



International Child Development Programmes

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This is a collection of some earlier papers written between 2001-2004. K.H.

Some general ICDP principles for intervention

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In this paper I try to state some general principles of development and change that are as applicable in the context of caregiver-child interaction and care as in the field of treatment of traumatic experiences as well as in community participation and development. The principles of development and change seem to be roughly the same although there are modifications to the different contexts.

1. Facilitation

Instead of intervening in the traditional way by importing an external program into a cultural environment that may be in conflict with the program's assumptions, there is an alternative strategy, namely that of facilitation and reactivation of cultural practices and initiatives in the relevant field.

Facilitation implies that there is some seed of initiative and activity in the recipient/participant (which can be person or a community) that can serve as a basis for further reactivation, support and extension. Therefore the first action in a process of facilitation is to assess what are the existing resources, initiatives and activities that can be expanded and developed further. Especially in the psycho-social field most mechanisms of human care are usually, in some form, part of a community's (or family's) cultural tradition and practice, therefore the first step is to identify these mechanisms and support and extend them - when that is needed. This is another kind of intervention, because it is more like an extension through facilitation of existing initiatives, and not an intrusion of something new and possibly alien.

Facilitation can take place as "guided participation" where the facilitator joins in with the recipient and expands and enriches her initiatives (Rogoff 1990, Wood 1996), or it can be through consciousness-raising where the recipient is made aware of her existing potential skills for coping, or the emphasis may be on confirmation and encouragement of what they are already doing.

In a context of community development, facilitation may involve identification and support of existing networks and institutions that may cope with the present challenge at a community level (Hundeide 1991).

We also assume that working in this direction may initiate a developmental process that is in tune with existing cultural patterns and initiatives and therefore more sustainable than interventions that are not adjusted to local conditions and practices.

2. Reciprocity and sharing of experiences as a basis for facilitation and care

In order to get access to existing resources and initiatives, it is necessary to become a partner in the recipient's world ("phenomenal world" is also used) and this implies that one has to operate according to the principles of reciprocity and dialogue.

This implies first of all respect for the recipient (child, mother, victim or community) and his initiatives and practices, conceptions and values, willingness to listen and to receive his experiences and to respond back in a way that is meaningful in relation to his or her world of understanding. (Patin 1986).

This principle applies just as well to an interaction with a baby as with a traumatised subject who has been exposed to extreme situations of stress, or to a new community. In all such cases there has to be a willingness to listen and share and then respond back in a meaningful way based on the initiatives of the other. This is the principle of dialogue instead of dominance and monologue (Jaregg 1994, Rommetveit 1996).

In a psychosocial context sharing should also take place at a non-verbal level as **attunement to the emotional state and timing of the other** - and such sharing or synchronisation of feeling states seems to have a consoling and opening effect both on babies and on victims exposed to traumatic experiences.

Thus creating an atmosphere of reciprocity and sharing is a precondition for getting into contact with the recipient's world of experiences that constitute the basis for further development.

3. Sharing of meanings and narratives of what happened

Sharing does not stop at the level of attunement of states of feeling; it also involves simple sharing by identifying and describing what and how one experiences the surrounding world. This is very important with babies and young children (Klein and Hundede 1989). At a later stage the sharing of meanings may involve sharing of world-views, opinions. Thus becoming a partner in another person's world thus goes beyond sharing of feelings into sharing of "what happened?" Sharing of conceptions, stories, ideas and values.

For a traumatised person it is particularly important to be able to identify, share and recount what happened so that the experience is clarified and made predictable/controllable and may, in this way, help to desensitise associated fears and anxieties. For this reason most traumatised victims have a need to recount and share their story of the traumatic event either through telling or through different modes of symbolisation or art expression. Through support and guidance cognitive control may gradually be gained over the traumatic experience.

In a similar way a baby gains cognitive control of his environment, through labelling, sharing and confirmation of meaning from significant others in his surroundings.

In a more general sense, sharing of meaning in the sense of symbolising or narrating the way people understand their experiences and their problems, is also the key to solutions that are not imposed from the outside, but in tune with the recipients' needs and interpretive background

This applies also to community participation - appropriate solutions are generally extension of existing ways of understanding...

4. Guided expansion of existing initiatives and activities of the client

In order for development to take place, sharing may not be enough; guidance and expansion of the participant's initiatives and activities may be necessary. As the Russian psychologist Vygotsky maintained, there is always a "zone of proximal development" where further development can take place if sensitive assistance is given. In the case of young children an important form of assistance is what we call "expansion", that is expanding the child's initiatives beyond the present situation, giving explanation and telling stories etc. We know from research that this is essential for a child's cognitive development (Carew 1980, Schaffer 1996).

But in order for expansion to take place without intrusion, the caregiver or "guide" has to operate inside the child's phenomenal world of meaning according to the principle of facilitation, reciprocity and sharing. This is sometimes described as a **participatory approach** or **guided participation** (Rogoff 1990), where the caregiver guides the child through hints and questions that points out a direction for the child's

exploration and discoveries - inside the potential of the child's phenomenal world and resources. On this basis it is possible to expand further with explanations and hints...

The same principle also applies also to traumatised subjects; they are invited to participate in a curriculum that will guide them through a process of expressing, sharing and reconstructing a traumatic event. In this context concrete alternative ways of understanding what happened may be suggested that are more acceptable to the person's self-respect and developmental initiatives. But also in this case the advice has to be based on insight into the victim's world, his perception of his situation and the developmental potential or trajectories that originate in his definition of his situation.

5. Gaining mastery and control through self-initiated activity and through taking an active, responsible role

Any kind of assistance whether it is through therapy or parental guidance or developmental aid, is fraught with the danger of dependency (Hundeide 1991). Therefore an important principle in all "assisted learning" (Tharp and Gallimore 1987) or "scaffolding" (Wood 1996) is reversal or transfer of control. That is handing over control to the participant (i.e. child. or victim). In an early phase of assistance, usually the teacher or guide may play a dominating and modelling role, but as the participant's competence grows, control is gradually transferred so that he in the end has the feeling of mastery and self-initiated control.

Throughout the whole process of assistance there should be the underlying intention that the participant at end is going to master the operation by himself. Therefore **preparation for autonomy is an important part of the assistance.**

Therefore if a child is going to gain mastery of his situation, he has to exercise "being in control" through his own self-initiated activity and projects. Through such guided experiences children learn to explore reality and to trust their own initiatives. Confirmation from caregivers is important in this process.

In the context of trauma, taking on an active role for example in helping other victims seems to be a therapeutic principle that helps the victims to gain control (Ayalon 1988). But being active does not necessarily involve taking a new role; even a more modest process of exploration and search may slowly create a basis for autonomy and for taking on a more responsible role at a later stage.

In the case of community development this principles is extremely important: at the same time as guidance and training is given in line with participants' phenomenal world of meaning and understanding, there is at the same time a preparation for taking over so that at the end, when assistance is withdrawn, key-persons in the community is prepared to take over with sufficient competence and autonomy to continue the activity that was started. This is preparation for sustainability in the psychosocial field, which is very often neglected. Training in the skill itself is not enough.

6. Operating inside the cultural system of norms, values and worldviews

As already mentioned, facilitation implies that there already exists some initiative, some intention that can serve as a basis for expansion. This implies at a community level that we operate in line with the existing resources, customs, skills and values. Child rearing is an example of a skill that is not only individual, but deeply embedded in normative family and community traditions (LeVine 1990) that we have to take into account if we wish to promote a developmental process that is "appropriate" and sustainable over time.

This applies also to trauma; most societies have traditional ritual procedures for how to cope with persons in states of mourning after loss. Such rituals are deeply ingrained in people's psychological reactions, and it is therefore important to map such cultural coping mechanisms and promote and facilitate those that are still relevant along with other suitable methods. If not, if we approach a traditional population with modern therapeutic methods that may upset their sense of dignity and honour, ignoring the extended family system

of care, we may easily end up by "making things worse" as was pointed out in a recent conference in Nairobi.

7. An interpretative approach - assessing conceptions of world and positive resources

Basically what has been suggested in this paper is what has been called an interpretative approach (Geertz 1980, Hundeide 1987).

In order to facilitate a client's initiatives, we need to know him "from the inside" - how he sees the world what are his basic goals, needs and intentions. Along these lines, it is the child, the caregiver, the client or the key persons in the community, who are their own best interpreters and guides for further development. This is an important principle both ethically and psychologically. It is only when we know how a person sees the world and define his situation that we can start to **understand his behaviour as meaningful reactions to the way the world appears to him or her**. It is important to add here that how a person defines his situation is more than a purely cognitive assessment, it includes all his commitment, emotions, fears and anticipations..... Therefore the assessment of his definitions and conceptions of the world become very important, because it is these, not the physical stimuli, that constitutes the basis both for his external actions and for his psychological reactions - happiness and sufferings.

Only through understanding how victims of war experience the traumatic situation can we understand their reactions as plausible and meaningful, in the sense that "if I had been there I would have reacted similarly". This approach therefore puts special emphasis on respecting the victim's experience and on getting the more subtle nuances of their perception and interpretation of what they have been going through. This is an approach different from presenting a list of symptoms with automatic prescription of treatment.

But such assessment requires patience, respect and empathy - willingness to listen - and to take seemingly nonsensical manifestations as expressions of a meaningful but divergent understanding his reality.

In addition to knowing how a person sees his world, his interests, initiatives and commitments, one also needs to know his existing patterns of competence or coping skills that are available, in order to facilitate development.

This can be achieved through presenting the person with practical situations where his skills are exposed, like in interactive situations between mother and child where the interactive skills of the mother is exposed through video-recordings in real everyday situations. Or it can be achieved through role-playing a stress-situation that simulates the real situations. Also interviewing the subject can be useful, like asking the victim what they felt helped and disturbed them when they were in the stressful situation.

The point is to arrive at **an assessment of the positive resources** that can serve as a practical basis for intervention in "the zone of proximal development" where trajectories of already existing initiatives, competencies or skills can be facilitated to further perfection or to a more healthy relationship to ones surroundings. We can only arrive there by focusing on the positive resources, not on the failures and deficiencies. A person's **developmental potential** is thus based on the commitments, initiatives and resources he is able to mobilise for worthwhile life-goals within his phenomenal world.

The path of healing is thus contained within the client's own phenomenal world; his understanding of his situation, his relationships and his conception of the future, on the one hand, and within the initiatives, resources and the commitments he is able to mobilise for something to live for within this world - on the other.

In fact this point of view is as valid for the development of communities as for persons.....

PRINCIPLES OF IMPLEMENTING THE ICDP PROGRAM IN A NEW COMMUNITY OR INSTITUTION

Human care is not a complicated skill, it is something basic in human life that most persons are doing, like the three dialogues and the guidelines of good interaction, but due to stress, negative definitions and stigmatizations of the child (or victim/client) these basic social skills/competencies are often prevented from being practiced when they are most needed. Therefore it is important to create a positive and confident atmosphere where the caregivers feel at ease and where they can open up and express their feelings for their child.

As already pointed out, in order to promote empowerment and prevent dependency, the ICDP program uses a facilitative strategy of training where we, instead of correction and focusing on failures, *point out the positive sides that already exist in the caregiver's interaction with her child. In other words, we try to reactivate their existing positive patterns of care and reconfirm these in such a way that the caregivers' competence and confidence in himself as carer is sustained and strengthened.* This is an important principle in our training.

In addition, in order to promote change in the practical activities like caring for a child, it is not enough to talk and instruct, in order for a change to take place in practice, ***self-initiated practical caring activity is necessary.*** *Therefore those who go through our sensitization courses have to carry out a series of exercises in the form of observations, self-evaluations, testing out different initiatives (the guidelines) and reporting back is important in order to promote attitudes of agency and efficacy in the caregivers.*

Below is a summary of the principles and the sequences we follow when we sensitize or train caregivers:

- Establishing a contract of trust with clear information about the program and the course - both demands and advantages
- Restoring a positive redefinition of the child (see pages 4 to 6)
- Pointing out and confirming positive features in the caregiver's interaction and relationship with her child
- The guidelines of good interaction and the three dialogues provide a common language and frame of reference for sensitization (see page 6 to 14)
- Activating caregiver in relation to the guidelines through different exercises, also homework
- Sharing experiences of caring for own children in groups based on the guidelines of good interaction with other caregivers in a similar situation so that an enthusiastic committed atmosphere develops
- Using a personal and interpretive way of communicating with examples and stories that invites a caring positive attitude to their children.

All this is taking place in groups between 5 to 15 caregivers.¹

¹ For more details see Armstrong 2002, Hundeide 1996, 2000, 2001.

Going beyond caregiver-child interaction to mobilising community and networks of care.

The ICDP principles as stated above refer primarily to the *proximal* conditions that influence the child's experience directly, like the definition/conception of the child and the quality of caregiver child interaction indicated in the three dialogues, but there are also *distal* or secondary conditions like availability of caring alternatives, level of poverty, workload of the caregiver and size of family, housing and crowdedness, family and survival stress, quality of health, availability of adequate nutrition and water, social and health policy priorities etc. All these factors constitute "framing conditions" that influence the way the proximal conditions operate in relation to the child. If the distal framing conditions degenerate, like increase in poverty, it may be difficult proximally to sustain an adequate level of psycho-social care and quality interaction between caregiver and child.

Therefore it is necessary in most cases to intervene at other levels also in order to open up and sustain the quality of care between caregiver and child.

In the table below four levels of intervention are indicated:

Table 3 Intervention to improve psycho-social care can take place at 4 different levels ²:

<ol style="list-style-type: none">1. Intervention can be <i>individually</i> directed to the quality of care and interaction with the suffering child directly - in a traditional clinical way2. Intervention can be directed towards sensitization of the caregivers' and <i>families'</i> interaction with the child(ren)3. Intervention can be directed towards <i>community</i> - mobilization and awareness raising preventing risk behavior, or more directly; finding practical solution of new caring arrangements from extended family, foster care, to institutions/orphanages or support to child headed families.4. Intervention can be directed at the <i>policy level</i>, improving economic conditions of families and children, human and children's legal rights etc Advocacy
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As the table indicates, the ICDP Principles can be used in an individual clinical way by interacting directly with a withdrawn and traumatized child (see ICDP Film from Angola). This is very much in line both with clinical work in the object relations tradition (Fonagy 2001) and with research within early mother-child communication (Trevarthen 1992, Stern 2000, Tronick 1989, Klein 1992 and Rogoff 2003). A simple and idealized description of these forms of interaction is provided through the three dialogues and the eight guidelines of good interaction. This is what most people associate with the ICDP Program.

But the ICDP Program also provides guidelines for how the Program can be implemented through a community based strategy where resource persons in the community are trained to transfer this competence to caregivers and networks of care inside the community so that the impact becomes much wider and greater than through individual clinical intervention. In a development context this is the only realistic way of working, as expertise for individual consultation will not be available.

In summary we can say there are five modes of intervention in the ICDP Program these are summarized in the table below:

² There are different models for how interaction is embedded in wider societal systems (Bronfenbrenner 1979, Super & Harkness 1986, Sameroff & Fiese 1990, Mc Loyd 1990, Kagitcibaci 1996, Cole 1996, Rogoff 2003).

Table 4: Summary of five ICDP methods of intervention.

ICDP Modes of intervention:	Level of interaction Family-care	Local community	National policy
1.Redefinitions and focussing on the positive resources	<i>To counteract a negative conception/ image of the child and stigmatization</i>	Mobilization to counter-act stigmatization	Raise awareness mobilization to counter-act stigmatization media, radio, TV
2.The emotional Expressive dialogue (4 guidelines)	<i>To promote love and affectionate care, trust and self-esteem</i>	Raise awareness for the need for affectionate care for vulnerable children	Raise awareness for the need for affection and care – media, radio, TV
3.The comprehension dialogue of meaning/expansion (3 guidelines)	<i>To expand the child understanding of the world and his situation (narrative memory work also)</i>	Counteract prejudice and provide information/ stories, education that facilitate hope	Advocacy, policy and priority setting of psychosocial care for children
4.The regulative dialogue/ limit- setting	<i>To help the child organize, plan and regulate his life, develop self-control</i>	Create settings and opportunities where children can act in collaborative and organized ways ...	“
5. Principles of sensitization – how to train/sensitize facilitators and caregivers	<i>Sensitize primary caregivers in how to use the 1-4 principles above in everydaylife</i>	How to train and sensitize community facilitators who train primary caregivers	“

As the table shows, these modes of intervention can be applied at the interactive level of caregiver child, at the level of community and at the national level of policy, advocacy and human/children’s rights, although the focus and emphasis in the ICDP Program will be on the interactive level.

How the program is implemented in practice.

Before any implementation of a program can be initiated, in a community, in an institution or in a family, certain conditions need to be in place, like *carrying out a situation and needs assessment, deciding what will be the target group, mapping the situation, and the goals of the intervention, getting access, selection key-persons to be trained, identifying the conditions that may block or prevent the implementation of the project.*

As a competence building organization we generally work, not so much with individuals, as with communities, with established local networks/ organizations dealing with children at disadvantage

Below are some principles that we apply before starting the implementation of a project:

- Collect available statistics and relevant information on the state of the target group – what are the macro-factors contributing to reduced quality of care and neglect?
- Ways of getting access to the community have to be investigated in each case – usually through some influential local persons or organizations already established and working there.
- Focused-group interviews with key informants, parents, nurses and social workers in the community on these issues – the local conceptions of what are needed and relevant, local conception of why things go wrong...

- Interviews with both caregivers and children on their conceptions of children and ideal child care – parental assessment of their child(ren)
- Visiting typical families in the community and mapping a typical day of a child through observation and interview – routine activities and interactions when, with whom, why, how etc.
- What are the potentials for promoting better care inside the child’s everyday context – the child’s developmental niche?
- What are the obstacles?
- Before training starts there need to be a clear plan of intervention with material and manuals prepared both for caregivers and facilitators.
- In the first training (in a region) it is important to select and include resource persons who are committed and can become future facilitators and trainers
- We generally work in groups with caregivers. The meetings last about 2 hours and they usually follow a clear agenda inside which there is participatory activity. The sequence of meetings can be from 10 to 20 every week or every fortnight
- Follow up after the training is finished is essential in order to sustain the results achieved. This may go on for a year after the training is finished.

In addition to these preparatory principles, we have also some **principles of implementation** that need to be investigated before implementation starts. This is important because *the impact of a program is not only dependent upon the quality of the program as such, but also on the condition, the context and the quality of implementation.*

The principles of implementation

1. Support from and co-operation with local authorities

To implement the program in a new community it is very important to get support and if possible co-operation with the local responsible authorities. An information meeting should be held as the first step in the process, to give an introduction to the program. An agreement about the implementation should also be made.

2. Clarify institutional and administrative-economical issues

When you have chosen where the program is going to be implemented, the following should be clarified:

- Is there staff that has time available to implement the program?
- Is the staff personally suited to be trained?
- If needed, is there funding available for the project?
- Is there approval from the senior staff?

3. Willingness and motivation for the training

When there is a request for training, we should ask whether there is a serious intention to implement the program. The staff should before the training starts get comprehensive information about the criteria they have to fulfil to become an ICDP facilitator (or trainer). The training should not be initiated without a kind of agreement with the staff to follow the whole training procedure. It is important to make the staff understand that this training implies their active participation.

4. Plan of action

In order to implement the program in practice a plan of action is needed. This should specify all details of implementation with goals, sub-goals and time-limits. The plan should include who the target group is, who is responsible for the training, when, where and how the training is going to be carried out and how long the training will take. It should also specify who is responsible for what (the trainer/the trainees/the institution).

It should state how intensive the program is going to be implemented: Meetings held every week? For how long time? How many families and how many children will be affected by the implementation? Is this a **pilot-project** before a larger implementation? How broad is the larger implementation etc. A long-term training of facilitators and trainers should not be initiated without having presented a **detailed plan of how the program is going to be implemented in the local milieu or institution.**

5. Marking officially the initiation of the implementation

of the program by a ceremony and with media, TV etc. is not necessary, but can be an advantage. This creates motivation and it also obliges the participants to take it seriously. They get some status benefit from participating...

6. Evaluation/internal monitoring

The internal monitoring should assess whether or not **the sub-goals of the implementation** are achieved within the set timeframes. In order to sustain the quality of the implementation it is important to introduce **internal monitoring of quality.** This could be either some **questionnaire** to be filled in every month or **regular video-feedback** showing the participants' interaction with the caregivers where they present themselves in regular meetings for the rest of the staff as a companion-training supervision.

Finally there should be an obligation by the leadership team to give **regular reports** about the progress of the implementation to the authorities that support the program - if there are any. Anyhow reporting is also important as a self-monitoring ...

7. Follow-up

In addition it is important that there is inside the implementation plan also included a **follow-up program of meetings and supervision** every third month for two years for example....This is extremely important for the sustainability of the effect which has initially been achieved.

When a group of facilitators or trainers have been certified, a network should be established, so that they can exchange experiences and support each other. If an ICDP network already exists, the new facilitators/trainers should be included in this.

8. Some key-questions

1. **Do you have support from the political or governmental authorities that are above the leadership of the institutions?**

2. **How is the institutional leadership's conception of their institution and the quality of their work?**
 What is the quality of the institution and the quality of the work with children?
 Are they open for improvement or are they satisfied with the quality of the work that they are doing? Is this conception realistic? Why do they think it is good or bad? (What is their conception of a good or bad institution - good or bad care of children? This is important!)

3. **How do the leadership of the institution consider us as outsiders (foreigners) coming to the institution to give advice and training?**
 Are they threatened and provoked by our "intrusion" or do they accept that they can benefit from our assistance? How should we proceed to reduce the provocative aspect?
 Pointing out what they do positively and support further development ...

4. **Is it possible to come to an agreement and to establish a contract of co-operation with the leadership on intervention?**
 Is possible to come into a position that we join forces so that they also can see the benefit for themselves (and their status) that the quality of the institution is raised? Is it possible to make the leadership of the institution partners in the implementation of the program?

5. **How far is the leadership willing to go with regard to organisational changes and changes of routines in the institution?**
 Are they willing to make organisational changes so that the personnel being trained have a strong impact on the organisation of care of the children?
 Are they willing to give up and change old routines in order to create more individual and positive contact with children?
 Are they prepared to make changes in the grouping of children so that more intimacy and a family atmosphere can be created wherever that is spatially possible?

6. **Creating "space" for the intervention/program:**
 What are the obstacle for implementation of the program at the level of staff, time and space?
 Do the caregivers have time or are they running around cleaning and feeding the children without any time for intimacy?
 Are there enough caregivers/staff?
 Is there opening in the daily agenda and routines of the children? What is the agenda?
 (A mapping is necessary!)
 Is there physical space for the program that is, for intimacy and dialogue?
 Are the situations or settings of the child's day inviting positive interaction or are they one-sided?
 Is there "mental and emotional space" for the program or are the caregivers too preoccupied with their own survival and stress?

7. **Is the staff to be trained motivated and prepared for the training?**
 How do they see themselves and us as outsiders? Are we a threat for them? How can that be reduced?
 How can the program expand their involvement with children? How can the program raise their feeling of status and importance? (Pointing out positively what they do well is only the beginning of that...)
 Are they prepared for the efforts involved in the training - like self-training? Are they willing to commit themselves contractually if necessary to complete the training- and then to implement it in their daily work?
 Are there any extra incentives that we can offer to the staff to be trained?

8. Do the leadership and the staffs agree to a plan of implementation with a long-term program of follow-up with supervision?

Do they agree with the implementation plan and are they willing to release the staff who is going to be trained? Do they agree with schedule of follow-up, for example every second month for one year or more? Are they prepared to sign a contract of long-term involvement and follow-up training with supervision?

9. Do the leadership accept that there is going to be an evaluation of the effects of the program both on the staff and the children?

Do they accept the use of video and observational scales, interviews and maybe also tests?

10. How can the planned programme be implemented so that it is sustained after we withdraw?

This is a crucial question that should be raised at the very beginning. Most of the questions raised above are related to the question of sustainability.

Do we have a program of follow-up?

Are there controlling and monitoring routines within the institution that establish routines of reporting according to criteria linked to the program? Is there a system of supervision?

Are those trained part of a network of trainers that can support each other professionally and morally - meeting regularly?

These are some important questions that should be raised before intervention in an institution. This comes in addition to the assessment of children's needs - which is a different issue not be mixed with the principles of implementation.

THREE DIFFERENT MEANINGS OF SUSTAINABILITY

Referring to the ICDP competence building project in Angola sustainability may have three different meanings:

1. *Sustaining the organisation of ICDP as a local NGO with its employees*. In relation to NORAD this is clearly not an important objective. The organisation is an instrument in order to implement the competence building objectives, namely to build up caring competence amongst local organisations and network in Angola. To sustain the organisation may have significance for the future spreading of ICDP in Angola, but we have to make clear the difference between saving employees work and salaries and the saving of the organisation in order to continue the spreading of ICDP after funding from NORAD is finished. Saving the organisation of ICDP as an Angolan NGO may be important – or not – depending upon which roles it will play in future development and which assignments it receives from central donors. There is no point in sustaining the organisation for its own sake!
2. *Sustaining the functions of ICDP – through handover and transfer of competence to local agencies*. This is very much the concept of sustainability that seems to be implied in NORAD's idea of five years support. In a context of competence building we are expected to train key-persons within local organisations who can then gradually take over the training task and *continue the function of training and competence building* – what we would call handover and transfer of competence and responsibility to local organisations. This is what is implied in our strategy paper and the contract.
3. *Sustaining the effects of the training*. This is a completely different from sustaining the functions and the organisation. When we talk about sustain the effects, we refer to the effects of ICDP training or sensitisation of caregivers or promoters. In the field of ICDP competence building this refers to two different groups:
 - The effects on the caregivers: Do they feel that they have benefited from the training they have been through? Is there any visible change in their attitude and interaction with their children? Is the quality of care better than before the training? Is there any change in their attitude?
 - The effects on the children – which are the real target-group and the objective of the whole operation: Is there any effects on the children: Have their mental states improved? Have they developed as expected?
 - Assuming there are effects of both kinds mentioned above – do these effects continue and is there further development or is there regress back to the original situation. This is an important question.

All these effects are important but it is difficult and very laborious to assess these effects and to assess their long-term continuity.

The sustainability of ICDP's work in Angola.

When it comes to evaluation of the sustainability to ICDP's work in Angola, it is important to keep these different meanings of sustainability clear and separate:

Whether ICDP Angola will be sustained as an organisation (1) or not, this is really not of relevance for our commitment to NORAD. Still it may be important for the long-term work of ICDP independent of NORAD

When it comes to the sustainability of functions (2), that is the crucial question: Have we been able to transfer competence to local person, and organisations so that the content of our competence building work will be sustained? To this questions we have to reply a qualified “yes” – the period is not over, there is still another year to mobilise for this goal, still till now, I think we have done what is possible to reach that goal. The obstacles remain in fact to a large extent inside the Angolan institutions.

When it comes to the third meaning of sustainability of effects (3), it is limited what we can do because this is not a research project. Still, we have done reception studies and they show unanimously a very positive reception by the caregivers who have been going through the training (see also school study). We have also casuistic evidence of effects both on attitudes and interaction, and effects on children, but these important aspects of sustainability remain beyond what we can investigate with our limited resources. Like most others working in the clinical field, we have to rely on casuistic evidence and on other research which has used similar methods to our own. In this respect, the main points in our program is very much supported by research from different sources – although it has not been evaluated specifically in the Angolan context – as this was beyond our project goals.

PRINCIPLES FOR MANAGING A LARGE SCALE PROJECT AN EXAMPLE FROM THE PROJECT IN ANGOLA:

Procedures for managing and controlling the implementation of the ICDP Program on wide (national) scale and sustaining its quality

1. The year-plans

The year plans should be based on the objectives stated in the original proposal for economic support. The year plan is the instrument that specifies the concrete goals of the work for each year and it is therefore the key document for directing the work each year.

The year plan should be developed at the annual meeting each autumn by the project leadership team in co-operation with the provincial co-ordinators. The year-plan has the following content:

- A. The quantitative part stating the planned scope of our activity, and
- B. Recommendations describing new components in the program and development with time-plan for implementation.

Procedure 1: It is important that this plan is prepared in a responsible way through participation by the co-ordinators before and during the annual meeting and through discussions inside the project leadership team. The plan should be presented as one comprehensive document that can be presented to the outside. Before finalisation, the ICDP board shall approve the plan.

It is the program director's task to write and present the plan, and the representative's responsibility to see to that the plan is sent to the board for approval before December each year.

2. The annual budget

The annual budget is based on the year plan and on the directions implied in the donation's papers from NORAD. This is the responsibility of the representative and the administrative team of the project and ICDP central. The approved year-plan and the budget should be presented together as one publication. This is the most important document for directing and controlling the work.

Procedure 2: When the year plan is available after the annual meeting, the representative meets with the administrator of ICDP and develops the budget for the coming year, which should be approved by the ICDP board.

3. Application and reporting to NORAD for each year

The year-plan and the budget is the basis for the application to NORAD each year.

Procedure 3: a) The annual application for economic support for the project (inside the frame that is agreed) should be prepared by the ICDP administration in co-operation with the representative in Angola (through e-mail). The application should be presented to NORAD before the deadline.

b) The reporting to NORAD twice a year (dates:) should be based on the quarterly reports from the provinces (see 4.) and on the impressions of and evaluative procedures of the program director and the project co-ordinator. A first draft of the report should be written by the project director and sent further to

the ICDP board after having been presented and discussed by the leadership team in Luanda. The report is then finalised by the ICDP board and sent further to NORAD.

4. The implementation of the year plan

The direct control of the implementation of the year plan rests with the national project co-ordinator and with the provincial co-ordinators. The overall responsibility rests with the representative.

Procedure 4: Each provincial team under its co-ordinator, makes quarterly logistic plans based on the year-plan, and reports quarterly what has been achieved to the national co-ordinator and the leadership team. The national co-ordinator visits each provincial team twice a year to supervise the implementation, its direction, efficiency, logistics/planning and needs. After each visit a short report is written to the representative, which is filed.

5. Implementing the Program in each province

Based on the quarterly plan, each provincial team sets up an agenda of visits to the locations of intervention. These visits should be properly prepared and planned in advance and discussed with one or more members of the team, and each visit should have a clear focus based on experiences with the target group.

Procedure 5: Before the training starts in each location, there should be:

1. An assessment-visit by two experienced members of the provincial team.
2. They should assess the situation based on the schemes prepared for that and come up with
3. A recommendation - an intervention agenda - for how the training should proceed; its focus or emphasis (based on the topical guide) and for how long (normally not more than 10 times - after that starts the «follow-ups»).
4. The promoter visiting the location should follow the intervention agenda that is prepared, and discuss possible changes with the trainer in the team or with the visiting program director.
5. In addition he shall at regular intervals (that is twice) during the training assess himself by using the self-monitoring form (Yes - No)
6. When the training is finished the trainer/promoter is supposed to fill in the finalisation form.

6. Follow-up training

This is essential for the sustainability of our work.

Procedure 6: The follow-up should have the following format:

1. One month after the training is finished two experienced member of the team should visit the location in order to assess/observe the implementation of the program in practice plus presentation of self-monitoring scheme for the promoters and caregivers.
2. Based on the self-monitoring and observation, the promoters/trainers should give positive feedback and discuss in a practical way that the implementation can be improved.
3. Based on this information, an intervention plan or agenda for the team that is going to implement the follow-up should be prepared. It may be useful to use pictures/video and to practice the implementation in role-play in everyday situations.

4. The follow-up training should be scheduled in the following way: After 1 month - 3 - 6 - 9 - 1 year. At most three meetings each time.

7. Evaluation and monitoring of the sensitisation training and follow-up

This is primarily the responsibility of the program director. The quality of the work should be sustained and monitored through forms for planning before intervention, through self-monitoring forms and through external assessment, also at the location. Forms have been prepared for all these phases. (See 'A guide for the evaluation of the ICDP programme').

Procedure 7: The program director shall visit each provincial team twice a year. On each visit he will help the team that is preparing routines for the intervention through the following phases:

1. Assessment of need at the location,
2. Discuss the focus of intervention with the team using the topical agenda guide,
3. Instructing in the use of the self-monitoring scheme,
4. Together with the provincial co-ordinator observe and assess each promoter (form plus narrative assessment)
5. Finally he will communicate in a meeting with the whole provincial team his findings and in a discrete way point out and sensitise them for aspects in the program that have been neglected or not understood.
6. After each visit he shall write a short report to the representative where he also encloses the results of his assessments as they appear in evaluative schemes.

8. Consultants

At regular intervals we need consultants to upgrade the quality of our work.

Procedure 8: A clear assignment with detailed description of the tasks; the timetable and conditions of the consultant should be presented to him/her in advance as a written contract.

After finishing his mission he/she should write a report about the mission relating it to the assignment that was given in advance.

9. Salaries

It is important for the image of ICDP that we have a clear policy of deciding salaries for the different categories of personnel working in Angola. The standards established by major NGOs that are receiving support from NORAD should be our guideline.

Procedure 9: Salaries for the different categories of personnel should be adjusted to the standards established by other Norwegian NGOs receiving support from NORAD. Every second year there should be a checking and adjustment of these salaries in accordance with the existing standard. (Check Christian Church Aid, NPA or Redd Barna)

10. Dismissal of personnel

It is important that we have a fair and just policy in this field that can be justified in public both in Angola and in Norway.

Procedure 10:

If an employee performs below acceptable standards in his work, he or she should be assessed in a neutral way by using the assessment scheme already prepared.

If the performance is clearly beyond standard after this investigation, a meeting should be arranged where this person is presented with the specific points where he fails. He/she is then given a second chance for correcting the performance based on the information provided in the meeting. A contract can be issued where this is stated and the time limit for improvement should be indicated. Dismissal then consists in not renewing the contract.

11. Expanding our operations going into new areas

Expanding or reducing our operations is a major decision that belongs to the board of ICDP and should be discussed at the Annual meeting. It should be carefully analysed in relation to the project's objectives and investigated before a decision is taken. For that reason it is important that relevant locations are investigated and decisions are taken according to a set of criteria.

These criteria could be:

1. The level of need
2. Support from local authorities
3. Availability of competent personnel to be trained
4. Access for trainers from other centres to carry out training
5. The likelihood that our intervention would make a difference for the target population concerned (not only creating new dependencies).
6. The likelihood that the operation can be sustained and transferred to local institutions after the period of intervention is over.
7. The cost of the operations in relation to our existing budget.

An expert team in line with the information collected should then carry out the planning and designing of the operation.

Procedure 11: Before we start any new intervention or expansion of our operations, there should be a pre-investigation by two members of the leadership team. Each of the criteria mentioned above should be considered and presented in a report by the team making the pre-investigation. This report should be presented to the representative and to the board of ICDP before any further actions are taken. If decision is positive, a clear design and planning of the operation should be presented before operation is started.

12. Going into the poorest communities selecting local promoters

This is a new strategy that has the objective of reaching the children among the poorest population. In order to get access to these communities we may have to operate through religious groups, women's organizations, local NGOs and through schools. The appointment of a local promoter is decisive for the success of the intervention and should be carefully considered before selection is made.

Procedure 12: The following steps should be considered when starting the program in a poor community:

1. Two members of the leadership team should contact local religious groups, women's groups or local NGOs and schools, to investigate their willingness for cooperation. If positive
2. Local authorities are contacted and they are informed about the plan and their support is sought - brochures about our work are presented (also large posters).
3. A semi-public meeting is arranged with local key-persons, social/health workers and teachers and information about our work is presented in an appealing way. If possible a video about our work should be presented or theatrical performance (if possible with African

puppets) where our main messages are presented. It is important that the first presentation of the program makes an impact on the population.

4. There is then an open invitation to participate in a training course - in a normal way, run by our promoters. About 25 persons are selected and the training is carried out in the normal way with about 10 sessions.

5. During the training it will become evident who among the participants are suitable candidates to be selected for further training to become local promoters. (Criteria are already available in assessments that have been prepared). The participants in the course should confirm the selection - so that there is an element of participation.

6. One, two or at most three persons are then selected to become local promoters - depending upon the need in the community. The local promoters are selected for part-time work.

7. These promoters are then further trained-in-practice by two central trainers/promoters for two months. After that they start operating by themselves visiting the most vulnerable families in the community, either individually or in groups, according to a plan prepared by the local promoters in cooperation with the central trainer or local organization.

8. The central trainers should supervise their work at regular intervals and help them to focus the intervention in line with the emerging needs. The health preventive program may become an important part of the intervention.

9. The local promoters are paid a subsidy every month. This can be regulated (within limits) in accordance with the workload and scope of their efforts.

10. It is important to avoid developing dependencies and promises about future employment and to present this as a temporary intervention, normally for not more than one year.

ICDP POLICY GUIDELINES FOR HELPING DISLOCATED CHILDREN

1. CHILDREN SHOULD GENERALLY BE WITH THE FAMILY OR RELATIVES.

If not, a family like environment should be provided where there will be stable, positive caregivers children can attach to on long term basis.

Implications:

Tracing and family reunion will be important.

Institutional solutions will not be recommended because they tend to last longer. When children are placed in institutions it is important that there are stable caregivers that children can relate to and that smaller family like units are encouraged. The caregivers in institutions usually need sensitisation about the children's psychological and individual needs.

2. PEERS AND COMPANIONSHIP IS IMPORTANT FOR A CHILD'S NORMAL DEVELOPMENT.

This involves opportunities for play, games and co-operative activities with friends where they learn to relate to each other through shared activities, shared joy and laughter, exploring the world together, adventure, competing, but also caring and responsibility for each other.

Implications:

This is like another safety network both of care and of socialisation that comes in addition to the family. When children have a network of friends they cope better and they are also more realistically prepared to face the challenges of adult life. It is therefore important to try to locate children in such environments where there are other children available as potential friend and companions.

3. A PREDICTABLE STABLE, ENVIRONMENT SHOULD BE CREATED, WHERE THE CHILD CAN FEEL SAFE IN FAMILIAR SURROUNDINGS.

This also involves the establishment of fixed routines and a stable agenda for the child's day with a balance of play and imagination on the one hand and duties and responsibilities on the other.

Implications:

This implies that one should avoid introducing too many changes and dislocations in the child's life so that s/he can develop normal expectations to what is going to happen.

Also it is important that the stable environment has inbuilt challenges and tasks so that the child develops a sense of responsibility and care. This may create a basis of a more active mastering experience and attitude where the child's attention is focused on normal daily tasks and activities instead of dwelling on traumatic or negative experiences of the past.

4. HELP THE CHILD TO GIVE MEANING AND VALUE TO HIS EXPERIENCE.

Adults need to help children develop an understanding of their situation: what happened, why they are in the present situation and what is likely to happen further. If possible, giving some realistic hope for the future. A story can be created either through listening and verbal exchange or through creative art, drawings and drama.

Implications:

In order to cope in difficult situation, it is helpful for children to have some time for intimacy and close contact with a trusted caregiver. During such moments the caregiver should be attentive and willing to listen, without putting any pressure on the child. Together the caregiver and the child may recreate what happened and what is likely to happen further. In this connection it is important to be aware that creating some hope for the future is an essential aspect of effective coping.

It is also possible to create a story that conveys some self-respect and dignity to their suffering. For example, this can happen through indicating the courage and strength they have shown in the process of migration. In some cases, when it is appropriate, even ideological and nationalistic aspects can be included in order to give meaning and value to the experience they have gone through - it was for a big cause. This is like redefining their experience from one of humiliation and misery to one of strength and courage.

5. A CHILD NEEDS AT ALL LEVELS OF DEVELOPMENT AN EDUCATIONAL ENVIRONMENT.

Children need to be in an educational environment that inspires development of knowledge and skills that are needed for future participation in society.

Implications:

Attending school is important for children in a transitional situation because this provides concrete tasks and challenges that focuses children's attention away from the painful experiences of loss and longing, at the same time as it creates a feeling of normality and routine.

An educational environment is also important at earlier age levels in the form of an environment that invites activities and challenges guided by an adult caregiver who can expand and direct the child's initiatives and give explanations to his experiences. (see the 'ICDP guidelines for good interaction' from 5 to 8).

It is important that to create an educational environment that facilitates the development of autonomy, a feeling of mastery and self-confidence in the child, not only obedience and repetition.

6. APPROACHING THE CHILDREN, AS FAR AS POSSIBLE, IN LINE WITH THEIR CULTURAL BACKGROUND.

Adults need to be sensitive to children's cultural backgrounds and allow them to participate in cultural activities, religious practices and ways of understanding and feeling which are normal for their community. This strengthens children's feelings of identity and belonging to their cultural group.

Implications:

It is important to respect the cultural background of the child and to search for explanations and solution that are in line with his ways of understanding and deeper feelings. For children who have a religious background it may important to sustain their religious practices of regular prayers and religious services and to seek explanations that are in line with their religious and moral conceptions and feelings.

Traditional rituals may also be important as a way to indicate important changes in a child's life. For example, in cases of death of parents or relatives, it may be important that one follows the traditional rituals of mourning and burial; or when the child has been exposed to negative experiences rituals of purification may be employed to relieve the negative experience. Psycho-social interventions should take such indigenous practices into account and include them.

A strategy of sensitisation/facilitation implies that we try to bring out cultural knowledge and skills that are still useful and acceptable and help the caregivers to use them in their daily interaction with children. Concretely, this can mean use of songs, dances, proverbs and poems or typical ways of interacting with children that are part of their cultural tradition.

7. PROJECTS FOR CHILDREN SHOULD PREFERABLY EMPLOY A COMMUNITY-BASED STRATEGY FOR INTERVENTION

A community-based strategy will have as a starting point, building up local competence.

Implications:

This means that we should first try to identify which local resources are available; resource persons and institutional networks of care. When these are identified, we need to establish contracts of co-operation and try to support and help their work in the most feasible way. One way is to train them so that they may become more effective in carrying out their work. Knowledge has the characteristic that it does not easily disappear, therefore competence-building is one of the most sustainable ways to support an existing organisation or network. In the case of child care this means building up teams of competence in the different regions and these teams are again training caregivers in different institutions, camps, homes or the different settings where the children are. Through this strategy we are able to reach many more children than we would be able to do through direct consultation with individual families or children.

8. ANY PSYCHO-SOCIAL INTERVENTION STRATEGY FOR CHILDREN AND PARTICULARLY YOUTHS WILL DEPEND ON SOCIETY CREATING WORK AND SCHOOL OPPORTUNITIES FOR THESE CHILDREN.

This is in order that children's socialisation becomes realistic in relation to the tasks and jobs that will be available in the future within their societies.

Implications:

This is a big problem in many developing countries because the society is still not yet sufficiently organised to be able to provide children with realistic educational and work opportunities. It is therefore, crucial that parallel to psycho-social rehabilitation work, there is political, economic support so that a job market and an economy is developed that can generate opportunities for all the children when they grow up. On a small-scale income generating enterprises at the local level are an example of this strategy. Only through a combination of psycho-social and moral education and enterprise development, can development in a true sense, be achieved. It is important to be aware that if people are to survive psychologically and develop in a normal way, pure economy is not enough, they need goals and moral values to live up to and to fight for. This is an essential part of early socialisation and education.