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Chapter 17
Interaction Competencies with Children (ICC): An Approach for Preventing Violence, Abuse, and Neglect in Institutional Care in Sub-Saharan Africa

Tobias Hecker, Getrude Mkinga, Joseph Ssenyonga, and Katharin Hermenau

"Our children are our future and one of the basic responsibilities is to care for them in the best and most compassionate manner possible".

Nelson Mandela Children's Fund (2016).

1 Introduction

With more than 56 million orphans, Sub-Saharan Africa is the most affected region worldwide regarding the number of orphans needing care (UNICEF, 2014). An orphan is hereby defined as a child under the age of 18, who lost one or both parents

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due to death from any cause (UNICEF, 2006). For example, in Tanzania, one in four girls and one in five boys were orphaned in 2009 (UNICEF, 2011). As a result of poverty, political conflicts, and the HIV/AIDS pandemic, the traditional system of care within extended families is overburdened by the rising numbers of orphans (Better Care Network & UNICEF, 2015; Li et al., 2008; Wolff & Fesseha, 1998). Thus, in many Sub-Saharan African countries, childcare institutions, such as orphanages and children's homes, still constitute the most frequently utilized form of providing formal alternative care for children without parents (Rygaard, 2010; Wolff & Fesseha, 1998). Children who are institutionalized are in most cases 5 years or older. Various reasons like poverty, war, and conflict, as well as parental illness or disabilities of the child, can lead to abandonment of the children. Above all, HIV/AIDS is one of the most common reasons for orphanhood and institutionalization in Sub-Saharan Africa (UNICEF, 2006). In most countries, gender distribution of institutionalized children is more or less equal (SOS Children's Villages International & University of Bedfordshire, 2014). Most common are childcare institutions housing large groups of children with very few mostly untrained, female caregivers (SOS Children's Villages International & University of Bedfordshire, 2014). Yet, there has been very little research on the living conditions in African orphanages and other childcare institutions so far. The few studies that have focused on African orphanages have reported a lack of adequate caregiving (Espié et al., 2011; Hermenau et al., 2011; Levin & Haines, 2007; Wolff & Fesseha, 1998, 1999). Besides the lack of educated and competent caregivers, orphans in African countries are additionally confronted with exposure to violent discipline strategies and physical abuse (Hermenau et al., 2011; SOS Children's Villages International & University of Bedfordshire, 2014). Thus, in addition to parental loss, possible maltreatment in the family of origin, and the often unresponsive and distant caregiving in institutional care, orphans are burdened with further experiences of maltreatment in orphanages and other institutional care facilities. Physical and emotional abuse and neglect during childhood are associated with mental health problems and aggressive behavior in children, particularly in those who have been institutionalized early in life (Hermenau, Hecker, Elbert, & Ruf-Leuschner, 2014; Johnson, Browne, & Hamilton-Giachritsis, 2006).

Despite the high risk of maltreatment in institutional care, interventions that focus on the prevention of violence and abuse are rare. We addressed this issue and designed with *Interaction Competencies with Children – for Caregivers (ICC-C)* in institutional care a training workshop that aims at improving care quality and at preventing maltreatment in institutional care, particularly in low-income countries in Sub-Saharan Africa (Hermenau, Kaltenbach, Mkinga, & Hecker, 2015). ICC-C proved its feasibility and showed first promising results in a feasibility study with caregivers in Tanzanian orphanages.

This chapter will give an (1) overview of the current literature on maltreatment and its consequences on the children's development and well-being in African orphanages. Furthermore, we will present arguments that (2) underline the necessity of implementing maltreatment prevention approaches in institutional care. As the

main focus of the chapter, we will present (3) with ICC-C an intervention approach in detail that aims at improving care quality and preventing maltreatment in childcare institutions, particularly in countries in which harsh discipline is regarded as culturally accepted and is highly prevalent. The chapter concludes (4) with practical implications and policy recommendations.

2 Maltreatment in African Orphanages

2.1 Institutional Care in Sub-Saharan Africa

The African countries south of the Sahara differ widely in history, culture, language, politics, economics, and social systems. This diversity is also reflected in the welfare systems, child protection systems, and orphan care (e.g., Better Care Network, 2014). In recent years, several organizations and governments have put effort into structuring and formalizing care systems for orphans and other vulnerable children, setting up guidelines in order to strengthen the child protection systems (Better Care Network & UNICEF, 2015; Inter-agency Group on Child Protection Systems in Sub-Saharan Africa, 2012). Formal alternative care encompasses institutional care (private and governmental), foster care in families or communities, and adoption as opposed to informal (i.e., without any official structures and placements) family and kinship care (i.e., care within the extended family or community) (SOS Children's Villages International & University of Bedfordshire, 2014). In general, the efforts support family- and community-based approaches (family and kinship care) and aim to reduce institutional care (Better Care Network, 2015; Better Care Network & UNICEF, 2015). Yet, due to the rising number of orphans, institutional care is still very common in Sub-Saharan Africa. Most institutional care is financed by nongovernmental or religious organizations, a minority of these are state run (Better Care Network & UNICEF, 2015; Chiwaula, Dobson, & Elsley, 2014). In many countries a substantial number of care institutions are unregistered and uncontrolled. The registration rates range from high, for example, in Rwanda and Kenya, to about half in Togo, to very low in Malawi, Tanzania, and Uganda (Better Care Network & UNICEF, 2015; Chiwaula et al., 2014; Walakira, Dumba-Nyanzi, & Bukenya, 2015). Further, Riley (2012) noted that in Uganda more than one third of the childcare institutions were unknown to the officials in districts where they are operating. In addition, the newly introduced registration processes in some countries were reported to be confusing, incomprehensible, or long winded, resulting in many unregistered operating facilities (Better Care Network, 2014; Chiwaula et al., 2014). The high number of unregistered and uncontrolled institutions and the lack of governmental resources make it difficult to collect information and to survey whether a minimum of childcare quality is met. For example, no effective system to monitor institutional care exists in Togo, Tanzania, and Zimbabwe (Better Care Network, 2014; Chiwaula et al., 2014).

Additionally, most countries lack structures that assure adequate training of caregivers. In Malawi, 71% of the caregivers did not undergo any training in childcare. Kenya set standards for caregivers being trained, but the training duration ranged from over a year to only 1 day (Chiwaula et al., 2014). In Tanzania, the governmental social welfare department established an institute to train staff in governmental facilities. However, there were no standards for nongovernmental facilities. The number of staff and the caregiver–child ratio in Tanzanian institutions depended on the funds both in private and governmental institutions. Consequently, many facilities fail to meet standards and have no child protection policy. For example, below 10% of surveyed care facilities in Malawi had a care plan (Chiwaula et al., 2014; SOS Children's Villages International & University of Bedfordshire, 2014). Despite these shortcomings among institutions, sanctions and consequences against unauthorized facilities are mostly not put into action. Although many countries have policy guidelines, which should ensure that competent authorities make placement decisions in the best interest of the child, implementation is often difficult without sufficient resources. For example, in Tanzania, government placements went through a court, but nongovernmental institutions admitted children on their own criteria (Chiwaula et al., 2014). In sum, though in many Sub-Saharan African countries structures exist in which governmental or juridical authorities order placements of children in formal care, these structures are often very weak and do not reach private and unregistered institutions, and it remains in many cases uncertain whether the actions taken are indeed in the child's best interest.

As a consequence of the struggles with controlling institutional care and in awareness of its adverse effects, many countries aim for a complete deinstitutionalization of orphans and other vulnerable children. They plan to transfer children to other formal care settings like formal family or kinship care, foster care, and adoption (Better Care Network, 2015; Better Care Network & UNICEF, 2015). Depending on the country, these forms of care are more or less common (Better Care Network, 2014; Chiwaula et al., 2014). For example, in Ghana and Liberia, formal family care options were underdeveloped and under-resourced (Better Care Network & UNICEF, 2015). In some countries, adoption and even foster care are not common due to cultural customs and attitudes. Again, the lack of resources leads to little data on and monitoring of these formal care settings in many countries (Better Care Network, 2014; Chiwaula et al., 2014; Riley, 2012; Walakira et al., 2015).

Besides the formal care system, many orphans in Sub-Saharan Africa live in informal family or kinship care. The data on and control of informal care is mostly nonexistent because such efforts exceed the capacity of the social welfare system (Better Care Network, 2014; Better Care Network & UNICEF, 2015; Chiwaula et al., 2014). Experts rate the informal care system as the traditional practice in most Sub-Saharan countries, yet it has become overburdened (SOS Children's Villages International & University of Bedfordshire, 2014). Some countries encourage voluntary registration of informal care in order to gather more information and to establish some control for informal care settings. However, most informal care settings are still unknown and un-surveyed. Often no mechanisms are available to protect the

children in informal care from abuse and neglect (Better Care Network & UNICEF, 2015).

In summary, countries in Sub-Saharan Africa have started to develop guidelines and monitoring systems. However, weaknesses of governance, and lack of resources and of comprehensive data, still lead to many children living in inadequate care settings. Deinstitutionalization per se may not be the solution to this problem, when institutional care is discontinued without first ensuring sufficient care quality in alternative settings. Thus, because institutional care will remain part of the care system at least medium term, it is of extreme importance to improve the conditions for children in institutional care (Better Care Network & UNICEF, 2015; Chiwaula et al., 2014; McCall, 2013).

3 Prevalence of Abuse and Neglect

Most children in Sub-Saharan Africa, orphans and non-orphans, frequently experience physical and emotional violence (UNICEF, 2014). Though the UN Sustainable Development Goal Nr. 16.2 "end abuse, exploitation, trafficking and all forms of violence and torture against children" has a target for ending all forms of violence against children (United Nations, 2016), only seven (e.g., Benin, Kenya, Togo) of the 54 states in Africa fully prohibit violence against children in all settings. Yet, also in these states prevalence rates of violence against children are still very high, for example, with prevalence rates of physical punishment in the past year of over 50% in Kenya or the Republic of Congo. Overall, one quarter of Africa's children live in the seven states (e.g., Eritrea, Nigeria, Tanzania) that do not prohibit violence against children in any setting (Global Initiative to End All Corporal Punishment of Children, 2016a, 2016b).

Therefore, it is not surprising that research studies repeatedly reported that physical violence and harsh discipline methods (e.g., spanking or beating with objects) and emotional violence (e.g., insulting, humiliating) are highly prevalent in Sub-Saharan Africa (Feinstein & Mwahombela, 2010; Straus, 2010). For example, UNICEF (2014) reported that more than 7 in 10 children between 2 and 14 years of age in Sub-Saharan Africa experience violent disciplining. With more than a quarter of children who experienced severe physical punishment (e.g., hit on the head, face, or ears, or hit hard and repeatedly), worldwide the highest levels of violence against children at home are concentrated in Sub-Saharan Africa. Also school corporal punishment remains widespread in many states in Africa (Global Initiative to End All Corporal Punishment of Children, 2016b). In a recent study in Tanzania, nearly all children reported that they had experienced corporal punishment at some point during their lifetime both in family and school (Hecker, Hermenau, Isele, & Elbert, 2014). Half of the respondents reported having experienced corporal punishment by a family member within the last year. Accordingly, in a national, representative survey in Tanzania, the majority of adolescents (almost 75%) reported exposure to physical violence and one quarter to emotional maltreatment (UNICEF, 2011).

Concerning orphans in different care settings, the findings on childhood abuse and physical punishment are diverse. Qualitative studies have documented cases of the emotional and physical abuse of orphans in community-based care (Morantz, Cole, Vreeman et al., 2013). UNICEF reported from a household-based national survey in Tanzania that approximately 70% of orphans in family or kinship care reported physical abuse and about 30% reported emotional abuse during childhood (UNICEF, 2011). The orphans reported higher rates of emotional abuse but not of physical abuse than non-orphans. Concordantly, child abuse was equally common for orphans and non-orphans in Eastern Zimbabwe (Nyamukapa et al., 2010). A recent meta-analysis of 10 studies from different African countries, such as Zimbabwe, South Africa, Kenya, and Uganda, examined whether orphans in family or kinship care were more likely to experience physical and/or sexual abuse compared to non-orphans in Sub-Saharan Africa. Findings showed that orphans were not more likely to experience physical abuse (OR = 0.96) or sexual abuse (OR = 1.25) compared to non-orphans (Nichols et al., 2014). The authors remarked that their research focused on orphans in family or kinship care and advocated for further research on child maltreatment in institutions.

Moratz, Cole, Ayaya, Ayuku, and Braitstein (2013) carried out a file review in Kenya analyzing the rates of experienced violence and abuse prior to institutional placement. They found that non-orphans were institutionalized more often due to maltreatment than orphans. Orphans reported lower rates of maltreatment prior to institutional placement, as they were mostly institutionalized due to poverty or a lack of suitable caregivers. However, other studies showed that children are not protected from further maltreatment in institutions. The already high rates of maltreatment experienced by children in the general population in Sub-Saharan Africa are often estimated to be even higher in institutional care (Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2014; UNICEF, 2014). Concordantly, we found high rates of maltreatment experienced by most of the children in studies in Tanzanian orphanages (Hermenau et al., 2011, 2014). In Benin, children in residential or institutional care reported regular corporal punishment (Chiwaula et al., 2014). In institutional care settings, underqualified and overworked caregivers, in particular, physically maltreat children, frequently use corporal punishment for disciplinary reasons (Chiwaula et al., 2014; SOS Children's Villages International & University of Bedfordshire, 2014). Thus, in addition to possible maltreatment in the family of origin and the often unresponsive and distant caregiving in institutional care, orphans are burdened with further experiences of maltreatment and corporal punishment in orphanages and other facilities of institutional care (Hermenau et al., 2011). Yet, the exposure to violence and other forms of abuse in institutional care have received comparably little attention (SOS Children's Villages International & University of Bedfordshire, 2014).

The Positive Outcomes for Orphans study examined institutionalized and family cared orphans and separated children in five low- and middle-income countries in Sub-Saharan Africa (e.g., Ethiopia, Kenya, Tanzania) and Asia (Gray et al., 2015). Most of the children were institutionalized when they were 5 years or older. Lifetime prevalence by age 13 of any potentially traumatic event, excluding loss of a parent,

was 91% in institutionalized children and 92% in children living with extended families. More than half of children in institutions and in family care had experienced physical or sexual abuse by age 13. Prevalence and incidence of potentially traumatic events were high among the surveyed children, but contrary to common assumptions, children living in institutions did not report more potentially traumatic events or more abuse than children living in family care. Gray et al. (2015) concluded that deinstitutionalization would not protect the children from further maltreatment and that protecting orphans and separated children from maltreatment is of high priority, regardless of the setting. They also hypothesized that the risk of maltreatment may be higher for younger children and they therefore need even more protection. We compared Tanzanian children who were institutionalized at birth to 4 years of age with a matched group of children who were institutionalized at 5–14 years of age (Hermenau et al., 2014). Results showed that early-institutionalized children reported more adverse experiences during their time in institutional care and a greater variety of mental health problems than did late institutionalized children. We concluded that adverse experiences in institutional care play an important, but negative, role for early-institutionalized children who instead need protection from these experiences as well as developmentally appropriate and nurturing care from adequately educated caregivers.

When focusing on neglect, however, orphans were generally more likely than non-orphans to go to bed hungry (Makame, Ani, & Grantham-McGregor, 2002), to be underweight (Miller, Gruskin, Subramanian, & Heymann, 2007), and to lack social support and basic needs (Puffer et al., 2012). Consistently, we systematically investigated orphans' experiences of maltreatment, and our findings revealed that orphans reported significantly more experiences of neglect, but not of abuse compared to non-orphans (Hermenau, Eggert, Landolt, & Hecker, 2015). Research on institutional childcare has documented poor caregiver–child ratios and inadequate caregiving as factors increasing the risk of physical and emotional neglect (Hermenau et al., 2011; Johnson et al., 2006).

4 Maltreatment and Mental Health Problems

Prior research, mostly from Western countries, showed that in addition to physical injury, child maltreatment is associated with a number of emotional and behavioral problems that begin in childhood but may last through adolescence and adulthood (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013). Adverse effects of child maltreatment include depression, anxiety disorders, substance abuse, and aggressive or delinquent behavior (Dube et al., 2003; Sugaya et al., 2012). In Tanzania, though a society in which harsh disciplinary methods are culturally normed and highly prevalent, we found a strong relationship between harsh discipline and internalizing as well as externalizing problems (Hecker et al., 2014; Hecker, Hermenau, Salmen, Teicher, & Elbert, 2016). Via internalizing problems, harsh discipline was also indirectly related to impaired cognitive functioning and school performance.

Furthermore, maltreatment has shown to be associated with differential methylation in the genes of the stress response axis (Hecker, Radtke, Hermenau, Papassotiropoulos, & Elbert, 2016). These findings emphasize the detrimental consequences of maltreatment based on both molecular and behavioral grounds.

As a consequence of parental loss, maltreatment in the family of origin, and further maltreatment in institutional care settings, orphans are at increased risk for mental health problems. For example, we found a positive relation between maltreatment and mental health problems in institutionalized children (Hermenau et al., 2011, 2014). Interestingly, the violence that children experienced in the orphanage (vs. the violence that children experienced in the family of origin) was positively correlated with mental health problems.

In a number of studies, evidence has shown that orphans living in African countries in different care settings suffer from more depressive symptoms (Puffer et al., 2012; Unterhitzenberger & Rosner, 2014), more internalizing and externalizing problems (Atwine, Cantor-Graae, & Bajunirwe, 2005; Wild, Flisher, & Robertson, 2011), and greater posttraumatic stress disorder symptom severity than non-orphaned children (Cluver, Gardner, & Operario, 2007; Puffer et al., 2012). Consistently, we found that orphans reported more depressive symptoms, posttraumatic stress symptoms, and aggressive behavior than non-orphans (Hermenau, Eggert et al., 2015). In our study, neglect, abuse, and stigmatization correlated with orphans' internalizing and externalizing problems and neglect and stigmatization with orphans' depression severity. Perceived stigmatization moderated the relationship between neglect and depression (i.e., the relationship was always positive, but it was much stronger when an orphan reported high levels of perceived stigmatization). These findings suggest that maltreatment and perceived stigmatization may play an important role in orphans' psychological distress. In sum, the review of the current literature clearly suggests that maltreatment in institutional care is one important risk factor that is associated with impaired mental health of orphans. Thus, improving the mental health of orphans in institutional care begins certainly with preventing further maltreatment in institutional care.

5 Necessity of Maltreatment Prevention Approaches in Institutional Care

Though a great majority of institutionalized children reported at least one adverse childhood experience during their time in institutional care, the current literature indicates that orphans in institutional care are not generally at higher risk to experience physical or sexual abuse compared to non-orphans or orphans in family or kinship care (e.g., Gray et al., 2015; Nichols et al., 2014). Yet, this is not surprising in countries, in which corporal punishment is legal, highly prevalent, and generally regarded as effective, such as in many countries in Sub-Saharan Africa (UNICEF, 2014). In these countries, the placement in institutional care does not represent a

protection from further maltreatment. On the contrary, corporal punishment in institutional care can add to the psychological burden of prior parental loss and possible adverse experiences in the family of origin. Therefore, protecting orphans from maltreatment in institutional care and in other care settings must be a high priority (Gray et al., 2015; SOS Children's Villages International & University of Bedfordshire, 2014).

Furthermore, quality of childcare has been shown to have a crucial impact on children's development and psychological adjustment, particularly for orphans with a history of maltreatment and trauma (Johnson et al., 2006). However, adequate care for orphans is often impacted by unfavorable caregiver–child ratios and in most cases poorly trained, overburdened personnel. This is the status quo in institutional care settings in countries with limited resources and large numbers of orphans, like in many countries in Sub-Saharan Africa (Hermenau et al., 2011; Hermenau, Kaltenbach et al., 2015; SOS Children's Villages International & University of Bedfordshire, 2014).

In a recent systematic review, we investigated the effects of structural interventions and caregiver trainings on child development in institutional environments (Hermenau, Goessmann, Rygaard, Landolt, & Hecker, 2016). The 24 intervention studies reported beneficial effects on the children's emotional, social, and cognitive development. Yet, only four of these studies have been conducted in Sub-Saharan Africa (Espié et al., 2011; Hermenau et al., 2011; Hermenau, Kaltenbach et al., 2015; Wolff, Dawit, & Zere, 1995). Furthermore, very few studies focused on effects of interventions on violence and abuse prevention (Hermenau et al., 2016). Therefore, we argue that it is highly important to develop, implement, and scientifically evaluate interventions that aim at improving care quality and at the same time preventing abuse and neglect in institutional care in Sub-Saharan Africa (Hermenau et al., 2016; SOS Children's Villages International & University of Bedfordshire, 2014).

6 Interaction Competencies with Children: A Preventive Approach for Caregivers Improving Care Quality and Preventing Maltreatment in Institutional Care

6.1 Theoretical Background

The preventive intervention approach *Interaction Competencies with Children (ICC)* aims to improve adult–child relationships and to prevent maltreatment. Following *chronic stress hypothesis* (Johnson & Gunnar, 2011), the typical care environment in an institutional care setting is stressful for children because of the lack of a consistent, warm, sensitive, contingent caregiver, which otherwise would reduce the stressful nature of an insecure environment. Furthermore, ICC is based on *attachment theory* (Bakermans-Kranenburg et al., 2011). As a consequence of

parental loss, and the many and varying caregivers, institutionalized children often lack a secure, stable attachment to a caregiver. Attachment theory and chronic stress hypothesis both imply that long-term adverse effects might be avoided if caregiving in the institution were improved (McCall, 2013). Consistently, interventions aiming to improve care quality in institutional care have shown promising results (McCall, 2013). Nevertheless, interventions focusing on both improving care quality and preventing further maltreatment are scarce. Therefore, we expanded the theoretical foundation to elements from social learning, cognitive behavioral, and developmental theories. Besides prevention of neglect through strengthening attachment and bonding, ICC-C in institutional care additionally focuses on the prevention of harsh discipline and other forms of maltreatment. ICC-C has been inspired by the parenting guidelines of the American Academy of Pediatrics (The American Academy of Pediatrics, 1999) and the FairstartGlobal[1] training concept (Rygaard, 2010). As in low-income countries, particularly in Sub-Saharan Africa, the majority of children are institutionalized at the age 5 or older (Gray et al., 2015), we designed ICC-C for caregivers caring for children of preschool to primary school age and early adolescence (4–14 years).

6.2 ICC Training Workshop for Caregivers in Institutional Care

ICC-C has been designed as a 2-week training workshop (2 × 5.5 days) for caregivers working in institutional care settings. ICC-C offers a basic introduction to the essential interaction competencies in the work with children focusing mainly on warm, sensitive, and reliable caregiver–child relationships and nonviolent, warm, and sensitive caregiving strategies. ICC-C is guided by the following key principles:

- Participative approach: Trainees are invited to participate actively, to tailor the program, and to develop their own strategies on how to implement the training content in their daily work.
- Practice orientation: Practice units utilize the theoretical foundations to produce practical applications and skills that trainees can use in their daily work.
- Trustful atmosphere: Trainees are encouraged to talk openly about work problems and their own experiences of harsh punishment and maltreatment, with the aim of creating a trusting and open atmosphere assuring confidentiality.
- Sustainability: Sustainability of the training is ensured through intensive practicing, repetition of the new knowledge, self-reflection, and the training component *teamwork and supervision*, described below.

[1] http://www.fairstartglobal.com/

- Teambuilding and new ideas for games: To facilitate teambuilding and to exchange ideas that caregivers can use in their daily work with children, trainers and trainees suggest and play games, sing songs, or dance together.

ICC-C begins with a welcome session in which the expectations, wishes, and concerns of the trainees are explored. Seven core components form the content of ICC-C. They are conducted in the following order:

1. *Child development (3 sessions at 90 min)*: The aim of the first component is fostering empathy and understanding toward the children and enabling trainees to better assess the children's abilities, thus forming age-appropriate expectations. In the beginning, the trainees discuss the needs of children of different ages in a small-group brainstorming. The small groups discuss one of the following questions: *What does a child need to feel happy? What does a child need to be healthy? What does a child need to be good at school? What does a child need to be self-confident? What does a child need to be helpful and cooperative?* The short brainstorming should support the participants to look into the topic of children's needs. A short presentation of topics that came up in the small groups is followed by theoretical input about important steps in the physical, emotional, and cognitive development of children from infanthood to adolescence. The subsequent discussion relates the knowledge about child development to implications for the daily work with children of various ages. A small-group exercise helps trainees to practice forming age-appropriate expectations and caring approaches.
2. *Caregiver–child relationship (4 sessions at 90 min)*: This component aims to point out the importance of secure attachment and bonding as well as elements of how to establish and improve a caregiver–child relationship. In this way, this component aims to reduce or to prevent emotional neglect of the orphans in institutional care. During instruction of theoretical foundations, the importance of secure attachment and bonding for children is emphasized, and possibilities to improve attachment and bonding in institutional care settings are outlined. Subsequently, trainees in small groups elaborate on the implications of being a parental figure and role model for children living in institutional care (e.g., whose parents have died or are unable to care for them). They discuss the following questions in small groups: *Who are important role models in the lives of children? How do children learn from them*? The aim of the small-group discussion is that trainees may realize that children learn more from the caregiver's behavior in daily interaction than from their instructions. In the next unit, communication skills used in a warm, understanding, and sensitive manner are developed together with the trainees and practiced in role-plays. Subsequently, the trainees discuss and practice communicating clear and age-appropriate instructions in small-group discussions and role-plays. In role-plays, different ways of giving instructions are played through (e.g., shouting with a harsh voice, begging and discussion, clear and short instruction with a calm and friendly voice and full attention). By putting the trainees in the shoes of the children, the role-plays

sensitize the trainees to the importance of setting expectations in a realistic and supportive way for the success of the interaction.

3. *Effective caregiving strategies (8 sessions at 90 min)*: This component seeks to provide alternative caregiving strategies in place of harsh discipline and to reduce feelings of helplessness. It starts with a discussion about which caregiving strategies trainees consider useful and effective. As the trainees already have lots of experience in caregiving and working with children, their experiences and views should be valued and integrated in the training workshop. Subsequently, theoretical instruction including discussion of learning theory is used to introduce different strategies to aid in maintaining good behavior and to change misbehavior (e.g., logical consequence, reinforcement systems, privilege removal, behavioral contracts, time-out). Particularly, the role of attention as (unintentional) reinforcement is discussed. In the following units, these strategies are deepened and practiced in small groups using interactive elements such as role-plays. For example, in role-plays trainees practice both how to introduce time-out to the children they work with and how to use time-out in different situations. Reward systems (e.g., chore charts) are developed and adjusted for the use in their particular institutional care setting. Behavioral contracts that may facilitate the modification of certain problem behaviors of particular children are developed based on individual cases. In role-plays, the trainees practice discussing with children the problem behavior, the desired behavior, and the consequences, using the learned communication skills. This unit encompasses several sessions as these nonviolent caregiving strategies are adapted to specific contexts together with the trainees, practiced, and repeated a number of times to include these strategies in the active action repertoire of the trainees. Trainees' ideas about challenges that may occur when implementing new skills in their daily routine are discussed intensively, and potential adaptations that would facilitate implementation are developed together.
4. *Maltreatment prevention (7 sessions at 90 min)*: The aim of this component is to raise awareness of the detrimental consequences of harsh punishment and other forms of child maltreatment. This component is closely linked to the newly learned effective caregiving strategies. ICC-C emphasizes action alternatives as many caregivers use harsh punishment because they lack nonviolent techniques. By developing nonviolent caregiving strategies beforehand, trainees may be more open to question commonly used strategies. At the start of this unit, all trainees are invited to reflect on and share their own experiences of harsh punishment and maltreatment during childhood. First, trainees are invited to reflect individually on their childhood experiences of harsh punishment and maltreatment and the related feelings, but also their experiences of maltreatment in adulthood and related feelings. Trainees should also reflect how their own experiences of harsh discipline and maltreatment affect their own ways of punishing and treating the children they care for or their own children. In the second step, trainees are invited to share their experiences and thoughts with their fellow trainees. To create a trustful atmosphere, trainees agree that all information shared during self-reflection will be confidential and will not be shared with anybody outside

of the workshop. Self-reflection often helps to allow a personal discussion about potential risks and consequences of harsh punishment and other forms of maltreatment that is not so much influenced by societal attitudes. Furthermore, through self-reflection trainees are less likely to feel offended, which will reduce resistance. In the following discussion, common caregiving and discipline strategies in the country and culture are discussed. This also includes a discussion about legal aspects concerning harsh punishment in the home country of the trainees as well as in other countries, in which the use of any form of violence against children is illegal. Instruction in the theoretical foundation points out potential consequences of harsh punishment and other forms of maltreatment on behavioral, emotional, and cognitive development. Subsequently, common myths about corporal punishment are explored and discussed in small groups (e.g., *corporal punishment teaches respect, some children only understand corporal punishment, corporal punishment is time efficient*, etc.). To reinforce a change in attitude, the trainees are invited to reflect on their own use of harsh punishment toward children and their feelings when using harsh punishment. For most caregivers the use of harsh punishment is related to negative feelings. Yet, they are often not aware of these negative emotions. Spending some time for self-reflection may raise their awareness and thus help them to consider nonviolent action alternatives. In small groups and role-plays, trainees develop and discuss ideas, opportunities, and challenges for replacing harsh punishment with nonviolent caregiving strategies in their daily work.

5. *Supporting burdened children (7 sessions at 90 min)*: This component seeks to provide knowledge of common emotional and behavioral problems that children in institutional care may face. It also communicates that burdened children may not misbehave purposely, but rather that it is an expression of psychological problems. Furthermore, this component also aims to reduce the fears and helplessness of caregivers. Common emotional and behavioral problems, such as (traumatic) stress reactions, depression, oppositional and aggressive behavior, bedwetting, delayed development, and being HIV positive, are addressed. Strategies for handling such challenges are introduced and discussed. In small groups the trainees develop ideas and strategies to support particularly burdened children within their institutions. This component also leaves room for the caregivers to describe other common difficulties of at-risk children and to discuss strategies to support these children.
6. *Child-centered institutional care (7 sessions at 90 min)*: The aim of this component is to enable the trainees to realize changes that are possible in their own workplace which may improve the living conditions for children and working conditions for caregivers. In this way, this component aims to reduce or to prevent (emotional) neglect of the orphans in institutional care. Although structural changes are not generally implemented when conducting ICC-C, the importance of an adequate caregiver–child ratio; warm, sensitive, and stable caregiver–child relationship; and family-like groups is explained. In small groups, trainees compare the situations of children in families and in institutional care settings. In many institutional care settings in resource-poor countries, numerous children

live in large groups with few caregivers. Groups are often age homogenously organized, and caregivers are rarely assigned as primary caregiver for specific children. Theoretical instruction emphasizes key elements of institutional care settings that impact children's development, physical, and mental health. Subsequently, together with the trainers, trainees develop ideas about how to change their work environment to make the institutional care setting more family-like. Possible components that may be discussed are assigning each child to a primary caregiver, creating age-heterogeneous subgroups within a large institution and caregivers spending regular quality time with an assigned group of children. In small groups trainees discuss ideas, challenges, and strategies to introduce these key elements into their particular workplace. Furthermore, the importance of daily and weekly structures and schedules, rituals, and rules as a way to make life predictable for the children is introduced and discussed. In small groups, trainees develop ideas and strategies on how to implement the discussed aspects in their work environment. Further, the importance of play for a healthy development is emphasized. This may be increasingly important as in many resource-poor countries education has become a high priority and is seen as a promising approach to break the cycle of poverty, particularly for orphans and other vulnerable children. Therefore, even very young children spend most of their time learning at school or at their home. We stress that learning begins with playing and that for children, playing is more than leisure time and amusement but an important part of their healthy development. Other aspects like safety at home are also introduced and discussed.

7. *Teamwork and supervision (2 sessions at 90 min)*: This component covers improving immediate working conditions and ensuring the implementation of the training contents in the workplace. The importance of a good work atmosphere and supporting colleagues is discussed. Possibilities for peer supervision and where to seek help are discussed together with the trainees.

At the end of the first and second week, one session of 90 min should be used to repeat and highlight what the caregivers have learned and for an open discussion of questions from the group. The intervention ends with a feedback and session, including a farewell ritual.

6.3 Feasibility and First Empirical Evidence of ICC-C

In our recent feasibility study with caregivers in Tanzania (Hermenau, Kaltenbach et al., 2015), the participating caregivers rated the feasibility and effectiveness of ICC-C immediately before, directly after, and 3 months following the intervention. The trainers reported high satisfaction with the implementation of the units, the caregivers' participation, comprehension, and motivation. Consistently, caregivers reported a high demand, good feasibility, and high motivation and acceptance of the intervention. For example, none of the trainees had undergone any training in

childcare. Most trainees reported the frequent use of harsh punishment in their daily work with children, and most lacked nonviolent action alternatives to corporal punishment and yelling. But they were highly motivated to participate and had high expectations concerning the usefulness of ICC-C. Most trainees were highly satisfied with the application of the ICC-C training workshop, and all would recommend ICC-C to other caregivers. Three months after the training workshop, trainees reported the frequent use of the ICC-C content in their daily work. Almost all trainees described improvements in caregiver–child relationships, as well as in child behavior. Furthermore, we assessed exposure to harsh punishment and maltreatment, as well as the mental health of all children living in one institution from which all caregivers had been trained. The children were interviewed 20 months before, 1 month before, and 3 months after the training. Children reported a decrease in harsh punishment and physical maltreatment and a decrease in mental health problems. As such, ICC-C seems feasible under challenging circumstances, and our study provides the first glimpses of its effectiveness.

In an earlier study, we implemented a preliminary version of ICC-C in combination with structural changes and a psychotherapeutic treatment (Narrative Exposure Therapy for children; Ruf et al., 2010; Schauer, Neuner, & Elbert, 2011) for trauma-related illness in a Tanzanian orphanage (Hermenau et al., 2011). In response to all, children reported a decline in exposure to harsh punishment and violence by caregivers as well as in PTSD symptoms and related mental health problems. These findings indicate that caregiver training and structural changes may be combined with psychotherapeutic interventions to foster the mental health of heavily burdened and traumatized children.

6.4 Challenges During Implementation

ICC-C is designed to be applicable in low- and middle-income countries and has been particularly developed for its implementation in Sub-Saharan Africa with all its sociocultural similarities and diversities. Through its participative and adaptive approach that considers the particularly background and needs of both the caregivers and the childcare institution, *ICC-C* can be applied in countries with different cultural and socioeconomic background. However, due to limited resources in many of these countries, institutional care settings are often limited to offering only basic provisions of food and shelter and face major difficulties providing sensitive and child-oriented care. For example, unfavorable caregiver–child ratios (e.g., one caregiver caring for 20 or more children) and poorly trained, overburdened personnel rarely allow for sensitive caregiving that will meet the needs of children. Where it is not possible to secure funds necessary to hire more staff, ICC-C can enable caregivers to implement structural changes within the limited opportunities of the particular setting (e.g., creating family-like groups, assigning each child to a primary caregiver, introducing regular meetings within family-like age-heterogeneous

groups, etc.). However, the particular circumstances of the institutional care setting determine which and how many of the suggested changes can be implemented.

Many caregivers lack training in childcare as it is often assumed that everyone can raise children. Nevertheless, being a caregiver in African orphanages means raising children who are often burdened with various psychological problems. ICC-C may raise awareness of children's needs and may contribute to improvements in caregiver–child relationships. However, it does not replace long-term and in-depth training in effective child-rearing practices. Rather ICC-C reduces the gap in knowledge between what is required and what exists. Ideally, ICC-C should be implemented on top of a basic education in childcare in order to foster nonviolent caregiving.

It may be that the management of an institution chooses to implement ICC-C without consulting the caregivers. This could result in resistance to actively participate in the training workshop. Caregivers may experience a threat to their self-esteem when outsiders wish to educate them about how to deal with "their" children. Therefore, it is highly important to build trust. It is crucial that trainers adopt an open attitude that acknowledges the difficult work conditions of the trainees and the willingness to collaborate with them. Collegial learning, acceptance of cultural diversity, and empathy are vital here. Teambuilding activities and involving the caregivers and their feedback in the program design help to create an open and trusting atmosphere.

Changing long-standing norms is challenging, especially because the use of corporal punishment and other harsh discipline measures is very common, socially accepted, and generally regarded as effective in Sub-Saharan Africa and many regions throughout the world. Hence, trainees may confront the trainers with strong resistance toward rethinking disciplinary measures. However, involving the trainees in creating the change and formulating their own training may help to promote engagement in the process. Reflections about the caregivers' own experiences of harsh punishment and maltreatment, discussions about consequences of maltreatment for children, and intensive practicing of effective nonviolent caregiving strategies may facilitate a change of attitude regarding harmful discipline and maltreatment.

The support of the management staff of the childcare institution is crucial for achieving long-term sustainability. The management needs to support the ideas that are developed during the implementation of ICC-C and should provide room for peer supervision. Trainees may also become aware of their poor working conditions during ICC-C training. If the management is unwilling or unable to contribute to changes in working conditions, this may reduce the motivation to implement the newly learned strategies and potential structural changes. So, involving the management as well as the caregivers and promoting a dialogue between the different interests is essential to ensure long-term changes.

7 Practical Implication and Policy Recommendation

The demand for a change of policy and for guidelines on alternative childcare in general, and on institutional care in particular, in Sub-Saharan Africa is huge and progress is slow (Chiwaula et al., 2014). Most orphanages in Sub-Saharan Africa are run by nongovernmental organizations, and often there is no overall structure to ensure at least a minimal quality standard (Better Care Network, 2014). We argue that governments need to establish common practices and guidelines that apply to all childcare institutions to ensure a minimum of quality in childcare (Hermenau et al., 2014). Moreover, policies should include an obligation to adequately train caregivers (SOS Children's Villages International & University of Bedfordshire, 2014).

Many countries in Sub-Saharan Africa have signed the United Nations Convention on the Rights of the Child, yet this convention is only a declaration of intent. It remains unclear whether the weak governmental structures, the subordinate governmental priority, the strong societal resistance, or anything else impedes the application of the principles of the UN convention. Yet, fact is that violence against children occurs on a daily basis. That is why more than ever, programs improving caregiving in institutional care in these countries also need to address corporal punishment and maltreatment. An important step is to raise awareness of the consequences of poor and violent caregiving in institutional care among governmental agencies, child welfare systems, and nongovernmental organizations. The common belief still is that providing basic physical needs, such as food and accommodation, and sometimes education equals good caregiving. Policy makers and funding organizations need to become aware that caregiving is more than feeding and housing children and that warm, sensitive, and nonviolent caregiving lays the foundation for a healthy development.

The few scientifically evaluated intervention approaches that aim at improving institutional care settings have some important components in common: they all aim at improving the caregiver–child relationship (attachment and bonding), enriching the caregiving environment through additional stimulation and quality time, and have at least some focus on preventing maltreatment and further harm (Hermenau et al., 2016; McCall & Groark, 2015). When aiming to improve institutional childcare, governmental officials, institutional directors, and caregivers should focus on these core elements. A mandatory adequate caregiver–child ratio for all institutions is needed as orphans need more attention and positive emotional care by their caregivers. Poor caregiver–child ratios contribute to overworked caregivers who are then more likely to react violently toward children who need more assistance, are slower to move or react to instructions, or just try to get the caregivers' attention. Furthermore, overworked caregivers are at higher risk to emotionally neglect orphans due to limited time and capacity.

8 Conclusions

In this chapter we demonstrated once more that maltreatment is common in African childcare institutions and that its consequences have so far not been adequately addressed. While guidelines emphasize family and kinship care, many children in Sub-Saharan Africa remain in institutions. Consequently, a substantial number of children can benefit from improving the care quality in institutions. However, it is important to note that in countries, in which harsh discipline and violence against children are highly prevalent and generally regarded as effective, orphans living in institutions do not report more maltreatment than orphans living in family or kinship care. Also in family and kinship care, often no mechanisms are available to protect children from abuse and neglect (Better Care Network, 2014; Better Care Network & UNICEF, 2015). Therefore, the need for maltreatment prevention includes not only institutional care but also other alternative care settings. Deinstitutionalization can only be a medium- or long-term aim; meanwhile we need to put efforts into fostering nonviolent care in childcare institutions and other alternative care settings (e.g., Better Care Network & UNICEF, 2015; Hermenau et al., 2014; McCall, 2013).

From successful attempts to improve care quality and to prevent maltreatment in institutional care, we can conclude four important implications: (a) broad, theory-based prevention approaches are needed and should be tested using rigorous scientific standards, (b) although basic nutrition, sanitation, safety, and medical care are essential, responsive nonviolent caregiving is crucial to children's healthy development; (c) improving care quality (e.g., adequate caregiver–child ratio, ban of violent discipline, etc.) is more important than the type of care (institutional care vs. family or kinship care); and (d) beyond improving caregiver–child relationships, caregiver trainings in Sub-Saharan Africa (and elsewhere) should also focus on prevention of violence and abuse in institutional care (Hermenau et al., 2016; McCall, Groark, & Rygaard, 2014). With this chapter, we advocate for educating government officials, managers of childcare institutions, and caregivers about the adverse consequences of maltreatment and for training caregivers in nonviolent caregiving strategies to provide them with adequate and nonviolent action alternatives (Hermenau et al., 2014). The prevention of maltreatment in childcare institutions will enable more children in Sub-Saharan Africa and elsewhere to grow up in supportive and nonviolent environments, thereby helping them to develop in a healthy manner (Hermenau et al., 2016).

Questions for Discussion

- Which factors contribute to the high rates of violence and maltreatment in African orphanages? Explain why.
- Which elements of ICC-C may contribute to reduce violence and maltreatment in African orphanages? Explain why.
- Should care quality in institutional care settings be improved or should countries in Sub-Sahara Africa solely focus on deinstitutionalization? Why or why not?

References

Atwine, B., Cantor-Graae, E., & Bajunirwe, F. (2005). Psychological distress among AIDS orphans in rural Uganda. *Social Science & Medicine*, *61*(3), 555–564. doi:10.1016/j.socscimed.2004.12.018.

Bakermans-Kranenburg, M. J., Steele, H., Zeanah, C. H., Muhamedrahimov, R. J., Vorria, P., Dobrova-Krol, N. A., … Gunnar, M. R. (2011). III. Attachment and emotional development in institutional care: Characteristics and catch up. *Monographs of the Society for Research in Child Development*, *76*(4), 62–91. doi: 10.1111/j.1540-5834.2011.00628.x.

Better Care Network. (2014). *Alternative care assesment in 6 countries (Kenya, Malawi, Swaziland, Tanzania, Zambia, and Zimbabwe)*. Retrieved from http://www.bettercarenetwork.org/library/social-welfare-systems/child-care-and-protection-policies/alternative-care-assessment-in-6-countries-kenya-malawi-swaziland-tanzania-zambia-and-zimbabwe

Better Care Network. (2015). *Country care review Tanzania*. Retrieved from http://www.bettercarenetwork.org/international-framework/country-care-reviews/country-care-review-tanzania

Better Care Network, & UNICEF. (2015). *An analysis of child-care reform in three African countries. Summary of key findings*. New York, NY: Better Care Network and United Nations Children's Fund (UNICEF).

Carr, C. P., Martins, C. M. S., Stingel, A. M., Lemgruber, V. B., & Juruena, M. F. (2013). The role of early life stress in adult psychiatric disorders: A systematic review according to childhood trauma subtypes. *The Journal of Nervous and Mental Disease*, *201*(12), 1007–1020. doi:10.1097/NMD.0000000000000049.

Chiwaula, L., Dobson, R., & Elsley, S. (2014). *Drumming together for change: A child's right to quality care in Sub-Saharan Africa*. Glasgow, UK: SOS Children's Villages International, CELCIS at the University of Strathclyde, and University of Malawi.

Cluver, L. D., Gardner, F., & Operario, D. (2007). Psychological distress amongst AIDS-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *48*(8), 755–763. doi:10.1111/j.1469-7610.2007.01757.x.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, *111*(3), 564–572. doi:10.1542/peds.111.3.564.

Espié, E., Ouss, L., Gaboulaud, V., Candilis, D., Ahmed, K., Cohuet, S., … Moro, M.-R. (2011). Against the odds: Psychomotor development of children under 2 years in a Sudanese orphanage. *Journal of Tropical Pediatrics*, *57*(6), 412–417. doi: 10.1093/tropej/fmq117.

Euser, S., Alink, L. R. A., Tharner, A., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2014). Out of home placement to promote safety? The prevalence of physical abuse in residential and foster care. *Children and Youth Services Review*, *37*, 64–70. doi:10.1016/j.childyouth.2013.12.002.

Feinstein, S., & Mwahombela, L. (2010). Corporal punishment in Tanzania's schools. *International Review of Education*, *56*, 399–410. doi:10.1007/s11159-010-9169-5.

Global Initiative to End All Corporal Punishment of Children. (2016a). *Corporal punishment of children: Summaries of prevalence and attitudinal research in the last 10 years – Africa*. Retrieved from http://endcorporalpunishment.org/research/prevalence-research/

Global Initiative to End All Corporal Punishment of Children. (2016b). *Prohibiting all corporal punishment of children in Africa: Progress and delay*. Retrieved from www.endcorporalpunishment.org

Gray, C. L., Pence, B. W., Ostermann, J., Whetten, R. A., O'Donnell, K., Thielman, N. M., & Whetten, K. (2015). Prevalence and incidence of traumatic experiences among orphans in institutional and family-based settings in 5 low- and middle-income countries: A longitudinal study. *Global Health, Science and Practice*, *3*(3), 395–404. doi:10.9745/GHSP-D-15-00093.

Hecker, T., Hermenau, K., Isele, D., & Elbert, T. (2014). Corporal punishment and children's externalizing problems: A cross-sectional study of Tanzanian primary school students. *Child Abuse & Neglect*, *38*(5), 884–892. doi:10.1016/j.chiabu.2013.11.007.

Hecker, T., Hermenau, K., Salmen, C., Teicher, M., & Elbert, T. (2016). Harsh discipline relates to internalizing problems and cognitive functioning: Findings from a cross-sectional study with school children in Tanzania. *BMC Psychiatry*, *16*, 118. doi:10.1186/s12888-016-0828-3.

Hecker, T., Radtke, K., Hermenau, K., Papassotiropoulos, A., & Elbert, T. (2016). Associations between child abuse, mental health and epigenetic modifications in the proopiomelanocortin gene (POMC): A study with children in Tanzania. *Development and Psychopathology*. doi:10.1017/S0954579415001248.

Hermenau, K., Eggert, I., Landolt, M. A., & Hecker, T. (2015). Neglect and perceived stigmatization impact psychological distress of orphans in Tanzania. *European Journal of Psychotraumatology*, *6*, 28617. doi:10.3402/ejpt.v6.28617.

Hermenau, K., Goessmann, K., Rygaard, N. P., Landolt, M. A., & Hecker, T. (2016). Fostering child development by improving care quality: A systematic review of the effectiveness of structural interventions and caregiver trainings in institutional care. *Trauma, Violence, & Abuse*. doi:10.1177/1524838016641918.

Hermenau, K., Hecker, T., Elbert, T., & Ruf-Leuschner, M. (2014). Maltreatment and mental health in institutional care – Comparing early- and late-institutionalized children in Tanzania. *Infant Mental Health Journal*, *35*(2), 102–110. doi:10.1002/imhj.21440.

Hermenau, K., Hecker, T., Ruf, M., Schauer, E., Elbert, T., & Schauer, M. (2011). Childhood adversity, mental ill-health and aggressive behavior in an African orphanage: Changes in response to trauma-focused therapy and the implementation of a new instructional system. *Child and Adolescent Psychiatry and Mental Health*, *5*(1), 29. doi:10.1186/1753-2000-5-29.

Hermenau, K., Kaltenbach, E., Mkinga, G., & Hecker, T. (2015). Improving care quality and preventing maltreatment in institutional care – A feasibility study with caregivers. *Frontiers in Psychology*, *6*, 937. doi:10.3389/fpsyg.2015.00937.

Inter-agency Group on Child Protection Systems in Sub-Saharan Africa. (2012). *Strengthening child protection systems in Sub-Saharan Africa* (Working paper).

Johnson, D. E., & Gunnar, M. R. (2011). IV. Growth failure in institutionalized children. *Monographs of the Society for Research in Child Development*, *76*(4), 92–126. doi:10.1111/j.1540-5834.2011.00629.x.

Johnson, R., Browne, K., & Hamilton-Giachritsis, C. (2006). Young children in institutional care at risk of harm. *Trauma, Violence, & Abuse*, *7*(1), 34–60. doi:10.1177/1524838005283696.

Levin, K., & Haines, S. (2007). Opportunities for the development of communicative competence for children in an orphanage in South Africa. *Child Care in Practice*, *13*(3), 221–237. doi:10.1080/13575270701353564.

Li, X., Naar-King, S., Barnett, D., Stanton, B., Fang, X., Thurston, C., & Turston, C. (2008). A developmental psychopathology framework of the psychosocial needs of children orphaned by HIV. *Journal of the Association of Nurses in AIDS Care*, *19*(2), 147–157. doi:10.1016/j.jana.2007.08.004.

Makame, V., Ani, C., & Grantham-McGregor, S. (2002). Psychological well-being of orphans in Dar es Salaam, Tanzania. *Acta Paediatrica*, *91*(4), 459–465. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12061364

McCall, R. B. (2013). The consequences of early institutionalization: Can institutions be improved? – Should they? *Child and Adolescent Mental Health*, *18*(4), 193–201. doi:10.1111/camh.12025.

McCall, R. B., & Groark, C. J. (2015). Research on institutionalized children: Implications for international child welfare practitioners and policymakers. *International Perspectives in Psychology: Research, Practice, Consultation*, *4*(2), 142–159. doi:10.1037/ipp0000033.

McCall, R. B., Groark, C. J., & Rygaard, N. P. (2014). Global research, practice, and policy issues on the care of infants and young children at risk: The articles in context. *Infant Mental Health Journal*, *35*(2), 87–93. doi:10.1002/imhj.21441.

Miller, C. M., Gruskin, S., Subramanian, S. V., & Heymann, J. (2007). Emerging health disparities in Botswana: Examining the situation of orphans during the AIDS epidemic. *Social Science and Medicine*, *64*, 2476–2486. doi:10.1016/j.socscimed.2007.03.002.

Morantz, G., Cole, D., Vreeman, R., Ayaya, S., Ayuku, D., & Braitstein, P. (2013a). Child abuse and neglect among orphaned children and youth living in extended families in Sub-Saharan Africa: What have we learned from qualitative inquiry? *Vulnerable Children and Youth Studies*, *8*(4), 338–352. doi:10.1080/17450128.2013.764476.

Morantz, G., Cole, D. C., Ayaya, S., Ayuku, D., & Braitstein, P. (2013b). Maltreatment experiences and associated factors prior to admission to residential care: A sample of institutionalized children and youth in western Kenya. *Child Abuse & Neglect*, *37*, 778–787. doi:10.1016/j.chiabu.2012.10.007.

Nelson Mandela Children's Fund. (2016). *Nelson Mandela quotes about children*. Retrieved from http://www.nelsonmandelachildrensfund.com/nelson-mandela-quotes-about-children/

Nichols, J., Embleton, L., Mwangi, A., Morantz, G., Vreeman, R., Ayaya, S., … Braitstein, P. (2014). Physical and sexual abuse in orphaned compared to non-orphaned children in Sub-Saharan Africa: A systematic review and meta-analysis. *Child Abuse & Neglect*, *38*(2), 304–316. doi: 10.1016/j.chiabu.2013.09.012.

Nyamukapa, C. A., Gregson, S., Wambe, M., Mushore, P., Lopman, B., Mupambireyi, Z., … Jukes, M. C. H. (2010). Causes and consequences of psychological distress among orphans in eastern Zimbabwe. *AIDS Care*, *22*(8), 988–996. doi: 10.1080/09540121003615061.

Puffer, E. S., Drabkin, A. S., Stashko, A. L., Broverman, S., Ogwang-Odhiambo, R., & Sikkema, K. J. (2012). Orphan status, HIV risk behavior, and mental health among adolescents in rural Kenya. *Journal of Pediatric Psychology*, *37*(8), 868–878. doi:10.1093/jpepsy/jss077.

Riley, M. (2012). *Baseline study: The state of institutional care in Uganda*. Kampala, Uganda: Departments of Youth and Children, Ministry of Gender, Labour and Social Development. Retrieved from http://alternative-care-uganda.org/resources/moglsd-baseline-study-institutional-care-in-uganda-june-2012.pdf.

Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children. *Journal of Traumatic Stress*, *23*(4), 437–445. doi:10.1002/jts.20548.

Rygaard, N. P. (2010). Designing the fair start project – A free E-learning and organizational development program for orphanages and foster families in quality caregivning. *Clinical Neuropsychology*, *7*(6), 181–187. Retrieved from http://www.clinicalneuropsychiatry.org/pdf/02_rygaard.pdf.

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative Exposure Therapy (NET). A short-term intervention for traumatic stress* (2nd ed.). Cambidge, MA/Göttingen, Germany: Hogrefe & Huber Publishers.

SOS Children's Villages International, & University of Bedfordshire. (2014). *From a whisper to a shout: A call to end violence against children in alternative care*. Insbruck, Austria: SOS Children's Villages International.

Straus, M. A. (2010). Prevalence, societal causes, and trends in corporal punishment by parents in world perspective. *Law and Contemporary Problems*, *31*, 1–30. Retrieved from http://scholarship.law.duke.edu/lcp/vol73/iss2/2.

Sugaya, L., Hasin, D. S., Olfson, M., Lin, K., Grant, B. F., & Blanco, C. (2012). Child physical abuse and adult mental health: A national study. *Journal of Traumatic Stress*, *25*, 384–392. doi:10.1002/jts.21719.

The American Academy of Pediatrics. (1999). In E. L. Schoor (Ed.), *Caring for your school-age child: Ages 5 to 12* (Rev.). New York, NY: Bantam Books.

UNICEF. (2006). *Africa's orphaned and vulnerable generations: Children affected by aids*. New York, NY.: Retrieved from http://www.unicef.org/publications/files/Africas_Orphaned_and_Vulnerable_Generations_Children_Affected_by_AIDS.pdf.

UNICEF. (2011). *Violence against children in Tanzania: Results from a National Survey 2009*. Dar es Salaam, Tanzania: UNICEF. Retrieved from http://www.unicef.org/media/files/VIOLENCE_AGAINST_CHILDREN_IN_TANZANIA_REPORT.pdf.

UNICEF. (2014). *Hidden in plain sight – A statistical analysis of violence against children*. New York, NY: United Nations Children's Fund.

United Nations. (2016). *Open working group proposal for sustainable development goals*. Retrieved from https://sustainabledevelopment.un.org/sdgsproposal.html

Unterhitzenberger, J., & Rosner, R. (2014). Lessons from writing sessions: A school-based randomized trial with adolescent orphans in Rwanda. *European Journal of Psychotraumatology*, *5*, 24917. doi:10.3402/ejpt.v5.24917.

Walakira, E. J., Dumba-Nyanzi, I., & Bukenya, B. (2015). *Child care institutions in selected districts in Uganda and the situation of children in care: A baseline survey report for the strong beginnings project*. Kampala, Uganda: Terres des Hommes Netherlands. Retrieved from http://www.anppcanug.org/wp-content/uploads/research_reports/2015/Baseline_Survey_Report_Full.PDF.

Wild, L. G., Flisher, A. J., & Robertson, B. A. (2011). Risk and resilience in orphaned adolescents living in a community affected by AIDS. *Youth & Society*, *45*(1), 140–162. doi:10.1177/0044118X11409256.

Wolff, P. H., Dawit, Y., & Zere, B. (1995). The Solomuna orphanage: A historical survey. *Social Science & Medicine*, *40*(8), 1133–1139.

Wolff, P. H., & Fesseha, G. (1998). The orphans of Eritrea: Are orphanages part of the problem or part of the solution? *The American Journal of Psychiatry*, *155*(10), 1319–1324. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9766761

Wolff, P. H., & Fesseha, G. (1999). The orphans of Eritrea: A five-year follow-up study. *Journal of Child Psychology and Psychiatry*, *40*(8), 1231–1237.

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