skills | 262 |
| | |
| Activity 3: Strategies for Equipping OVC with Life Skills | 265 |

Introduction and Objectives for Topic 2

Community members and home visitors need to be aware of the skills that children, and orphans and vulnerable children in particular, need in order to cope with life's challenges. These special skills are referred to as 'Life Skills'. Life skills are broadly defined as skills or abilities we acquire, practise and apply in our daily lives in order to deal constructively and positively with daily challenges. These skills are personal skills (such as the ability to make decisions, solve problems and the ability to negotiate with others) which help us to live effectively in a wider social environment.

Mentoring in life skills can be very helpful to orphans and vulnerable children who have lost the opportunity to receive proper parental guidance, care and support.

Life skills should also be linked into general schooling for children, and vocational training for older children and the youth. In this topic, life skills are discussed in the context of equipping orphans and vulnerable children with the self-esteem and the personal and social skills that will help them cope with their lives.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of life skills.
- ◆ Describe the importance of life skills for vulnerable children.
- ◆ Discuss different types of life skills.
- ◆ Discuss strategies on how to pass on life skills to OVC.



Activity 1 The Importance of Life Skills



In this activity, you will:

- Define what *life skills* are and discuss why they are so important

Facilitator's notes:

What are Life Skills?

Life skills are abilities we acquire, practise and apply to our day-to-day lives in order to constructively and positively deal with daily challenges.

Life skills refer to those abilities needed by an individual to operate effectively in society in an acceptable way.

Life skills will help orphans and vulnerable children to live positively with themselves, their families, and their wider community.

Life skills are important to help children, as well as OVC, to:

- Make positive choices about their health
- Recognise and avoid risky situations and behaviour
- Make informed decisions
- Make a positive contribution to the wider community.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



- Ask participants what they understand by life skills. Then clarify what *life skills* mean by presenting the definitions in your facilitator's notes.
- Ask participants to give examples of life skills and to explain why these skills are important. Use the information in your facilitator's notes to clarify and summarise. Give participants the opportunity to ask questions and discuss.

Activity 2 Types of Life Skills



In this activity, you will:

- Explore different types of life skills with participants

Facilitator's notes:

To start this activity, review the points from the previous activity on the importance of life skills. In this activity, you will discuss the life skills we all need to conduct our lives in a positive, effective and healthy way. These life skills are categorised below.

Skills necessary to have a good relationship with yourself:

- *The ability to cope with emotions.* Emotions, such as anger and fear, are usually reactions to a situation and may cause regret if they are acted upon impulsively. It is a useful and constructive skill to be able to contain these emotions and to think before taking action. This will help young people to act with thought and purpose in their lives, instead of simply reacting to events or circumstances that they may find themselves facing.
- *Self-esteem.* Often vulnerable children lose self-esteem because of their situation. They may be intimidated easily or develop inferiority complexes. These children need their self-esteem boosted in order to know that they are important and highly valued.
- *Assertiveness.* Assertiveness involves knowing what you want and why you want it, and being able to take necessary action. Vulnerable children especially need this skill to learn how to express their feelings in a positive way. Assertiveness also entails children being able to say what they don't want or don't like, and can help to reduce the sexual exploitation of children.



- *Self awareness.* All children need to be aware of their individual abilities and talents; and to develop them, knowing that each individual is unique, created in God's image.
- *The ability to cope with stress.* Many children live in very stressful situations. Constant stress can be destructive to the growth and development of children, and cause debilitating depression. Therefore, children need to know the causes and signs of stress; and how to get help and support to deal with stress to ensure proper development and growth.

Skills necessary to have a good relationship with others:

- *Good social manners.* Orphans must often adapt to living with new families. In order to adapt successfully, they must know how to behave, how to communicate, how to respond to stressful situations, and how to deal with people from different backgrounds.
- *Friendship formation.* Forming friendships is an important social skill for children. Peer friendships give children support, guidance and experience in sharing and communicating.
- *Peer resistance.* Children need peer resistance skills to enable them to stand up for their own values and beliefs in the face of conflicting ideas and practices from peers. Children with low self-esteem are often unable to challenge peer pressure, for example, in experimenting with sex, substance abuse and general deviancy. Children with healthy self-esteem are able to stand up for themselves if they think something is wrong, even if it means being treated with ridicule or facing exclusion from the group.
- *Effective communication.* Children need to know how to express themselves clearly and appropriately during interactions with other people in any given circumstances. Communication is especially important, as it is the essence of human relationships.
- *Negotiation.* Negotiation involves the ability to see both sides of a specific issue and agree to a resolution without compromising one's principles. Negotiation should not be confrontational.
- *Non-violent conflict resolution.* When involved in an argument or dispute, children should be encouraged to remain calm, negotiate and avoid the use of violence and emotional blackmail.

Skills necessary for making good decisions:

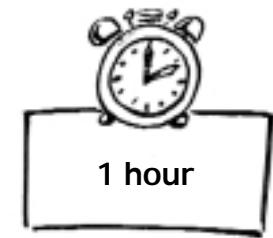
- *Critical thinking.* Children face many contradictory messages, expectations and demands from teachers, guardians and peers, as well as from radio and television. They need to be able to analyse their choices and decide what is best for themselves. Children need the ability to think through situations adequately, weighing the advantages and the disadvantages so that they may make informed decisions.
- *Creative thinking.* This involves devising different means of dealing with a situation. It involves coming up with new ideas and trying out more than one way to solve a problem.
- *Decision making.* Children may be confronted with serious demands, which require them to make appropriate decisions. They must be able to prioritise and weigh the advantages and disadvantages of a course of action.
- *Problem solving.* Problem solving is the ability to identify, cope with and find solutions to the difficult and challenging situations that OVC experience.





For this activity you will need:

- Flipchart and markers
- Copies of Handout 1



To facilitate this activity:

- 1 Start this activity by explaining to the group that life skills are an important part of a child's psychological and emotional development. As such, these skills may often only become evident through a child's behaviour. For example, a child with low self-esteem may not necessarily be a shy, withdrawn child; it could also be an aggressive child who bullies others. Self-esteem in a child means a quality of self-respect and self confidence, rather than a display of extrovert behaviour.
- 2 Divide the participants into three groups. Each group should be assigned one of the following topics:
 - Skills necessary to have a good relationship with yourself
 - Skills necessary to have good relationships with others
 - Skills necessary for making good decisions.
- 3 Ask each group to brainstorm the life skills in their category. Bring the groups together in plenary and get each group to present their ideas. Write their responses on flipchart paper, adding to and clarifying their inputs by using the facilitator's notes. Encourage participants to give examples of the life skills they identified and discuss these with the group.
- 4 If time permits, ask for volunteers to act out some of the life skills. Each volunteer should act out the life skill twice – once showing a person with poor life skills, and once showing a person with good life skills. For example, a volunteer could role-play a child with good self-esteem and then a child displaying poor self-esteem.
- 5 Hand out the copies of Handout 1 to the group.

Handout 1 – Module 4 Topic 2
The Importance of Life Skills

Skills necessary to have a good relationship with yourself:

- The ability to savor and control cravings. Cravings, such as sugar and fat, are usually reactions to a situation and may cause regret if they are acted upon impulsively.
- Self-esteem. Children with low self-esteem have a lack of self-confidence. These children need their self-esteem boosted in order for them to know that they are important and highly valued.
- Assertiveness. Assertiveness involves knowing what you want and why you want it, and being able to take necessary action.
- Self-awareness. All children need to be aware of their individual abilities and talents, and to develop them, knowing that each individual is unique, created in God's image.
- The ability to cope with stress. Many children live in very stressful situations which can be destructive to their growth and development.

Skills necessary to have a good relationship with others:

- Good social norms. Orphans must often adapt to living with new families. In order to do this successfully, they must know how to behave, how to communicate, how to respond to stressful situations, and how to deal with people from different backgrounds.
- Friendship formation. Forming friendships is an important social skill for children. Peer relationships give children support, guidance and experience in sharing and communicating.
- Peer assistance. Children need peer assistance skills to enable them to stand up for their own values and beliefs in the face of conflicting ideas and practices from peers.
- Effective communication. Children need to know how to express themselves clearly and appropriately during interactions with other people in any given circumstance. Communication is an especially important, as it is the essence of human relationships.
- Negotiation. Negotiation involves the ability to see both sides of a specific issue and agree to a resolution without compromising one's principles or becoming confrontational.
- Non-violent conflict resolution. When involved in an argument or dispute, children should be encouraged to remain calm and avoid the use of violence and emotional blackmail.

Skills necessary for making good decisions:

- Discerning. Children face many contradictory messages, expectations and demands from teachers, guardians and peers. They need to be able to analyze their choices, weigh up the advantages and the disadvantages and decide what is best for themselves. Children need to think through situations adequately so that they may make informed decisions.
- Creative thinking. This involves devising different means of dealing with a situation. It involves coming up with new ideas and trying out more than one way to solve a problem.
- Decision making. Children may be confronted with various demands, which require them to make appropriate decisions. They must be able to prioritize and weigh up the advantages and disadvantages of a course of action.
- Problem solving. Problem solving is the ability to identify, cope with and find solutions to difficult and challenging situations.

Activity 3 Strategies to Equip OVC with Life Skills



In this activity, you will:

- Discuss strategies that communities can use to equip OVC with positive life skills

Facilitator's notes:

The following are some possible strategies for passing on life skills to OVC:

- Make sure OVC have access to informal and formal counselling in the community, in order to discuss their feelings and problems.
- Make sure OVC are told through words and actions that they are valued and loved.
- Help OVC find positive ways to work through emotions such as grief, fear, anger, stress and depression.
- Encourage OVC to identify and develop their special talents.
- Help OVC stay in school.
- Support OVC in taking positive decisions. Help them to form friendships with like-minded peers through support groups, youth groups or Sunday School classes.
- Make sure OVC have access to information about the transmission and prevention of HIV/AIDS and other STIs.
- Ensure that OVC have access to adult support and advice when they need to make difficult decisions.
- Advocate for life skills courses to be made available to OVC through schools, churches, FBOs, and community-based organisations.
- Provide training and support to those caring for OVC. Make parenting courses available to them.
- Train home visitors to teach life skills to OVC.
- Speak out against practices that limit the power OVC have over their lives, such as child abuse and the exploitation of and discrimination against girls.



For this activity you will need:

- Flipchart and markers

To facilitate this activity:



45 minutes

- 1 Divide the participants into the same groups used for the previous activity. Again, one group should focus on skills necessary to have a good relationship with yourself, one group on skills necessary to have a good relationship with others, and the last group on skills necessary for making good decisions. This time, ask the groups to brainstorm ways that community members can pass these skills on to OVC, referring to the lists of skills developed in the previous session.
- 2 Come together in plenary and have each group present their ideas. Suggest additions based on the facilitator's notes. Ask participants which strategies for passing on life skills are likely to be most feasible and successful. Allow time for questions and discussion.

Topic 3

Supporting Behaviour Change in OVC

| | |
|--|------------|
| Introduction and Objectives for Topic 3 | 268 |
| Activity 1: What does <i>Behaviour Change</i> Mean? | 269 |
| Activity 2: Factors that Influence Behaviour | 270 |
| Activity 3: The Behaviour Change Process | 272 |
| Activity 4: Helping Children to Change Behaviour | 274 |
| Activity 5: Preparing for Home Visits: Behaviour Change | 275 |

Introduction and Objectives for Topic 3

Children, the youth and young adults who are orphaned or otherwise vulnerable are at higher risk of HIV infection if they engage in behaviour that places them at risk. In such cases, youth need to be supported to change their behaviour, as part of a larger process of care and support.

Behaviour change is a long process, and involves stages that need to be understood in order to effectively assist children in need. It is likely that most of the activities in this topic have older children and youth in mind, as they have developed to the stage where they are wanting to explore the wider world and experience different things.

Learning Objectives

By the end of this topic, participants will be able to:

- ◆ Explain what behaviour change means.
- ◆ Discuss factors that influence behaviour and hinder positive behaviour change.
- ◆ Discuss the behaviour change process.
- ◆ Discuss ways of helping children change their behaviour, if necessary.



Activity 1 What does Behaviour Change Mean?



In this activity, you will:

- Define what behaviour change means

Facilitator's notes:

In this activity you will help to define, with participants, what behaviour and behaviour change are.

In this topic, you'll be using these definitions to underpin all discussions on behaviour in relation to orphans and vulnerable children.

The following are definitions of behaviour and behaviour change:

Behaviour refers to how one conducts oneself in one's life; our actions and manners towards ourselves and others.

Behaviour change is the positive reversal of a certain conduct towards a better and more acceptable conduct. It is the gradual process from an unacceptable lifestyle to an acceptable lifestyle.



For this activity you will need:

- Flipchart and markers



15 minutes

To facilitate this activity:

- 1 Brainstorm with participants what they understand by behaviour and behaviour change. Write up their responses, then give them the definition of behaviour change from your facilitator's notes. Ask them to give examples of behaviour change, describing each stage of the process.
- 2 If they feel comfortable doing so, volunteers may share examples of behaviour change from their own lives and describe the process of undergoing change to the group. It is useful to emphasise to the group that behaviour change is a process that takes place over time; and that this process often entails children and youth learning and practising life skills.

Activity 2 Factors that Influence Behaviour



In this activity, you will:

- Explore the different factors that can influence the way that children may behave

Facilitator's notes:

In this activity, you'll be discussing the environmental and psychological factors that may cause children to behave in certain ways. You'll also discuss how these factors may hinder positive behavioural changes from taking place.

Factors that influence behaviour include the following:

- Environment / life circumstances
- Peer groups
- Culture
- Knowledge and experience
- Beliefs
- Personality
- Emotions/feelings and attitudes
- Instincts
- Intelligence.

The following factors can hinder behaviour change:

- Lack of control over one's life or destiny
- Inability to express or act on what one needs or wants
- Lack of information
- Peer pressure
- Poor decision making skills
- Harmful cultural factors, such as the devaluation of girls.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:



- 1 Ask participants to list the factors that they think influence behaviour. Then ask the group:
 - How do these factors influence behaviour in a positive way?
 - How can these factors influence a child's behaviour in a negative way?
 - How can negative factors be minimised or changed?

- 2 Then ask participants to give examples of children's behaviour based on what they have seen in their communities. Allow time for discussion and questions and add ideas from the facilitator's notes.
- 3 Then ask the group to brainstorm practical solutions to factors that hinder positive behaviour change.

Write these up on the flipchart. Allow time for discussion and questions and add any further ideas from your facilitator's notes.

- 4 Hand out copies of Handout 1 for reference. This will also be referred to in the next activity.

note

For this section, you may want to refer to Module 2 on page 173 which deals with how children communicate. For example, the lack of good communication skills in a child may often be mistaken for a display of anti-social behaviour.

Handout 1 - Module 4 Topic 3
Factors that Influence Behaviour

Factors that influence behaviour include the following:

- Environment / life circumstances
- Peer groups
- Culture
- Knowledge and experience
- Beliefs
- Personality
- Emotions/feelings and attitudes
- Instincts
- Intelligence

The following factors can hinder behaviour change:

- Lack of control over one's life or destiny
- Inability to express or act on what one wants
- Lack of information
- Peer pressure
- Poor decision making skills
- Harmful cultural factors, such as the devaluation of girls

Activity 3 The Behaviour Change Process



In this activity, you will:

- Discuss ways that behaviour patterns can be changed

Facilitator's notes:

Behaviour change is a process. It is composed of stages an individual goes through in order to change a particular behaviour pattern, as outlined below. An important point in behaviour change occurs when a person's intentions are translated into actions. However, it is not enough to have information, good intentions and strength of will to make changes happen. Behaviour change is often more permanent and sustainable when someone is encouraged to take small actions and to uphold these, than if they try radical changes that are too difficult to abide by.

Steps to Behaviour Change

Step 1 - Knowledge and awareness of his or her behaviour

The person whose behaviour needs to be changed must become aware of the reasons that this behaviour is negative. He or she needs to receive information about, for example, the dangers and the consequences of the behaviour. Once an individual has got that information, then he or she has a choice to begin a journey to change his or her behaviour, or not.

Step 2 - Significance to self to change behaviour

Someone who is in the process of behaviour change will have to understand the significance of the behaviour change to him or herself. For example, it is not enough for a person to know that unprotected sex can lead to HIV infection. He or she must apply this knowledge to his or her own situation. In this way, he or she will understand on a personal level that it is important for him or her to change certain behaviours. Once the person realises this, then he or she is in the process of behaviour change.

Step 3 - Analysing the costs and benefits of behaviour change

An individual who is willing to change must understand the costs and benefits of change. For example, a young person who wants to stop smoking will realise that the cost of stopping is losing a pleasure, but the benefit of stopping is saved money, better health and a longer life. Once it is clear that the benefits of stopping far outweigh the costs, the individual will be ready to change his or her behaviour.

Step 4 - Provisional trying of new behaviour

This is when the new behaviour is tried out in a risky situation. For example, using a condom with a reluctant partner; or deciding not to smoke when all of one's peers are still smoking and risking their disapproval.

Step 5 - Complete behaviour change

This is the step in which the provisional behaviour change becomes permanent.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 2



To facilitate this activity:

- 1 Present the steps of the behaviour change process, as explained in your facilitator's notes. Ask the participants to describe how each step might happen for a particular example: such as a young person's decision to stop smoking; or a young person deciding not to try smoking when their friends are experimenting with smoking.
- 2 Then divide the participants into groups and assign a behaviour to each group. Ask them to create and act out a role-play that shows a person starting out with a harmful or risky behaviour; and then going through the process of change. Other group members can play the roles of sensitisers, offering information, encouraging self-reflection, and so forth. Possible behaviours could be:
 - ◆ a sex worker who decides to find a different job
 - ◆ a heavy drinker who wants to stop drinking
 - ◆ a youth who skips school and needs help.
- 3 Have each group act out their skit for the plenary and allow time for questions and comments.
- 4 Hand out copies of Handout 2 for reference.

Handout 3 > Module 4: Topic 3
The Behaviour Change Process

Steps to Behaviour Change

Step 1 - Knowledge and awareness of his or her behaviour
 The person whose behaviour needs to be changed must become aware of the reasons that this behaviour is negative. He or she needs to receive information about, for example, the dangers and the consequences of the behaviour. Once an individual has got this information, then he or she will begin a journey to change his or her behaviour, or not.

Step 2 - Significance as to why change behaviour
 Behaviour change is in the process of behaviour change will have to understand the significance of the behaviour change to him or herself. For example, it is not enough for a person to know that unprotected sex can lead to HIV infection. He or she must apply this knowledge to his or her own situation. In this way he or she will understand on a personal level that it is important for him or her to change certain behaviours. Once the person realises this, then he or she is in the process of behaviour change.

Step 3 - Analysing the costs and benefits of behaviour change
 An individual who is willing to change must understand the costs and benefits of change. For example, a young person who wants to stop smoking will realise that the cost of stopping is losing a pleasure, but the benefit of stopping is saved money, better health, and a longer life. Once it is clear that the benefit of stopping outweighs the costs, the individual will be ready to change his or her behaviour.

Step 4 - Provisional trying of new behaviour
 This is where the new behaviour is tried out in a risky situation. For example, using a condom with a romantic partner; or deciding not to smoke when all of one's peers are still smoking and making their disapproval.

Step 5 - Complete behaviour change
 This is the step in which the provisional behaviour change becomes permanent.

Activity 4 Helping Children to Change Behaviour



In this activity, you will:

- Discuss with the group how home visitors can help children with behaviour change

Facilitator's notes:

The CCC and home visitors can play a useful role in helping young people to change their behaviour.

The following suggestions may be useful:

- Affirm and reinforce acceptable or positive behaviour in children.
- Point out unacceptable behaviour without labelling the child. Remember to separate the behaviour from the child. For example, say that you don't like lies, rather than telling the child that they are a liar.
- It helps to give reasons why a child's behaviour is unacceptable. Get the child to picture how he or she will feel if they change their behaviour and how it will affect others.
- Be realistic in helping young people to assess the 'costs' of behaviour change. Let the individual tell you the cost for himself or herself. Help the young person see how the benefits outweigh the costs.
- Let young people identify the time or circumstances when behaviour change will be most difficult. Help the child to plan how to handle these circumstances.
- Young people will need support and mentoring for behaviour change. Home visitors will need to act as role models to them.



For this activity you will need:

- Flipchart and markers
- Extra sheets of blank paper



To facilitate this activity:

- Divide participants into small groups and assign each group a behaviour pattern that needs to be changed. Possible examples: a youth is having unprotected sex with a peer, a girl is having sex with an older man who is paying her school fees, a child is drinking alcohol, a child is skipping school. Ask each group to discuss how they would go about trying to change this risky behaviour pattern. What kind of things would they say to the child? How would they follow up? How would they respond if the negative behaviour continues?
- Ask each group to present their plans for behaviour change in plenary. Give participants the opportunity to discuss their plan and to make suggestions. After each group has made their presentation, supplement their ideas with the suggestions in the facilitator's notes. Ask the participants how they might go about applying these ideas to the children they may visit.
- Hand out sheets of blank paper and get the participants to write down the examples of how a home visitor can help a child, based on the inputs that have been made. These pages will form part of their home visitor's handbook.

Activity 5 Preparing for Home Visits: Behaviour Change



In this activity, you will:

- Discuss how home visitors can monitor and advocate for behaviour change when making home visits

Facilitator's notes:

Orphans and vulnerable children may be more susceptible to risky behaviour patterns due to their vulnerability, lack of life skills guidance and need of the care and support of a guardian or mentor.

Home visitors and guardians of children should be prepared to take on the role of mentor or role model. They should aim to have a good enough relationship with the children that they visit, so that the children can communicate openly with them.

In this activity, you will review the handouts dealing with behaviour change with participants. The handouts will form part of their home visitor's handbook and they will use them as references to help them be aware of any negative behaviour patterns in the children they visit.



Participants will also consider a course of action to follow when they see evidence of these children making risky lifestyle choices that may be hazardous to their health and well-being.



For this activity you will need:

- Copies of Handouts 1 and 2
- Extra sheets of blank paper



To facilitate this activity:

- Review the information in this topic with the group.
- Get participants to consider a course of action to follow when they see evidence of the children that they visit making risky lifestyle choices that may be hazardous to their health and well-being. They can write their ideas on the sheets of paper. Remind participants that such behaviour usually stems from a deeper psychological or emotional need in a child.
- Discuss all the ideas with the group and have them add any new points to their list. These lists and the handouts will be added to their home visitor's handbooks for reference.



Topic 4

Succession Planning

| | |
|--|------------|
| Introduction and Objectives for Topic 4 | 278 |
| Activity 1: What is Succession Planning? | 279 |
| Activity 2: Protecting the Inheritance Rights of Children | 280 |
| Activity 3: The Importance of Making a Will | 281 |
| Activity 4: Practising Making a Will | 283 |
| Activity 5: Memory Books and Memory Boxes | 285 |
| Activity 6: Disclosing Sensitive Information to Children | 287 |
| Activity 7: Separation Issues for Children | 289 |
| Activity 8: Identifying a Standby Guardian | 290 |
| Activity 9: Supporting a Standby Guardian | 291 |
| Activity 10: Preparing for Home Visits: Succession Planning | 293 |
| Activity 11: Review of the Home Visitor's Handbook | 294 |

Introduction and Objectives for Topic 4

It is important for people who are facing an untimely death to be introduced to the idea of succession planning for their families. This involves will-making (which will legally secure the property of the family after the parents' death); and recording family stories and histories in memory books and boxes (to preserve the family's history and background for the children).

Succession planning also involves parents considering a standby guardian to look after their children when they are no longer around. The standby guardian could be a friend or a relative of the family, who can become involved with the children even before their parent dies.

In order for people to have their wishes honoured and carried out after death, it is necessary to have these wishes planned and documented. This calls for home visitors to support families by educating them on will-making and its importance; and by helping chronically ill family members to write wills and to plan for their children's future. All these issues will be discussed in this topic.

Learning Objectives for this Topic:

By the end of this topic, participants will be able to:

- ◆ Explain the meaning of succession planning.
- ◆ Discuss why succession planning is important.
- ◆ Discuss the protection of inheritance rights, especially for children
- ◆ Discuss the importance of making a will and what should be included in a will.
- ◆ Discuss memory books and memory boxes.
- ◆ Discuss the idea of a standby guardian and how to prepare a child for this.
- ◆ Discuss ways to support a standby guardian.

note

The information on will-making in this topic is intended as a general guide. For more specific information on the laws and regulations regarding wills in your country, you will need to do further research to get the relevant information before you run these sessions.

Activity 1 What is Succession Planning?



In this activity, you will:

- Define what *succession planning* means and why it is important

Facilitator's notes:

In this activity you will define what *succession planning* means and what it entails.

Succession planning refers to a person making plans on how their assets (property and possessions) should be handled after they die. It also refers to planning for who will take over guardianship of the children.

Many orphans and vulnerable children become entangled in complicated situations, due to the lack of succession planning by their late parents or guardians. This often results in their possessions and property being grabbed by greedy relatives or neighbours, leaving young children very vulnerable and powerless. HIV/AIDS has created a situation where many households are run by child-headed families, due to the death of both parents. These orphans are rendered vulnerable due to the lack of adult support to fall back on. In addition to the lack of parental guidance and care, they do not have the means or the power to maintain the homestead in the face of the claims of others.

As well as losing the physical possessions belonging to their family, some of these orphans (especially the very young) grow up having no knowledge of their social or historical background and cultural heritage because they do not know who their parents, their clan or tribe were. Home visitors can help families to protect the inheritance rights of their children and to preserve their family history and memories by helping parents to:

- Write wills
- Make memory books and boxes
- Prepare for a guardian to take over the children after the parents die.



For this activity you will need:

- Flipchart
- Stick it pads

To facilitate this activity:



- Divide the participants into pairs and ask them to discuss what they understand by *succession planning*. Each pair should write their responses on stick it notes and stick them up on the flipchart. When they have finished this exercise, discuss the responses with the group and give them the definition in your notes.
- Then, open a discussion with the group on why succession planning is important. From your notes, outline the strategies that can be taken by parents to plan for their children's future. Tell the group that these will be covered in the following sections of this topic.

Activity 2 Protecting the Inheritance Rights of Children



In this activity, you will:

- Discuss what *inheritance rights* are and why it is important to protect the inheritance rights of children

Facilitator's notes:

Inheritance rights are privileges or claims to property and possessions that children are morally and legally entitled to, based on the succession plans of their late parents. These plans, such as wills, outline their wishes for who should inherit their possessions, and what should happen to their children. Inheritance rights are important for the children left behind because it means that:

- They will be able to keep their family home and familiar possessions
- They have some emotional link with their parents
- They have a sense of emotional security and belonging
- They will be looked after by a guardian of their own and their parents' choosing.

When legally binding, the instructions in succession plans must be obeyed. However, if no legal plans have been made to secure the property of the parents and to find a guardian for the children, then problems can arise. After the death of a parent (especially the breadwinner) and there is no will, then inheritance rights are often denied. This may cause the following problems:

- House, property and possessions could be taken over by relatives
- Family faces homelessness and poverty; children may take to the streets
- Possible separation of children
- Children experience stress and anxiety
- Children lose a sense of their family identity and social background
- Children have no guardian or may be placed in unfamiliar surroundings.

Home visitor's can help ensure that these events do not occur, by helping people to secure their children's future by making plans for them before they die.



For this activity you will need:

- Flipchart and markers
- Stick it pads

To facilitate this activity:



- 1 Divide the participants into pairs and ask them to discuss what they understand by inheritance rights. Once they have definitions, they can write them on stick it notes and stick them up on the flipchart. When they have finished this, discuss the responses with the group in plenary, adding any more points from your facilitator's notes.
- 2 Next, discuss with the group what can happen if children are denied their inheritance rights. Write these up on the flipchart, and add points from your facilitator's notes. Then get the group to brainstorm actions that parents can take to ensure that children enjoy their inheritance rights after their death.

Activity 3 The Importance of Making a Will



In this activity, you will:

- Discuss the importance of making a will and what it should contain

Facilitator's notes:

Definition of a will:

A will is a legal statement made during a person's life in which he/she directs how his/her property should be shared out after his/her death. A will provides for orderly succession; that is, it spells out clearly the wishes of the person making the will and how his/her assets should be divided. It may also provide instructions for the guardianship of the children and care for the aged, thus leaving the family in harmony.

In this activity, you will discuss with the group the importance of will-making in succession planning. You will also discuss the contents of a will, as well as the requirements of making a will.

Making or writing a will is an important way for parents to make plans for their children's future. A will is legally binding if correct procedures are followed when it is made. When you discuss will-making with participants, emphasise the importance of making sure that the will is legally valid, so that there are no complications when the will is executed (when the instructions are carried out). Invalidated wills may entail lengthy court procedures to sort them out.



The person appointed to manage the will should realise that executing a will is a legal process and mismanagement of the estate can result in legal action.



For this activity you will need:

- Flipchart and markers
- Copies of Handout 1

To facilitate this activity:

- This activity follows on from the last one, where participants discussed ways to ensure a child's inheritance. Offer the information on wills in this activity as a mini lecture, but allow participants time to ask questions. Use your facilitator's notes, reference notes and boxes giving definitions and terms (see Activity 3 and 4) used in wills to help you answer them.
- Distribute copies of Handout 1 to participants and go through it with them. They will file it in their home visitor's handbooks for reference.



note

There are further notes on will-making and a section on questions and answers about wills in Appendix 2 on page 360

◎ **Requirements for a will:**

- A will must be made voluntarily. Nobody should be forced or frightened into making a will.
- Anyone who is 21 years or older can make a will, irrespective of sex, marital status or state of health. Every adult, not only an ill person, should make a will.
- The person making a will must have a sound mind. This means that they should be fully aware of what they are doing. A will made by a person who does not know what he/she is doing is not valid (invalid).

◎ **A will should have the following features:**

- It can be in any form, but the most common and valid form is a written will.
- It must have a date.
- Two adults must witness you signing the will and they must also sign it. If the will is more than one page long, then every page must be signed. The witnesses should not be beneficiaries of the will to which they sign as witnesses.
- A testator (person writing the will) must have only one will. However, he or she may make an addition to the will, which must be signed and attached to the main will. If the testator leaves more than one will, only the most recent will is recognised.

◎ **The contents of a will must include:**

- Name, address and place of origin of testator (will-maker)
- Names and addresses of the people (beneficiaries) to whom you are leaving property.
- How you would wish your property to be distributed after your death.
- The person you wish to have legal responsibility of your children (a legal guardian).
- The person you appoint to carry out your wishes in the will (the executor or executrix).
- Your wishes regarding your funeral and burial.
- The amount you owe in debts and the amount people owe you.
- The person who should take whatever property you have forgotten to mention.
- Any conditions you want to impose on the people to whom you leave your property.

◎ **A will may be kept by:**

- Registrars of the High Court or appropriate legal officials
- A bank or reputable financial institution (i.e. in a safety deposit box)
- An advocate or counsellor
- A trustworthy friend who will produce it after your death.

◎ **Execution of a will:**

After the death of the testator, the will is read out. It will identify the person or people appointed to execute (carry out) the deceased's instructions. However, the executor/s of the will must have court clearance and permission before they can distribute or handle the property of the deceased in any way, as the will is part of a legal process. The first task the executor has to do when executing the will, is to settle the debts of the deceased. After this is done, then the property and possessions can be sorted out for the beneficiaries according to the instructions in the will.

Activity 4 Practising Making a Will



In this activity, you will:

- Get your group to practise making or writing a will

Facilitator's notes:

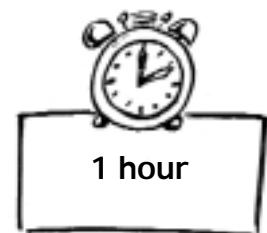
In this activity, you will take the participants through the process of writing or making a will. This will help them to put into practice the information you gave them in the last activity. You may need to provide assistance to participants with this exercise, especially if literacy levels are not high.



For this activity you will need:

- Copies of Handout 2
- Extra sheets of blank paper

To facilitate this activity:



- Hand out copies of the sample will and sheets of blank paper to all participants. Spend a few minutes going through the handout with the group to make sure that everyone understands what information is required at each point. Explain that not every section will apply to every testator (will-maker), and that more lines or even more pages can be added to sections, if needed.
- Get participants to make a list of their assets on the sheet of blank paper. This should cover their property, possessions and any money or savings they have. Next, they should write a list of people they want to give their assets to, such as their children.
- Then participants should attempt to fill in the example will. Provide assistance where needed. Allow enough time at the end of the session for more questions and answers, as it is likely that many issues will be raised from this exercise.

Handout 3 - Module 4 - Topic 4

Sample Will

1. I, _____, of _____, declare this my last Will.

2. I give my property as follows:

To _____, my _____ (relationship), I give _____ (description of property).
To _____, my _____ (relationship), I give _____ (description of property).
To _____, my _____ (relationship), I give _____ (description of property).
3. I appoint _____ (name) of _____ (address) to be the guardian of my children.

4. The other following properties I give to my minor children, to be managed by their guardian (named above) for their education, maintenance and upbringing until they reach mature age:
To _____, my _____ (name of minor), I give _____ (description of property).
To _____, my _____ (name of minor), I give _____ (description of property).
4. I direct my body be buried at _____ (place), with the following instructions:

5. I give the people listed below the following money and direct payment from account no. _____ at _____ (name) _____ (address) _____ (relationship).
6. The following people owe me the money mentioned and I direct collection of that money:
To _____, my _____ (name), my _____ (relationship).
7. My property which I have not mentioned in this will or otherwise, I give to: _____ (name), my _____ (relationship).
8. I appoint _____ (name) of _____ (address) to be executor of my Will.

Signed by _____ on _____ (day/month/year)
At _____ (place of signing)
In the presence of the following witnesses:
1. _____ (name) _____ (signature)
2. _____ (name) _____ (signature)

Facilitator's signature or thumb-mark:

Some terms relating to wills:

testator - person writing or making the will
 executor - person appointed to manage the will
 execute - perform the instructions outlined in the will
 beneficiary - person who receives benefits (for example, possessions) from the will
 assets - money, property and possessions owned
 estate - the assets of the deceased

example of a will

I, (name)
 of (address)
 on (date) declare this my last WILL.

1. I give my property as follows:

To (name), my (relationship),
 I give (description of property).

To (name), my (relationship),
 I give (description of property).

2. I appoint (name) of (address)
 to be the guardian of my children.

3. The other following properties I give to my minor children, to be managed by their guardian
 (named above) for their education, maintenance and upbringing until they reach mature age.

To (name of minor), I give (description of property),
 To (name of minor), I give (description of property).

4. I direct my body be buried at (place), with the following
 instructions:

5. I owe the people listed below the following money and direct payment from account no.:
 at (bank):
 (name) (address) (amount).

6. The following people owe me the money mentioned and I direct collection of that money:
 (name) (address) (amount).

7. My property which I have not mentioned in this will or otherwise, I give to:
 (name), my (relationship).

8. I appoint (name) of (address)
 to be the executor of my WILL.

Signed by (testator) on (day/month/year)
 at (place of signing)
 (testator's signature or thumb mark)

In the presence of the following witnesses:

1. (name) (signature)
 2. (name) (signature)

Activity 5 Memory Books and Memory Boxes



In this activity, you will:

- Introduce the concept of memory books and memory boxes to the group

Facilitator's notes:

Often family histories are lost when parents die, as much of this knowledge was anecdotal or told in stories. Parents facing an untimely death can plan for their children's future by making remembrance tools for them, in the form of memory books and memory boxes.

A memory book can contain information about the children's family, so that they have a record of their family's history. Information that could go in the book is outlined in the box on the next page.

Photos, drawings and stories can be included in the book to make it interesting. An important function of memory books is to disclose information that the children may be too young to understand, such as a parent's HIV status. This information will help the child to come to terms with their parent's death when they are older.

Important letters, documents and certificates relating to the family; and any precious objects can be kept in a memory box for the children.



For this activity you will need:

- Copies of Handout 3
- Extra sheets of blank paper

To facilitate this activity:



1 Spend some time telling participants about what a memory book is, using your facilitator's notes. Then hand out copies of Handout 3 and go through the points with participants. Tell the group that they will be working on a memory book as homework, but that they will start on the preparation for their books during the session by making notes on sheets of paper. Their memory book can be for one of the participant's own children (even if the participant is not ill), or it can be made for a child that a participant is caring for.

2 Tell participants that by making a memory book, they will be able to help parents and guardians who are ill to do the same thing for their children.

Participants can give parents the following guidelines when making a memory book:

- Don't rush while writing; write when you are ready
- Make a rough copy (on a piece of paper) before writing in the memory book to avoid crossing things out and making the book untidy
- You can start from any page
- Seek out a friend or counsellor for emotional support if what you are writing about is painful
- If someone cannot write, their child or a friend can help them to write.

Memory Books and Boxes

A memory book can be made for each child in the household. Memory books are important because:

- They can help a child locate his or her relatives as they include family trees, which show the history of the child
- They can help a child to know important background information about where they come from and about their family
- They may help to facilitate the disclosure of a parent's HIV status.



A memory book can be written by:

- The mother, father or guardian of a child who would like to record the child's life and his or her relationship with the child
- Anybody who wants to record important information about his or her family and life.

A memory book can be kept safely for the child:

- In a clean place in the guardian's or family's house
- With a close friend
- With a counsellor
- At a church

A memory book can include the following information about the child:

- A family tree of the parents, grandparents and relatives of the child
- The child's birth: where, which doctor, what hospital, who was around and photos, if possible
- The child's first smile, first words, when the child began crawling and walking
- The child's early experiences and memorable things about the child's life
- The child's health history. This could include early illnesses and immunisations recorded
- The child's education: nursery school, his/her first day at primary school and other records
- Things the child used to like and dislike
- The parent or caretaker's hopes and expectations for the child
- The child's recent achievements and experiences.

All this information should be as detailed as possible. Where possible, include photographs.

Information about the mother and father:

- Names of the mother and father and their parents, included in the family tree
- Where and how they grew up, including their childhood memories, how they used to look
- What they liked and disliked as children and as adults
- Their education, talents, work skills and job
- Their religious background and beliefs
- Their health history, including any illness
- Disclosure of important information (this is where his or her HIV status can be disclosed)
- Their special message for the child.

Activity 6 Disclosing Sensitive Information to Children



In this activity, you will:

- Discuss ways to disclose sensitive information to children

Facilitator's notes:

If a person is sick with HIV/AIDS or another serious illness, it is important for this person to disclose this information to his or her children. Age-sensitive disclosure will help children to understand what is happening to their parent or guardian, so that they have some emotional and psychological preparation for their loss. It is important that a child has this preparation, as secrecy only creates confusion in children. When children are not told the truth, they have a gap in their understanding and cannot grieve appropriately. It also creates shame in a child, as all they know is that something went wrong and that somehow they were involved.

Disclosure can also help children begin to prepare for their lives after the death of their parents. For example, the sick person can tell the children who will look after them, what relatives can help them and what property the parents will leave for their support. This will give them a sense of security, especially if they are able to have an input into the choice of guardian.

In this activity, you will discuss ways that ill parents can be helped to disclose this information to their children.

note

Refer to Module 2 on pages 178 to 183 for more information on communicating with children; and advice on helping grieving children in Module 2 on page 185

Disclosing sensitive information to children

Benefits of disclosing one's HIV status or any other serious illness to children:

- It prepares children for the future
- It reduces confusion, and the resulting depression, after the parents have died
- It may stop children from running to the streets
- It reduces the spread of HIV, as children become aware of this disease
- It gives parents the chance to give children important information about themselves and the family
- It helps the child understand their late parents' values and wishes
- It helps the child to take on responsibility
- It increases openness and respect between parents and children.

Times and situations for the disclosure of difficult information:

- When you are alone with your child
- When you are sober
- When you are feeling healthy
- In a quiet place (for example, in your bedroom or sitting room after a meal).

The process of disclosure:

- Plan what you would like to disclose and how you would like to disclose it.
- Seek advice and support from others who have disclosed their health status to their children.
- When the time comes to disclose, be cautious. Watch the reactions of the child. If you realise that the news may cause harm at that moment, then postpone it.
- Express concern, care and love for the child as you make your disclosure.
- Speak directly and clearly and tell the truth.

Reactions to expect:

- The child may feel sad
- The child may be afraid
- The child may ask questions
- The child may doubt what you are saying
- The child may be upset if you have told others but not him or her about your HIV status or serious illness.

In all these cases, express your care and love for the child, and that you have his or her well-being taken care of. It will help the child to feel secure if he or she is made to understand that they will be looked after and cared for; and that they will not be left alone.

**For this activity you will need:**

- Flipchart and markers

**To facilitate this activity:**

- 1 Explain to participants that making a memory book provides the opportunity for parents to disclose sensitive or difficult information to children, in particular the parents' HIV status. (Other difficult information may include the child's HIV status, who the child's father is, whether the child has siblings born out of wedlock). Then ask the participants to brainstorm the costs and benefits of disclosing one's HIV status to one's children. Explain that while disclosure is difficult for both the parent and the child, it has many benefits. Add to the list of benefits developed in the brainstorming session using your facilitator's notes.
- 2 Next, ask the participants what they think the best approach is to disclosing sensitive information to children. For example: Which times and situations are best? How should the parent prepare? What kind of language and tone should the parent use? What reactions should the parent expect? Summarise and supplement the participants' ideas using your facilitator's notes.
- 3 If there is time, you may ask for participants to volunteer to role-play a parent disclosing his or her HIV status to his or her child. Allow questions and discussion afterwards, if time permits.

Activity 7 Separation Issues for Children



In this activity, you will:

- Discuss the effects of separation on children

Facilitator's notes:

Separation is a situation where people of the same family may be forced to live apart from each other, for a given time. Other than losing parents and property, children may be faced with separation because of their parent's death, which can cause them great anxiety. This is another reason why parents need to plan for their children's future before they die.

Forms of separation

- Temporary separation - when a child is looked after by a guardian for a while
- Permanent separation - when a child is placed permanently under the care of a guardian.

Effects of separation on children:

- Stress
- Depression
- Suffering
- Poverty
- Loss of property and possessions
- Children living on the streets
- Child neglect.



For this activity you will need:

- Flipchart and markers



40 minutes

To facilitate this activity:

- 1 Start this activity by getting the group to brainstorm what effects separation may have on a child who has lost his or her parents. Write these up on the flipchart. Add points from your facilitator's notes, if necessary.
- 2 Ask participants to volunteer to role-play the effects of separation on OVC. The role-play group should consist of about six players: one representing the chronically ill parent, two representing the children, one representing a guardian, and two representing threats to the family (for example, a person taking furniture after the death of the parent). The role-play should also show what happens to the children if there is no one to care for them after the death of their parents.
- 3 Then get participants to brainstorm how the effects of separation could be minimised for OVC. Write these up on the flipchart. If time permits, get them to discuss how a home visitor could help in such a situation.

Activity 8 Identifying a Standby Guardian



In this activity, you will:

- Discuss the idea of a *standby guardian* with your group

Facilitator's notes:

This activity links with the last one, where the group looked at issues that OVC faced after the death of their parents. In this activity, you will discuss the concept of standby guardians with the group.

When children lose their parents they are faced with a lot of challenges to cope and manage in life. One way that parents can help them is to identify a standby guardian who will become part of the children's lives even before the parents die. Knowing that there will be someone to look after them, will stop children suffering much stress and anxiety. The standby guardian can be a family friend or a relative. The standby guardian will be a support to the children in their day-to-day lives.



For this activity you will need:

- Flipchart and markers



40 minutes

To facilitate this activity:

- Remind the group of the lists of points raised in the last activity, where you looked at the effects of separation for OVC, and possible ways to minimise these effects. In this activity, you will be looking more closely at the idea of a standby guardian.
- Divide the participants into five groups and ask them to discuss the following topics in their groups:
 - Group 1: The role of the standby guardian
 - Group 2: Why the standby guardian is important and who should identify the standby guardian
 - Group 3: Discuss how children can be prepared when the parents are still sick and after they die
 - Group 4: Discuss the key issues affecting OVC that were presented in the role-play (in the previous activity)
 - Group 5: The role of the home visitor.
- Groups should choose one person to outline the points that were raised in their discussion. In plenary, get the speaker from each group to present their group's ideas. Write these up on the flipchart.
- If time permits, you may discuss further ideas for the role of the standby guardian in the lives of OVC. Discuss what their roles will be and what responsibilities they will have in caring for these children.



Activity 9 Supporting a Standby Guardian



In this activity, you will:

- Discuss ways to support a standby guardian

Facilitator's notes:

As a caregiver, a standby guardian will need support from both home visitors and the community. Caregivers need care and support themselves, in order to give effective care and support to orphans and vulnerable children. Apart from needing to make sure that their own needs are met, caregivers and standby guardians may need:

- counselling
- training in OVC care
- psychosocial support
- food security production packs and other material support.

note

Refer to Module 2 on page 207 for more information on care and support for caregivers and guardians of OVC

In this activity, you will get the participants to brainstorm ways that standby guardians may need support; as well as how home visitors can provide the means to that support. This will require participants to also refer to their *Referral Information* lists, where they have kept relevant information on support structures and their details.



For this activity you will need:

- Flipchart and markers
- Participants will need their *Referral Information* lists
- Copies of Handout 4



To facilitate this activity:

- 1 Remind the group about the section on support for the caregiver in Module 2, Topic 8 of this guide. Review some of the relevant points raised in this section, especially the information about the importance of support groups for caregivers. These local support groups meet regularly in order to share their problems, their experiences, lessons they have learnt and to offer advice and support to those whose work involves the caring and support of others.
- 2 Get participants to brainstorm further ways that guardians can be supported by the general community in their care of OVC. You can list these on the flipchart.
- 3 Then ask the group to think about practical actions that home visitors can do to help guardians, using some of the points from your facilitator's notes above. Refer participants to their *Referral Information* lists when thinking about how guardians can be supported. They should consider all the needs that guardians may have. For example, they may need material support in the form of food packages; or they may need psychosocial support to deal with the stresses of coping with children who are vulnerable and dealing with trauma.

- 4 As participants give their input, you can write their suggestions up on the flipchart.
- 5 Next, make the link to the role of the home visitors. Discuss how home visitors will also need to be part of support groups where they can discuss their problems, ideas and experiences. It is crucial that home visitors who will be working in communities that are most likely suffering from trauma and depression, need to guard against the secondary effects of their experience.
- 6 Distribute copies of Handout 4 to the group. There is space for participants to write up any extra points raised on the handout.

 Handout 1 - Module 4 - Topic 4

Support to Standby Guardians

As a caregiver, a standby guardian will need support from both home visitors and the community. Caregivers need care and support themselves, in order to give effective care and support to orphans and vulnerable children. Apart from needing to make sure that their own needs are met, caregivers and standby guardians may need:

- counselling
- training in CVC care
- psychosocial support
- food security production packs



Activity 10 Preparing for Home Visits: Succession Planning



In this activity, you will:

- Discuss how home visitors can give input on succession planning to OVC households

Facilitator's notes:

In this activity, you will be reviewing the information from this topic on succession planning with the group. You will also get the group to work on outlining a plan that they can refer to when they need to engage terminally ill parents in succession planning.



For this activity you will need:

- Flipchart and markers
- Extra sheets of blank paper for participants to write on



To facilitate this activity:

- 1 Briefly review with participants the subjects raised in this topic on succession planning.
- 2 Hand out sheets of blank paper to the group. Ask them to think about and write down how they would use this information in their role as home visitors. For example, they need to consider some of the following points:
 - How would a home visitor raise the need for succession planning, such as will-making, with an ill parent they are visiting?
 - What advice would they give a person who wanted to write a will?
 - How would they explain the need for a memory box?
 - How would they get someone to choose a standby guardian?
 - How would they show support to a standby guardian?

Refer the group again to their *Referral Information* lists. For example, if a guardian needs emotional support, then the home visitor should be able to identify where they can get counselling and to have the details listed.

- 3 When participants have all come up with ideas of succession planning points that they can take action on, discuss their ideas in plenary. You may write them up on the flipchart for the group to copy if they wish to.
- 4 Have the participants add these pages to their home visitor's handbooks for reference, along with all the handouts relevant to this topic.



Activity 11 Review of the Home Visitor's Handbook



In this activity, you will:

- Review the home visitor's handbook with the group

Facilitator's notes:

You have now finished your fourth module of the home visitor training. At this point it is best to review the home visitor's handbooks with the participants to ensure that each participant has compiled all the necessary handouts in their handbooks. The home visitor's handbook should now include the following reference pages from the four topics discussed in this module:



Home Visitor's Handbook – Module Four

Topic 1: Ensuring Access to Education for OVC

- The Importance of Education and Barriers to OVC Access to Education
- Steps to Take when OVC are not in School (participants' own worksheet)

Topic 2: Life Skills for Orphans and Vulnerable Children

- The Importance of Life Skills

Topic 3: Supporting Behaviour Change in OVC

- Factors That Influence Behaviour
- The Behaviour Change Process

Topic 4: Succession Planning

- Information on Wills
- Sample Will
- Memory Boxes and Books
- Support to Standby Guardians

APPENDIX 1

Activity Handouts for Unit 2



What are HIV and AIDS?

HIV - Human Immunodeficiency Virus

H - Human

I - Immunodeficiency

V - Virus

AIDS - Acquired Immune Deficiency Syndrome

A - Acquired - Been given (not born with)

I - Immune - The body's defence system

D - Deficiency - Lack

S - Syndrome - Group of symptoms of a sickness



HIV germs attacking white blood cells in the body



How is HIV transmitted?

HIV IS transmitted by:

Having unprotected sex
(sex without a condom) with
an infected person

Coming into contact with infected
blood

Skin piercing or other practices
where exchange of blood is likely
(through infected needles or razors)

A mother infecting her unborn
baby, either during pregnancy or
at delivery, or while breastfeeding

HIV IS NOT transmitted by:

Mosquito bites

Sharing cups, plates and
utensils

Living with a relative who has
HIV or AIDS

Shaking hands or touching an
infected person



How is HIV transmitted?

HIV IS NOT transmitted by:



Having your hair cut

Sharing food and drinks

Wearing second-hand clothes

Sitting next to an infected person

Using the same toilet or bath
as an infected person

Coughing and sneezing

Swimming



Ways of Preventing HIV Infection

The most common strategies for preventing HIV transmission and infection are:

- Abstain from sex
- Be faithful to your partner
- Use condoms (practise safe sex)
- Avoid sharing sharp instruments such as razors or needles (where you may come into contact with infected blood)
- Prevent mother-to-child transmission of HIV (join a PMTCT programme)



Defining *Psychological and Socio-economic*

- **Psychological** = relating to the mind. In this context, it would mean the effects of mental anguish, stress, grief and depression that a person suffers.

Some **psychological** impacts of HIV/AIDS on children, their families and communities are:

- ⦿ **Socio-economic** = relating to social and economic factors.

Some **socio-economic** impacts of HIV/AIDS on children, their families and communities are:



The Impact of HIV/AIDS on Children

Examples of Impacts of HIV/AIDS on Children:





The Impact of HIV/AIDS on Families

Examples of Impacts of HIV/AIDS on Families:





The Impact of HIV/AIDS on Communities

Examples of Impacts of HIV/AIDS on Communities:





Government Strategies on Children's Rights

What Government has done or needs to do for children's rights in the following service areas:

Child Welfare

Child Safety and Protection

Education

Health

Psychosocial Support

Socio-economic Support

Legal Aid and Representation

Social Development



Stakeholder's Roles in the Support of OVC

There are many stakeholders in society that have roles and responsibilities to protect children's rights and support OVC:

Parents, guardians, caregivers

Local authorities

Civil society organisations

Community groups

The private sector



The Seven Components of OVC Support

1 Welfare (Care and Support)

- Provision of basic needs (food, water, shelter, clothing, bedding)
- Community support to households that care for OVC
- Support to OVC who are mothers
- Awareness of benefits of family planning

2 Child Protection

- Fostering, guardianship and adoption
- Protection from child labour
- Succession planning and inheritance issues
- Protection from sexual abuse and other forms of abuse and exploitation

3 Education

- Formal and informal education
- Life skills training
- Vocational training
- Caregiver education (and adult literacy)
- Special needs education

4 Health

- Access to healthcare
- Immunisations
- Nutrition
- Treatment of HIV/AIDS, including ARVs
- Caregiver health

5 Psychosocial Support

- Community-based (and institutional) psychosocial support
- Child-friendly health and education services
- Recreation activities for children and youth
- Mentoring
- Peer groups

6 Socio-economic Security

- Income generating activities
- Financial and entrepreneurial initiatives
- Job development in formal and informal sector
- Internships and apprenticeships
- Social security benefits (for orphans, for elderly caregivers)

7 Legal Aid and Representation

- Rights, including gender advocacy
- Inheritance rights
- Policy formulation and implementation



The Meaning of Children's Rights

Definitions of children and children's rights:

- ◆ A **child** is defined as a human, male or female, aged 18 or under.
- ◆ A **right** is what any person, child or adult, is entitled to legally and morally.
- ◆ The rights of **all** children are enshrined in law and must not be violated. When there is violation of the rights of children, legal action can and should be taken.
- ◆ Nobody, not even parents, can violate the rights of a child.





Categories of Children's Rights

There are four categories of children's rights:

◆ **Survival Rights:**

- The right to a name and a nationality
- The right to grow peacefully in a caring and secure environment
- The right to the basic necessities of life - food, shelter and clothing
- The right to one's parents

◆ **Protection Rights:**

- The right to have one's health protected through immunisation and appropriate healthcare
- The right to protection from abuse and exploitation
- The right to be treated fairly and humanely
- The right not to be employed or engaged in activities that harm one's health, education, mental, physical and functional development

◆ **Developmental Rights:**

- The right to a basic education
- The right to leisure and to socialise in an environment that is not physically and morally harmful

◆ **Participation Rights:**

- The right to express one's opinion
- The right to be listened to
- The right to be consulted according to one's understanding

Based on definitions from the *United Nations Convention on the Rights of the Child*



The Abuse of Children

Child abuse is a violation of a child's rights and takes many forms:

- ◆ **Physical abuse**



When a child's body is injured through punching, hitting, beating, shaking, biting, child sacrifice, burning or any other harmful actions. Physical abuse often manifests as bruises, swellings and broken bones.

- ◆ **Emotional abuse**



When a child's self-esteem, confidence and sense of worth is destroyed by someone's behaviour towards the child. It includes constant criticism, belittling, blaming, withdrawals of affection, ignoring, excessive teasing and nicknaming children who are infected with HIV/AIDS.

- ◆ **Child neglect**



Failure to provide a child with basic needs such as food, shelter, clothing, hygiene, education, adequate supervision, medical and dental care, love and affection, and other necessities of life.

- ◆ **Child labour**



Refers to work which is hazardous and jeopardises the health, safety and morals of a child. Examples of work dangerous to children include:

- Domestic service by children
- Commercial sex exploitation
- Children in self-employment on the streets
- Children in commercial agriculture.

- ◆ **Sexual abuse**



Refers to an adult involving a child in sexual activity. Sexual abuse includes sexual suggestions, exhibitionism, inappropriate touching of the private parts of a child, masturbation, oral sex and rape. Sexual abuse also refers to incest, sexual harassment and forced early marriage.



Sexual Abuse of Children

Possible signs of sexual abuse in children

The following list of possible signs of sexual abuse do not mean that sexual abuse has absolutely occurred, but such signs must not be ignored. If a home visitor or guardian thinks that a child displays the signs of possible sexual abuse, they should contact the CCC who should have a mechanism in place for child protection, psychosocial and medical support, and referrals. Under no circumstances should home visitors try to determine sexual abuse on their own. If they do so, this could be considered further abuse of a child's rights and dignity and may be against the law. Only a person qualified to physically examine a child, should be allowed to do so.

Physical Signs (girls):

- Tearing, unusual bleeding and discharge (pus) from the vagina
- Pain in the area of the vagina
- Need for frequent urination (which could indicate an infection).

Physical Signs (boys and girls):

- Tearing of and bleeding from the anus (child's bottom)
- Pain in area of the anus.

Behavioural changes in boys and girls:

- Depression, withdrawing and loss of interest in life
- Difficulty in sleeping and nightmares
- Over- and under-eating and sudden weight gain or loss
- Clinging to other people
- Frequent crying for no obvious reason
- Doing less well at school or avoiding school
- Staying away from people or not trusting people
- Washing too often or not at all
- Seeking attention
- Self-destructive behaviour
- Sexual knowledge and sexual behaviour not normal in a child.



Sexual Abuse of Children

Guidelines for caregivers to help prevent sexual abuse

Parents / guardians / caregivers:

- Show affection and attention to your child. Children who do not feel loved are more likely to be sexually abused because they seek attention from others
- Talk to children about child sexual abuse. Ask them if they are worried or uncomfortable about anything that someone said or did to them. This is the responsibility of both male and female parents or caregivers
- Be cautious about who looks after for your children
- Do not send them to stay with other people, if possible
- Do not send your children out alone, especially after dark
- Teach your children self-defence and life skills
- Treat children well
- If children are in your care, behave like a good parent. Think about the dangers of sexual abuse and teach the child how to protect him or herself.

Tell your children:

- To be careful of being alone with anyone who could abuse them
- That if someone frightens them, they must run away and shout loudly for help
- To avoid dark or lonely places like isolated well-sides and empty buildings (even churches)
- To avoid walking around on their own and to stay in a group, if possible
- To avoid other people's bedrooms and bathrooms
- Not to go to public toilets or latrines on their own
- To think about what they wear
- That even friends can sexually abuse them
- To report anyone who tells them to do anything that makes them feel uncomfortable and may lead to sexual abuse
- Not to accept a present or money from a stranger or someone who they wouldn't normally expect it from
- Not to enter the vehicle of an unknown adult, even if that adult seems friendly
- Not to go into the houses of neighbours, teachers, religious leaders or other adults on their own.



Sexual Abuse of Children

Steps to take when sexual abuse of a child is suspected

With the child

Listen calmly to the child's story – it is very difficult for a child to talk about sexual abuse. The child may have been threatened with harm or even death by the abuser if they tell what happened. You should help them report the incident to the nearest authorities. There are often specially trained police at police stations that a child can speak to.

Child sexual abuse can also be reported to local council leaders, probation officers, teachers, community development officers, or child rights services. Your CCC and/or your home visitor trainer should have explained the correct channels for you to follow if you suspect that one of the children you are visiting has been abused. In the space below, record the authority in your community where you can report suspected cases of child abuse to.

Report to: _____

Medical assistance

If the child has been sexually assaulted, he or she will need medical attention. If possible, two healthcare workers should examine the child, ideally those appointed by the police. This must be done within 24 hours and before the child bathes or washes his/her clothes, especially underwear. Keep the clothes in a plastic bag and give them to the police to preserve the evidence of the crime.

Review of steps to take

- Comfort and reassure the child, provide the child with loving care and a safe place to talk.
- Inform the parent or guardian.
- Do not tamper with evidence: clothes, blood stains and bruises should not be washed.
- The child should not wash or bathe before a medical examination.
- Torn dresses or pants should not be washed before reporting to the police or other authority – they will be used as evidence.
- Take action: report the case of abuse to the authority you have identified during your training.



Gender Roles of Boys and Girls

Examples of gender-based roles

Examples of roles usually assigned to boys:

Examples of roles usually assigned to girls:

Examples of roles usually assigned to both girls and boys:



Gender Roles of Boys and Girls

Disadvantages of gender-based roles, especially for girls:

- Lack of access to information and schooling, because of the nature and long hours of girls' work
- Low levels of education and life skills because girls often withdraw from school to look after siblings and sick parents
- Early marriages because girls often lack education and economic independence
- Girls may become commercial sex workers because of economic vulnerability
- Risk of unprotected sex because girls often lack adequate knowledge and information
- Rape and difficulty in negotiating for safer sex for girls, exposing them to a high risk of HIV infection
- Violence against women
- Male drunkenness and drug abuse impacts on the physical safety of girls.

Cultural considerations:

In many cases both married or unmarried men have multiple partners, including sex workers, and this behaviour is culturally accepted. Cultural attitudes condone or even encourage male sexual freedom and repress female sexuality. The practice of multiple partners and commercial sex services, places girls and women at risk and is a significant factor in promoting the spread of HIV/AIDS, thus fuelling the problems that further lead to orphans and vulnerable children.

In many other cases, women are expected to have relations with, or marry, older men who are more sexually experienced and more likely to be infected. Men may also seek younger partners in order to avoid infection and in the unfounded belief that sex with a virgin cures AIDS and other diseases.

The main results of being disadvantaged:

- Violence against women, including all forms of coerced or forced sex
- Harmful traditional practices
- Stigma and discrimination associated with AIDS – violence, abandonment and neglect
- Lack of access to HIV/AIDS education, prevention and services for adolescents
- Sexual abuse of girls and girls and women's lack of control over sexuality and sexual relationships
- Poor reproductive and sexual health
- Neglect of health needs, nutrition and medical care
- Issues of non-disclosure of HIV status (partner notification vs. total confidentiality), thus the practise of unsafe sex.



The Different Needs of Children

Physical needs:

- Clothing
- Food
- Shelter
- Medical care
- Protection

Spiritual needs:

- Faith and prayer
- Sense of hope for the future
- Sense of moral life

**Physical
needs****Spiritual
needs****Social
needs****Emotional
needs****Social needs:**

- Schooling
- Play / leisure
- Friends / relationships

Emotional needs:

- Love
- Acceptance
- Care
- Being appreciated



Indicators of Children's Problems

1. Sadness and irritability

Children who are unhappy will look sad, cry a lot and will not want to play. They may be depressed and withdrawn and may not react to what happens around them. Feelings may also come out as irritability or getting upset very easily.

2. Suspicion and lack of trust

Vulnerable children living on their own, in child-headed households or in other difficult circumstances, often have good reasons to be suspicious of people. They feel vulnerable and may be afraid that adults will take advantage of them or exploit them.

3. Anger and hostility

Some children may be hostile towards adults because they have been treated badly by adults and not cared for properly; or they may fear physical abuse or punishment.

4. Guilt, self-blame and shame

OVC are often ashamed of what has happened to them, especially if they have been victims of rape or humiliation, or are disabled and bear the brunt of stigmatisation. They may blame themselves for not protecting their family or for surviving when others have died.

5. Loss of interest and energy

Usually children enjoy playing and display a lot of energy in doing so. A child who is miserable, worried or frightened may be depressed and will show no interest in doing anything and seems to lose her or his energy and appetite.

6. Poor concentration and restlessness

Children who are worried or unhappy often find it difficult to concentrate. They may be very tense and restless. They may find it impossible to sit still and behave.

7. Aggression and destructiveness

Some children, especially young ones, become aggressive or destructive when they are experiencing strong emotions. Because they cannot put feelings into words, they may hit other people in the family or school friends when they feel tense, upset or frightened.

8. Isolation

If a child is on her or his own most of the time and never plays with other children or is rejected by them, she or he becomes isolated, loses trust in other children and experiences loneliness.



Development in Children

Indicators of healthy development in children:

- ◆ Playing, especially with other children
- ◆ Forming friendships
- ◆ Participating in decision-making
- ◆ Good appetite
- ◆ Peaceful sleep
- ◆ School attendance
- ◆ Good performance in school
- ◆ Participating in spiritual activities

Indicators of possible problems in children:

- ◆ Lack of interest and energy in playing
- ◆ Isolation
- ◆ Inarticulate
- ◆ Displays of anger and hostility
- ◆ Sadness and depression
- ◆ Poor concentration and tiredness
- ◆ Aggressive behaviour



The Community's Role in Child Development

Positive developments:

Physical

Social

Intellectual

Moral / Spiritual

Negative influences:

Physical

Social

Intellectual

Moral / Spiritual



Characteristics of a Child

Happy children are:

Active and energetic

Open-minded

Flexible

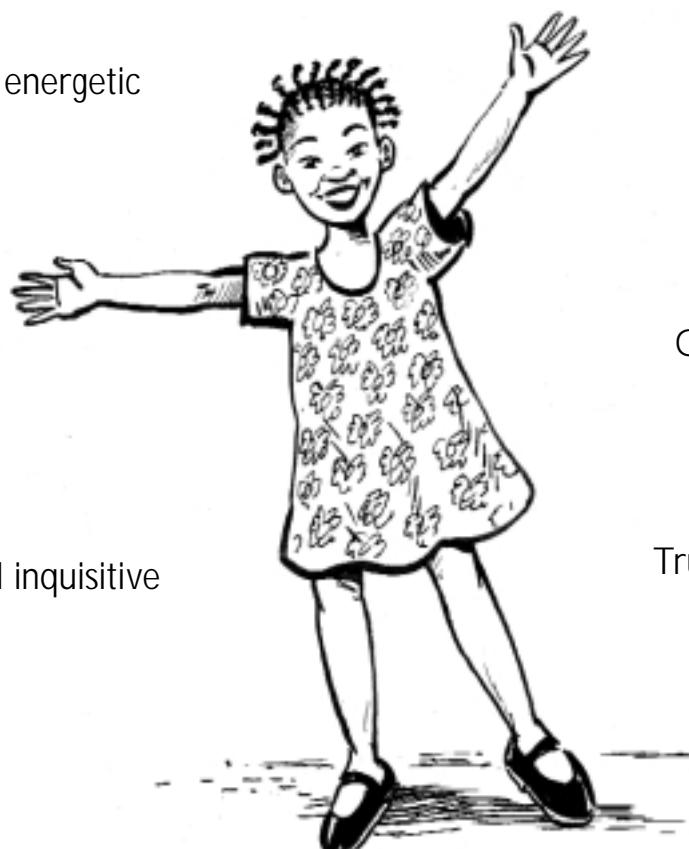
Quick to make friends

Curious and inquisitive

Trusting and trustworthy

Honest

Eager to learn





How Children Communicate

Children use the following means to communicate:

- ◆ Body language
- ◆ The language of play
- ◆ Spoken / verbal language
- ◆ Silence – this could mean that the child feels too overwhelmed to communicate their experience.

Children may hesitate to discuss their problems for a variety of reasons, such as:

- ◆ Children may feel embarrassed or ashamed talking about issues related to sex, HIV/AIDS, and death because these are perceived culturally as taboo subjects.
- ◆ Children may be too young to put their feelings or experiences into words.
- ◆ Some cultures forbid children to question or disagree with adults.
- ◆ Children fear hurting those they love. They might hide their feelings in order to protect their parents or teachers, and adults in general, particularly if these adults are unhappy.

Some indirect, but fun and non-threatening ways of helping a child to communicate are:

- ◆ Drawing
- ◆ Storytelling
- ◆ Drama
- ◆ Playing games.



Preparing Children for a Death in the Family

Whether a child or a child's family member has AIDS, you can help the child to prepare for the idea of death by:

- ◆ Remembering that children from 18 months to about five years have 'magical thinking'. They may fear that their thoughts or behaviour have caused themselves or others to get sick, for example by not doing well at school or not following a traditional custom.
- ◆ Communicating openly, honestly and factually. This involves giving information that is adjusted according to the child's age. Avoid using abstract or misleading explanations, such as 'your mother has gone to sleep'.
- ◆ Allowing the child to express anger or fear and helping the child to do so without harming himself, herself or anyone else.
- ◆ Acknowledging that a child's most natural reaction to death might be denial. Help the child to work through this by gently, but continually, discussing the facts about death and HIV/AIDS; and enabling the child to express fears and to ask questions.
- ◆ Ensuring that the child is not alone with worries and fears. For example, encourage family members to discuss issues of death and bereavement at home, as well as in counselling sessions. Also, where appropriate, consider involving others such as church leaders in counselling the child about what death and dying mean in the context of their own culture and religion.
- ◆ Allowing children to discuss how they would like themselves or their family members to be remembered. For example, they might like to prepare a 'memory book' of drawings, poems and photographs.





Reasons why Children Play

Why children play:

- ◆ Play is one of the most effective ways in which children communicate, especially young children. Caregivers and counsellors can therefore utilise play activities to gauge how a child is coping. Supervised play can also be used to help children come to terms with and overcome difficult circumstances.
- ◆ Play is a way in which children practise social skills; and develop skills in communicating, relating with others, negotiating and problem-solving.
- ◆ Games such as solving puzzles, building things and drawing help to stimulate a child's mental, nervous and muscular systems; and aid the development of co-ordination.

Though not consciously aware of it, children engage in play due to various reasons:

- ◆ To explore their environment
- ◆ For fun and recreation
- ◆ To learn from peers and their surroundings
- ◆ To develop personalities
- ◆ To build and maintain relationships
- ◆ To express their feelings
- ◆ To develop competencies and skills.

When children do not play:

Children may be reluctant to play for many reasons. If they do not take part in games and play activities, it should be of concern to the counsellor or home visitor and may need to be monitored. Some reasons for a child not taking part in play are:

- ◆ They are tired
- ◆ They are sick
- ◆ They are hungry
- ◆ They do not understand the language other children are using
- ◆ They are sad and depressed
- ◆ They are afraid of being bullied
- ◆ They are insecure and have low self-esteem
- ◆ They feel isolated and not part of a group.





Spiritual Health in Children

Spiritual - concerning the spirit rather than the external material world or body; dealing with a sense of the sacred or religious.

Moral - having a sense of right and wrong; living according to an accepted code of behaviours

Some signs of spiritual distress

- ◆ **Lack of meaning and purpose in life, expressed as:**

- Feelings of despair, helplessness, loneliness and not wanting to live
- Withdrawal from life – loss of the desire to communicate or eat
- Exhibiting angry and disruptive behaviour.

- ◆ **Lack of love, expressed as:**

- Cautious about loving people
- Worry and depression
- Guilt
- Anger
- Not able to receive love
- Not trusting people.

- ◆ **Lack of hope, creativity and independence, expressed as:**

- Anxiety about the future
- Displaying overly dependant behaviour or seeking attention
- Denial of the reality of the condition.

Some signs of spiritual and moral health

- ◆ **Has meaning and purpose in life, expressed as:**

- A desire to participate in religious activities according to faith
- Hope for the future
- Contentment in life.

- ◆ **Needs to and is able to receive love, expressed as:**

- Confidence in caregivers
- Feeling forgiven by God and other people; shows freedom from guilt feelings
- Trust in God / others with situations which he or she has no control over.

- ◆ **Needs to give love, expressed as:**

- Love for others through actions
- Seeking the good for others.

- ◆ **Expresses hope, creativity and independence, expressed as:**

- Asking questions about his condition
- Learning to value his or her inner self, besides his or her physical self
- Setting goals and having a sense of a future
- Having hope in life and wanting to achieve positive things.



Enhancing Self-Awareness in Caregivers

Caregivers need to be helped to introspect and to determine what their own needs are; and to identify their challenges, their strengths and their weaknesses. To do this, caregivers need to go through a process of self-evaluation to find out their strengths and inner resources.

Caregivers need to find out what their strengths, skills, qualities and abilities are. Some questions to help caregivers reflect on their lives are:

- ◆ What do you enjoy the most about giving care?
- ◆ What are the main challenges you face as a caregiver?
- ◆ What do you enjoy doing during your spare time?
- ◆ How often do you take time off from your caregiving duties to pursue other interests?
- ◆ Do you have anyone to share feelings, thoughts and problems with?

Home visitors can also help caregivers by making sure that they are able to:

- ◆ Relax and have time to do the things they enjoy (for example, a hobby such as sewing)
- ◆ Make sure they are eating properly and getting enough rest
- ◆ Share their experiences and problems with someone
- ◆ Get support with household chores, shopping and planting, etc.
- ◆ Have some spiritual support when they need it
- ◆ Spend time with friends and people they like.



Community Initiatives to Enhance Food Security for OVC

Threats to OVC food security may include any or all of the following:

- Sickness or absence of household head to tend to crops
- Sickness or absence of household head to prepare food and cook
- Child- or elderly-headed household has difficulty attending to all the tasks required to grow or prepare food
- Time is spent on tending to the sick or attending funerals instead of farming or food preparation
- Money for food is spent on medicines or burial costs instead
- Livestock, farming equipment and tools may be sold to pay for medical or burial costs
- Knowledge about farming techniques is not passed down because parents have died
- Adults in the household no longer able to bring in income to buy food
- Lack of money to buy seeds, tools or food
- Community stores of grain and food are depleted because so many people are falling ill and dying
- OVC who have been brought into other households may not receive as much food as other family members
- Lack of understanding about good nutrition.

Some community-based initiatives to enhance the food security of OVC:

- Provide emergency rations to OVC who lack food
- Teach households caring for OVC more productive farming techniques
- Make sure OVC households are taught how to farm, grow vegetables and prepare food
- Provide OVC and their caregivers with seeds, tools, livestock, etc.
- Involve OVC and their caregivers in income-generating projects
- Provide OVC and their caregivers with nutritional information
- Help households headed by ill adults or children with farming and food preparation tasks
- Provide home-based care to ill adults, so children are free to tend crops and prepare food
- Encourage households that have taken in OVC to treat these children the same as their own children and to feed them adequately.





Important Food Groups

Energy-giving foods:

Carbohydrates - The main source of carbohydrates in the diet is from staples and sugars.

- **Staples or starches** make up the biggest part of any meal for the majority of the population.

They include maize, matooke, Irish, potatoes, sweet potatoes, cassava, sorghum, millet, yams, rice and bread. Staples need to be eaten in combination with other foods to provide enough nutrients.

- **Sugars** are also rich sources of energy, but are not very nutritious.

- **Fats and oils** are rich sources of energy, but people only need fats in small quantities.

Vegetable oils are obtained from corn, simsim, sunflower, cottonseed, shea butter, palm oil and margarine. Animal sources of fats include lard, butter, cheese, meat and fish.



Body-building foods:

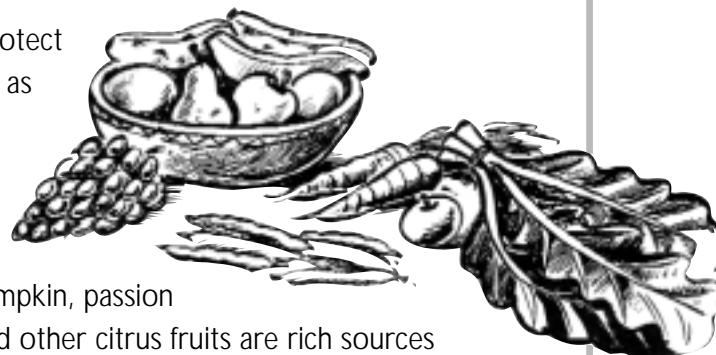
Proteins are body-building foods. They are essential for cell growth and support the functioning and formation of the general structure of all tissues, including muscles, bones, teeth, skin and nails. Main types of proteins are:

- **Plant proteins** include beans and peas, green grams, groundnuts, soybeans and simsim.
- **Animal proteins** are meat, milk (including products like cheese, yoghurt and fermented milk) and eggs.



Protective Foods:

These foods keep the body working properly and protect against disease. **Fruits and vegetables** are known as protective foods because they provide vitamins and minerals that strengthen the immune system. They supply vitamins and minerals, which are required by the body for its normal physiological functions.



- **Fruits** include avocados, mangoes, pawpaws, pumpkin, passion fruit, pineapple and jackfruit. Oranges, lemons and other citrus fruits are rich sources of vitamin C.
- **Vegetables** contain useful immune substances called beta-carotenes. In many cases, vegetables are seasonal in availability, quality and prices.
- **Vitamins** are vital for the body to function properly.
- **Minerals** are needed for the functioning of the immune system. Important minerals include iron, selenium, zinc, iodine, calcium and magnesium.



Nutritional Support for Infants Born to HIV Positive Mothers

Infants who are born to HIV positive mothers are at risk of becoming HIV positive themselves, through breastfeeding from the infected mother. In such cases, it is recommended that a mother choose one of two options to feed her child:

- ◆ **Exclusive breastfeeding** (with no other foods given, not even water)
- ◆ **Exclusive replacement feeding** (with all breastfeeding replaced with a food substitute, such as cow's milk).

It is important that a mother does not mix the two feeding options, as this will increase the risk of HIV transmission. There are risks and benefits associated with each of the feeding options, so a mother will need to be aware of these so that she can make an informed choice.

1 Exclusive breastfeeding:

Benefits -

- ◆ Breast milk contains everything a baby needs, including water energy, proteins and micro-nutrients.
- ◆ Breast milk is easy to provide to the child, is always available and is not costly.
- ◆ It gives emotional benefits to the mother and baby.
- ◆ It has contraceptive benefit for the mother.
- ◆ It is culturally appropriate.

Risks -

- ◆ HIV can be passed on the infant through breast milk.
- ◆ Breastfeeding can drain the strength of the mother and expose her to infections.

2 Replacement feeding:

Benefits -

- ◆ Replacement feeding reduces the risk of transmission of HIV from the mother to the infant.
- ◆ The mother's body reserves are not depleted and this means she is stronger.

Risks -

- ◆ There is a higher risk of other non-HIV infections for the infant.
- ◆ Other foods do not transfer mother's protective antibodies and vitamins.
- ◆ Foods such as milk formulas are expensive, and the fuel for boiling the water and making the foods up also drains resources.
- ◆ If foods are not prepared properly, they can cause diseases that lead to malnutrition.
- ◆ If the mother does not breastfeed, it may not be culturally acceptable and may increase stigma for the infected mother.





Nutritional Support for Children over Two Years who are HIV Positive

Children who are HIV positive will often not grow and develop properly; and are at greater risk of death. They can easily get illnesses such as diarrhoea, acute respiratory infections (ARI), malaria, neurological problems and experience poor growth. They may also risk malnutrition due to poor appetite, swallowing difficulties and nausea. As such, HIV infected children should be given special attention to ensure they receive adequate nutrition and care.

Children infected with HIV need nutritious diets to boost their immune systems so they can deal adequately with infections. Foods enriched with Vitamin A, in particular, can help to boost a child's immune system. Also, food for children with HIV must be prepared with extra hygienic care, as their bodies are vulnerable to infections from germs found in food that is not cooked adequately or prepared safely (for example, all dishes and cooking utensils must be clean).

Children infected with HIV need:

- ◆ Foods high in energy, proteins and micro-nutrients.
- ◆ To be fed more often, with smaller, frequent meals and snacks. This will aid the absorption of nutrients better.
- ◆ To be fed with a variety of fruit and vegetables, to ensure adequate nutritional intake.
- ◆ To be fed with foods that are fortified with added micro-nutrients, if possible.
- ◆ Adequate clean water to drink (preferably boiled water that has been left to cool).

A child with HIV may experience a decreased food intake because of difficulties in eating due to sores or ulcers in the mouth that make it hard to swallow food. Infections such as fevers and respiratory infections (coughs) cause increased energy needs in children. Diarrhoea can result in dehydration (water loss) and loss of nutrients, so increased energy requirements are needed. Children with HIV also have a poor absorption of nutrients, so if a child's diet is not adequate in meeting the increased nutritional needs, the child may be at risk of malnutrition.

Some tips to aid the nutritional intake of children with HIV:

- ◆ Porridge can be enriched with milk, soya flour, groundnuts or simsim
- ◆ Add a small amount of uncooked vegetable oil to foods – this will aid digestion
- ◆ Vegetables and fruits such as bananas, pawpaws, pumpkins and avocados can be eaten mashed to make them easier to swallow
- ◆ Avoid fried and spicy foods – they are hard to digest, cause irritation in the stomach and can cause further diarrhoea
- ◆ Avoid sugary foods (sweets and colddrinks) – they encourage fungal infections
- ◆ Yoghurt or maas helps to stop fungal infections in the stomach and aids digestion
- ◆ Dried pumpkin seeds and garlic are good for stopping stomach parasites
- ◆ The older the child, the more food they need to eat.



Steps to Help Malnourished Children

Some community-based strategies for addressing poor nutrition among OVC:

- Educate caregivers about proper nutrition and provide practical advice about improving nutrition in the household
- Train home visitors to provide nutrition information and advice
- Help households to start vegetable gardens (individually or communally)
- Train caregiver households in more effective farming practices
- Provide vulnerable households with seeds and tools to cultivate nutrient-rich foods
- Help households to start income-generating activities that can raise money for food
- Advocate for children to get treated for worms and other illnesses that cause poor nutrition
- Raise community awareness about good nutrition and advocate against cultural beliefs and practices that promote poor nutrition
- Help dangerously malnourished children to access food rations mobilised from within the community or from an NGO that provides food aid.





Basic Healthcare Needs of Children

All children have the same healthcare needs.

They need preventative healthcare, including:

- ◆ Regular medical check-ups done by a healthcare worker, to monitor whether they are developing properly (including disabled children or those HIV positive)
- ◆ Immunisation against serious diseases
- ◆ Insecticide-treated bed nets, or other means, to prevent malaria
- ◆ Good nutrition
- ◆ Age-appropriate information about preventing HIV infection.

They also need curative healthcare, including:

- ◆ The treatment of any illness or disease with appropriate medication
- ◆ Extra nutritional intake if they have been ill
- ◆ Regular deworming treatment.

In order for these needs to be met, children also need:

- Parents or guardians to understand the importance of preventative healthcare
- Parents or guardians to know where to seek medical help to treat a child's illness
- Parents or guardians to seek early medical help to treat a child's illness
- Access to immunisations through clinics or healthcare programmes
- Access to well-baby and well-child check-ups to make sure that the child does not have any developing health problems
- Access to clean water and proper sanitation
- Knowledge about basic good hygiene practices
- Access to healthcare workers, clinics and medicines when they are ill.





Immunisation

Immunisation is when a child is given a vaccine that is either injected into the body or swallowed to protect against certain serious preventable diseases that can cause deaths in children.

The following are the immunisable diseases in most African countries: Measles, poliomyelitis, whooping cough, tetanus, tuberculosis, diphtheria, Hepatitis B, Haemophilus Influenzae type B, yellow fever.

All children need to be immunised

- ◆ All children under one year need to be immunised. Half of the deaths from the nine diseases occur before the age of one year. Those children who are older and who are not fully immunised, should still be vaccinated.
- ◆ Infants must complete the full course of immunisation, or the vaccine may not work. The parent/guardian must take the child to be vaccinated at least four times to be able to complete the immunisation. A baby cannot be fully immunised against all the diseases in one visit to the clinic.
- ◆ Caregivers should not be afraid of having their children immunised. The vaccines are safe and effective.
- ◆ A child who is not immunised may get measles or tuberculosis. These diseases can kill children. Even if they survive them, they will be weakened and may not develop properly.
- ◆ A child who is not immunised could get the disease and infect other children.

Even sick children should be immunised

- ◆ It is safe to immunise sick children. One of the main reasons why children are not brought for immunisation is that they have a fever or a cough, but this should not prevent them from receiving their immunisations.
- ◆ All children should be vaccinated, even when they are sick. The healthcare worker will check if there are any reasons why a child should not be vaccinated.



Common Illnesses that Affect Children



◦ **Malaria**

Malaria is a life-threatening disease spread by disease-carrying mosquitoes.

The first signs of malaria are body weakness, fever, aching body and

headaches. Malaria kills large numbers of children under five years old.

Young children should sleep under treated mosquito nets to help stop malaria.

◦ **Diarrhoeal diseases**

A child with diarrhoea will pass of three or more stools a day, with more water in the stools than is normal for the child, making the child dehydrated (loss of fluid from the body). Diarrhoeal diseases are common and cause many deaths in young children, especially those under two years old. These diseases are often caused by poor water and sanitation; and by the consumption of infected food, especially meat. A child with diarrhoea loses essential nutrients, loses weight, becomes malnourished and may not grow properly. These children need to drink more fluids than usual to replace the fluids they have lost, as well as frequent small meals to help them to gain strength and weight.

◦ **Respiratory tract infections**

A child with a persistent cough and breathing difficulties may have pneumonia, asthma, Tuberculosis or another serious respiratory infection and should be taken for treatment. Other signs of lung infections are breathing that is very fast, wheezy or rasping. Children with breathing difficulties should be taken to a clinic for better assessment and treatment.

◦ **Intestinal worms**

Intestinal worms are mainly passed on to humans through poor sanitation, rather than from food. Hygiene practices such as washing the hands after defecating; and before eating or preparing food, are vital to stop worm eggs from entering the mouth. Worms are parasites (they live off a person's body); and children with worms are robbed of their food and nutrients, causing weakness and poor growth. There are many different types of worms that are dangerous, so children should be treated regularly with medicine to get rid of the worms. Most worms are spread from human and animal faeces. To prevent worm eggs (which are usually too small to see) from spreading, all faeces must be properly disposed of. Animals should be kept away from areas where children play.

◦ **Skin infections**

Skin infections, such as scabies, are also caused by poor sanitation or where people do not have access to enough water to wash themselves and their clothes regularly.

Scabies is a skin disease that is caused by a small parasite which lives in the skin and

spreads easily from person to person. Scabies causes very itchy bumps on the skin and,

because it is caused by parasites, it makes a child weak and not able to grow properly.

Children with scabies should be treated.

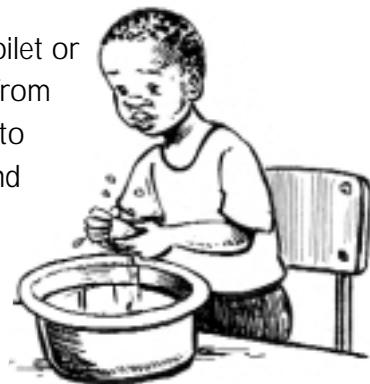


Basic Hygiene Practices

◦ **Clean hands with soap and water or ash**

Illness can be prevented by washing hands after going to the toilet or after contact with faeces. Hand washing helps to stop germs from getting into food or into the mouth. It is especially important to wash hands after defecating, before handling or eating food, and after cleaning the bottom of a baby who has defecated.

Children often put their hands into their mouths, so it is important to clean a child's hands often, especially before eating food and after going to the toilet.



◦ **Dispose of all faeces safely**

Prevent the spread of germs by safely disposing of all human and animal faeces. Illnesses, such as diarrhoea and worms, come from germs found in faeces which can get into water, food, onto the hands and cooking and eating utensils. All faeces of adults, children and babies are dangerous and should be disposed of in a toilet or latrine. If there is no toilet, people should defecate away from the home, walking paths, water sources (such as rivers) and areas where children play. The faeces can also be buried to stop germs and flies. Animal faeces is a main breeding place for germs that cause disease, so animals should be kept away from areas where children play. Animals should also be fenced away from water supply points so that they do not contaminate the water supply.

◦ **Food and water safety**

Illness can be prevented by taking care with the storage and preparation of food.

The home and areas where food is stored or prepared should be kept clean.

All cooking utensils should be kept clean. Food and water should be stored in clean containers with lids, so that flies and animals do not spread germs to them. Fly control is a positive way to prevent the spread of germs. When cooking, make sure that food is cooked properly before eating. Cooked food should not be eaten if it has been left unrefridgerated for more than six hours. If the safety of water is not guaranteed, water for drinking and cooking can be purified or boiled before use. Babies' feeding utensils (cup and spoon) should be kept especially clean, as they are one of the ways that diarrhoeal germs are spread to babies.

◦ **Other basic hygiene practices that help to stop the spread of disease:**

- Wash body, clothes and bedding regularly
- Wash hands before preparing food, eating and giving medicines
- Wash hands after changing soiled clothes or bedding
- Avoid spitting as it spreads germs and can spread TB, for example
- Dispose of household waste in a pit latrine or by burying or burning
- Cover bleeding cuts or wounds and avoid contact with the blood of other people
- Wear latex gloves when helping a bleeding person.



Child Health Monitoring Sheet

FOR QUARTERLY MONITORING

Child's Name: _____ ID No. _____

Male Female

Community / Village: _____

Parish / Location / Division: _____

Guardian's Name: _____

Guardian's Signature: _____

Child's Health Record:

1 Height (m): _____ 2 Weight (Kg): _____

3 Age _____ (In years, but if less than five years old, quote in months)

4 Immunisation Status (for only children under 60 months):

DPT+ BCG DPT2+ DPT3+
 OPV0 OPV1 OPV2 OPV3 Measles

5 Did the child fall sick in the last 3 months? (i.e. since the last WV health check-up)

Yes No If yes, explain:

(a) Type of sickness: _____

(b) Action taken: _____

General Health Observations:

Head (observe hair, teeth, eyes and ears):

(a) Hair: Normal Abnormal If abnormal, explain: _____

(b) Teeth: Normal Abnormal If abnormal, explain: _____

(c) Eyes: Normal Abnormal If abnormal, explain: _____

Body (observe arms, legs and feet for skin disorders, wounds etc.):

Normal Abnormal If abnormal, explain: _____

7 Overall comments or actions to be taken: _____

Date: _____

Form filled in by: _____ Title: _____

ADP Name: _____ ADP No.: _____



Basic Health Information

Symptoms of illness: Look out for symptoms of illness, especially coughs, fever, rapid or difficult breathing, loss of appetite, poor weight gain, diarrhoea and vomiting. Seek treatment for as many of these symptoms as soon as possible.

Immunisations: Ensure that all children are immunised, but a child with HIV should not be given a BCG or yellow fever vaccine.

Diarrhoea: Give foods containing potassium, such as bananas, spinach and coconut water. Give a child with diarrhoea more fluids to drink than usual, such as an oral rehydration solution, water, soups, yoghurt drinks, coconut water and rice water. Feed the child regularly and seek help if the diarrhoea continues for more than three days, or there is blood in the stool, the child vomits often, eats or drinks poorly, or has a fever.

Fever: Give plenty of fluids to children with fever, and paracetamol to reduce the temperature. Take the child to a clinic if the fever lasts more than three days, and as soon as possible if the child also has convulsions, diarrhoea, stiff neck and a cough, or if there is malaria in the area.

Malaria: If possible, children should sleep under an insecticide-treated mosquito net.

Infectious diseases: Take care to keep children away from people infected with TB, pneumonia and measles.

Nausea: Give lemon juice in warm water or a ginger drink to reduce nausea.

Vaginal thrush (itchiness in the vagina): A tampon dipped in plain yoghurt or a peeled clove of garlic can be inserted into the vagina. They should be removed and replaced twice a day; and removed when the condition clears.

Oral thrush (white patches or fungus-like growth in mouth):

Give unsweetened yoghurt or sour porridge.

Sore throat: Give mashed foods such as bananas and sweet potatoes to children who cannot swallow easily.

Preventing infections: Give herbs like garlic, ginger, turmeric and moringa leaf powder to prevent many infections.

Pain: Give paracetamol for pain.



The Importance of Education and Barriers to OVC Access to Education

Reasons why it is important for OVC to receive an education:

- It prepares them to support themselves in the future
- It gives them the opportunity to form friendships and promotes social integration
- It gives them an opportunity to work with adults who care about them and wish to prepare them for their future
- It prevents isolation and marginalisation, and boosts self-esteem and sense of purpose
- It is good for their mental and psychological health and development
- It provides them with positive, meaningful activities
- It gives them the opportunity to learn life skills and gain information
- It helps prevent the spread of HIV/AIDS through information and awareness
- For girls, it helps prevent early pregnancies and marriages, and sexual exploitation and abuse, through both girls and boys learning to respect and understand one another.

Possible barriers to children's access to education:

- The child may be needed at home to care for a sick parent or to attend to other household tasks, such as looking after younger children.
- The child's parents or guardian may not understand the importance of educating the child, or there may be neglect of a child's needs in a dysfunctional household.
- Parents or guardians may not think the school curriculum is relevant to the child's and family's needs.
- Children may not have the money for school fees, uniform costs, books, etc.
- Children may suffer from stigma or discrimination at school because of HIV/AIDS in their family; or because of being disabled, or because of poverty.
- Female children may be discouraged from attending school because they are girls.
- The local school might not have adequate staff or facilities to cope with children with special needs, for example, physically or mentally disabled children.



The Importance of Life Skills

Skills necessary to have a good relationship with yourself:

- *The ability to cope with and control emotions.* Emotions, such as anger and fear, are usually reactions to a situation and may cause regret if they are acted upon impulsively.
- *Self-esteem.* Often vulnerable children lose self-esteem because of their situation. They may be intimidated easily or develop inferiority complexes. These children need their self-esteem boosted in order to know that they are important and highly valued.
- *Assertiveness.* Assertiveness involves knowing what you want and why you want it, and being able to take necessary action.
- *Self awareness.* All children need to be aware of their individual abilities and talents; and to develop them, knowing that each individual is unique, created in God's image.
- *The ability to cope with stress.* Many children live in very stressful situations which can be destructive to their growth and development.

Skills necessary to have a good relationship with others:

- *Good social manners.* Orphans must often adapt to living with new families. In order to adapt successfully, they must know how to behave, how to communicate, how to respond to stressful situations, and how to deal with people from different backgrounds.
- *Friendship formation.* Forming friendships is an important social skill for children. Peer friendships give children support, guidance and experience in sharing and communicating.
- *Peer resistance.* Children need peer resistance skills to enable them to stand up for their own values and beliefs in the face of conflicting ideas and practices from peers.
- *Effective communication.* Children need to know how to express themselves clearly and appropriately during interactions with other people in any given circumstances. Communication is an especially important, as it is the essence of human relationships.
- *Negotiation.* Negotiation involves the ability to see both sides of a specific issue and agree to a resolution without compromising one's principles or becoming confrontational.
- *Non-violent conflict resolution.* When involved in an argument or dispute, children should be encouraged to remain calm and avoid the use of violence and emotional blackmail.

Skills necessary for making good decisions:

- *Critical thinking.* Children face many contradictory messages, expectations and demands from teachers, guardians and peers. They need to be able to analyse their choices, weigh up the advantages and the disadvantages and decide what is best for themselves. Children need to think through situations adequately so that they may make informed decisions.
- *Creative thinking.* This involves devising different means of dealing with a situation. It involves coming up with new ideas and trying out more than one way to solve a problem.
- *Decision making.* Children may be confronted with serious demands, which require them to make appropriate decisions. They must be able to prioritise and weigh up the advantages and disadvantages of a course of action.
- *Problem solving.* Problem solving is the ability to identify, cope with and find solutions to difficult and challenging situations.



Factors that Influence Behaviour

Factors that influence behaviour include the following:

- Environment / life circumstances
- Peer groups
- Culture
- Knowledge and experience
- Beliefs
- Personality
- Emotions/feelings and attitudes
- Instincts
- Intelligence

The following factors can hinder behaviour change:

- Lack of control over one's life or destiny
- Inability to express or act on what one needs or wants
- Lack of information
- Peer pressure
- Poor decision making skills
- Harmful cultural factors, such as the devaluation of girls



The Behaviour Change Process

Steps to Behaviour Change

Step 1 - Knowledge and awareness of his or her behaviour

The person whose behaviour needs to be changed must become aware of the reasons that this behaviour is negative. He or she needs to receive information about, for example, the dangers and the consequences of the behaviour. Once an individual has got that information, then he or she has a choice to begin a journey to change his or her behaviour, or not.

Step 2 - Significance to self to change behaviour

Someone who is in the process of behaviour change will have to understand the significance of the behaviour change to him or herself. For example, it is not enough for a person to know that unprotected sex can lead to HIV infection. He or she must apply this knowledge to his or her own situation. In this way, he or she will understand on a personal level that it is important for him or her to change certain behaviours. Once the person realises this, then he or she is in the process of behaviour change.

Step 3 - Analysing the costs and benefits of behaviour change

An individual who is willing to change must understand the costs and benefits of change. For example, a young person who wants to stop smoking will realise that the cost of stopping is losing a pleasure, but the benefit of stopping is saved money, better health, and a longer life. Once it is clear that the benefits of stopping far outweigh the costs, the individual will be ready to change his or her behaviour.

Step 4 - Provisional trying of new behaviour

This is when the new behaviour is tried out in a risky situation. For example, using a condom with a reluctant partner; or deciding not to smoke when all of one's peers are still smoking and risking their disapproval.

Step 5 - Complete behaviour change

This is the step in which the provisional behaviour change becomes permanent.



Information on Wills

◦ Requirements for a will:

- A will must be made voluntarily. Nobody should be forced or frightened into making a will.
- Anyone who is 21 years or older can make a will, irrespective of sex, marital status or state of health. Every adult, not only ill people, should make a will.
- The person making a will must have a sound mind. This means that they should be fully aware of what they are doing, otherwise the will is not valid (invalid).

◦ A will should have the following features:

- It can be in any form, but the most common and valid form is a written will.
- It must have a date.
- Two adults must witness you signing the will and they must also sign it. If the will is more than one page long, then every page must be signed. The witnesses should not be beneficiaries of the will to which they sign as witnesses.
- A testator (person writing the will) must have only one will. However, he/she may make an addition to the will, which must be signed and attached to the main will. If the testator leaves more than one will, only the most recent will is recognised.

◦ The contents of a will must include:

- Name, address and place of origin of testator (will-maker).
- Names and addresses of the people (beneficiaries) to whom you are leaving property.
- How you would wish your property to be distributed after your death.
- The person you wish to have legal responsibility of your children (a legal guardian).
- The person you appoint to carry out your wishes in the will (the executor or executrix).
- Your wishes regarding your funeral and burial.
- The amount you owe in debts and the amount people owe you.
- The person who should take whatever property you have forgotten to mention.
- Any conditions you want to impose on the people to whom you leave your property.

◦ A will may be kept by:

- Registrars of the High Court or appropriate legal officials
- A bank or reputable financial institution (i.e. in a safety deposit box)
- An advocate or counsellor
- A trustworthy friend who will produce it after your death.

◦ Execution of a will:

After the death of the testator, the will is read out. It will identify the person or people appointed to execute (carry out) the deceased's instructions. However, the executor/s of the will must have court clearance and permission before they can distribute or handle the property of the deceased in any way, as the will is part of a legal process. The first task the executor has to do when executing the will, is to settle the debts of the deceased. After this is done, then the property and possessions can be sorted out for the beneficiaries according to the instructions in the will.



Sample Will

I, (name)
of (address)
on (date) declare this my last WILL.

1. I give my property as follows:

To (name), my (relationship),
I give (description of property).

To (name), my (relationship),
I give (description of property).

2. I appoint (name) of (address)
to be the guardian of my children.

3. The other following properties I give to my minor children, to be managed by their guardian
(named above) for their education, maintenance and upbringing until they reach mature age.
To (name of minor), I give (description of property),
To (name of minor), I give (description of property).

4. I direct my body be buried at (place), with the following
instructions:

5. I owe the people listed below the following money and direct payment from account no.:
..... at (bank):
..... (name) (address) (amount).

6. The following people owe me the money mentioned and I direct collection of that money:
..... (name) (address) (amount).

7. My property which I have not mentioned in this will or otherwise, I give to:
..... (name), my (relationship).

8. I appoint (name) of (address)
to be executor of my WILL.

Signed by (testator) on (day/month/year)
at (place of signing)
..... (testator's signature or thumb mark)

In the presence of the following witnesses:

1. (name) (signature)
2. (name) (signature)



Memory Boxes and Books

A memory book can be made for each child in the household.

Memory books are important because:

- They can help a child locate his or her relatives because they include family trees, which show the history of the child
- They can help a child to know important background information about where they come from and about their family
- They may help to facilitate the disclosure of a parent's HIV status.



A memory book can be written by:

- The mother, father or guardian of a child who would like to record the child's life and his or her relationship with the child
- Anybody who wants to record important information about his or her family and life.

A memory book can be kept safely for the child:

- In a clean place in the guardian's or family's house
- With a close friend
- With a counsellor
- At a church.

A memory book can include the following information about the child:

- A family tree of the parents, grandparents and relatives of the child
- The child's birth: where, which doctor, what hospital, who was around and photos, if possible
- The child's first smile, first words, when the child began crawling and walking
- The child's early experiences and memorable things about the child's life
- The child's health history. This could include early illnesses and immunisations recorded
- The child's education: nursery school, his or her first day at primary school and other records
- Things the child used to like and dislike
- The parent or caretaker's hopes and expectations for the child
- The child's recent achievements and experiences.

All this information should be as detailed as possible. Include photographs, if possible.

Information about the mother and father:

- Names of the mother and father and their parents, included in the family tree
- Where and how they grew up, including their childhood memories, how they used to look
- What they liked and disliked as children and as adults
- Their education, talents, work skills and jobs
- Their religious background and beliefs
- Their health history, including any illness
- Disclosure of important information (this is where his or her HIV status can be disclosed)
- Their special message for the child.



Support to Standby Guardians

As a caregiver, a standby guardian will need support from both home visitors and the community. Caregivers need care and support themselves, in order to give effective care and support to orphans and vulnerable children. Apart from needing to make sure that their own needs are met, caregivers and standby guardians may need:

- counselling
- training in OVC care
- psychosocial support
- food security production packs



APPENDIX 2

Further information for Unit 2

Appendix 2

Further Information for Unit 2

FACILITATOR'S GUIDELINES

Notes on facilitation skills and techniques (see pages 62 and 75)

Facilitator or Trainer Evaluation Sheet (see pages 62 and 75)

MODULE 1 HIV/AIDS and the Situation of OVC

Topic 3: Support Responsibilities towards OVC (see p109)

MODULE 2 Addressing the Psychosocial Needs of OVC

Topic 4: Non-threatening activities you can do with children to help them to communicate (see page 166)

Topic 4: Practising communication and counselling skills (see page 173)

MODULE 3 Addressing the Physical Needs of OVC

Topic 3: Nutritional care for people living with HIV/AIDS (see page 226)

Topic 4: Immunisation Schedule (see page 231)

MODULE 4 Equipping OVC for the Future

Topic 4: Wills - Questions and Answers (see page 271)

MODULE 5 Equipping OVC for the Future

Facilitator or Trainer Evaluation Sheet (see page 293)

Notes on facilitation skills and techniques (see pages 62 and 75)

The basic principles of facilitation are:

1. Focus on the situation, issue, or behaviour, not on the person.
2. Maintain the self-confidence and self-esteem of others.
3. Maintain constructive relationships.
4. Take the initiative to make things better.
5. Lead by example.

Establishing a comfortable learning environment:

- *Ground rules* help encourage the development of positive group behaviours.
- *Show interest* in what participants have to say, the experiences they bring, and the issues they face. Do this by maintaining eye contact, smiling, moving towards participants and nodding your head.
- *Listen for the emotion behind the words* as well as the message. Respond to both.
- *Respond to non-verbal cues*: Fidgeting, avoiding eye contact, sighing, pulling on a sweater, or leaving the room are cues that participants are uncomfortable with something (e.g. the room temperature). Address these appropriately so they don't interrupt the learning environment.
- *Use humour appropriately* and not as your main style of communication.
- *Generate participant interest* in a topic by making it relevant to their experience and organisation.
- *Resist the temptation to lecture*; encourage participants to do at least 60% of the talking.
- *Ask open-ended questions* that can't be answered with just a 'yes' or a 'no'. If there is no response to a question after an adequate time, rephrase it or ask you question again.
- *Use polling techniques* (for example, a show of hands to answer a question) to bring out otherwise quiet people or equalise overly talkative participants.
- *Get participants into situations where they have to network*: Get participants to talk to each other rather than have them interact only with you.
- *Defer to the group* instead of answering questions yourself, get the group to answer.
- *Provide examples*, but be aware of maintaining confidentiality if sharing an example based on someone else's experience.

Give clear and concise instructions:

- *Use simple sentences* and keep your delivery straight forward and uncomplicated.
- *Give step-by-step instructions* to help ensure positive results.
- *Make smooth links* or connections between one learning activity or idea and another.
- *Speak clearly* and audibly and project your voice a little beyond your participants to be heard and understood.
- *Use visual aids effectively* to enhance understanding and learning. Be careful to not over-do the visual aids so as to distract from the participants' learning.
- *Check for understanding* and clarify points. Allow participants the chance to ask questions; get them to summarise.
- *Refer to the ground rules*.
- *Use reflecting statements* that paraphrase points.
- *Ask others for opinions* to focus attention away from an one participant.
- *Summarise main points and move on*.

Dealing with aggressive behaviour

- *Maintain a relaxed posture* so that you project your openness to the group - keep your arms at your sides, smile, sit on a table, lean forward; let your 'body language' create an open posture.
- *Remain non-defensive*. Don't try to personally defend the training, the organisation's strategy or your own position.
- *Clarify and acknowledge*: Show the participants you really want to hear them by paraphrasing key statements, checking for understanding, and generally letting people know you can see their point of view.
- *Clearly state the behaviour change needed*. Be specific about what behaviour you want to the participant to stop, as well as the impact of their current behaviour. Give them the choice to act on your feedback.
- *Use a problem-solving approach*: To avoid becoming part of the problem, move the focus to problem solving. For example, ask the group what approaches could be taken to solve the issue.

Facilitator or Trainer Evaluation Sheet

Trainer being observed: _____

Training activity: _____

Date: _____ **Venue:** _____

Response options:

0 = none of the time

2 = some of the time

4 = all of the time

1. Knowledge and preparation

- Was the trainer well prepared?
- Was the trainer's presentation well organised?
- Did the trainer know the subject matter?
- Did the trainer present accurate information?
- Did the trainer use appropriate language?
- Did the trainer stay on the prescribed subject?

2. Delivery and manner

- Did the trainer use appropriate body language?
(good eye contact, facial expressions, etc)
- Was the trainer interesting and engaging?
- Was the trainer self confident?
- Did the trainer's appearance (e.g. dress, etc) detract from the presentation?
- Was the trainer creative and innovative?
- Did the trainer speak clearly and loudly enough?
- Did the trainer explain information clearly and in understandable terms?
- Did the trainer conduct the training at a desirable pace?

3. Visual aids

- Did the trainer use aids appropriately?
- Was the trainer effective in relating the information from the visual aid?
- Did the trainer write legibly on the flipchart?

4. Sensitivity

- Did the trainer display sensitivity towards the feelings and cultural concerns of participants?
- Did the trainer express appreciation for participant input?
- Did the trainer treat participants with respect?
- Did the trainer respect confidentiality?
- Did the trainer respond to signals (e.g. when a participant appeared to be upset or tired)?
- Did the trainer appear to be sincere and personally convinced about the subject?

5. Methods and skills

- After an experiential activity, did the trainer ask questions that lead to an effective critical analysis?
- Did the trainer use a variety of training methods effectively?
- Did the trainer facilitate participation in the group effectively?
- Did the trainer demonstrate the ability to deal with a difficult situation adequately?
- Did the trainer document and use feedback from participants?
- Did the trainer display an ability to build on what participants already knew?
- Did the trainer ask appropriate questions to see if participants were following the presentation?
- Did the trainer probe participants to ask questions and raise concerns?
- Did the trainer provide constructive criticism?

6. Summary

The trainer's strengths: _____

What the trainer can do to improve: _____

What were the objectives of the training: _____

Did the training accomplish these objectives? Say why or why not: _____

Signed: _____

Date: _____

National and Local Government Support Responsibilities towards OVC (see page 109)

Some further responsibilities of national and local government towards orphans and vulnerable children are:

- ◆ National Ministries of Gender, Labour, Social Development and Welfare need to ensure provision of quality services for OVC. The ministry, therefore, plays a lead role in the implementation of policies and aid the co-ordination of programmes related to OVC. This entails:

- Spearheading the development of the national strategic programme plan of interventions
- Developing policy guidelines
- Initiating legal instruments to support the implementation of the policy
- Publicising and popularising the policy
- Initiation of legal instruments to support the implementation of the policy
- Working with CSOs and other development partners to ensure effective and efficient resource allocation and use in conformity with government policies and strategies
- Mobilising resources and capacity building
- Promoting of initiatives aimed at addressing the needs of OVC
- Researching and disseminating information.

Ministries or government agencies responsible for childcare, support and protection, education, health, psychosocial support, socio-economic security and capacity enhancement for improved OVC service delivery are responsible for ensuring implementation of the policies and programmes in the respective sectors. The roles include:

- Development of sectoral implementation guidelines
- Building capacities in the respective sectors
- Integration of OVC concerns in sectoral policies, programmes and plans
- Quality assurance in the respective sectors

- ◆ Provincial or regional level government implementation of the policies and programmes include:
 - Planning and implement programmes for OVC
 - Maintaining a management information system on OVC
 - Initiating specific bylaws and ordinance to support the implementation of the OVC policy
 - Sensitising and training district local leaders and technical persons in provision of services that target OVC
 - Mobilising and allocating resources for implementation of the policy
 - Co-ordinating, supervising and monitoring the implementation of the policy at district and local levels.
- ◆ Local level authorities are responsible for:
 - Incorporating OVC concerns in the plans and budgets
 - Mobilising, allocating and utilising funds for implementation of the policy
 - Ensuring data on OVC is collected, collated and disseminated for improved targeting and OVC service delivery
 - Co-ordinating activities of OVC stakeholders at the community or district levels.

Non-threatening activities you can do with children to help them communicate in counselling (see page 166)

Drawing

Drawing can be a powerful activity for opening hidden cupboards in a child's life. Drawing enables children to communicate their emotional state without having to put it into words. Most children enjoy drawing and it is a useful practical tool for counselling. After a child has drawn something, gently follow up by asking the child to describe what is happening in their drawing.

Example: Jane drew a picture of a man who used to do "bad things" to her. When the counsellor asked her about her drawing, she told how she had been sexually abused by an uncle, who ended up infecting her with HIV.

Storytelling

Children usually do not like to answer lots of direct questions or listen to long lectures. When they are finding it difficult to talk about painful issues, asking them to tell a story may help them express themselves. A story can also serve as a useful tool for problem solving.

Example: A counsellor could ask children to tell a story about their school, home, friends or parents. They could be asked to tell a story about things that bother them in their lives.

Drama / music

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

Example: Children could be asked to act out or even sing about how they spend their time at home, or to act out their relationships with parents or siblings. Children who are abused at home could demonstrate their situation through drama.

Play

Adults often think play serves no serious purpose. But play is an important way that children express their feelings about events and make sense of their world. When children play, much of their activity involves imitation or acting out things that concern them in their lives. By watching children play, adults can begin to understand what types of emotions they are experiencing.

Example: Four HIV positive children were told to go and play before going to see the doctor. They began acting out a situation in which a person had died in the home. One of the children acted as a dead body, and three other children were crying. The counsellor watched what was happening and then asked for an explanation. The children explained why they were acting out this situation.

Watch children at play as a way to understand what they are feeling and observe what they are doing. Try not to direct their playing, but follow up on what it is communicating. Innovative, creative and child-friendly methods of communicating are very important to help children feel involved and express their feelings and emotions.

Practising communication and counselling skills - 10 Scenarios (page 173)

Scenario 1

Child: You are a four year-old boy whose mother has just passed away. You are frightened and confused and do not know what will happen to you. You do not have the words to express what you are feeling, but you may be able to draw or act out these feelings.

Scenario 1

Counsellor: The child you will be counselling is four years old and his mother has just passed away. Your job is to find out how the child is feeling and if he has any questions that you can answer. You may need to use indirect methods, such as drawing, storytelling, drama or playing to find out how this boy is feeling.

Scenario 2

Child: You are a fifteen year-old girl whose parents have died. You are the head of a household and taking care of a young brother and sister. An older man has come and said that he will pay your brother's and sister's school fees if you will become his girlfriend. You are a virgin and do not wish to be this man's girlfriend, but you do not have money to pay the school fees. You are confused and do not know what to do.

Scenario 2

Counsellor: The child you will be counselling is a fifteen year-old girl whose parents have died. She is the head of a household and taking care of a young brother and sister. Lately, you have noticed that she appears to be sad and preoccupied. Your job is to find out if anything is troubling her and to try to help.

Scenario 3

Child: You are a ten year-old boy, and your father died of AIDS one month ago. Your schoolmates have told you that they can no longer be your friends because of this disease you have in your family. You feel angry and ashamed. At first, you feel these things so strongly that you do not want to answer the questions of your counsellor.

Scenario 3

Counsellor: The child you will be counselling is a ten year-old boy whose father died of AIDS one month ago. Your job is to find out how he is coping with the loss and if he is having any problems.

Scenario 4

Child: You are a seven year-old girl. One year ago your father died. Now your mother has become ill. You have begun to miss school because you stay home to take care of her. You are frightened because she is becoming weaker and it is more difficult to help her. You are afraid that she may die as well.

Scenario 4

Counsellor: The child you will be counselling is a seven year-old girl whose father died one year ago. Lately she has not been attending school. Your job is to find out why she is no longer going to school and to help her with any problem she may be having.

Scenario 5

Child: You are a sixteen year-old boy who has just had sexual intercourse for the first time. You are frightened because you know that you can become infected with HIV/AIDS this way. You are looking for answers and help but you are embarrassed to talk about sex and do not want to get in trouble.

Scenario 5

Counsellor: The child you will be counselling is a sixteen year-old boy. Lately he has seemed withdrawn and unhappy. Your job is to find out what has been troubling him and to help him with any problem he may be having.

Scenario 6

Child: You are a twelve year-old girl. For the past year your uncle has been touching you in ways that make you uncomfortable. You are worried that he wants to defile you. You want to stop this from happening but you feel ashamed about what has been happening and are afraid that you will be blamed if you tell anyone. You have difficulty talking about it.

Scenario 6

Counsellor: The child you will be counselling is a twelve year-old girl who has stopped playing with her friends and who is getting poor marks in school. Your job is to find out what is troubling her. It may be necessary to use indirect methods (such as drawing, storytelling, drama, or play) to find out what is happening.

Scenario 7

Child: You are an eight year-old boy whose father and mother have died, and you are living with an older sister. She got married three months ago and her husband has been forcing you to do all of the work around the house and beating you. You are unhappy but you fear that if you complain you will have to leave your sister's house. You are not sure if you have anywhere else to go.

Scenario 7

Counsellor: The child you will be counselling is an eight year-old boy whose mother and father have died and who is living with an older sister. The older sister recently got married, and your job is to find out how the new situation at home is working out.

Scenario 8

Child: You are a ten year-old girl whose father has died and whose mother is sick. Recently some children at school told you that your father died and your mother is sick because she is a bad woman. You are confused and frightened by what these children are saying.

Scenario 8

Counsellor: The child you will be counselling is a ten year-old girl whose father has died and whose mother is sick. Lately, she has been avoiding her friends and coming late to school. Your job is to find out the reason for this behaviour and to see if there is any way that you can help her.

Scenario 9

Child: You are a thirteen year-old boy whose parents have died and who is caring for three young brothers and sisters. You often cannot find enough for your brothers and sisters to eat and there is no money for school fees or clothes. You are tired and sad and thinking of running away to the street, where you will only have to care for yourself. You do not want to leave your brothers and sisters, but you do not know how much longer you can continue the way things are.

Scenario 9

Counsellor: The child you will be counselling is a thirteen year-old boy whose parents have died and who is caring for three young brothers and sisters. Lately he has seemed tired and lacks interest in the activities he used to enjoy. Your job is to find out what is troubling him and to see if there is anything you can do to help.

Scenario 10

Child: You are a fourteen year-old girl whose mother has died and whose father is ill. You know about HIV/AIDS and you suspect that your mother died from that disease. You are concerned that your father may have AIDS, and you would like to ask him whether he is HIV positive. You are afraid to bring up this subject with him, because he is a traditional man who does not believe that daughters should question fathers. But you would like to understand his situation so that you can help him and plan for the future.

Scenario 10

Counsellor: The child you will be counselling is a fourteen year-old girl whose mother has died and whose father is ill. She has asked if she may come discuss her father's illness with you. Your job is to listen to her concerns and to seek ways to help her.

Nutritional Care for People Living with HIV/AIDS (see page 222)

Adults with HIV/AIDS

Nutritional care is important for adults with HIV/AIDS who may suffer from loss of appetite, difficulty eating and poor absorption of nutrients. This compromises their nutrition and results in deteriorating health. Attainment of good nutrition will contribute to the adoption of a positive attitude, which normally improves the quality of life for adults with HIV/AIDS.

An HIV infected adult will need between 10 to 30% more energy. Early identification and treatment of symptoms or conditions that affect a patient's appetite or ability to eat can improve nutritional status.

It is important to note that many adults who are HIV positive may not display any symptoms, but will still need nutritional care and extra energy intake to keep their bodies strong.

Adults with HIV/AIDS should be encouraged to periodically check their nutritional status:

- Encourage adults with HIV/AIDS to periodically (at least every two months) check their weight. If possible, they should have their haemoglobin level determined and recorded.
- Their weight, height and other records should be recorded and the records kept and shown to service providers with whom they may come into contact.

Support adults with HIV/AIDS to know how to prevent weight loss; and how to gain weight by increasing their energy and nutrient intake though:

- Increasing the amount of the frequency of eating meals rich in energy, protein and plenty of fruits and vegetables.
- Eating nutritious snacks between meals as often as possible.
- Eating foods that are fortified with essential micronutrients like vitamins A,C,E,K and iron.
- Using micro-nutrient supplements in consultation with a doctor. If clients prefer this option, discuss the costs of this option to relative the cost of food-based approaches.
- Help adults with HIV/AIDS make meal plans using locally available foods to meet their nutrition needs. The counsellor should consider food accessibility, availability, affordability, preservation and storage. The counsellor should also consider fuel needs of the client, as well as tastes and preferences of their client, household and community. The plan should also consider whether the client is taking medication or has infections.
- Encourage the client to drink at least eight glasses of water per day.
- Advise adults with HIV/AIDS to seek prompt treatment for HIV-related conditions, particularly those that affect food intake such as fever, oral thrush, ulcers/sores in the mouth, diarrhoea, vomiting, nausea and loss of appetite.
- Advise adults to avoid habits that may interfere with their food intake, absorption and utilisation. These include consumption of alcohol, smoking, drug abuse, and drinking tea or coffee.
- Advise caregivers of elderly PHA to regularly supervise their meals to ensure adequate food consumption.

Other health advice to give to adults who are HIV positive:

- Seek prompt treatment for all opportunistic infections and conditions that might undermine nutrition, including fever oral thrush, sores/ulcers in the mouth, nausea, vomiting and loss of appetite.
- Practice food and water safety and personal hygiene, e.g. wash hands before handling food, thoroughly cook animal products, boil drinking water, wash fresh fruits and vegetables in clean water and store food appropriately.
- Get dewormed twice a year.
- Practice safer sex (Abstain, Be Faithful, use Condoms) in order to avoid re-infection.
- Suggest nutritional interventions that will increase nutrient intake such as: having more frequent meals, using mashed food, and increasing the intake of liquids.
- Refer adults to services that offer ARVs to be assessed whether they meet the criteria to start on them.
- Encourage adults with HIV/AIDS to have a positive attitude towards the illness and life: it can make a difference to their health.

Pregnant women and breastfeeding mothers with HIV/AIDS should monitor their nutritional status

- Every pregnant mother should have an antenatal card to record weight changes during pregnancy.
- Mothers infected with HIV should have periodic nutritional status monitoring (e.g. weight and height). They need to know whether they are gaining adequate weight (as a pregnancy) or are losing weight at a rate detrimental to their health.
- If a pregnant mother has a weight gain that falls below the recommended range, it may indicate a possible medical problem (e.g. an opportunistic infection) or inappropriate energy intake, and/or food insecurity. Women gaining less than one kilogram per month in the second and third trimester should be referred to a health unit immediately where they can receive more care.
- Discuss with the pregnant mother to identify the probable causes of insufficient gestational weight gain and work with her to figure out the best course of action to promote weight gain.
- A breastfeeding mother who is HIV positive should not lose weight.
- Haemoglobin levels should be checked. Pale inner eyelids and palms may be signs of anaemia should be referred for immediate treatment. The best treatments are food-based approaches and iron supplements.
- Encourage pregnant and breastfeeding mothers to consume foods rich in micronutrients and go to ANC services for guidance on micronutrient supplementation.
- Ensure that breastfeeding mothers get vitamin A supplementation at delivery or at least within the first eight weeks of delivery.
- Encourage pregnant and breastfeeding mothers to get prompt treatment for malaria, including presumptive treatment and prevention by using treated mosquito nets.
- Encourage them to go for hookworm infestation checks and regular deworming.

Children with HIV/AIDS need extra nutritional care

For children who are 6-24 months old:

- Promote foods and fluids that are rich in energy and nutrients.
- Give porridge enriched with any of the following: milk, oil, sugar, groundnut/simsim paste, bean powder or soya bean flour.
- Given semi-solid food enriched with any of the foods mentioned above, but also with fish powder.
- Add a small amount of oil/margarine to the child's food.
- Give the baby mashed fruits and vegetables such as ripe bananas, pawpaws, avocados and pumpkins as frequently as possible.
- Continue giving animal milk.

Support the mother/caretaker to:

- Provide nutritious food according to the weight and age of the child, and increase the food portions as the child grows older.
- Feed the child frequently (five to six times per day) and provide nutritious snacks in between meals.
- Make sure that the child's food is prepared appropriately.
- Review the child's diet at every contact to ensure appropriate feeding.
- Help mothers to practice active and responsive feeding, including small but frequent meals, feeding the child patiently, not forcing the child to eat, and feeding the child the food she/he likes.
- Assess and promote good hygiene and proper food safety and handling.
- Encourage mothers to seek health support if the child is either not growing well, has eating problems, has sores/ulcers in its mouth, or gets opportunistic and other infections, such as malaria or fever, diarrhoea and respiratory infections.
- Promote continued adequate dietary care and support during and after illness.
- Create awareness about psychological and socio-economic support that households with HIV/AIDS infected children can access in their locality.

For children who are more than two years old:

- Encourage the mother to ensure that children consume adequate food to meet their increased energy needs. Consult the previous section and the previous chapter for more information on how to ensure meeting of increased energy needs.
- Develop a plan in consultation with the mother for feeding the child that includes sources of adequate protein and micro-nutrients.

Support mothers/caretakers to use essential child survival services:

- Ensure that each child has a Child Health Card. These can be accessed at health facilities.
- Assess the children for complete and up-to-date immunisation. Refer children whose immunisation is not up-to-date.
- Assess whether children are receiving vitamin A supplementation and undergoing regular deworming. If these have not been done in the last six months, refer the children to where they can get the services.
- Advise mothers/caretakers to always take their children to outreach services or health units nearest to them to receive all immunisations and vitamin A supplementations.
- Ensure that all immunisations and vitamin A supplementation have been recorded on the Child Health Card.
- Nutritional counselling should be given to all mothers/caretakers irrespective of the growth status of the child.
- Encourage mothers/caregivers to keep the Child Health Card properly. The Child Health Card should be brought each time the child is brought to the health unit or for weighing, to ensure that there is continuous plotting of the weight on the same card.

Be aware of the signs of severe malnutrition:

- Look out for visible severe wasting, especially of the trunk and buttocks.
- Look out for oedema (swelling) of both feet.
- Look for anaemia, pallor of the palms and mucus membranes.
- If possible, weigh the child and plot weight on the Child Health Card.

Check for and attend to complications that might lead to death:

- If the child has a very low body temperature (Below 35°C), keep the child warm.
- If the child is dehydrated or has diarrhoea, give an oral rehydration solution to replace lost fluids.
- If the child had hypoglycaemia (characterised by drowsiness and stupour), he or she will need a glucose solution.
- All children with severe malnutrition need broad – spectrum antibiotics .
- Counsel the mothers/caretakers on the need for referral and urgently refer children with severe malnutrition to a rehabilitation institution, where they should receive treatment and a high calory diet.

After discharge from a rehabilitation institution:

- Encourage the mother/caretaker to feed the child frequently with energy and nutrient-dense food.
- Encourage the mother/caretaker to involve the child in play and stimulation in order to foster the child's development.
- Advise the mother/caretaker to take the child for regular follow-up to ensure the child completes immunisation, receives 6-monthly vitamin A and undergoes monthly growth monitoring.
- Severely malnourished children with HIV/AIDS who are not on ARVs should be referred to providers of anti-retroviral therapy services, if such services are available.

Immunisation Schedule (see page 231)

| | Vaccine | Protects against | How given | Date given |
|--------------------|-------------------|---|------------------|------------|
| At birth | BCG | Tuberculosis | Right upper arm | |
| | Polio 0 | Polio | Mouth drops | |
| | Polio 1 | Polio | Mouth drops | |
| At 6 weeks | DPT- HebB+Hib1 | Diphtheria/Tetanus/ Whooping cough/Hepatitis B/ Haemophilus Influenzae type B | Left upper thigh | |
| At 10 weeks | Polio 2 | Polio | Mouth drops | |
| | DPT- HebB+Hib2 | Diphtheria/Tetanus/ Whooping cough/ Hepatitis B/ Haemophilus Influenzae type B | Left upper thigh | |
| At 14 weeks | Polio 3 | Polio | Mouth drops | |
| | DPT- HebB+Hib3 | Diphtheria/Tetanus/ Whooping cough/ Hepatitis B/ Haemophilus Influenzae type B | Left upper thigh | |
| At 9 months | Measles | Measles | Left upper arm | |

Children should be taken for immunisation even if the schedule date is missed.

Wills - Questions and answers (see page 271)

Execution of a will

Note: Laws with regard to wills may differ from country to country, so it is best that the facilitator does adequate research before dealing with this topic in the workshop. The following questions and answers may need to be adapted appropriately.

What makes a will invalid (not legal)?

A will is invalidated if:

- ◆ It is made by a person of unsound mind or a person who does not understand what he or she is doing.
- ◆ It is made under force, duress or threat.
- ◆ It is unclear regarding the distribution of property or the property mentioned in the will has already been sold, distributed or used before the death of the testator.
- ◆ It does not mention the wife/wives or husband, minor children aged less than 21 years or any of the dependant relatives. The dependent relatives are those who are substantially dependent on the deceased for their survival, not those who are merely receiving assistance.

According to the law, the testator must not omit certain essential people in his/her will, including wife/wives, husband, children and dependent relatives. The matrimonial home should not be passed on to any other beneficiary because it is automatically taken over by the testator's spouse if the testator is married. Otherwise, the testator may extend the will to other persons of his/her choice.

If a will is found to be invalid, the testator's property is divided up like that of a person who has left no will.

What happens if there are objections to the will?

If any person is dissatisfied with the content of a will or the people applying for probate, he can lodge a protest in court. The court may hear the grounds of objection. It can then declare that the will is valid and authorise the property to be distributed. If the court finds that the will is invalid, the property is distributed as if the deceased left no will. If the person complaining is supposed to be a beneficiary of the will but was left out or did not benefit from the will, then the court may make adjustments to the will to provide for that person.

What are the legal implications of failing to leave a will?

If a person fails to make a will or leaves an invalid will, he or she is said to have died *intestate*.

In order to manage the estate of a person who has died without leaving a will, one has to apply for letters of administration from the court. A report of the death of the deceased must be submitted to the Administrator General or other relevant court representative within 14 days after the death.

After being satisfied that the applicants are the proper people to apply for letters of administration, that all the facts given in the report of death are true and that there are no other claimants to the estate, the relevant authorities will issue a letter of no objection. This letter has the following effects:

- ◆ Everything that the person owned at the time of his/her death becomes part of the estate.
- ◆ The personal representatives of the deceased duly appointed by the court keep the estate in trust.

Once a letter of no objection has been issued, an application can be filed in court requesting a letter of administration. The application is advertised in newspapers to alert the general public about the applicants' request to administer the estate. If anyone raises any objections, the court hears them and decides whether to accept the objections or to issue letters of administration. Once letters of administration are issued, the people managing the deceased's estate must report on the estate in six months' time.

Under the following conditions, the Administrator General or relevant authority, may manage the deceased's estate:

- ◆ When he/she is named in the will
- ◆ When the deceased person does not appoint a representative
- ◆ When the person named as executor in the will dies before the testator
- ◆ When the deceased's representatives are not in agreement as to whom should administrate the estate
- ◆ When nobody has applied for probate or letters of administration within two months from the date of the death of the deceased.
- ◆ When the Administrator General sees that the executor is mismanaging the estate.

The beneficiaries when there is no will

The following people automatically inherit the deceased's property when there is no will:

- ◆ Husband or wife: There must be a legally recognised marriage at the time of death.
- ◆ Children of the deceased: These include legitimate (children born within the marriage), illegitimate (children born outside the marriage) and adopted children.
- ◆ Dependant relatives: These are relatives who completely depend on the deceased person for their survival.
- ◆ Customary heir: This depends on the local customs applicable to the dead by the people in a particular area.
- ◆ Legal heir: This must be a living relative of the intestate person who usually takes over when there is no customary heir.

The distribution of the estate when there is no will is subject to legal processes applicable in a particular country.

APPENDIX 3

References

Carter, Isabel. *Building the Capacity of Local Groups: A PILLARS Guide*. Tearfund, Teddington, UK, 2001.

Center for Development and Population Activities (CEDPA), *Training Trainers for Development: Conducting a Workshop on Participatory Training Techniques*, Washington, DC, USA, 1995.

Child Protection Society, Zimbabwe & UNICEF, *Approaches to Community-Based Care: A Guide for Groups and Organizations Wishing to Assist Orphans and Other Children in Distress*, Harare, Zimbabwe, 2003.

Cook, Michele, *Starting from Strengths: Community Care for Orphaned Children: A Training Manual Supporting the Community Care of Vulnerable Orphans*, University of Victoria, Unit for Research and Education on the Convention on the Rights of the Child, School of Children and Youth, Canada, and Chancellor College, Department of Psychology, Malawi, 1998.

de Beer, Frik and Hennie Swanepoel, *Community Development and Beyond: Issues, Structures and Procedures*, J.L.Van Schaik Publishers, Pretoria, South Africa, 1998.

Dyregrov, Atle, *Grief in Children: A Handbook for Adults*, Jessica Kingsley Publishers Ltd., London, UK, 1991.

Family Health International and SCOPE OVC Programme, *Compilation of Psychosocial Training Materials for the Emotional Well-Being Evaluation of Orphans and Vulnerable Children*, Lusaka, Zambia, 2001.

First Regional Think Tank on Psychosocial Support for Children Affected by HIV/AIDS, Salvation Army, Bulawayo, Zimbabwe, 2001.

Gilborn, Laelia Zoe, Rebecca Nyonyintono, Robert Kabumbuli and Gabriel Jagwe-Wadda; *Making a Difference for Children Affected by AIDS: Baseline Findings from Operations Research in Uganda*, The Population Council, Inc., 2001.

Greyling, Christo, *Channels of Hope, Facilitator's Manual, Presenting Effective HIV and AIDS Workshops for Churches and Faith Based Organizations*, Unpublished, Christian AIDS Bureau, South Africa, 2003.

International HIV/AIDS Alliance, *Assessing Factors of Community/Social Context: PCA Project Design Toolkit # 2*, Alliance Publications, Brighton, UK, 2001.

International HIV/AIDS Alliance, *Building Blocks: Africa-Wide Briefing Notes. Resources for Communities Working with Orphans and Vulnerable Children*, Alliance Publications, Brighton, UK, 2003.

International HIV/AIDS Alliance, *Children's Participation in HIV/AIDS Programming*, Alliance Publications, Brighton, UK, 2004.

International HIV/AIDS Alliance, *Expanding Community-Based Support for Orphans and Vulnerable Children*, Alliance Publications, Brighton, UK, 2002.

International HIV/AIDS Alliance; *A Facilitator's Guide to Participatory Workshops with NGOs/CBOs Responding to HIV/AIDS*, Alliance Publications, Brighton, UK, 2003.

International HIV/AIDS Alliance; *Toolkit: Pathways to Partnerships*, Alliance Publications, Brighton, UK., 2003.

Kara Counseling Trust, *Foundation Course in Psychosocial Support Counseling Skills, Parts One and Two*, Lusaka, Zambia, 2001.

Liebowitz, Jeremy (ed.), *Nutritional Care and Support for People Living with HIV/AIDS in Uganda: Guidelines for Service Providers*, Ministry of Health, Kampala, Uganda, 2004.

Liebowitz, Jeremy (ed.), *Improving the Quality of Life through Nutrition: A Guide for Feeding People Living with HIV/AIDS*, Ministry of Health, Kampala, Uganda, 2004.

Mallmann, S.A. Sr., *Building Resilience Among Children Affected by HIV/AIDS*, Catholic AIDS Action, Namibia, 2002.

Mildmay Centre, *Training Manual on Counselling and Communicating with Children: A Course for Counsellors, School Teachers and Health Workers*, Unpublished, Kampala, Uganda, 2002.

Munaaba, F., Owar, J. et al., *Comparative Studies of Orphans and Non-Orphans in Uganda*, Center for International Health and Development, Boston University School of Public Health, 2004.

Mutonyi, Simon; *Getting the Most Out of a Participatory Community Assessment for HIV/AIDS Prevention: The Case of Kasana Child Crisis Center*, ZIHP, Lusaka, Zambia, 2003.

Ncube, N. and T. Watt, *Introduction to Psychosocial Support in the Context of Orphans and Other Children and Youth Made Vulnerable by AIDS*, Masiye Camp/Regional Psychosocial Support Initiative, Bulawayo, Zimbabwe, 2004.

Nyonyintono, Rebecca and Laelia Gilborn, *Succession Planning in Uganda: Early Outreach for AIDS-Affected Children and Their Families*, Population Council/Horizons Communications Unit, Washington, DC, USA, 2003.

Regional Psychosocial Support Initiative, *The Journey of Life: A Community Workshop to Support Children*. REPSSI, Zimbabwe, 2004.

Save the Children Federation USA, *Mobilizing Communities: Building Capacity and Resources to Address HIV/AIDS*, Save the Children, USA, 2000.

Save the Children UK, *Children's Participation in OVC Programming: A Resource Kit of Materials for Increasing Children's Participation*. Save the Children UK Southern Africa, Pretoria, South Africa, 2004.

Seifert, Kelvin L. and Robert J. Hoffnung, *Child and Adolescent Development*, Houghton Mifflin Company, Boston, USA, 1987.

Southern Africa AIDS Training Programme, *Guidelines for Counseling Children Who Are Infected with HIV or Affected by HIV and AIDS*, Harare, Zimbabwe, 2003.

Southern African AIDS Trust, *Children and Home-Based Care: Integrating Support for Children Affected by HIV and AIDS into Home-Based Care Programmes*, August 2004.

UNAIDS, *HIV/AIDS and Young People: Hope for Tomorrow*, August 2003

UNAIDS, *Investing in our Future: Psychosocial Support for Children Affected by AIDS: A Case Study in Zimbabwe and the United Republic of Tanzania*, 2001.

UNAIDS, UNICEF, USAID, *Children on the Brink 2004: A Joint Report of New Orphan Estimates and A Framework for Action*, 2004.

UNICEF, *Facing the Future Together: Report of the United Nation's Secretary-General's Task Force on Women, Girls and HIV/AIDS in South Africa*, 2004.

UNICEF, UNAIDS, WHO, *Young People and HIV/AIDS: Opportunity in Crisis*, 2002.

UNICEF, USAID, UNAIDS et al., *Framework For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, 2004.

USAID, HelpAge International, International HIV/AIDS Alliance. *Forgotten Families: Older People as Carers of Orphans and Vulnerable Children*, Washington, DC, USA, 2003.

Williams, Suzanne, *The Oxfam Gender Training Manual*, Oxfam, Oxford, UK, 1994.

Witter, Sophie, *Breaking the Silence: Memory Books and Succession Planning, The Experience of NACWOLA and Save the Children UK in Uganda*, Save the Children, London, UK, 2004.

World Vision International, *ADP Toolkit for HIV/AIDS Programming*, World Vision International, Monrovia, CA, USA, 2003.

World Vision International, *Implementation Guide for Community-Led OVC Care*, World Vision International, Monrovia, CA, USA, 2005.