Coalition to Stop the Use of Child Soldiers

International Secretariat
2-12 Pentonville Road, 2nd floor, London N1 9HF
Tel: +44 207 713 2761 Fax: +44 207 713 2794
Email: info@child-soldiers.org Web: www.child-soldiers.org

Registered as a limited company (no. 4411965) in England

This document is part of the Coalition's psychosocial web page. For more information on the psychosocial impact of armed conflict upon children go to: www.child-soldiers.org/resources/psychosocial

Psychosocial web page Editor's introduction:

In this edition of our psychosocial web page, we present a paper by Dr. Castelli and colleagues: **Psychosocial support for war affected children in northern Uganda: lessons learned.** The authors describe the psycho-social programme for war affected children run by Associazione Volontari per il Servizio Internazionale (AVSI) in two districts of northern Uganda. The paper outlines the principles underlying these programmes – emphasising the breadth of psychosocial intervention, as well as the inter-connectedness of each type of intervention employed. The AVSI team have carefully developed evaluation tools to enable them to collect data both on different aspects of their programmes and on the progress of each individual child. Their data base offers AVSI staff opportunities to assess how their programmes are applied in different geographical areas, and which aspects of their interventions appear useful at the local level. A reflective, evaluative approach of this kind allows flexible programming which can be made relevant to the local family and community context as well as the children's needs. Finally, Dr. Castelli and her colleagues list the lessons learned from implementing psycho-social programmes in Northern Uganda since l997.

Dr. Linda Dowdney
Editor

The Coalition to Stop the Use of Child Soldiers unites national, regional and international organisations and Coalitions in Africa, Asia, Europe, Latin America and the Middle East. Its founding organisations are Amnesty International, Defence for Children International, Human Rights Watch, International Federation Terre des Hommes, International Save the Children Alliance, Jesuit Refugee Service, the Quaker United Nations Office-Geneva and World Vision International.

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PSYCHO-SOCIAL SUPPORT FOR WAR AFFECTED CHILDREN IN NORTHERN UGANDA: LESSONS LEARNED

By Dr Lucia Castelli, Elena Locatelli and Mark Canavera (2005)

SUMMARY

This article shares lessons learned for providing psychosocial support to war-affected children, including formerly abducted children (FACs), by describing the recent interventions undertaken by the humanitarian NGO Associazione Volontari per il Servizio Internazionale (AVSI) in two districts of northern Uganda.

INTRODUCTION

AVSI' has had a[1] presence in Northern Uganda since the nineteen eighties. The first sectors of interventions were health and agriculture, but education and psychosocial components have always been present in any sector of AVSI interventions. AVSI started implementing psychosocial programs per se in Acholiland in 1997, where the population suffered, and is still suffering, from years of conflict and violence mainly due to the activities of a rebel group known as the Lord´s Resistance Army (LRA). The LRA has been terrorizing the population by looting, burning, raping, killing and abducting children. Between 20 and 25,000 children have been abducted in the past 17 years, and some 3,000 of these currently serve as combatants. When these children escape or are rescued and return home, they re-enter family and community life and attempt to rebuild a future for themselves. Most of them, however, return to environments that are heavily affected by conflict and where socio-economic structures have severely deteriorated.

[1] . Founded in Italy in 1972, AVSI (Associazione Volontari per il Servizio Internazionale), is an international NGO that promotes human development based on the Catholic Church's social teachings, beginning with the centrality of the person to any programme interventions. Other guiding principles include the need to strengthen local networks and subsidiarity, the concept that decisions and interventions need to be made at the level closest to the individual.

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The legacy of these long years of ongoing conflict is disheartening. Individuals have been displaced and families separated, death and disability are pervasive, physical illness and psychological distress has become an integral part of Acholi people's daily lives. At present more than 92% of the entire population of Kitgum and Pader districts is confined in displaced camps (IDPs). Almost all the schools are been relocated near the sub-county local authorities and clustered together in precarious conditions.

THE PSYCHO-SOCIAL PROGRAM IN NORTHERN UGANDA

In light of the scope and the complexity of the needs felt by communities, families, and individuals in northern Uganda, in 1998 the local government of Kitgum district (which was subsequently divided into Kitgum and Pader districts), UNICEF, and AVSI signed a Tri-Partite agreement establishing the Kitgum Psycho-Social Support Programme (PSSP). Under the agreement, the government would—with technical and material support from AVSI practitioners—coordinate the psychosocial activities of the area's many agencies, including international and national NGOs, religious bodies, and community-based organisations. The Tripartite agreement is a model of how governments, NGOs, international structures, and local agencies can put their heads together to the benefit of the people. The program, which is still going on with funds from other donors like USAID and ECHO, has different activities in various sectors (health, education, economic development, recreational, empowerment of local partners) aims to support and increase the resilience of the war affected communities, and to promote the reintegration of formerly abducted children. Interventions are linked together in a holistic approach, by keeping the single person at the centre, looking at his/her needs, emphasizing his/her resources as well as those of the family and community he/she belongs to.

Since 2002, AVSI's psychosocial sector for Kitgum and Pader districts has given individual support to over 2,000 war-affected people, primarily children and youth. Typical clients include: formerly abducted children (75% of clients since 2002); internally displaced people; HIV/AIDS orphans; orphans whose parents have been killed as a direct result of war; and child mothers.

THE STRATEGY

The child is supported both directly and indirectly by implementing activities at different levels.

Direct support:
AVSI supports individual children with a wide array of interventions, each tailored to the specific needs of a child and his or her family. AVSI's psychosocial team seeks to support its children holistically, often providing several interventions to a child and his or her family rather than simply a "one time only" intervention. The program provides medical and/or orthopedic support, specialized counseling, basic material support, business skills training, support for Income Generating Activities (IGAs), vocational education support, secondary education, remedial education, support for reintegrative rituals and prayers, and community sensitization. Children often receive more than one intervention, which is why the number of interventions is more than twice the number of children (see table 1). The social workers decide on the type of intervention(s) given based on the person' s needs, expressed interests, capacities, resources (individual and social), and the program' s capacity.

Table 1: Interventions provided to 1481 children and youth June 2002 – June 2004

Intervention	No. of interventions	Percentage of clients
Medical Support	606	41%
Orthopedic	7	0.5%
Material Support	149	10%
Agricultural remedial training	12	0.8%
Business Skills training	626	42%
Income Generating Activities	439	30%
Counseling	156	10%
Rituals	38	3%
Vocational Training School	408	28%
Remedial/Alternative Education	88	6%
Secondary School Sponsorship	483	33%
TOTAL INTERVENTIONS	3012	

Educational interventions are a main part of the program. Nine hundred eighty one children (67%) received some form of school support, including fees and school materials for secondary school, agricultural training, vocational training, and remedial education.

Indirect support

The child is supported by a social network identified and strengthened at different levels The figure in annex 1 shows the global approach implemented by AVSI in Acholiland (Northern Uganda): to have the war affected people at the centre means to care for the most vulnerable people, who are the F.A.C./A. (Former Abducted Children/Adults), the trauma victims and the IDPs (Internally Displaced People). The assistance is integrated in all the sectors where needs arise: health, water and sanitation, education, agriculture/food security. The local community and authorities are always involved in the planning and implementation process. Many interventions are implemented to enhance the community's capacity to identify, plan and address the psychosocial needs of the children inside their community. For this AVSI has given institutional support to schools, teachers and district education and community development offices. To build capacities at community level, AVSI has designed a psychosocial training course and manual for teachers.[2] The training course sensitises teachers to the effects of war on children and promotes classroom management techniques that improve the learning environment. AVSI has trained over 1000 primary school teachers (2 per school) in psychosocial support to date. AVSI has also trained teachers in the creation of peace clubs at the schools to promote non violent communication, artistic expression of emotions, music, and dance among primary school children.

MEASURING SUCCESS: THE DATA BASE

AVSI has standardised its system for monitoring and evaluating its children's wellbeing. Using a combination of the children's self-report and their own observations, AVSI social workers rate the children's wellbeing as "bad," "fair," or

[2] The *Training Manual,* and *Handbook for Teachers* are recognised among the **good practices** by the INEE groups (Interagency Network for Education in Emergency). The material is present in their website under the chapter "Training teachers to meet their psycho-social needs" (www.ineesite.org/edcon/psy_soc.asp) where it can also be downloaded. INEE group decided also to include it in the package for teachers working in emergencies.

"good," in six domains: physical, economic, psychological, relationship with family, acceptance from community, and sense of belonging to community.
The table below show the results of rating on 1481 children during the first assessment.

Table 2: Domain ratings

Domains	Bad	Fair	Good	Missing Data
Overall Physical Health	420 (32%)	327 (24.9%)	565 (43.1%)	169
Overall Home/Economic Condition	326 (41.3%)	339 (43%)	124 (15.7%)	692
Overall Psychological Well Being	336 (27.4%)	327 (26.6%)	565 (46%)	185
Overall Relationship with Family	82 (6.7%)	67 (5.5%)	1072 (87.8%)	260
Overall Acceptance from Community	152 (12%)	108 (8.5%)	1009 (79.5%)	212
Overall Sense of Belonging to the Community	8 (4.1%)	11 (5.7%)	175 (90.2%)	1287

Each of these domains is further broken down by specific indicators of recovery and well-being, which are rated as "worsened", "same", or "improved." These ratings are collected when AVSI first encounters the children (see in annex 2 the assessment form used by the social workers) and during eventual follow-up visits after interventions have been implemented.

The information collected is then entered into a data base and regularly analysed. By tracking these ratings over time and coupling them with the narrative information collected at assessment and follow up, AVSI staff can, to some extent, gauge the impact of their interventions on the children's wellbeing. The use of the data base also helps AVSI staff to monitor the program and take decisions on the implementation process. Using the data base, for example, AVSI staff can decipher quickly whether or not one province is receiving a disproportionate amount of assistance or if another province is being neglected. They can also assess whether or not a certain intervention (for example the provision of school fees or medical assistance) has a positive or negative correlation with most clients' relationships with their families or communities.

In evaluating intervention effectiveness, though, the real challenge confronting AVSI staff is in isolating individual interventions for consideration, given the holistic and often complementary nature of various interventions. If a child has received both counselling and secondary school support, for example, it is impossible to determine which of the two interventions has had the greater impact.

Our analyses so far indicate that, on the whole, the wellbeing of clients receiving educational support has either stayed the same or improved. Very few clients either reported, or were observed, to have worsened in terms of the six indicators above. Moreover, those clients who improved in one domain (e.g., physical) also tended to improve in other domains (e.g., psychological). These results are indicative of both AVSI's holistic approach to intervention as well as the interdependence of psychological, social, physical, and material factors in contributing to human wellbeing.

LESSONS LEARNED

AVSI's multiplicity of experiences with psychosocial interventions for war-affected children in northern Uganda points to one simple lesson that cannot be

overemphasised: education - be it formal or informal, basic or advanced, technical or general - generally improves the wellbeing of children, adolescents, and adults. This premise remains true even, or perhaps especially, in war zones. With very rare exceptions, education is a positive and empowering experience. In fact to go back to school for a child means to go back to a normal life, which is needed for his/her equilibrium, in a social environment that helps the expression and communication of his/her problems and feelings. Moreover the support given to reactivate the schools in an area has an indirect effect on the community, helping its re-establishment in this area where children are going to school.

Another overarching lesson that stems from AVSI's experience is that humanitarian intervention best benefits an individual by addressing the family and community that surrounds him or her. Communities in northern Uganda remain strong despite the conflict, and they are a resource that service providers should tap to maximise the beneficial impact of their interventions.

Particular groups of children should not be singled out for interventions (as former child soldiers frequently are). Such singling out can contribute to the stigmatisation of those children and create jealousy among other vulnerable community members who are not receiving assistance. The child who has lost both parents in a war might rightly wonder, "Why has that former child soldier received school fees when I haven't?"

Fourthly, agencies providing educational support must be willing to self-evaluate critically and to revise their programmes accordingly. Circumstances change quickly in areas of conflict, and a great deal of patience and flexibility are required, demonstrating the delicate balance that programmers must strike between strategic planning and responsiveness to the community. AVSI continues to monitor its programmes, such as the remedial education programme and the pairing of one year of secondary school support with business skills training and IGA start-up support, to evaluate their effectiveness and usefulness.

Finally, not all lessons are measurable, and not all successes are replicable. The more important lesson for the implementer is a lesson of life, as it is well expressed in this statement of one of AVSI's expatriate staff working in the program for four years:

"Here we are living in the same reality - the same conflict area. We cannot start helping until we have been 'touched,' ourselves. If I can understand myself then I can share more of the suffering and needs of others, and also ways of coping."
Anne Devreux, PSSP Advisor

Annex I - Integrated Assistance to war-affected people in Acholi Land

AVSI KITGUM - February 2002

COMMUNITY
SERVICES
HEALTH
AGRICULTURE FOOD SECURITY
EDUCATION
WATER SANITATION
ROADS AND COMMUNICATIONS
COMMUNITIES / IDPs
WAR AFFECTED PEOPLE
RESETTLEMENT
FIRST ARRIVAL
TRACING
Reintegration
Follow-up
F.A.C./A.
PHYSICAL & MENTAL HEALTH
Landmine Awareness Prevention
Hospitals & Rehab. Serv.
IGAs
V.T.-EDU.
COUNSELING & SENSITISATION
Trauma Victims
COMMUNITY
COMMUNITY

[Annex II] Ref No:__________

Key Social Worker:______________

(determined during case review)

AVSI - INITIAL ASSESSMENT

This form is used for all psychosocial projects implemented by AVSI

Date of visit ____/___/_____ Assessed by ____________________ Other AVSI staff present:________________________

WHO referred the case? (name & position) ____

WHY? (Specify the problem) ____

1. General Information

Name____ In the presence of____

Sex: M ☐ F☐ Age_____Place of birth____________________

Current Address: Village ___________ Parish ____________ Subcounty____________District ______________________

Family status:

CHILD: lives w/ 2 parents☐ lives w/ 1 parent☐ which parent? ________________

Lives with guardian☐ Relationship to client _______________ Lives without parent or guardian☐

ADULT: Lives with partner ☐ Single☐ Lives with parents ☐

		Alive	Deceased
Mother's name ______________________	Education: last class completed _____ illiterate☐	☐	☐
Father's name ______________________	Education: last class completed _____ illiterate☐	☐	☐
Guardian's name _____________________	Education: last class completed _____ illiterate☐		

Number of family members in household (compound) _____ Number of dependents _____

Comments on family status: ____

____

IF formerly abducted person:

Date of last abduction____/___/_____ Date of return home ____/___/_____

No. of times abducted ____________ Amnesty certificate YES☐ NO☐

Returned through: home☐ KICWA☐ CPA☐ World Vision☐ GUSCO☐ Caritas☐ Other☐specify________

Length of stay in centre____________________ Received resettlement kit: YES ☐ NO ☐

If YES names of items received:____

Training/Skills/Educational support received from centre YES☐ NO☐

If YES specify:_______________________________________

Were any rituals/ceremonies performed for client? Does s/he feel others are needed? _____________________________

____

____

2. **Physical health**

What is the physical health of the client? (Write from own observations and from client and family members' perspective; include pain and injuries, sickness, medicine taking, energy and fatigue, sleep. Assess if STIs/HIV are a concern.) Note anything that interferes with normal daily functioning. How much does problem affect daily functioning?

____

____

____

____

Name:________________________ Ref. No.________

	Bad	Fair	Good
▪ Carries out daily activities	☐	☐	☐
▪ Pain/illness affects sleep	☐	☐	☐
▪ Appetite	☐	☐	☐
▪ Takes care of self (hygiene)	☐	☐	☐

Rate overall physical health: **Bad**☐ **Fair**☐ **Good** ☐

3. Economic conditions

A. What is the condition of the home (shelter, clothes, nourishment, bedding)? ____________________________________

____

____

____

B. What are the family's main sources of food and income? How have they planned for the year? How long will their food stock last? Include outside sources of help, such as relatives, community, NGOs, or GoU.

____

____

____

____

C. Has the client received any vocational or business training? Describe. ____________________________________

D. What IGAs has the client tried? Reasons for success/failure?____________________________________

____

____

E. What initiatives and/or experiences do other family members have for income generation?________________________

____

	Bad	Fair	Good
▪ Able to purchase basic necessities	☐	☐	☐
▪ Able to send children to school	☐	☐	☐
▪ Able to save money	☐	☐	☐

Rate overall engagement in productive activities: **Bad**☐ **Fair**☐ **Good**☐

4. **Education**

Is s/he attending school: YES☐ NO☐

If **YES** Name of the school ____ Class_____________

If **NO,** why not: ____

Last class completed ______ in which school? _________________________what year?_______________

Does s/he want to go back to school? YES☐ NO☐

If **NO** what does s/he desire to do**?** ____

If **YES**, what does s/he see as the best school option? (Explain reasons for this choice. Discuss long-term goals.)

____

____

____

What does the family see as the best school option?____

____

____

Name:________________________ Ref. No.________

What is the main work of the child?____

Estimate the amount of time that the child spends working per day (during school periods):

	None	A little	Half	All
Morning	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐
Evening	☐	☐	☐	☐

Does work interfere with the child's education? YES☐ NO☐

5. Psycho-Social/Spiritual

A. **Describe relationship with family.** How does the client's family/guardian support and accept him/her? Get perspective from the client & family members if possible.

Is alcohol/drug use a problem in the home? YES ☐ NO☐ Physical violence in the home? YES☐ NO☐

Describe____

____

____

____

B. Describe relationship with community members.

What are the feelings of the community toward the client? (Include your own observation as well as perspectives of the client, family & members of the community (LC, CVC) when possible.)

____

____

____

How does client know the community's feelings towards him/her (calls him/her names, involves him/her in community activities,etc.)?____

____

Identify key community supporters for client:

	Name	Support given
Relatives (not living in household)		
CVC		
Teacher		
Elder		
Religious leader		
Groups		
Other		

Does s/he attend church/mosque? Does s/he feel supported?______________________________

____

What recreational activities is the client involved in? ___________________________________

If none, reason for lack of involvement____

C. Describe client's thoughts and feelings (positive and negative).

____

____

____

____

Name:______________________ Ref. No.________

How much do thoughts/feelings about problems affect daily functioning? A LOT☐ SOME ☐ NONE☐

Suicidal thoughts/attempts? ____

Places/things that trigger these thoughts/feelings more than others ____________________

	Bad	Fair	Good
▪ Talks openly/freely	☐	☐	☐
▪ Able to talk about other things (not just problems)	☐	☐	☐
▪ Experiences nightmares	☐	☐	☐
▪ Makes plans or expresses hope for the future	☐	☐	☐
▪ Expresses sense of meaning in life	☐	☐	☐
▪ Recognises own responsibility	☐	☐	☐
▪ Feelings of revenge or blaming of others	☐	☐	☐
▪ Aggression/violence	☐	☐	☐
▪ Engages in risky behaviour	☐	☐	☐
▪ Alcohol or drug abuse	☐	☐	☐
▪ Staying with friends and family	☐	☐	☐
▪ Involved in community activities	☐	☐	☐

Rate overall relationship with family: **Bad**☐ **Fair**☐ **Good** ☐
Rate overall acceptance from community: **Bad**☐ **Fair**☐ **Good** ☐
Rate overall sense of belonging to community: **Bad**☐ **Fair**☐ **Good** ☐
Rate overall psychological well-being: **Bad**☐ **Fair**☐ **Good** ☐

FINISH BY DISCUSSING/EMPHASIZING POSITIVE COPING MECHANISMS WITH CLIENT AND ENCOURAGING SUPPORT FROM THOSE S/HE TRUSTS IN FAMILY/COMMUNITY

6. Description of coping mechanisms discussed______________________________________

____

____

7. Describe any intervention during assessment (i.e. discussing possible solutions with client and family, assurance that effects are normal reactions, encouraging parents to link with relatives or community members, etc.).

____

____

____

Other comments ____

____

____

Next visit scheduled______________________ Signed______________________________

No support given☐ Reason____

Client categories (check all that apply): Child head of family☐ Child mother☐ Full orphan☐ Partial orphan☐
HIV/AIDS orphan☐ IDP☐ Person living with HIV/AIDS☐ Formerly abducted child☐
War-affected child☐ War-affected adult☐