Resiliency of children in child-headed households in Rwanda: implications for community based psychosocial interventions

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This article focuses on the resilience of children facing extreme hardship and adversity. It is based on participatory research with children living in child headed households in Rwanda. It emphasizes the importance of listening to children's voices and recognizing their capacities when designing interventions to strengthen their psychosocial wellbeing. This study shows that children have developed innovative and profitable coping strategies and some have even developed the capacity to thrive through their situation of extreme hardship. The study of these coping strategies suggests that the children displayed resourcefulness, responsibility, and a sense of morality. However, when the stressors in a child's life became too great, they tended to employ negative, and potentially harmful, strategies to cope. A community based approach should focus on strengthening overall community wellbeing, and should aim to build on the capacities of children, such as their positive coping mechanisms and resilient characteristics. At the same time, it should appropriately address their areas of vulnerability. Existing protective factors should also be identified and further developed in interventions.

Keywords: psychosocial interventions, child headed households, resilience, coping strategies, Rwanda

Introduction

Psychosocial interventions for children, which encompass a broad range of programmes and activities, have been increasing in number in Rwanda since the mid 1990s. At a national level, psychosocial programmes are being encouraged as part of the total aid package for orphans and vulnerable children (OVC)[1] (Ministry of Local Government and Social Affairs (MINALOC), 2003). Programming guidelines are not only important for coordination of efforts but also, as highlighted by Boyden (2003), essential so that psychosocial interventions can be tailored through a firm understanding of the social and cultural context of specific populations and individuals. This is true, even when the specific populations and individuals are within the same culture. Boyden comments; *'the dominant idea of childhood as a universalized and (paradoxically) individualized construct that is built on notions of vulnerability and incompetence has led to interventions that, unintentionally, undermine children's resilience and denigrate coping efforts'.*

Increasingly, attention has been focused away from perceiving children as victims or passive recipients of assistance, instead viewing children as valuable members of society who are active agents of change (Johnson & Ivan-Smith, 1995; Christiansen, Daniel & Yamba, 2005). *'Agency'* in this case, refers to the children's ability to participate as *'active agents in their own development'*

(McCallin, 2001). However, when designing interventions for OVC, there is still a risk of focussing on vulnerability, while disregarding their strengths. Interventions with this focus may impede the children's ability to cope, and to reach their potential.

This paper, therefore, takes an in depth look at the vulnerability, strengths and coping strategies of a particular subgroup of children who are living in child headed households (CHH) in Rwanda. Through this particular population of children, ways to build on their capacities and their resilience through psychosocial programming are explored. The aim of this research is to improve the capacity of the community, and the children's overall coping ability.

Theoretical background: resiliency and the social world of child headed households

A child's resiliency or vulnerability has been defined by the complex interplay of individual characteristics, and risk and protective factors, in a child's environment (Engle, Castle & Menon, 1996; Stewart, Reid & Mangham, 1997). Risk and protective factors function at various levels; in the attributes of the child themselves, at the household level, within the broader community, and the wider social system (i.e. government and cultural values) (Luthar, Cicchetti & Becker, 2000).

Vulnerability and resilience are seen as dynamic processes, where the interaction of various environmental factors and personal characteristics will change over time. Various factors may impact the course of these processes, for example, the child's degree of self confidence, the presence of a caring adult, the household's economic security, access to educational opportunities, the presence of peer support, and community participation within a faith group. Furthermore, the accumulation of one or more stressors may produce an additive affect. Daniel (2005) suggests that the cumulative effect of multiple risk factors reduces the child's ability to form and engage with supportive social networks and undermines their sense of self esteem and self worth. Similarly, the presence of one or more protective factors, and promotion of children's own capacities, should enhance their resiliency and their ability to employ positive coping mechanisms in the future (Duncan & Arnston, 2004).

Building on positive coping strategies

Coping has been defined as *'anything that increases the survival likelihood of the child emotionally and/or physically, whether or not the strategy the child employs is socially acceptable or devoid of appreciable risk'* (Grover, 2005). Therefore, these coping strategies can be positive or negative, and in the short term at least, aim to increase the survival of the child. Children facing severe adversity may be forced to deal with the impact of multiple stressors, and therefore, become increasingly unable to cope. In an effort to survive, children may resort to employing negative coping mechanisms that are potentially harmful in the longer term. Young girls, for example, may prostitute themselves in exchange for food, shelter or money. Other children may seek casual work in hazardous environments, such as sand quarries. This underscores the need to provide protection and assistance to children. However, a perspective purely focused on vulnerability will overshadow the children's own competencies and the opportunity to build on coping mechanisms which are positive.

Stewart et al. (1997) suggests that *'successful coping in one situation strengthens the individual's competence to deal with adversity in the future.'* Boyden (2003) presents the example of children in middle childhood or adolescence.

She argues that many children in this age group are socially competent and demonstrate ingenuity and resourcefulness that helps them, not only to cope, but also to develop their personal capacities in the midst of adversity. Their coping strategies are enhanced by their ability to think critically, which shows their resilience in the face of hardship. Children's resilience can, therefore, be promoted through interventions that acknowledge and build on children's strengths and positive coping strategies.

Definitions of resilience

The concept of resilience brings an important dimension to psychosocial research and interventions. The literature presents varied perspectives of the meaning of '*resilience*'. Spaccarelli & Kim (1995) define a resilient child as demonstrating an absence of psychosomatic symptoms and maintenance of normal development for their age despite adversity. Grover (2005) argues that resilient children make '*a reasonable adjustment to the demands of daily life*' in the midst of hardship. Luthar et al. (2000) present a definition that has been often used; '*resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity*'. Additionally, children who adapt well despite '*major assaults on the development process*' are seen as resilient. Though these views correctly recognize coping ability, they also lack sufficient emphasis on the child's own capacities and ability to become *stronger* when faced with situations of adversity, and thus ultimately equipping them to face challenges in the future. Secondly, such concepts of resilience makes assumptions about the universal development of children, while discounting the ways that cultural and social contexts may impact on a child's development. A developmental stage that is not uniform across cultures, or even individuals within the same culture, will also factor into children's resiliency and ability to cope. (Boyden, 2003).

The following definition encapsulates the concept that children develop capacities *because of*, not only *despite*, the adversity they have faced; '*resilience is … the human capacity to face, overcome and be strengthened by, or even transformed by, the adversities of life*' (Grotberg, 1995). This is the concept that is adopted in this paper, through the careful analysis of children's own social and cultural context.

Child headed households in Rwanda

In Rwanda, AIDS, the 1994 genocide and other periodic conflicts have undermined traditional care giving structures. So, children that would have normally been cared for by members of the extended family, are left alone. The first national reaction to the huge number of unaccompanied children post genocide was to open children's centres (ACORD, 2001). By 1996, most centres were shut down, as the National Government's '*One child, one family*' campaign policy advocated for reunification, and encouraged absorption of children into households and communities (MINALOC & UNICEF, 2001). And yet, with siblings and peers prefering to stay together, it is estimated that up to 227 500 CHH have evolved within this context (Human Rights Watch, 2003). In 1996, 13% of all households nationwide were believed to be headed by children (ACORD, 2001). Moreover, CHH are considered to be an outcome of the HIV epidemic. Of the 810 000 orphans present in Rwanda in 2003, UNICEF (2003) estimated that 160 000 were orphaned by AIDS. MacLellan (2005) describes the '*havoc*' wreaked on Rwanda's children as '*the double attack of conflict and AIDS, like two horsemen of the apocalypse*'.

Psychosocial wellbeing of child headed households

In subSaharan Africa, the numbers of CHH has increased in parallel to the stripping of community, and extended family capacity, to provide social support to affected children. Roalkvam encapsulates the depth of social isolation experienced by children living in CHH in Zimbabwe:

> *'One of the most obvious characteristics of the child headed household is its isolation. These households appear to be invisible to their kinsmen, to the community surrounding them, to the state and state apparatus, however weak, who each fail to address, as well as act, in relation to the growing number of children left to stand alone'* (Roalkvam, 2005).

Previous research shows that children living in CHH in subSaharan Africa face a number of socioeconomic and psychosocial stressors (Box 1). Children not only confront adversity in the forms of stigmatisation, social alienation, exploitation and socioeconomic deprivation, but they also often take on sole responsibility for their siblings at a young age. In Rwanda, community social dynamics are complex. It is believed that a lack of trust may undermine the community's ability to absorb and care for unaccompanied children (Thurman et al., 2006).

An increasing number of studies are being dedicated to CHH as a group requiring special attention. Thurman et al. (2006) has described the extreme social alienation experienced by Rwandan youth who head households. The study reported that 87% of youth surveyed in Gikongoro felt rejected by their living relatives, and only 24% felt that their families would help them in time of need. Additionally, the consequences of displacement or experiencing the death of parents and others from violence or AIDS, can be detrimental to a child's psychosocial wellbeing. Children in CHH are also vulnerable to physical, economic and sexual exploitation. They often have no one to advocate for them, or are unaware of their rights (MINALOC & UNICEF, 2001). Studies based in Rwanda underscore the need to protect the children's right to land, education and health (Rose, 2005; MacLellan, 2005).

It is clear from the research that children in CHH need advocacy, protection, and assistance, but until now, comparatively few studies have also highlighted the resilience of children in CHH. As stated by Johnson & Ivan-Smith (1998); *'we must recognize*

Box 1: Psychosocial and socio-economic wellbeing of children living in CHH in sub Saharan Africa: General themes in the findings from studies based in sub Saharan Africa

- Extreme social isolation, marginalization and stigmatisation
- Lack of sense of security, belonging, and acceptance
- Consequences of past affecting psychosocial wellbeing
- Extreme poverty characterized by insufficient food, clothing, shelter
- Lack of access to social services: health and education
- Exploitation and abuse: neglect, emotional abuse, lack of advocacy
- Exploitation and abuse: sexual and physical abuse
- Exploitation and abuse: property grabbing, denial of children's rights, lack of advocacy

Sources: MINALOC & UNICEF, 2001; Donald & Clacherty, 2005; MacLellan, 200; Roalkvam, 2005; Rose, 2005; Yamba, 2005; Thurman et al., 2006.

children's own coping strategies in the face of difficulties and build on their resourcefulness, at the same time as acknowledging the need for proper protection and provision of services.' While presenting a situation of profound social isolation, collaborative studies on the psychosocial wellbeing of youth headed households in Rwanda have also recognized that the small degree of social capital of youth that should be tapped as a potential resource (Brown et al., 2005; Thurman et al., 2006)[2]. Donald & Clacherty (2005) intentionally avoid a '*deficit only*' perspective in their research with CHH in South Africa. Their analysis revealed that, in comparison to equally impoverished adult headed households, the strengths of the CHH were found in social networks, family interactions and time and money management. Grover (2005) suggests that researching children in CHH may be able to positively demonstrate children's agency, ability to advocate for themselves, and to thrive amid difficult circumstances.

The study

This research was undertaken as requested by The Sharing Way/Canadian Baptist Ministries and the Association of Baptist Churches of Rwanda (AEBR)[3] who work in partnership with community based initiatives coordinated by the AEBR. The AEBR has initiated community based initiatives to buffer the impacts of HIV and AIDS. However, the burden of orphans and other vulnerable children, particularly CHH, is large and therefore they would like to expand further care and support. This study seeks to describe the social vulnerability, coping strategies and resilience of children living in CHH in the AEBR project areas. Ultimately, this information will be used to suggest ways that programmes can be better tailored to support the children. By providing a voice for the children and exploring the views of the community, the children's strengths and vulnerabilities can be identified and current forms of support can be built upon and adapted to strengthen the children's wellbeing.

Methodology

The methodology of this study was qualitative and participatory in nature, allowing the children and other participants to present their perspective on issues that affect them directly. Participatory approaches facilitate the expression of the perspectives of diverse groups in society. Although participatory approaches have been criticized by Cooke & Kothari (2001) for actually facilitating power inequalities, Hickey & Mohan (2004) argue that this approach can lead to transformation in communities and people, as long as power structures are understood and confronted. In designing community psychosocial programs for children in Rwanda, it is important to understand the power structures already present in the society. Therefore, participatory approaches were used in this study to obtain the '*myriad of positions interests and needs*' (Neef, 2003) and to contribute to positive transformation in individual and community lives.

As highlighted by Boyden (2003),'*psychosocial assessments of children often rely on adult's views rather than children's own perspectives*'. Duncan & Arnston (2004) also argue that consulting the children for their input in a project may be a process that promotes their psychosocial wellbeing, giving them an increased sense of security. The act of sensitively listening to them will demonstrate that their experiences, opinions and ideas are valued. It is also a way to encourage their role as active participants and rights holders in society. As stated in the UN Convention of the Rights of the Child (CRC), children have a

Table 1. Description of the children in the sample

	Girls	Boys	Total
Children in sample			
Younger children: ages 5–13	52	12	64
Older children: ages 14 and above	29	11	40*
Total number of children in sample			104
Heads of household			
(also included in the total sample above)			
Younger children: ages 5–13	3	1	4**
Older children: ages 14 and above	14	7	24
Total number of household heads			28

* Three of the children were older than 18 years.
** The youngest head of household was 9 years old.

right to express their opinion and to participate in all matters that affect them (UN, 1989, Article 12).

Cultural norms and participant views were used to form the working definitions and research questions. MacLellan (2005) highlights the importance of contextual factors on the classification of CHH. For example, many children living in CHH are orphans who have lost one or both parents due to conflict or HIV, but there are also some who live with parents that are unable to care for them due to sickness or disability. In Rwanda, many are also separated from their parents due to imprisonment or displacement (MINALOC & UNICEF, 2001).

Therefore, in this study, *'CHH'* and very concept of *'child'* were defined by the community. At times, children were considered as those who were not yet married, and in some cases, a household was designated CHH by the community because at the time of the parents death, the oldest child in the household was under 18 years old[4]. Therefore, a total of 104 children aged 5 to 24 participated in this study (Table 1). Surrounding urban project areas were selected in each of Kigali, Butare and Gisenyi, and were based on accessibility and the presence of local leaders to assist in planning the research.

Research methods employed with children included participatory activities, focus group discussions (FGDs) and semi-structured interviews (SSIs).

Participatory activities used with children aged 5–13 included drawing, mapping and naming. With older children (aged 14 and above), activities used included problem identification and problem solving, construction of timelines, seasonal charts and daily schedules. Following participatory activities, visual outputs were probed and discussions were initiated. In order to get varied community perspectives and to triangulate the views of the children, thematic focus group discussions were done with community groups, such as members of HIV/AIDS support groups and women's groups. Semi-structured interviews were done with community leaders, such as church leaders and local authorities. Semi structured interviews were also done with child heads of households at their homes.

Participant observation was also used throughout the research, and was carried out in May and June of 2006. AEBR facilitators were each given a briefing about the methods and the themes to be discussed, and translated from Kinyarwanda into French or English[5].

Throughout the primary fieldwork, a daily field log was kept, tapes were transcribed and preliminary analysis was done. The early identification of themes served to guide the research process. Subsequently, the raw qualitative data (transcribed micro-cassette recordings, session notes and participatory activity visual outputs) was analyzed manually in several stages. The analysis began with familiarization of the data, this led to detailed coding, whereby categories were formed and data broken down into units of analysis, as described by Denscombe (1998). Further investigation of the data led to identification of subcategories that reflected emerging themes and relationships. Examination within and across categories unearthed the overarching themes and was then put into the context of broader theory from the literature. Data from field notes of unplanned conversations and observations were also analyzed in this procedure, with careful thought given to the authors' interpretation of these events.

The research was clearly explained to all participants and freely given, verbal, informed consent was sought. The children were reassured that continued support from the AEBR would be provided, regardless of their participation in the study. Care was taken to accommodate the schedules of the children, and to make them feel as comfortable as possible.

Findings

The situation for the children living in CHH involved in this study is one of severe adversity with multiple stressors, including severe food and economic insecurity, compounded by social alienation and exploitation. What is largely overlooked, however, is the resilience with which they face hardship. In this section, the children's social and economic situation will be described, highlighting the impact of multiple risk factors on a child's resilience. The coping strategies that children employ in the face of their problems will be presented as will a discussion on the children's strengths that are uncovered through this process. The protective and vulnerability processes will be discussed throughout the section, as situations are expressed through the children's perspectives. A case study will follow, demonstrating the importance of tailoring psychosocial interventions toward the unique situation of children in CHH.

Economic insecurity and social marginalization

As previously noted by Mann (2004) and ACORD (2001), children living in CHH become overwhelmed by their daily tasks and the days of hard labour that are necessary to meet their basic survival needs. Income was generated mainly through casual work of various forms in the informal sector. However, jobs were difficult to find, frequently unstable, and employers may or may not pay as promised. Jodine's comment shows how the lack of social support is intertwined with economic instability:

> *'You have to do the work in the home, then you have to do the work on the farm, then you have to take care of the younger children, and you have no one to help you, people don't come to visit you and sometimes you don't have enough money.'* (Jodine, 16, Rural Kigali)[6]

The children struggle to meet their basic needs, and often reported going without

food. One of the local church volunteers pointed out that some of the children don't even know that it is normal to eat two meals a day. Referring to the children, he commented:

> *'Once the [church] service is over, the young people do not want to return home. It's not because they love staying in the church, but no, they cannot return home. They cannot find food to eat. There is a girl who is in Standard 6, Primary School. It is just how she lives. She has a young brother who goes to town to find small jobs. It's the young brother who comes home with 200 Rwf or 300 Rwf[7] so they can buy food for the day. And for us [at church] we do not have hope that they will have food to eat. And sometimes, they don't eat.'* (Church volunteer, Gisenyi)

On a boy's daily schedule, made by gender segregated groups, the listlessness that some children felt is shown in their description of the evening routine:

> *'When we do not get the casual work allowing us to get food, we go to sleep waiting for God's help.'* (Boys, 8–16 years, Butare)

This caused anxiety in the children, especially those responsible for others in the household. Sometimes, efforts to find work were unsuccessful and older children would come home, empty handed and unable to feed the younger ones. This discouraged the children and lowered their self confidence, leaving them with a sense of powerlessness over their own lives, and of those in their household. Moreover, the social marginalization of the children was shown to intersect and compound all other stressors in their lives.

The effect of multiple risk factors

Children involved in this study were shown to be severely socially isolated, which supports previous CHH research based in Rwanda (MINALOC & UNICEF, 2001; Thurman et al., 2006). The children revealed that support from neighbours was limited, and the extended family could not often be counted on to help. An AEBR staff member remarked that because of the lack of adult support, *'there is no one to teach them the ways of Rwandans.'* Therefore, children fail to benefit from social interactions that would increase their cultural knowledge and enhance their sense of inclusion and involvement in cultural activities. These household and community level risk factors may hinder the development of their individual capacities, deepen feelings of loneliness and despair, and place them at an increased risk of exploitation. As Chantal, who lives alone with her younger brother, revealed:

> *'The neighbours have rejected me. My relatives have also rejected me. They don't support me. If I go to them for help, they won't help me.'* (Chantal, 16, Rural Kigali)

The cause of parental death also played a role on the social support, or alienation, of the children. Some children felt stigmatized by neighbours because they were providing ongoing support to their parents who were in prison[8]. Some children, who lost their parents from HIV, knew that they could approach the support groups that their parents once belonged to for help when needed. However some children, such as Noheli, felt stigmatized by their community:

> *'Sometimes people won't come near me and won't help me because they are afraid that I have AIDS like my parents.'* (Noheli, 17, Butare)

Box 2: Comments from visual outputs regarding the degree of social support: discouragement among the children

'We have no food and we have nobody who cares if we go to sleep hungry.'
- Problem identification matrix
'Wasting much time waiting in the house of other extended family for them to share food but they don't help us.'
- Problem solving diagram (response to employment problems)
'To leave that extended family.'
- Problem solving diagram (response to problem of property grabbing by relatives)
'For girls, they are isolated from others, sad and disappointed and we do prostitution to find survival.'
- Problem solving diagram (response of girls to problem of being socially isolated)

As Daniel (2005) described, when faced with multiple stressors, children may resort to harmful mechanisms in order to cope. The comments in Box 2 show the depth of isolation that some children feel, and how this negatively impacts their ability to cope with other stressors in their lives. The social problems are exacerbated by deprivation of economic resources, such as no food or income. The girls expressed a link between their isolation and prostitution, an act of desperation that stemmed from social and economic factors. For the girls, however, this harmful practice was not an outcome of mere lack of social support, but of physical and sexual exploitation. Delphine cares for five younger siblings and explains:

'Men can come if they know the situation of the household. They offer money for sexual favours. They take advantage of my situation.' (Delphine, 19, Rural Kigali)

Therefore, the added effect of severe economic problems, compounded by social isolation and exploitation, affected the children's coping ability and forced them to resort to harmful practices.

Peer and community support

In the midst of the social isolation experienced by children in CHH, there were a few positive examples of social support. A few children reported positive relationships with their extended families, saying that they felt free to go to a grandmother or a brother-in-law, for example, with their problems. Others who had been rejected by both the mothers' and fathers' extended family could name at least one person, such as a neighbour or pastor, who they could go to for advice. However, the most common emotional support available to the children was not from adults, but from other children, usually those who lived in the same situation. Younger children were more likely to have family members support them, as noted previously by Thurman et al. (2006). Children who were either alone, or the oldest in the household, felt as though they had no one they could confide in, as shown in the remarks of Afissa;

'In the case where there is a brother or an older sister we can present to them our problems. But when we do not have a brother or an older sister, sometimes we just let the problems drop because we cannot reveal our secrets to someone from the outside who does not care about our problems and who does not have the time to understand and who does not have the time to listen to our stories.' (Afissa, 15, Butare)

Peer support played an important role for both boys and girls. It was noted that they were very affectionate toward one another. Sixteen year-old Claudine had to stop school to take care of her younger brother. She is part of a group of girls who meet regularly at the local church and explains:

> *'When I stay here, I feel lonely and sad. When I go there with my friends, I don't feel so alone, but I feel happy.'* (Claudine, 16, Rural Kigali)

Some children who were involved in church choirs, or other activities, expressed that this made them happy; they had an opportunity to interact with other children their age and to have time away from their work. These involvements also served to enhance their self confidence. This was evident when the girls initiated and presented songs during session breaks with a sense of pride. Peer and community support were, therefore, shown to be protective factors that enhanced the children's psychosocial wellbeing.

Resilience and children's positive coping strategies

In the face of severe economic and social risk factors, some children have not only coped, but have exhibited great resilience through the expressions of their situation, and the way they deal with the challenges they face. The following discussion depicts the gravity of the situation, but also highlights the coping strategies employed and the characteristics that have helped them face, and sometimes overcome, adversity.

The children involved in this study exhibited many innovative coping strategies to deal with economic problems. For example, although several of the children had no land to farm, if they did had plots of land[9], the children made use of this by cultivating and selling what they harvested during the dry season, so that they could buy soap, clothes and school materials. Others made beer from bananas to sell in the market, or sold freshly grown bananas and avocados. The children showed ingenuity and discernment and used their existing resources creatively and wisely. The younger children also showed an understanding of household finances and some worked small jobs whenever they could, after school or on holidays if they were students.

Children involved in this study face extreme economic and physical vulnerability, and yet their reactions to hardships showed their ability to conduct themselves in a mature way. In a problem solving activity, children were able to discuss their problems, coming to terms with the issues they faced. They also generated possible solutions and identified those that were *'good'* and *'bad'*. When faced with economic deprivation, the children were able to generate innovative ways to improve household income, as shown in Table 2. Most children were also able to identify coping mechanisms that were potentially harmful, consistently ranking *'sexual relations'*, *'stealing'* and *'violence'* (with regard to property grabbing by their own relatives) as the worst options. A group of girls between the ages of 12 and 19 in rural Kigali chose to analyse the problem of *'sexual abuse'*. Their responses demonstrated a developed sense of fairness and justice. They stated that *'to teach [the abuser] equality of human beings'* was the best option, while to *'punish the abuser and sentence them to remain in prison until they die'* was the worst option because the person would have no chance to change their life. In the face of severe abuse, sometimes by the only adults in their lives, the girls showed mercy to their own abuser. The girls showed the capacity not only to cope, but also to demonstrate kindness, forgiveness and justice in the face of hardship.

Table 2. Children's solutions to economic problems (no school fees, food, nor clothes)

'Good' options	To find a well-wisher to help you
	To pray and ask God
	To do small jobs to get money (or food)
Neutral responses	To sell fruits and vegetables
	To cultivate (farm) for other people to get money
	To carry goods from the market and make some money
	To get money from washing clothes for other people
	To cultivate for other people
	To be adopted by rich people
	To sell what we have harvested
'Bad' options	To be an *'escort'*
	To steal
	To have sexual relations to get money
	To use violence (property grabbing by their own relatives)

*Compiled results from Problem Solving Diagrams by children and youth aged 12–19 from Rubungo (Rural Kigali) and Butare (Tumba B).

Resilient children and adolescents weighed the importance of earning extra income in the present, against the possibility of securing greater income in the future through education (McCallin, 2001). Both boys and girls showed deep commitment to their families, making sacrifices (such as giving up education or an opportunity to marry) so that a future could be secured for other members of the household. One boy, out of school because of lack of fees and trying to find work, described his hope for a secure future:

> '*When I think about the future, I dream of school fees, so that one day when I am finished my studies, I can finance myself.*' (Bosco, 15, Butare)

Protective factors and resilience of CHH

Despite the social isolation, the children desired to live wisely and coveted people in their lives who could guide, support, comfort and advise them. Younger children, describing drawings of what made them happy revealed; *'people who talk to us'* and *'people who give us advice.'* During focus group discussions and semi structured interviews, young girls and boys would ask of the facilitator; *'can you tell us how to live?'* or *'do you have advice for us?'* An older boy admitted:

> '*We do unwise things when we have no one to care, no one to guide us.*' (Jean-Claude, 21, Butare)

And yet, social support from peers, siblings and adults was shown to have a positive impact on the children's lives, allowing them to express resilient characteristics that they may have developed through their experiences of hardship. While it cannot be claimed that their harsh experiences have lead directly to resilience, the presence of coping strategies indicates that there is some relationship. It is important, not only to

recognize these social protective processes, but to design ways to mobilize and build on them.

How, then, can children facing severe adversity, be strengthened and uplifted in their efforts to cope with their challenges? How can children's resiliency be encouraged, equipping them to deal with problems in the future?

Implications for psychosocial interventions

Psychosocial interventions for children should be tailored to support the individuals within households to confront the issues that they face in the present, while giving them skills, confidence and the ability to sustain themselves in the future. Interventions should have the goal of building the capacity of children in CHH, their households *and* the community as a whole. Strengthening local efforts may *'encourage local pride and resilience.'* (Putter, 2003). Williamson & Robinson (2006) claim that *'the material, biological and psychosocial aspects of wellbeing are integrally related, and it is not helpful to try to separate them into separate areas of programming.'* They endorse an *integrated approach* to programming that seeks to strengthen overall wellbeing[10].

A household approach would require that a commitment is made to support all constituents of the household for a given period of time. Results of this study show that children living in CHH have a high degree of commitment to each other, and it is important to recognize that strengthening one member of the household means that other members must also be secure.

The strengths revealed through positive coping strategies should be built on, while practices that may cause harm need to be addressed and replaced by more constructive approaches. The principles proposed to guide action are outlined below.

a) Minimize risk factors through mobilization and sustainable input of resources

In order to provide integrated and comprehensive support to children living in CHH, financial and material input may be needed in order to minimize risk factors to a level where they can cope positively. A participatory baseline survey, which will also help to mobilize the community and to gather ideas for programming, will serve to identify and address priority areas of risk for children. Creative ways of fostering community participation (mobilising social processes) may include, for example, mobilization of the children and their neighbours to make bricks and provide physical labour, while providing them with iron sheeting and specialized materials for repairing houses. To foster a cooperative spirit and to build on cultural knowledge, food security activities may be planned where community members are used as agricultural instructors for children who may have never learned the techniques commonly used in their area.

b) Mobilize and strengthen protective social processes

Building the capacity of the community to care and support the children entails the strengthening of the individual capacities of the children, but also community wellbeing as a whole. Supporting socialization of the children has the potential to build on their capacities and to further develop their values and cultural understanding. Increasing social interactions in the community may work to build trust and unity. When community members are involved in initiatives to support the children, a sense of pride may be a benefit of their contribution (Putter (2003). Foster et al. (1996) suggest that *'the knowledge that there is an organization in the*

community concerned about the welfare of orphans may lead to less physical and sexual abuse'.

Ways to enhance socialization of the children include activities that encourage engagement with other children, such as music, drama, sports and encourages children to participate in community events. A mentorship element to programmes can be effective in various contexts, including Rwanda (Brown et al., 2005; Foster et al., 1996), This is also a way to build on existing social linkages through community members, often encouraging and formalizing what they are already trying to do, and to provide advocacy and social support at a household and community level.

c) Recognize and engage the human capacities of the children and build on positive coping strategies

Another important programming objective for children living in CHH in AEBR communities is to tap into the capacities and values the children have demonstrated, not only to build on this capacity, but also to contribute to community development. Positive coping strategies should be examined, identified and built on when designing programmes for CHH. Faith based organizations may include children in church activities that may encourage children and engage them in spiritual dimensions. Children in this study expressed the desire to increase their ability to deal with conflict and grief, skills that may help them, as well as others. Peer support should be encouraged, for example through the formation of youth associations, where they can discuss their challenges, encourage and advocate for each other. Grover (2005) remarks that many children are capable of self advocacy and that they should be supported in their efforts. They may also be given positions of responsibility in programme planning. Children's involvement in all aspects of the project cycle (baseline assessment, planning, design, implementation, monitoring and evaluation) is critical.

Suggestions for psychosocial programming in Rwanda

Therefore, community based psychosocial programmes should be designed to increase the capacity of the community to care for and support the children in their community. An integrated approach to programming that seeks to strengthen overall wellbeing may include several domains of programming, such as mentorship, community capacity building, sustainable food security, education, income generation, health and nutrition. Capacity building should be continuous and, as much as possible, involve all stakeholders in the community. Trainings could focus on issues such as child rights, HIV and AIDS, peace building and reconciliation[11].

Questions that practitioners may use for guiding programme design could include:

a) how, in our community, might the children's creativity, resourcefulness and responsibility be used to enhance community activities and community life, in general; or
b) how can we encourage the children to express their values in ways that strengthen others in the community?

Ways to strengthen the resilience of children could include leadership training and opportunities to exhibit responsibility in a positive and supportive community context. Wherever possible, children should be encouraged to lead the programme, for example, in conducting the initial baseline survey. It has also been argued that in post conflict environments, young people should also be encouraged to take ownership of their development in order to decrease *'the likelihood that adolescents and youth will violently destroy*

what they have stake in' (Women's Commission for Refugee Women & Children, 2002). Children who have proved particularly resilient should be encouraged to mentor other child heads of household. Capacity building for children could include how to form groups, counselling of peers, peace building and reconciliation, HIV, sexual and reproductive health, and training on practical issues such as literacy, household management, organic farming and small business training.

There remains a great need to identify appropriate assessment measures in order to evaluate outcomes of interventions. It is difficult to employ standardized measures of resilience that are often developed from a Western perspective. Further research is needed to develop tools to measure wellbeing, and to assess the effectiveness of interventions designed to strengthen resilience of individuals, households and communities.

Orphans are likely to be socially and economically marginalized throughout their lives, but by concentrating on promoting protective factors, their resilience can be strengthened (Daniel, 2005). These children have faced severe adversity out of necessity, but with dignity and courage have also shown that they can transform trials into opportunities for personal growth. By recognizing and enhancing the resiliency of children, they are given the opportunity to rise beyond mere survival, and to thrive as they face future challenges.

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[1] Orphans and Vulnerable Children (OVC) is a term commonly used in policy documents, programmes and interventions. This term will not be used in this paper, as it emphasizes the *vulnerability* of the children with no reference to resilience.

[2] Tulane University School of Public Health, Rwanda School of Public Health, World Vision Rwanda (WVR) and Horizons/Population Council (a USAID funded project) formed a partnership to design, implement and evaluate a psychosocial support initiative for youth headed households in Rwanda. Brown et al. (2005) and Thurman et al. (2006) report findings from the baseline data collection.

[3] AEBR = Association des Églises Baptistes au Rwanda (French).

[4] Though it was first anticipated that CHH would be headed by children less than 18 years, the definition was by necessity broadened in the field to include those who were up to the age of 24. This is consistent with MacLellan (2005), who found that many agencies in Rwanda include older youth heads in their programmes and still consider the households to be *'child headed'*. Because of the serious need for many of the older children to access psychosocial and other services, MacLellan argues that it may be disadvantageous to identify a CHH solely on the legal age of the head and that inclusion of older youth as CHH is reasonable and just.

[5] Every attempt was made by the facilitators to conduct this study without imposing their views on the subject matter, though it is recognized that the researcher's presence in the environment and the subsequent interpretation of events, conversations and conclusions will undoubtedly affect the findings.

[6] The quotations and examples are all from children involved in this study, however, the names are fictional.

[7] 100 Rwf = approximately 0.20 USD.

[8] Some children were also paying off debts because their late or imprisoned parents had been condemned of crimes during the genocide. These children were dealing with a financial burden that was compounded by social isolation.

[9] The ACORD (2001) survey showed that 74% of CHH said they had a plot of land, but 81% of the plots were less than 1 hectare.

[10] This is in line with government policies of Rwanda, which coordinates OVC initiatives through the National Aids Control Commission (NACC). The NACC recognizes the importance of comprehensive care and support of OVC and they require that groups working with OVC work in at least three of six defined categories; health, nutrition, formal and informal education, protection, psychosocial support and socioeconomic empowerment.

[11] Such an approach would also complement the Governments of Rwanda Strategic Plan for Orphans and Other and Vulnerable Children 2007–2011, where an integrated and multi sectoral response is proposed and outlined (Government of Rwanda, 2006).

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Special Note: putting theory into practice: *The initial research was done by Laura Ward for her MSc in 2006 through Canadian Baptist Ministries and their local partner, L'Association des Eglises Baptistes Au Rwanda. At that time, child headed households were identified by the partner as an issue that needed intervention, in addition to the HIV and AIDS work they were doing in the communities. Therefore, this research was taken seriously by both partners, who have since initiated a pilot project, overseen by Laura Ward. The community based, integrated programme was started in January 2007 with 188 households in three areas of Rwanda, with a focus on empowerment though mentorship, training and education, psychosocial support, food security and networking. The project has already made a strong impact in building the capacity of the communities to care for and support their children, and in strengthening the wellbeing of the children themselves.*