

**Reviving child care practices: Can a child be disciplined without a stick?**

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## **Abstract**

To create conducive conditions for the care of children is high on the international agenda. In 2006 the UN Secretary General presented a global study on violence against children (Pinheiro, 2006). The report clearly states that every society must stop all violence against children, “whether accepted as ‘tradition’ or disguised as ‘discipline’”. In the present paper we reflect on ways to enhance empathy and sensitivity towards children, to protect them from abuse and neglect. As part of action-oriented research in the Kilimanjaro region, Tanzania, a project was developed in partnership between the researchers and a local women’s grassroots organisation, KIWAKKUKI (Women against AIDS in the Kilimanjaro region). The Kilimanjaro region is severely affected by the HIV/AIDS pandemic, and the resources for care have long been overstretched. The objective of the project is to reactivate and strengthen good caregiving practices. The core of the project is an adaptation of the International Child Development Programme (ICDP) to the local context. Working methods include sensitising caregivers to children’s needs for positive interaction within an empathic and caring relationship. Among the most frequently reported outcomes of participation in the project is the abandonment of corporal punishment of children. This paper explores some of the steps in this process of change, by giving examples from two phases of the project: 1) the participatory training of 21 facilitators and 2) the 21 facilitators’ own work as change agents in their communities.

### **Global vs. local attitudes towards corporal punishment**

Normative recommendations from the UN exert strong pressure on nations to enact legislation banning abusive practices. Among these practices is the corporal punishment of children, a common strategy for disciplining children in the area of the present project, the Kilimanjaro region in Tanzania. Like at least 106 other nations in the world, corporal punishment is allowed in schools and in the penal system in Tanzania (Global Initiative to End all Corporal Punishment of Children, 2006). It is commonly feared that children will lose respect for their caregivers and elders if they are not beaten, and that the children will become impossible to control. In addition disciplining by beating is often seen as positive for the child's development, a view that fits well with the internationally popular proverb "spare the rod, spoil the child".

Corporal punishment has been defined as "hitting, striking, wounding, or bruising a dependent child for the purpose of punishing, disciplining or showing disapproval" (Ember & Ember, 2005). As a disciplining strategy it is used in 75 % of the world's societies (Ripoll-Nunez & Rohner, 2006), usually as part of a wider range of disciplining approaches. Whether or not corporal punishment is detrimental to the child's development is a highly debated topic. In research there have been a number of conceptual and methodological problems. In particular, simple associations between frequency/severity and outcome are drawn, without considering issues of for instance parental warmth, communication and the child's experience of fairness as third variables. Definitions of the phenomenon have also varied widely across the research designs, confounding results by a lack of clear boundaries between corporal punishment as such, and abuse/neglect (Ripoll-Nunez & Rohner, 2006).

In the new report on violence against children (Pinheiro, 2006), ending corporal punishment is said to require a change in the "mindset" of societies. Even if Tanzania as a nation should accept the recommendations, it is still a long, and complex process to "change the mindset" of local communities and caregivers. In the local community, the perceived imposition of western values and practices is strongly apprehended. This is accompanied by an emotional intensity that also relates to the former colonial rule, and the fact that changes in child care practices not only touch the core of the culture, but also the design of the culture's future society. In addition western children are held to be disrespectful and selfish, portraying

values and behaviour that are not wanted. The supposedly “universal” values underlying the UN recommendations as well as the Convention on the Rights of the Child are at the best seen as dubious. This form of apprehension is not only a local phenomenon, it is well known from other collective and authoritarian societies as well (Dawes, 1999; Dawes & Cairns, 1998; IICRD & ABLO, 2004; Nsamenang, 1999; Nsamenang & Dawes, 1998; Wainryb, 2004).

The global fight against violence towards children is well justified indeed. Our concern is how such a global crusade can be fought without jeopardizing existing local systems of care and socialisation. If already burdened caregivers feel left out and ostracised they may resume doing more of what they used to do - or simply abdicate their role as allegedly mistreating caregivers. Being fragile under the present burden of HIV/AIDS, sub-Saharan societies need all the support they can get. One in four children live with an adult in need of medical care due to HIV infection (Bauman et al., 2006), and 12 million children have lost either father, mother or both due to HIV/AIDS in the region (UNAIDS, 2006). Compared to non-orphaned children, orphaned children more often live in female-headed households, in larger households with more children depending on fewer caregivers, and with heads of the household being considerably older (Monasch & Boerma, 2004). Some fend for themselves, in child-headed households or on the streets. There is a constant struggle to keep orphaned and vulnerable children within the empathic protection of families and communities, to defy the processes of marginalisation that makes them subject to exploitation and abuse. Caregivers and communities struggle to cope with two major concerns: To protect their children in a risky environment, and to keep on believing that it is possible to give good care to the steadily increasing numbers of orphaned and vulnerable children.

If interventions are to be meaningful in the present situation they have to address the dominant problems related to socialisation and child development, as they are experienced and interpreted locally. The starting point for our joint project was the realisation of an increasing gap developing with regard to care: Children’s needs for protection, sensitive care and communication increase while the capacity of communities and caregivers to meet these needs decrease. One of the results is more abusive patterns of child care, as is often seen when stress increases and there is rapid social and cultural change (Hundeide, 2001b).

HIV/AIDS affected and orphaned children are particularly vulnerable to poverty, stigmatisation, exploitation and abuse, (Evans, 2002, 2005; Foster & Williamson, 2000; Makame, Ani, & Grantham-McGregor, 2002; Shetty & Powell, 2003) and they often lack of access to education and health services (Bicego, Rutstein, & Johnson, 2003; Burke & Beegle, 2004; Tungaraza & Sutherland, 2005). Interventions have focussed mainly on meeting socioeconomic needs, which is easier than more demanding, culturally based psychosocial interventions (Foster, 2002). However, the orphaned children's need for love and psychosocial support is widely acknowledged, likewise that this is best achieved in a family surrounding, with the care of committed and affectionate adults (Foster, 2002; Mrumbi, 2006; Richter, 2004; Richter, Foster, & Sherr, 2006; Richter, Manegold, & Pather, 2004; Subbarao & Coury, 2004; UNAIDS, UNICEF, & USAID, 2004). Such supportive care is seen as the key to children's ability to recover and to cope:

“Emotionally responsive caregiving, confident parenting, and warm and supportive family relationships are fundamental to children's achievement, adjustment and wellbeing. The inner circle of proximal influences on children is so strong that, if these break down, they can cause problems for children independently of external stressors. Similarly, positive experiences outside of the family, while helpful to children, may have little long-term beneficial effect if countered by ongoing negative family relationships” (Richter, Foster, & Sherr, 2006, p.47).

The aim of our project is to reactivate and strengthen empathic care for children in this difficult context; hence corporal punishment or violence towards children is not directly targeted. However, one of the most frequently reported outcomes so far from caregivers participating in the project is that they stop beating the children in their care. In this paper we explore the process leading to this outcome. Particular attention is given to the challenge of finding a common ground across cultural gaps, and to the process of changing practices without undermining the traditional building blocks of child socialisation in the region; the intergenerational structure of authority and the collective efficacy in care and protection.

**The project: Mawasiliano na malezi ya mtoto (Communication with, and care for the child)**

KIWAKKUKI (Kikundi cha Wanawake Kilimanjaro Kupamana na Ukimwi) is a women's grassroots organisation fighting the spread of HIV/AIDS. Presently they have more than 6000 members in 169 branches. They serve the entire Kilimanjaro region, where the main population belongs to the Chaga tribe. Their mission is to sensitise and educate the community on HIV/AIDS related matters, and to facilitate the provision of services to those infected and affected by HIV/AIDS in order to control the spread of HIV/AIDS and its effects. They have a wide range of activities organized in five departments, and are funded through international and national donors. The Orphan Department is presently supporting 11.000 orphaned and vulnerable children by a variety of activities like income generating projects, support to pay school expenses, distribution of food. The present focus on the psychosocial component reflects the recommendations in the external evaluation from Lie and Lothe (2002).

The origins of the present project stem from the experiences and knowledge of the KIWAKKUKI staff and volunteers, and a study on care-conditions and children's psychosocial development in the region (Snipstad, 2003; Snipstad, Lie, & Winje, 2005). The starting point was the many obstacles to good care that follow the HIV/AIDS pandemic; increasing poverty and the daily struggle to meet needs, traumas and the break down of community function and structure. Lack of resources and stress make caregivers feel inadequate and overwhelmed. Frustration, anger and negative conceptions of the child easily follow when it is hard to meet the child's needs adequately, and difficulties preoccupy the mind. The main working methods of the project is to enhance caregivers' self-confidence by pointing out the positive caring skills they already possess, and help them to redefine their negative perceptions of their child, and so facilitate a natural empathic process of care and sharing. A positive and playful, but also respectful relationship between caregiver and child is the goal. These assumptions are in concordance with the International Child Development Programmes (ICDP) (Hundeide, 1991, 2003a, 2003b), and through participatory seminars this program was expanded and adjusted to the local context and present challenges.

ICDP is a psychosocial program directed towards caregivers and networks of care, aiming to improve the quality of interaction and the relationship between caregiver and child. One important feature is to build on the local culture and to reactivate indigenous child rearing practices. The program is community based, using local resource-persons who are trained to work with groups of caregivers. The caregivers' capacity for positive care is vitalized through facilitative work in groups. The program is intentionally made simple so that caregivers of any background can utilize its principles about basic psychosocial care for children. At the same time the program summarizes current scientific knowledge about child care and development (Hundeide, 2005).

*The process of finding a shared vision*

There is naturally scepticism and apprehension towards 'foreign ideas' when 'wazungu' (Europeans) come to hold training sessions in childcare for 21 adult participants, of whom the majority has raised their own children. This was the case regardless of the joint effort in planning the project, and the participatory form of the training. In order to find some common ground to work from, we started with discussions on what a 'good child' is in the region. Obedient and respectful came on top, and the list became long as the participants eagerly filled in their views. The list resembled how African socialisation has been described in the literature (Rwezaura, 1998):

“Thus children were socialised and brought up to respect parents and others in position of authority or who are their seniors, to be courteous and generous to strangers, to respect their equals and to show politeness to their juniors, to display moderation and control over their instincts and emotions; and more generally to be hard working, trustworthy, sincere and kind to others” (op.cit p. 256)

The next step was to discuss what is held to be good quality care in Tanzania. In the context of rapid changes due to HIV/AIDS on top of the processes of modernisation and globalisation, work in groups was facilitated on the topic of important values and traditions in child rearing, both past and present. The problems of today were mainly attributed to the HIV/AIDS pandemic; with increased poverty, decreased accessibility to manpower and the

heavy burdens of taking care of many orphans. The current lack of love and time to be with the children were emphasized. The particular challenges in the relationship between caregivers and children were also described; “Previously children were respectful towards adults, but nowadays they don’t respect the limits set by their caregivers<sup>1</sup>.” Many expressed surprise when they realised how different childcare had become from what they themselves had experienced. Increased abuse and neglect were particularly mentioned. They also emphasized how the whole community took care of children previously, a practice distorted by ongoing process towards individualisation of responsibilities. The discussion on these topics was enthusiastic, and there was agreement that the present situation was tough both for caregivers and children. The importance of re-establishing positive interaction and good care emerged clearly as a shared vision. From there we moved on to the question of how we could work towards such a goal in a culturally appropriate way. Through group work and plenary discussions the participants agreed on a good outline for the project.

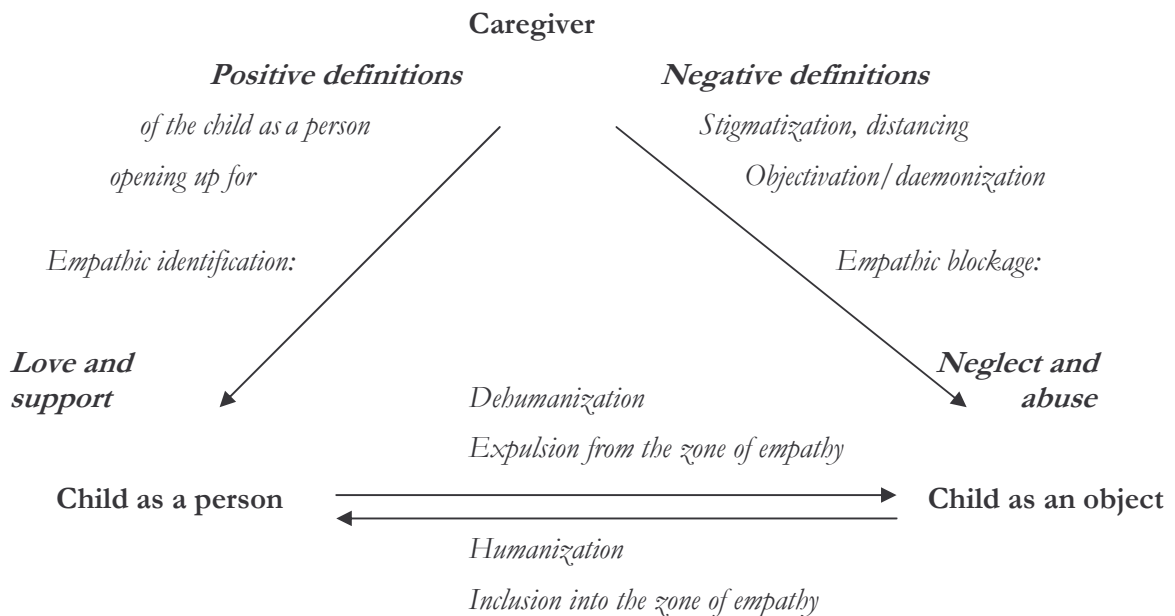
### **Raising awareness and reactivating empathy and sensitivity towards children**

The participants themselves went through the same process that they later facilitated in groups of caregivers in the communities, in order to become facilitators of more positive relationships between caregiver and child. Focusing on empathic awareness and responsiveness to children’s needs, the starting point was a discussion on the way our concept of a child influences our care for the child. The concept of ‘empathy’ is complex, and involves both an emotional and a cognitive element. One difficulty with regard to definitions of the concept is that they tend to be either process or outcome oriented (Davis, 1994). Here we will use ‘empathy’ both to describe the process through which the individual take the perspective of the other person, emotionally and/or cognitively, and the outcome of this process, whether it is an emotional response or a more accurate cognitive understanding of the other. Figure 1 illustrates the process of empathic inclusion or exclusion, in ICDP the expression to ‘include or expel a child from our zone of empathy’ is used (Hundeide, 2006)

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<sup>1</sup> This is not a rare phenomenon; it has been described through the history of most cultures, also the Chaga. In his classical anthropological text Raum (1940) described how Chaga youth acquire some of the European patterns of life: “Parents complain that their children do not listen to their advice, that they consider their school knowledge superior to traditional lore, that their conduct destroys tribal morality”

**Figure 1: The child as a person and the child as an object.**



Positive and negative labelling of a child contributes to our perception of the child, and influences our empathic responses. The participants discussed the most frequently used labels in the community, both positive and negative. They described how these labels often are clearly expressed in front of the child: “You lazy and naughty boy, you pig! Come and help me with this task!” The participants were also asked to point out positive characteristics of the children in their care and worked on redefining negative labels. In order to see the child as a person with intentions and feelings various supportive exercises was introduced:

- Interpreting photos showing different facial/non-verbal expressions of children: “What do you think the child thinks/feels?”
- Interpreting locally made drawings from typical situations where children need adult guidance and support, for example a child observing a funeral without being included, a child arriving to a new home, a child observing a sick person vomiting Questions include: “What happens here? What do you think the child thinks/feels in this situation? How can the child be supported?”
- Exercises where the participants were asked to think about their own childhood experiences: “How did you as a child think/feel in such a situation?”

The objective of using these exercises, and to spend several days on this topic, is that our schemas, or “working models” (Bowlby, 1988) of child care are mainly formed through our own experiences as a child. The schemas develop sub-consciously, and are seldom brought to reflective awareness. Consequently they are difficult to revise. In order to go back and explore childhood memories and to reflect on ways we function as caregivers for our own children these schemas need to be activated. The next step was discussions on features of caregiver-child interaction. The structure of these discussions was eight guidelines for good interaction as they are expressed in the ICDP programme. The guidelines are presented below, illustrated by their positive and negative pole (Hundeide, 2001a, 2003b).

### A bipolar dimensional presentation of the guidelines

<b>Positive pole:</b>	<b>Negative pole:</b>
1. Showing positive feelings of love	Showing negative feelings, rejecting the child
2. Following or responding to the initiative of the child	Imposing your own intentions and wishes on the child’s activity
3. Establishing a positive personal dialogue - verbal non-verbal	Not communicating with the child - ignoring him/her.
4. Praising and giving confirmations to the child	Discouraging and disconfirming the child
5. Helping the child to focus and share experiences	Distracting and confusing the child with conflicting experiences
6. Conveying meaning and enthusiasm to the child’s experience	Being silent and indifferent to the child’s experiences of the world.
7. Expanding and enriching the child’s experience by explanations, comparisons and fantasy	Being silent or only stating what is present and needed at the moment Do not take time to explain
8. Regulating and guiding the child’s actions and projects. Setting limits for what is allowed in a positive way. Giving alternatives for action.	Ignoring the child – laissez faire attitude, letting the child act as he wishes without any interference, support or limit. <sup>2</sup> Stating what he cannot do only

<sup>2</sup> Another negative version of the same guideline is commanding the child in an insensitive way, ignoring his needs and wishes.

These guidelines are not introduced as instructions for how to give good care, but as starting points for discussion and exemplification. The assumption is that all caregivers intuitively follow similar ways of interaction and care, if this natural way of caring has not been obstructed by poverty, sickness, stress or other difficulties. The participants were asked to give examples from their own caregiving practice, by observing ones own positive interaction with the children in the household over the weekend, and bring back examples to share with the group. They were also asked for examples from their childhood; how they remembered their caregivers and their own reactions in similar situations. In addition to their own examples, photos and video clips were used as starting points to discuss and analyze interaction between caregivers and children in different daily situations.

As mentioned, corporal punishment is not a main focus in the programme. However, guideline eight addresses the child's need for regulation of behaviour, focussing on how limits may be set for the child in a positive way. The reason for this guideline being the last to be introduced is that it builds on the others, through which the caregiver and the child have already established a relationship of love and guidance. A lot of ideas were given from the participants on how they themselves used positive limit setting: Leading the child in the right direction, saying no with explanations, negotiations with older children and so on. It is noteworthy that before this discussion the participants' idea was that their only way of regulating children's behaviour was spanking and slapping. They were not consciously aware of all the other strategies they also possessed and used. Hidden knowledge and the rich cultural variety of strategies for disciplining children were brought forward through these discussions. That various ways of disciplining is part of the Chaga culture is also described by Raum (1940):

“..parents realize the law of growth and the transience of their authority. They see the necessity of varying the instruments of control and of granting to their child an increasing amount of freedom.” (Op.cit. p. 292)

One particular exercise was to share with the group one episode from their childhood where they were beaten by their caregivers, and try to remember their thoughts and feelings

connected to the situation. Strong emotions and empathy with children were awoken during this exercise. The sharing of the episodes in the group afterwards built a strong cohesion and group feeling of corporal punishment as an unnecessary practice, and exclamation like: “We are beating our children as we if we are trying to kill a snake!” were given. Eager exploration started in order to understand how this practice had developed. With surprise they concluded that “this is not within our original culture, it has escalated and come to the frequency and intensity it has today during the harsh colonial rule, where beating became part of everyday life”. Even if corporal punishment had existed before, the extensive use and intensity as it is used today were not recognised as a customary practice. Hundeide (2001) describes the potential destructive character of a long period of alienation from cultural values and practices:

“Sometimes these (established) practices may degenerate or they may be overlaid and replaced by more alien and abusive patterns. In such cases the original practices may only exist as potentials or as dormant patterns of care and mediation (that can be reactivated)” (op.cit p. 8).

#### *Implementation of the project*

The 21 facilitators have established groups of caregivers in ten wards in the region, and so far 120 caregivers have attended the groups. The process in the groups has been similar to the process of sensitisation the facilitators themselves experienced during the seminar; focusing on building a trustful relationship between the facilitator and the group members, activating the group members by exercises, discussions and home tasks, verbalising good child care through the eight guidelines for good interaction and affirming the good practice of care-giving presented by the group members.

In order to implement the program, it was essential to get support from the community leaders. Not all were initially positive to implementation of the project: “Some of them were like resisting, thinking that we are now bringing a western culture to the community, but after a long talk and explanation they realised that we are not imposing a western culture to the community, it is just like talking about the good care we normally give to these children and strengthening the caregivers”. Afterwards all facilitators got the needed support, and the

community leaders contributed in the process of selecting caregivers to participate in the groups. The criteria included families in need of support, like caregivers with many orphaned and vulnerable children in the family. In addition, people with influence in the community were selected. The groups consisted of both women and men, even if childcare in Tanzania is mainly a responsibility of women. Since KIWAKKUKI is a women's organisation the inclusion of men was of particular importance. They are well aware of the need for men as active caregivers in the households.

In the following we will describe the process and the outcome in the groups in the words of one of the facilitators. The example is one of many similar stories from the groups:

*"We have seen many changes, for example one man (widower, with five children) who was very harsh and beating the children. Even the neighbours said: "When this man comes home, the children just run and hide, because they know they will be beaten without any reason". He was very angry with them (the children), because his wife was dead. And if the children asked: "What are we going to eat?" then they got beaten before they got an answer. He was one among those selected by the community leader, because of the hard time these children were having from their parent. In the first meeting he was very harsh, and he did not want to talk about rearing the children. He felt he could manage by beating - then the children behaved as he wanted them to, even if they were very far from him. At the first meeting he was very harsh, but at the second meeting he was a bit somehow listening to the other group members contributing to the meeting and giving examples from their own end. Then he said: "I am going to try these examples that I have heard from my friends in this group and the facilitators." He started to think about how he was going to introduce this subject, and how he was going to practice this in his house: "I am going just to practice, and then I will see." After a week, the next meeting, he came with a story: "You know, I can sit with my children now, laughing, and I can talk with them." I (the facilitator) asked him: "How did you manage to sit with your children?" He said: "I am not beating them again. I ask them what I want them to do, and they are doing it. I have learned from this group that if you want your child to do something, you don't ask them rudely or don't push them. You call them politely, talk with them, give them the reason why you want this to be done. They will see the reason, and they will do it without any problem. And these children have changed to my side now: I can call them, I can tell them what I want them to do, and I give the reason why I want this to be done, and they are now working with me hand in hand. I think I will continue trying, and then I will manage to do without beating them." And after two more meetings he said: "My home is a peaceful home now. When I come, every child is now within the house, and they say: what are we going to do today, father, what am I going to do, and*

*everybody is now doing whatever I want them to do. And I am happy because I can sit with them and joke. It didn't happen before." And even this father, one day he said he wanted to cry, because: "At first I was thinking that you are just joking or saying things that are impossible in this group. But it is a real thing that can help people. Can you call more people to listen what you are telling us, bring more people because my neighbours want to know what has happened in my house, and I cannot explain to them as you are doing it here. Expand this!" he is asking."*

The project has now indeed reached the level where it will be expanded. 13 of the 21 facilitators have been trained as trainers, and are in the process of training 72 new facilitators.

**Table 1: The reach of the project by the end of October 2006**

VENUE	ADULTS			CHILDREN		
	MALES	FEMALES	TOTAL	BOYS	GIRLS	TOTAL
<b>Kisamo</b>	1	11	12	27	38	65
<b>Mwanga</b>	1	11	12	34	51	85
<b>Same</b>	2	10	12	31	42	73
<b>Rombo</b>	3	9	12	40	62	102
<b>Hai</b>	2	10	12	33	47	80
<b>Msaranga</b>	4	8	12	20	36	56
<b>Majengo</b>	4	8	12	15	24	39
<b>Njoro</b>	6	6	12	19	27	46
<b>Nganyeni</b>	2	10	12	34	51	85
<b>Bondeni</b>	5	7	12	17	27	44
<b>TOTAL</b>	<b>26</b>	<b>94</b>	<b>120</b>	<b>270</b>	<b>405</b>	<b>675</b>

### **Mechanisms in the process of change**

The facilitators were asked to sum up the key factors and mechanisms leading to success. Their answers are presented and discussed below.

#### **1. Good collaboration with the community leaders/local anchoring**

Anchoring of the project in the local community is seen as essential in order to achieve success. As the facilitators point out, the community leaders were initially sceptical; some were closely monitoring the activities in the groups, until they were reassured that the activities fitted within the local ways of caring for children. To impose values and practices

unfamiliar to the culture and local community will inevitably raise apprehension and feelings of alienation. Transparency about the vision, the methods and the aims were important to get the support of the local leaders. Once they were supportive both the project and the ideas were accepted, and common ground was found. Today the community leaders are requesting KIWAKKUKI to expand in order to reach more caregivers, as they see positive changes in the community. Anchoring the project locally also means that the local community owns the project themselves.

Likewise, in the first phase of the project the success and sustainability of the project relied on a participatory approach, from the planning phase throughout the training period. The participants of the project have themselves defined the challenges, the structure and methods of work and the values of caregiving that we should strive towards. To enable such a participatory process has included, in addition to respect and sincerity, to work meticulously on translation issues and the language used – to make sure that the concepts used give the same meaning to everyone in the project.

## 2. Trustful atmosphere in the groups / secrets are kept within the group

The facilitators took time and effort initially to establish the rules for the group, of respect, listening and positive feedback. From the start the participants were active in defining these rules, which contributed to establish a sense of equality among the group members. To share personal examples from family life in a new group demands that the participants feel assured that the examples are well received, treated respectfully and not spread as gossip. Openness and sharing of personal examples from the facilitators' side also contributed to achieve this atmosphere in the groups.

## 3. Use of sensitising methodology in contrast to instructing new strategies

Related to a participatory and inclusive process is the use of sensitising methods, in contrast to instruction. This is probably essential to achieve the results we have seen in the families participating in the program. Asking for the participants' opinions and examples of good quality care activates the experiences and knowledge, and they become aware of their own "hidden knowledge".

### a. Testing strategies at home between meetings

By testing out strategies at home and reporting the results in the group, the knowledge and skills is internalised as the caregivers' own. Knowledge and ideas from the group discussions are thus transformed to fit within the individuals' practical life. The use of pressure/instruction to use new strategies in child socialisation can give a feeling of alienation and create dependency of experts and manuals / ready-made answers. By activating the caregivers to find their own answers their problem-solving skills are enhanced, and positive values and traditions in child rearing are reactivated. Thus the process in the groups becomes one of empowerment.

b. Meeting regularly in groups, sharing experiences

An important factor for success seems to be sharing of experiences in groups. By sharing experiences and ideas, different perspectives on caregiving emerge. The caregivers expand their understanding and motivate one another to test new ideas, as well as their repertoire of actions for care. When telling an example from daily life in the group, the individual's experience grows into a narrative dimension. Furthermore, by sharing the story with someone else and by getting their responses, the narrative is given added meaning by affirmation from the others in the group, and comes to include the dimension of competence on the side of the caregiver. In this process the caregiver's self-confidence is strengthened. An additional effect of telling the story of success in the group is that the caregiver is more committed to use the alternative strategies he or she has found useful. The fact that experiences are to be shared in the next meeting may also contribute to developing "stop mechanisms" for beating and harsh treatment. Through repeated trials and positive experiences these stop-mechanisms become internalised.

c. As mentioned above, affirmation of the caregiver's already existing skills and competence is an important part of the process of facilitation. When the caregiver has become aware of his own competence, he is encouraged to trust this capability so that he can make use of it. From the facilitator this is done by asking questions, showing interest and enthusiasm: "How did you manage to ... your child?" This is especially important in a situation where the caregivers experience heavy burdens

related to childcare, making them feel inadequate and often overwhelmed in their role as caregivers.

#### 4. The facilitators share their own personal examples in the group

The facilitators point to the fact that their use of a personalized style of communication in the groups is important in order to achieve results. The use of personal examples that is shared with the members of the group, implicates that the facilitator is no expert, but is on the same level as the participants. Her role is to facilitate the group process, not to teach the participants new strategies. In this way her expert role is minimized, and the caregivers' experiences are focused more.

#### 5. Enthusiasm, home visits and follow-ups

The intensity of the intervention is important to keep people in the process. Eight weekly meetings for each group of caregivers is the goal. However, the groups who have finished eight meetings all want to continue to be a part of the project, and have made their own meetings to create songs and dramas in order to share their good experiences with the community. Follow-up by home visits and meetings after the eight group meetings are also important to keep the motivation and enthusiasm alive. By these various activities behavioural change is sustained.

Another important aspect of success is that the facilitators themselves have experienced the importance of being sensitive to the children's needs. They express that they know from their heart that this is important, and they are very committed to, and enthusiastic about their work with the groups. Their genuine and enthusiastic way of facilitation and support make the project "stand out" as important to the caregivers. Networks are built both between the facilitators and the groups of caregivers. These networks are useful for support, for exchange of experiences, for new ideas and for learning new skills in running the groups. However, it is important to notice that sensitisation takes time, as one of the facilitators expresses: "It is a long process, and we take it as a process, because you cannot change things immediately."

## **Conclusion**

The facilitators see the project as one of great relevance in the present-day situation, where the environment is seen as one of high risk to children and youth due to the HIV/AIDS pandemic, and caregivers are sought after high and low to cater for orphaned and vulnerable children. The heavy tasks the caregivers take on needs to be seen and appreciated, also internationally, in a consistent manner. In international reports and policy documents the fundamental intergenerational structure and collective efficacy in child care of the East African countries is rarely a topic. Neither are possible adverse effects of an enforced process of change of child caring practices. When children are targeted and empowered to enforce the ban on corporal punishment caregivers and elders experience this as undermining their authority and endangering their ability to fulfil their role as protectors of children. We argue that the effort to create better and more conducive care environments for children need to be a multi-cultural and joint exercise. Rogoff (2003) advises us to avoid thinking in terms of “switching” from one cultural system to another. Pointing to the benefits of learning from each other’s ways, she argues that there is no need to assume that other (or our own) communities’ ways are simply either noble or barbaric. Similarly Hundeide (2001) points out:

“Any viable culture seems to have, in some forms, its own narrative and dramaturgical resources, ways of mediating, style of caring and bringing up children that are packaged into traditional practices and the challenges that human beings in that society have to face” (op.cit s. 8)

The facilitators and the caregivers who have participated in the groups have absorbed the ideas of positive interaction with great speed, enthusiasm and joy. This could hardly be so if a process of learning something new needed to take place. On the contrary good practices of care have been revived and adapted to the present challenges.

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