ABOUT ICDP

RATIONALE FOR THE ICDP APPROACH TO TRAINING

The ICDP programme aims to bring out and sustain good quality interaction between caregivers and their children, by raising the awareness of caregivers about their children's psycho-social needs and by increasing their ability to respond to these needs.

'START WITH WHAT THEY KNOW
BUILD WITH WHAT THEY HAVE'
LAO TSU 700 B.C.

The ICDP approach to training is based on the idea that the best way to help children is by helping the children's caregivers. The most feasible strategy for helping children on a large scale is to support and educate children's network of stable caregivers.

All cultures develop their own mechanisms for survival, development and care of children, and it is those 'indigenous practices' which need to be identified and reactivated in order to stimulate the development which is truly authentic and long-lasting. Help is understood in terms of building up competence and supporting the existing child caring-systems within a given community.

The first steps is to identify the local child rearing practices that can serve as a basis for further extensions and development, rather than impose concepts and regulations from outside.

ICDP facilitates culturally adaptable programmes whose guidelines are based on recent research in psychology, but are used as questions or themes for personal and group reflection and analysis of typical every day interactive episodes, for practical hands on observation and experimentation, for self monitoring and self evaluation, and for testing out and then adopting new, more positive ways of relating to children.

“ICDP is a competence-building NGO in the field of psycho-social and educational care of children at high risk. Our work is directed towards vulnerable children, their caregivers and families.

ICDP developed a simple programme that has been tested out in different societies all over the world from Indonesia to Latin American, from South Africa and Angola to Scandinavian countries and Western-Russia. There is evidence that the programme works in all these different societies and with caregivers with very different educational backgrounds.

The aim of the programme is to strengthen caregivers’ involvement with their children in a positive way, to give them confidence in their own capacity as carers, to facilitate those relationships that support children’s development and to prevent those relationships and conditions that may lead to neglect and abuse of children. Our programme is closely linked to the work of promoting children’s rights, by opening up a space for children to be heard and responded to and through its emphasis on empathy and compassion for the other, it also contributes to peace building both inside the family and community in general.

ICDP can be used in a prevention strategy or as part of a rehabilitation program. We are working in a community based way by training and mobilising resource persons in local networks and organisations to spread our programme further to local caregivers. Through this approach we are able to reach more caregivers, families and children at risk than if we used the traditional clinical or institutional approach employed by most NGOs working in this field.

Although we actively encourage the participation of men, in practice we mostly work with groups of women and networks in which women are strongly involved. This is so because children’s caregivers in most traditional societies are still women. Empowerment of women is therefore implicit in our programme.

Our aim is to provide for the psychosocial care of vulnerable children and families: children handicapped due to poverty, after-effects of war and uprooting, family-conflicts and violence, children in camps and institutions.

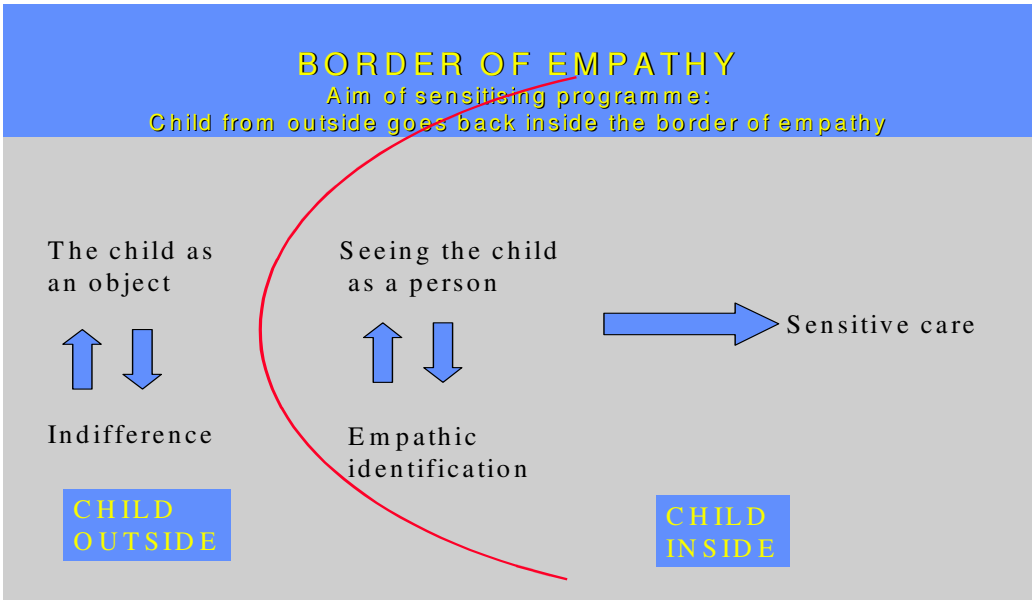
As our work is primarily competence-building and training, this means that when the training of caregivers and institutions is over and the quality of the work is evaluated, we withdraw, after having prepared local caregivers, or trainers, to take over the organisation and further implementation of our programme.

In order to ensure sustainability follow up of local teams over some time is important, and, whenever possible, we try to insert the ICDP Programme into existing institutional structures like government networks, leading NGOs working in the field of care for children and families, and educational institutions like high-schools and universities. In this way, the ICDP training may become an established part of the local institutions responsible for the care of children and for the education of future leaders and resource-persons in this field.”

- Professor Karsten Hundeide, ICDP founder

EMPATHY IS THE KEY TO GOOD QUALITY CARE

Under pressures caused by poverty, migration, catastrophes, wars, as well as cultural changes due to pressures of modern life, the basic psycho-social requirements for human development may be lacking, even though the child may physically survive. What is at the centre of these basic psycho-social needs that all children have is a long-term, stable, and caring relationship with their primary caregiver, without which children cannot develop properly. This is confirmed by evidence from many research studies in early affective deprivation (Spitz 1945, Hunt 1982, Skeels 1966)[1]. The objective, therefore, must be to sensitise caregivers, in order to enhance their ability to provide good quality care and to release empathic feelings towards their children.



Empathy, is the process of 'putting yourself into someone else's shoes', of reaching beyond the self, understanding and feeling what another person is understanding and feeling. Empathy facilitates communication - communication breaks down when false presuppositions or assumptions are made about the other person's state. Caregiver-child communication requires a sophisticated degree of empathy. In order to communicate effectively the caregiver needs to be able to understand the child's affective and cognitive states. Caregivers' ability to attune with, and respond to, children's needs and initiatives constitutes the basis for good quality care.

From repeated attunements an infant begins to develop a sense that other people can and will share in her feelings. This sense seems to develop around 8 months, and continues to be shaped by intimate relationships throughout life. When parents are mis-attuned to a child it is deeply upsetting and damaging. When a parent consistently fails to show any empathy with a range of emotions in the child – joys, tears, needing to cuddle - the child begins to avoid expressing and perhaps even feeling those same emotions. In this way an entire range of emotions can begin to be obliterated from the repertoire for intimate relations, especially if through childhood those feelings continue to be covertly or overtly discouraged.

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[1] Spitz, R. A. (1945), Hospitalism: an enquiry into the genesis of psychiatric conditions in early childhood. **The Psychoanalytic Study of the Child**, 2: 313-42.

Hunt, McVicker, (1982), Towards Solutions of Early Education. In Nir-Jav, Spodek & Steg (eds.), **Early Childhood Education.** New York: Plenum press.

Skeels, H.M. (1966), Adult status of children with contrasting life experiences**. Monograph of the Society for Research in Child Development**, 31 (105-33).

OBJECTIVES OF THE ICDP PROGRAMME

- To influence the caregiver's positive experience of the child, so that the caregiver can identify with and 'feel with the child', sense the child's state and needs and adjust her/his caring actions to the child's needs and initiatives.
- To strengthen self-confidence in the caregiver.
- To promote a sensitive emotional-expressive communication between caregiver and child that may lead to a positive emotional and developmental relationship between the two.
- To promote an enriching, stimulating interaction between caregiver and child that expands and guides the child's experiences and actions in relation to the surrounding world.
- To reactivate positive indigenous child-rearing practices and values, including the child culture of play, games, songs, co-operative activities.
- To provide children with a supportive and loving environment, by activating in caregivers empathic caring actions towards them.
- To give children the opportunity to express themselves, to be listened and responded to, by helping caregivers develop meaningful dialogues with them.
- To give children opportunities to follow their own initiatives by encouraging caregivers to acknowledge, support and extend these initiatives without taking the control of the situation away from the children.

FIELDS OF IMPLEMENTATION

- Families and children. To prevent neglect or abuse of children and promote peace and dialogue, through group meetings and home visits. It includes working with: families in general; families from ethnic minority groups; families in stress and poverty; families and children under protection; foster families, adoptive parents; parents in prisons.
- Vulnerable children and orphans. To develop minimal standards for human care within a child-care setting, when emergency situations arise due to war, migration, catastrophes, abuse and trauma, or abandoned street children.
- As an integral part of any primary health care programme, building competence and sensitizing caregivers about the importance of their role for the future development of their children.
- Directly in combination with any content-oriented pre-school programme, serving to enrich and increase the quality of interaction between adults and children, which is crucial for the development of children's emotional stability, as well as for their cognitive development.
- In schools, both working with teachers and the parents to create a more positive inter-subjective climate in the classroom and to help create better communication between pupils and their parents.
- Children in institutions. To sensitize staff and improve their quality of care.
- Special needs children. To sensitize caregivers about the psycho-social needs of their children and build their confidence as carers.

DEVELOPMENTAL APPROACH TO INTERACTION – 8 GUIDELINES FOR GOOD INTERACTION

I EMOTIONAL COMMUNICATION

In the early stages of interaction between mother and her baby, the ICDP programme emphasises the need for the emotional expressive responsiveness and communication through face-to-face interaction and bodily touching which is a precondition for the development of trust and attachment.
This is expressed in the 4 guidelines for emotional communication which represent the 'emotional dialogue':

1 Showing love and positive feelings

2 Following and responding to the initiative of the child

3 Establishing a positive personal dialogue – verbal or non-verbal

4 Praising and approving the child

II MEDIATION

The emotional-expressive communication seems to dominate the interaction between caregivers and babies in the first months of life. As the child grows older the caregiver is encouraged to develop gradually a guiding role, acting as a mediator between the child and the surrounding world. This kind of communication, called mediation, comes in more strongly at about 9 months, when infants develop 'co-operative awareness', which enables them to intentionally seek involvement from caregivers in their own actions towards the objects in the surrounding world.

Mediation, manifests in practice through two dialogues: comprehension dialogue and regulation dialogue. Through this experience of mediation, children gradually develop the competence they will need to adapt to the demands of his community.

Whenever a caregiver shares, describes and explains with enthusiasm what the child is doing and experiencing there is a 'comprehension dialogue'. The guidelines 5, 6 and 7 represent the 'comprehension dialogue'.

Whenever a caregiver regulates a child by establishing norms or setting limits, whenever a caregiver participates in the child's activities, by planning what they are going to do and giving guidance so that the child can carry out a project, there is regulation dialogue. The guideline 8, with its two aspects, represents the 'regulation dialogue':

GUIDELINES RELATED TO MEDIATION:

5 Helping the child to focus on things, situations in the environment

6 Conveying meaning and enthusiasm to the child's experiences

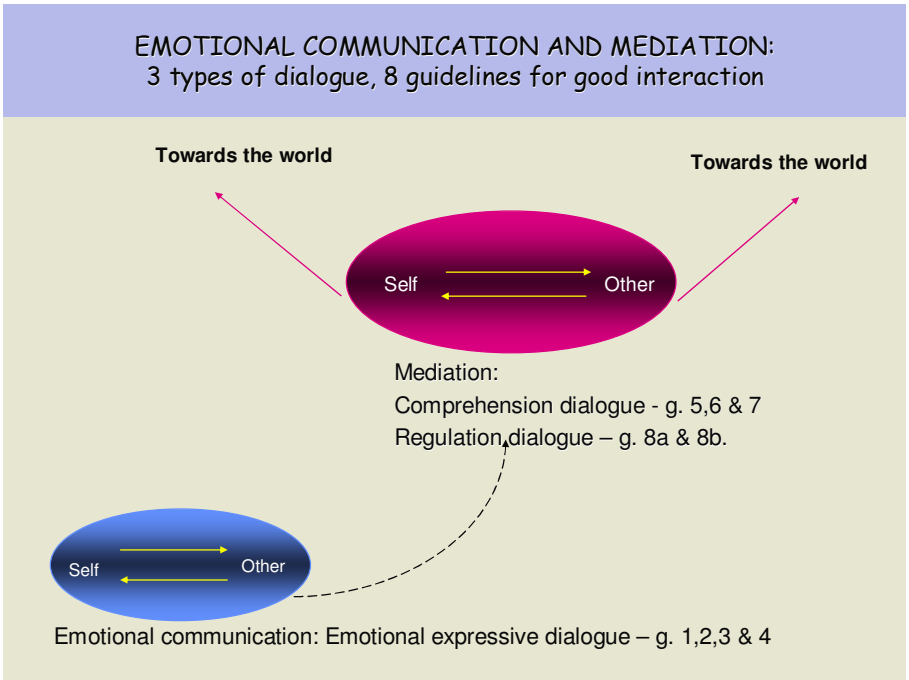
7 Expanding and enriching the child's experiences through explanations, comparisons and fantasy

8 8a. Supporting the child's actions and projects; guiding the child step by step towards a goal

8b. Regulating the child's behaviour by setting limits in a positive way with clear boundaries for what the child is allowed or not allowed to do

The messages of the 8 guidelines are simple and universal, naturally embedded in caregiver-child communication and present in any culture.

Clearly, there are great differences between cultures in the way the guidelines are expressed – finding out how they are specified is the first step in the programme.



Instead of teaching the 8 guidelines in an instructive way, they are used in question form:

'How do you express love when you are with your child?'
'How do you follow your child's initiatives?'
'How do you take turns in non verbal communication?'
'How do you praise him or her?'
'How do you regulate his/her behaviour and solve possible conflicts with other children?'
'How do you establish norms and set limits?'
'How do you participate in your child's project?'

This forms a basis for reflection, consciousness raising and sensitising, as well as creating confidence and trust in caregivers' capacity to care for their children.

ANALYSING INTERACTIONS

The guidelines are used as criteria to analyse the quality of caregiver-child interaction; an interaction profile can be made, by establishing the presence or absence of each of the 8 guidelines.

In ICDP research projects, interaction profiles are made for each individual pair (caregiver + child) before and after the intervention. By comparing the two profiles, it is then possible to make an evaluation of the impact the programme had on participant caregivers' ways of communicating with their children.

EIGHT GUIDELINES FOR GOOD INTERACTION

I need your love

1 HOW DO YOU SHOW POSITIVE FEELINGS, THAT YOU LOVE YOUR CHILD?

I am so happy when you allow me to do what I want; your interest in what I do gives me confidence

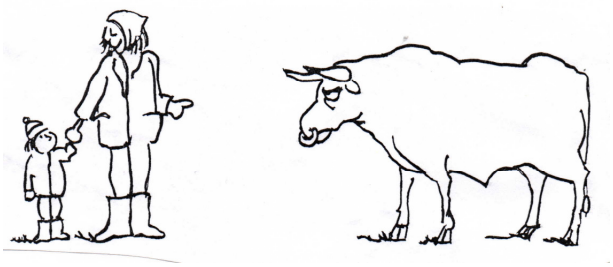
2. HOW DO YOU FOLLOW AND RESPOND TO THE INITIATIVES OF YOUR CHILD?

When we are close I can talk about what I feel

3 HOW DO YOU HOLD AN INTIMATE DIALOGUE WITH YOUR CHILD: WITH WORDS AND WITHOUT WORDS?

It feels so good when you appreciate me

4. HOW DO YOU GIVE PRAISE AND APPROVAL FOR WHAT YOUR CHILD DOES?



I enjoy it when we do things together and when you show me things

5. HOW DO YOU SHARE EXPERIENCES TOGETHER?
HOW DO YOU FOCUS YOUR CHILD'S ATTENTION WITH YOURS?

I love learning from you how things are and how they work

6. HOW DO YOU DESCRIBE AND GIVE MEANING TO YOUR CHILD'S EXPERIENCES?
HOW DO YOU SHOW ENTHUSIASM?

I like you telling me stories or when you explain about things

7. HOW DO YOU ENRICH, EXPAND AND CONNECT YOUR CHILD'S EXPERIENCES?

I need you to tell me why some things are allowed and others are not

With a bit of help I could learn to do many difficult things

8. HOW DO YOU REGULATE YOUR CHILD'S BEHAVIOUR IN A POSITIVE WAY?

Sketches by Dirk Campbell

8 GUIDELINES AND THE SITUATIONAL APPROACH

The 8 guidelines are embedded in the concrete experiences from everyday situations. As we can see below from the dominant interactive guidelines in parenthesis, different situations seem to invite different types of interactions. Pictures, posters and when possible video films are made of these situations; practical work with caregivers starts with the analysis of these typical interactive situations, which are discussed, shared, role-played, reconstructed and improved. The 8 guidelines will 'emerge' as result of the analysis of the situation itself.

TYPICAL INTERACTIVE SITUATIONS:

SHARING POSITIVE FEELINGS

Situations inviting intimate sharing, fun, joking, loving face-to-face interaction.
(Dominant interactive guidelines: 1,2,3,4,6)

CONSOLING

Consoling situations, the child needs or asks for emotional support.
(Dominant interactive guidelines: 2,4,1,3,6,7)

DAILY CHORES

Participating in daily chores, adult is leading:
(Dominant interactive guidelines: 8,4,6)
a. Helping the child with clothes, toilet, eating etc.
b. The child is assisting the adult in chores like preparing meals, cleaning up etc.

SUPPORTING THE CHILD IN PLAY PROJECT

Carrying out a play project; child is leading, and the adult supporting and regulating, helping the child to complete a project.
(Dominant interactive qualities: 2,8,6,4)

JOINT ATTENTION AND INFORMING

Didactic or playful informing and telling the child about the world, on either the child's or the adult's initiative: for example, when reading a book, when going for a walk. (Dominant interactive qualities: 6,7,2)

SETTING LIMITS/REGULATION

Limit-setting situations - regulating the child's self centred behaviour or negative feelings in relation to others and setting limits as to what is allowed in a situation.
(Dominant interactive qualities: 8,7)

CHILDREN CO-OPERATE

Children playing by themselves; there is no adult intervention except in emergency and danger.
(Dominant interactive qualities: 2,3,6,7,8)

8 GUIDELINES AND 3 TYPES OF DIALOGUE

The eight guidelines can be seen as interactive qualities belonging to three different types of dialogue: The emotional expressive (1), the meaning oriented (2), and the regulative and limit-setting dialogue (3). The table below shows the relation between the dialogues, the guidelines and the typical situations from the caregivers' daily life with children.

3 types of dialogue	8 guidelines	Typical situations
1. Emotional dialogue	1. Show positive feelings 2. Follow child's initiative 3. Intimate dialogue (verbal and non verbal) 4. Confirmation, praise	Situation with close contact (bed time, morning greeting, saying good-bye etc), situations demanding consolation (child looks upset, got physically hurt), encouragement, sensitive adjustment and confirmation (for example, the child is having difficulties in doing something by himself)
2. Comprehension dialogue	5. Shared attention and focusing 6. Mediation of meaning 7. Expansion and explanation	Situations inviting information and explanations about what is going on, for example: to talk about what is in a picture book, go for a walk and talk about things around…
3. Regulative dialogue	8. Regulation: a. Planning step-by-step with graded support / scaffolding; challenging the child b. Limit-setting in a positive way	a. Situations demanding goal-directed adjustment, strategic capacities and cooperation to solve a task. For example, to build a tower with bricks, make a paper plane. b. Situations demanding regulation of behaviour for something that is not allowed to do, establishing house rules, introducing values and beliefs, situations of sharing with others, situations demanding rules for social behaviour, situations demanding altruistic behaviour and empathy towards others, including animals, plants etc.

FACILITATIVE METHODOLOGY – 7 PRINCIPLES OF SENSITISING

It is clear, both from our experience and research of others, that just giving lectures and verbal instructions to passive receivers is not sufficient in order to change the course of their habits, in this case interactive habits. An active experiential and communicative approach to training is required.
Only when there is a self-initiated intention or hypothesis that is being explored, tested out and evaluated through some kind of feedback either from the experience itself or from other people, will there be learning. This type of learning will become integrated as part of the person's own knowledge and skills. Pure exposure to experience as such does not create this kind of personalised knowledge.

Therefore the objectives of the programme can only be achieved through facilitative, rather than instructive guidance, which encourages active involvement of its participants. The aim is to bring to surface the caregivers' inner resources, by creating a warm human environment, with plenty of space for self-discovery, without imposing ready-made formulas from outside.

Caregivers start by being given opportunities to discuss about the meaning of childhood; to promote a positive image of their own children; to explore local child-rearing practices; to look back at their own childhoods in order to understand what their own children need now from them; to express conceptions about their roles as caregivers and future expectations for their children; to share their views about children's developmental potential and how to nurture and enhance that potential. Then they are encouraged to explore, discuss and share their observations about their children's behaviour and their own responses to it, as well as testing out new ways of interacting with children.

The person facilitating the ICDP programme to caregivers is trained to use certain pedagogic principles which are summarized below:

7 PRINCIPLES OF SENSITISING

1 Establishing a contract of trust with caregivers.

2 Positive redefinition of the child – to see the child as a person:
- Pointing out to caregivers some positive features and qualities of their children.
- Re-labelling positively what appear to be negative features of their children.
- Reactivating past good memories of a caregiver's positive relationship with the child.
- Using exercises for caregivers to discover positive qualities and competencies of the child.

3 Activating caregivers in relation to the theme/guideline that was discussed by:
- Asking caregivers to make self-assessments of personal interactions with their child based on the 8 guidelines of good interaction
- Exemplification: asking caregivers to produce examples of their interactions with the children
- Giving caregivers observational tasks in relation to their children
- Asking caregivers to try and test out new ways of communicating and interacting with their children in order to find out what works the best

4 Confirming caregivers' competence by pointing out at that which is already positive in their existing interaction with their child.

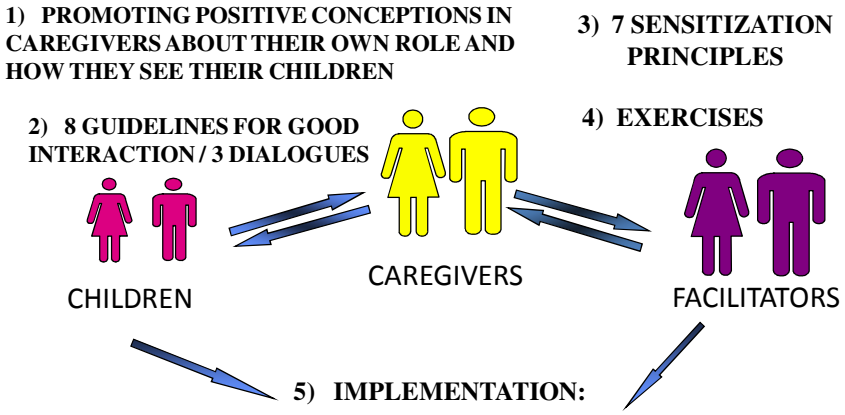
5 Using an inquiring approach to guide caregivers' discussions about what is good interaction.

6 Encouraging sharing and attentive listening among caregivers in group meetings to learn from each others' experiences.

7 Using two styles of communication in relation to caregivers.

- A personalised style of explanation, with examples from your own individual experience.
- An empathic interpretative style, i.e. describing how the child experiences the situation; comparing the experience of the child with similar adult situations

COMPONENTS OF THE PROGRAMME



The starting point of the ICDP programme is to explore with caregivers how they see their children, by promoting a positive image of their child and by reflecting about their role as caregivers.

The main message of the programme to caregivers is expressed in the "8 guidelines for good interaction"- these are 8 criteria which define good communication between caregivers and children and are used as topics for reflection in meetings with others and for personal application in daily routines with children.

How the main message is delivered to caregivers is just as important as the message itself. "The 7 Principles of Sensitising" are a set of pedagogic principles applied by the ICDP facilitator, i.e. the person in charge of facilitating the programme to caregivers, usually in group meetings.

The programme is very practical with many suggestions for exercises, both in group work and as home tasks.

Pre-implementation procedures are a checklist of important points which should be carefully considered before starting with the programme in practice in any setting. This is important in order to secure sustainable implementation on long term basis.

The ICDP facilitators deliver the programme to caregivers in group meetings that are usually held on weekly basis; prior each meeting with caregivers, there are planning sessions to revise the agenda of the previous meeting and to prepare for the next meeting. At each of these meetings promoters consult their field diaries and go through checklists.

All ICDP projects are evaluated, usually through the use of questionnaires, interviews, focus groups and case studies, to establish the impact of the programme on participant caregivers and children. Evaluation studies are carried out by professional teams from local universities.

COMMUNITY BASED TRAINING OF PARA-PROFESSIONALS

"As an alternative to guarding useful knowledge in professionalized monopolies, professionals could become promoters of preventive education within their sphere of knowledge, encouraging the local population to believe in their ability to control their lives and to acquire the skills that are needed. They could provide opportunities and challenges for people to display and practice their talents, selecting the best ones and teaching and supervising them to function practically within their sphere of competence. This would mean empowering communities to deal with their own problems on a large scale." - Hundeide, K. (1991), p.132, Helping Disadvantaged Children, Jessica Kingsley Publishers, London

World wide we are facing challenges of developmental deviations due to cultural deprivation and loss of affective attachment in early childhood. The most efficient way to face up to this challenge is not the traditional, institutional approach but a more radical one, in which a large number of caregivers can be reached.
The use of participatory groups, is one such approach, in which local resource persons, sometimes mothers, are trained as para-professional aides capable of leading groups of other mothers/caregivers. ICDP training uses this approach to sensitise caregivers about their children's developmental and human needs. Utilising para-professionals has a large spreading effect that can reach the whole community.
The general conclusion, after extensive research is that properly trained para-professionals can do as good a job as professionals, sometimes even better. This approach has additional positive effects on its participants who seem, not only to become able of improving their children's developmental conditions, but also develop courage to face their own life conditions, by becoming more self-confident and more future-orientated.

Training of para-professionals and supervision of their work in the field has to be carefully attended to, and therefore the best way to start is in a small exploratory way, with a pilot project that is evaluated. The pilot project will allow for local expertise to develop, before such a programme can be implemented on a large scale, with its multiplying effect in the community.

Co-operation with universities is a way to secure qualified local personnel, who can participate both in the assessment of the need and in the evaluation of the developmental effects of the sensitising programme. In the pilot project with emphasis on evaluation, professional assistance should be sought because this assessment will also serve as baseline for evaluation of later developmental effects.

One important assessment that is often overlooked is how the local population assesses the need, and do they want this type of project. The whole point of training is to sensitise, and build competence and confidence in members of an existing child caring system. This type of project should be sufficiently cheap, so that it can be taken over by the local community. Working in this way, it becomes possible to withdraw after some time and to transfer the project to the local resource persons.

ICDP IN ACTION

Quote from the report of a person trained as ICDP facilitator in Buenos Aires, Argentina:

"During my second field work I implemented ICDP through the local community centre "Friendship", which is in the outskirts of Buenos Aires, where poor migrant families and their children receive free meals, and have opportunities to socialize with each other.

I want to illustrate what ICDP means in practice through my experience with Juana, a mother with 6 children.

In our ICDP meetings, Juana revealed that the only way she can get her children to take any notice of her was to punish them physically; she went on, and not without some pride, to describe in detail her 'methods'. She also told us how her husband left to her all the responsibility of dealing with their children, and how straight after work, he would go to meet friends and get drunk, then return home only to fight with everyone.

I listened to Juana expressing her pain, her suffering, her feelings of loneliness and impotence about her family situation. My attitude was of total acceptance and empathy; without judgement or criticism. I let her feel my appreciation for her concern and efforts to educate and guide her children the best she can, under such difficult circumstances. At our meetings Juana was treated with love, was shown understanding, received praise for any positive aspect we noticed. After sometime, I noticed that she started to change. She trimmed her hair, her facial expression changed; she stopped looking angry about everything.

During one meeting we danced the typical local dance 'cumbia' and Juana really joined in, evidently enjoying herself. Afterwards, she went home and made herself look nice, waiting for her husband to come home. When he arrived she offered him a beer and that day he stayed at home and didn't go to meet his friends to drink. They talked in a positive way and from then onwards their relationship started to improve. Juana changed her behaviour with her children also. She stopped using physical punishments and found new ways of interacting which made gradually her children happier and which gave her happiness too, as well as confidence.

My example shows that the essence of the success of ICDP lies in our ability, as facilitators of the ICDP programme, to release our own ability for empathy and apply the 8 guidelines for good interaction in the way we relate to the caregivers we are working with. The sensitising exercises, the explanations, discussions, home tasks, role plays, analysis of interactive examples on the video or photographs, are all very important but for all that to work well and for an internal process of change to take place in participant caregivers, a change that is lasting and can have an effect on the rest of the community, we need to be an example of a patient, loving person ourselves. To put love in action is the essence of ICDP."

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An ICDP facilitator from Túquerres the province of Nariño, Colombia told us:

"I was training a group of foster mothers and one of them decided to implement ICDP on voluntary basis with 6 mothers who were doing their sentence in the local prison. Later the 6 mothers expressed that the participation in the ICDP programme restored hope in them, because they were able to express love without fear and because they could start to understand the needs of their children. "
After some time ICDP received a letter from the prison director saying that he found ICDP to be very beneficial and asking for ICDP courses to be given to the other mothers in prison.

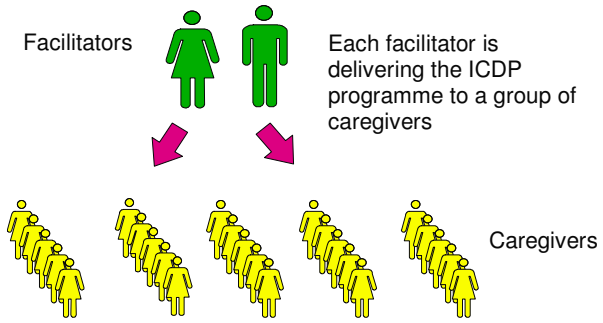
LEVELS OF TRAINING

The objective of ICDP work is competence building of personnel inside existing networks of care. Of particular interest are networks whose care reaches out to a large number of children.

Facilitator level

ICDP facilitators are the executors of the programme in practice with caregivers. They start by working with small groups of caregivers and gradually increase the numbers as they gain more practice.

Facilitators are not required to have formal education or previous psycho-social training. However, certain qualities are required, e.g. social acceptability in the community, social sensitivity, a joyful predisposition, and capacity for expressing enthusiasm and empathy.

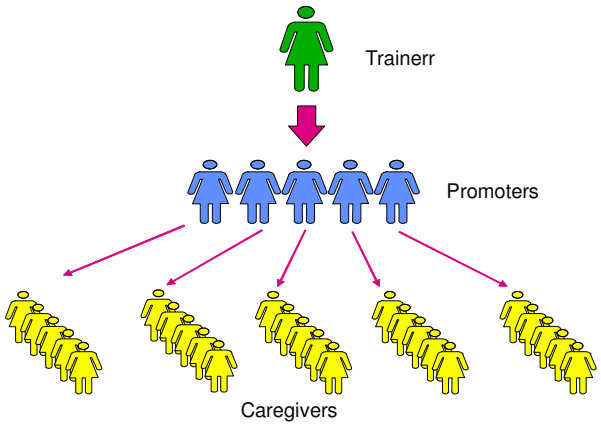


To become an ICDP facilitator a person needs to:

- Attend a training workshop, lasting 4 days
- Carry out a self-training project by applying the ICDP programme with a small number of caregivers and children, over a period of 3 months
- Give written and verbal report about project at an evaluation workshop

Trainer level

ICDP trainers are professionals trained in ICDP, whose task is to train others as facilitators of the ICDP programme, usually inside their organisations. This includes holding training workshops for new facilitators, as well as supporting and supervising their practical work with caregivers.



To qualify to become an ICDP trainer a person needs to have obtained the diploma as Facilitator and in addition to:

- Attend a trainer level workshop
- Carry out a second self-training project, by training and supervising a group of facilitators, over a period of 4 months
- Report about project at an evaluation workshop
- Produce written answers to 15 standard questions and write 4 pages about the theoretical background of the programme

HOW TO START

1 Introductory talks

At this initial stage the ICDP programme is presented to interested agencies, either as a talk, or a day seminar. The aim is to find out in general whether there are favourable conditions for the implementation of the programme in a sustainable way.

2 Feasibility study

In accordance with ICDP Pre-implementation checklist explore the local situation to find out about the need and the relevance of the ICDP programme for the local community. Make contracts with organizations that can spread the programme in a sustainable way. Contact local universities for possible future involvement in the evaluation. This is followed up by training at 2 levels:

3 Facilitator level

A 3,4 day workshop is held for up to 25 participants/trainees. Trainees then put ICDP into practice:

4 Self-training project

Trainees do practical work with ICDP applying it first with children and then implementing the programme with a small group of caregivers. Takes 3 month and there is support from ICDP. Afterwards they report about their experiences with the programme. An ICDP Facilitator level diploma is issued to those who fulfil the criteria and a cooperation agreement is signed with ICDP.

5 Trainer level

A workshop is held for those facilitators who wish to proceed with training to become ICDP qualified trainers.

6 Second self-training project

After the workshop there is a requirement for practical work, i.e. to carry out self training projects, which consists of training a new group of facilitators and supervising their work with caregivers. Takes 3,4 months.

7 Certification

Trainees report about their projects and produce the standard written work before receiving the ICDP Trainer Diploma. An agreement of cooperation is signed with ICDP.

THE BERGEN RESEARCH STUDY

In 1992, the ICDP programme was researched and positively evaluated by a team of experts from the University of Bergen, Norway, in a project linked to the Bergen health clinics.

The evaluation of the experimental and control groups was based on comparing the pre- and post-intervention assessments according to the same criteria.

All together 75 caregivers/children participated - 45 in experimental and 30 in the control group.
The participants were chosen from 4 different health clinics in the Bergen area and divided into 3 equal groups (A,B, and C). The following variables were used to determine the levels of psycho-social risk for the 3 groups: education, marital status, mother's age at the time when her child was born, handicap, illness and lack of ability to adjust to the child.

- In the first part of the project a video was made of all the participants in a play situation and the interaction between mother and child was registered and coded. All mothers were given an extensive questionnaire regarding demographic information, with questions also about their conceptions about child-rearing and their views about child development. An assessment was made by the nurses on the quality of interaction between each mother and child. Information gathered from the mothers about their own views about themselves and their children was recorded, using the Likert scale.

- During the second part, the ICDP programme was delivered to the experimental group over a period of 3 months. It consisted of meetings with the nurses, which alternated between group meetings without the child present and individual meetings with the mother and child. During the group meetings, there were 5 or 6 mothers present with one nurse.

- The third part of the project was concerned with making a new video of each mother's interaction with her child and the same questionnaires were used once more.

The questionnaires and the videos used in pre- and post-intervention were all coded in order to systematise and compare the results before and after the intervention.

RESULTS

The Bergen project was designed to see whether it was possible, through the ICDP programme, to sensitise the mothers involved so that they:

1. Improve their interaction with the child according to certain criteria.

2. Change their view of the child in a positive sense.

3. In addition, the project was to find out how each individual mother benefited from the sensitising program with regard to herself as well as her child.

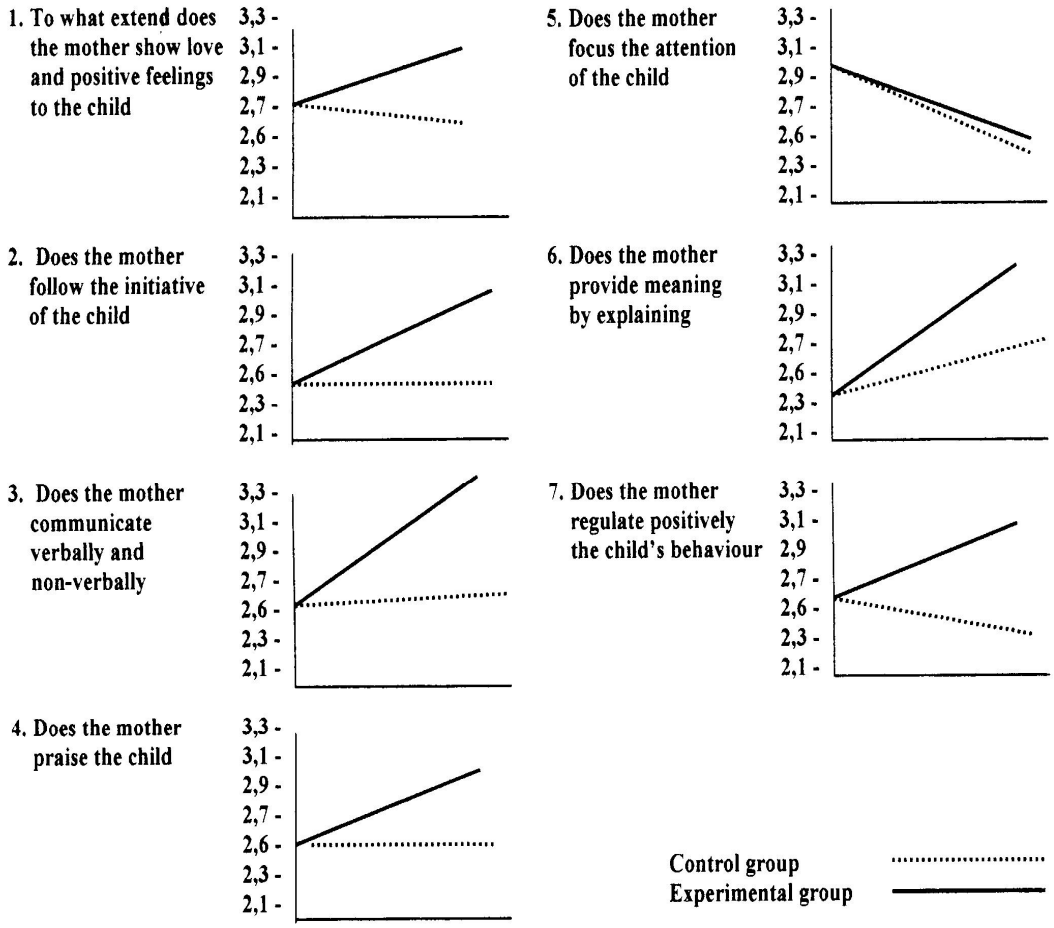
See next page for results.

CONCLUSION

The outcome of the evaluation proved on the whole to be very positive. This confirmed the assumption, that it is possible to upgrade psycho-social care (which of course, includes the affective side as an essential part of it) for children considerably, through a simple, sensitising training programme which reactivates existing child-rearing patterns of human care, without introducing any new techniques from outside.

BERGEN RESEARCH STUDY RESULTS

Results concerning the improvement of interaction are shown in the diagram below.



1. If one compares the experimental with the control group, one can see a clear improvement as far as the criteria for the emotional expressive dialogue are concerned (the first 4 criteria).
With regards to the mediational criteria there is a decrease in the first criteria (focusing) and an increase in the last 3 criteria (mediation of meaning, expansion and regulation of behaviour). This might have been due to the scoring procedure, since an increase in mediation of meaning will lead to a decrease in focusing, or it can be due to developmental changes since it happens in the control group as well.

2. Mothers from the experimental groups expressed the following changes in their perceptions of their child: they now saw their child as more active, independent, intelligent, more socially inclined, confident, peaceful, easier to have around, more loving and happy. This was in contrast with the changes in the control group which were seen to be more negative.

3. The mothers were asked to judge how much they benefited from the course scoring on the 5 point Likert scale: very little, little, medium, much, very much.
The results showed that 60% of the mothers answered 'much' and 40% 'very much'.
When asked how much did they judge their child benefited from the program, 65% answered 'much', 7,5% 'very much', and 27% 'medium'.

International Child Development Programme (ICDP) began developing its psychosocial intervention programme for children at risk in 1985 but an organisation was not founded until 1992 when it was registered as an international NGO, in Oslo, Norway.

The ethos of ICDP is to provide for human care by activating empathy and education of both caregivers and their children. The work of ICDP is based on the principles that are laid down in the UN Convention on the Rights of the Child. ICDP may participate directly or indirectly in activities run by other humanitarian organisations having corresponding objectives.

In 1993, the ICDP programme was evaluated by the Division for Mental Health of the World Health Organisation (WHO) in Geneva. The programme was later adopted and its manual published as a WHO document. Close cooperation with UNICEF has been established in several countries, particularly in Colombia, Guatemala and El Salvador.

ICDP offered training workshops to individuals, non governmental and governmental organisations in a number of countries, including Norway, Denmark, Sweden, Russia, Kyrgyzstan, Ukraine, Macedonia, Bosnia, Portugal, England, Italy, Palestine, Jamaica, Brazil, Colombia, Argentina, Paraguay, Uruguay, El Salvador, Guatemala, Angola, Ethiopia, Congo, Mozambique, Zimbabwe, South Africa, Indonesia, Sri Lanka and Australia. ICDP developed projects on large scales in Angola, Norway, Macedonia and Colombia. Local branches have been registered in several countries: ICDP Norway, ICDP Denmark, ICDP Sweden, ICDP Angola, ICDP Mozambique and ICDP Colombia.

Our focus:

Most agencies working with children who have undergone extreme deprivation naturally focus on their physical needs. But keeping them alive is only the first step. It is now well known that unless a child has a caring adult to love him and teach him life skills, social behaviour and morals that he needs, his mental and emotional development will be impaired. Recent research suggests that normal physical development of the brain depends on proper interaction between a caring adult and the growing child. In normal circumstances this happens naturally. But when there are stresses related to being uprooted through social changes, migration, catastrophes, children losing their parents, or having been numbed by severe deprivation and emotional shock, this care often breaks down and has to be reactivated through skilled help. If children do not receive sufficient love and attention while they are young, the problem also perpetuates itself because later on they become inadequate parents.

ICDP's focus, therefore, is on trying to break this cycle. It does so by reactivating and promoting caring skills inside families as well as inside relevant local networks working for the benefit of children and families.

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