



CARE FOR CHILD DEVELOPMENT

Adapted for the Latin American
and Caribbean Region

Technical Note



Care for Child Development. Adapted for the Latin America and the Caribbean Region

Contents: Participant manual – Facilitator notes – Guide for clinical practice – Framework for monitoring and evaluation.

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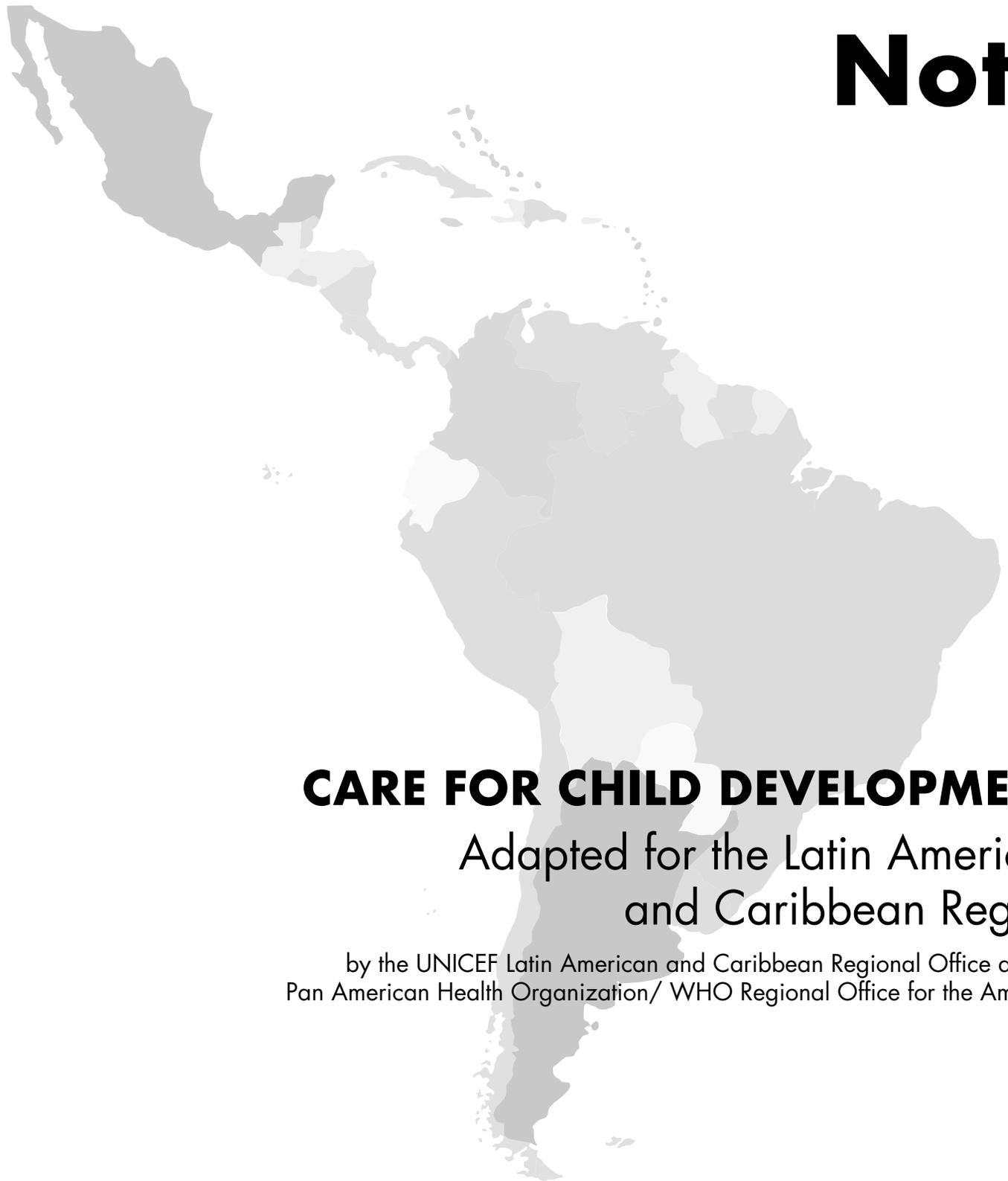
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The present document and accompanying package of materials were specifically prepared for the Latin America and Caribbean (LAC) region. They are adapted versions of the generic package developed and published by WHO/UNICEF in 2012. Modifications and additional content are based on inputs from regional experts in the early childhood development field and country professionals who participated in the workshops conducted in 2013-2015 in Panama, the Eastern Caribbean and Belize.

Technical Note



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Adapted for the Latin American
and Caribbean Region

by the UNICEF Latin American and Caribbean Regional Office and the
Pan American Health Organization/ WHO Regional Office for the Americas

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CARE FOR CHILD DEVELOPMENT: TECHNICAL NOTE

Executive summary

"If child survival is one of the most important unfinished challenges bequeathed to us by the twentieth century, then guaranteeing healthy growth and development for all children, a goal that is already being addressed in the twenty-first century, is key to meeting this challenge."

(PAHO/WHO, Monitoring Child Development in the IMCI Context)

The critical role of the health-care system, in coordination with other ECD, education, and social protection services, in ensuring every child's right to survival and development has long been recognized. It is the main system that reaches children under three years of age and their families, the most critical window for both risk and opportunity, and is responsible for ensuring a standard of health for children. More recently in the LAC region, other sectors and NGO partners are expanding ECD and family support services with a focus on the most disadvantaged (at-risk) children and families, as an integral part of a human rights-based approach to addressing survival and developmental issues.

Several strategies to incorporate psychosocial development (social-emotional, cognitive, communication, and physical (motor) development) into nutrition and health-care systems have been developed, such as including developmental milestones "on growth cards", but evidence for effectiveness has been slim. In response to this need, the World Health Organization (WHO) developed the Care for Development module to be a part of Integrated Management of Childhood Illnesses (IMCI) in the late 1990s. Additional support materials and training manuals were completed in 2001, and the module has been used in over 20 countries. Three evaluations of effectiveness have been completed. In Kazakhstan, Kyrgyzstan, and Tajikistan the intervention was associated with changes in the recommendations provided by the health care workers, by a few family behaviours, and in the two countries in which child outcomes were assessed, significantly higher scores among children under 3 years of age. An updated version of the global Care for Development module – renamed **Care for Child Development** – (2010) incorporates the revised WHO/UNICEF nutrition recommendations and the recent evidence demonstrating that critical caregiver skills (sensitivity and responsiveness) affecting the child's healthy growth and development can be taught to caregivers.

In LAC, numerous countries have included the use of development scales in center-based health and nutrition services for children under three, combined with other countries using specific screening instruments in community-based rehabilitation and/or early intervention programmes. Efforts are underway to build-on past experiences in the region and expand the implementation of actions which combined some form of developmental monitoring and/or screening with parent/family support initiatives.

This present document and corresponding CCD kit materials are modified versions of the original kit, prepared for validation in the LAC region. Changes to the initial text and incorporation of additional content are based on observations and inputs from regional experts in the ECD field – identified and prepared as part of a 2012 revision workshop and process.

Purpose of the new module – Counsel the Family on Care for Child Development

This new **Counsel the Family on Care for Child Development module** is to be used by a wider range of health workers in centre and community-based PHC and CBR services, along with other ECD, social protection and community workers to provide age-appropriate guidance to mothers, fathers and other caregivers for helping the child develop physical (or motor), cognitive, communication and social-emotional skills. The module has three parts: a list of recommendations by child age, a list of potential problems and possible solutions, and a checklist for the health-care and ECD workers to use to assess the interaction between the caregiver and child and help to decide whether more intensive work is needed. It is supported by training materials for health and other ECD workers, for facilitators, CCD field practice (in health clinics, ECD centres and community/home-based settings) and a framework and guide for monitoring and evaluation. This material should be considered as being a complementary tool to existing material and instruments, for use within existing IMCI, ECD and CBR programmes, with the aim to reinforce parent and caregiver support and competency building for key aspects related to child development.

How the module is used with the parents, family members and other caregivers

The module was originally developed to be part of IMCI, and was specifically linked to the guidance on infant and young child feeding on the Mother's Card. Thus the initial format is based on the IMCI model of assessing feeding and making recommendations for improvement. Using a counselling approach, the health or ECD worker asks parents or other caregivers about how she or he plays and communicates with her child. The health or ECD worker then listens to the answer, praises the actions of the caregiver that are positive, and provides advice if needed. Finally, the health or ECD worker checks to see whether the caregiver has received and remembered the information. In the new **Care for Child**

Development, the same four-step counselling approach is used (Ask and Listen, Praise, Advise, and Check Understanding). Suggestions for helping the caregiver with problem solving are included. In order to help the caregiver carry out the recommended actions, the health or ECD worker should encourage the caregiver to try out activities during the health visit and provide feedback, including discussions to see whether the caregiver is clear and competent on how to apply the activity in their home setting and improve the learning environment for continual support.

The assessment questions are: how do you play with your child, and how do you communicate? The reason for using the words “play” and “communicate” is that they should be understandable to families and not technical, but that they capture the dimensions of responsive and sensitive care. “Play” refers to the ways that children manipulate objects as they try to master new skills in the process of cognitive development. “Communicate” refers to the ways that parents and children send messages to each other, including signs, gestures and words, which reflect social, emotional and language development.

Revision of the module into Care for Child Development

The revised title incorporates the word “Child” in the title to make the focus more clear. The materials incorporate new issues (e.g. the non-breastfed child, maternal depression), and new age groups (e.g. the first week of life is separated). Through the initial review process in LAC, additional modification points have been identified for adapting content to best respond to the LAC context and development in this field. Some of the key points or new issues recommended are: include the incorporation of additional ECD and community workers to complement health services and family support actions; promote a rights-based approach to ECD efforts (in line with the CRC and CRPD); introduce initial ideas and recommendations pertaining to young children considered most excluded and at-risk: from poor families, especially in disperse rural areas; indigenous children, with a significant development delay and/or disability, and those facing situations of violence, conflict or natural disasters.

Evidence for effectiveness

Two pilot studies have been undertaken in Brazil and South Africa. The Brazil study identified that health workers could learn, and more of them were to complete, the tasks in the counselling on **Care for Child Development**. Caregivers could understand and try out the tasks at home. The South Africa research identified that counselling on **Care for Child Development** could occur during an IMCI sick child consultation and training in the Care intervention enhanced, rather than detracted from, the health workers' IMCI skills in assessing and treating children. Another two efficacy trials showed that the intervention could increase the play and communication activities of parents to stimulate their children (Turkey; Ertem et al., 2006) and enhance the child's development (rural China; Jin et al., 2007). An assessment of programme implementation in three countries showed that the intervention was able to be implemented at scale, and resulted in changes in health worker perceived competencies, recommendations made during consultations, a few parental behaviours and, in two countries, assessments of child -development (Engle et al., 2010).

As an integral component of the LAC process, new studies will be required to assess programme implementation and effectiveness, taking into consideration the proposed expanded focus and sector involvement.

Developmental assessment

The Care for Child Development materials support an intervention to stimulate the child's development and improve caregiver-child interactions, along with taking steps to strengthen the child's home or main environment for all aspects leading to development, learning and inclusion. Although the recommendations for play and communication are based on the child's age-related learning needs and growing capabilities, the materials do not provide family workers with the skills to assess developmental milestones. However, for many LAC countries, this CCD intervention and material is complementary to existing or emerging growth and developmental monitoring actions in the region.

In some LAC countries, health providers and other ECD workers are responsible for assessing the development of children at regular intervals in order to promote development and detect children in need of early intervention. Valid developmental assessments, however, should be part of a system that can also provide accessible and effective interventions for children identified with more significant developmental delays and/or disabilities. In countries with resources to set up a balanced assessment and intervention system, it is recommended that screening begins with family concerns about the child. Screening children with possible developmental delays, where families can get help, is preferable to expending financial and human resources for routine testing of all children.

In cases where a significant delay or disability are identified, the first response and orientation by health and ECD workers are critical elements for parents and other family members – even though a referral process is available and initiated. A positive and supportive attitude of health and ECD workers is essential. Parents need to know and believe that children with developmental delays and/or disabilities have the same rights and needs as all children and can learn and develop – even if the developmental process is slower. However, involvement and initial orientation by health and ECD workers will probably require additional activities and support for preparing a safe and inclusive learning environment in the home setting.

Care for development: the background

a. Basis for the recommendation

The decision to develop a module for care for development, and the basis for the model, was outlined in an extensive literature review of the links between nutrition and development, *A Critical Link* (WHO, 1999). The conclusion of the review was the importance of the earliest years and the interaction of nutrition and development, including the quality of care provided to the child, such as in responsive feeding. These two were to be merged in the module.

The report concluded, “There is ample evidence that successful nutrition interventions improve physical growth. There is also evidence that such interventions, including also promotion of sound breastfeeding practices, can significantly improve psychosocial development, and have a significant and positive impact on child cognitive and motor development if implemented early in life. This applies also to the disadvantaged children who live in a poor environment and are at higher risk of malnutrition, illness and poor development. It has also been shown that psychosocial interventions alone can improve child psychological development. These interventions, too, should start very early in life – as children are most vulnerable at this time – and would also be effective after this period. The first few years in life are therefore the most sensitive ones to both nutrition interventions and psychosocial interventions. When simultaneously implemented, interventions to promote growth and those to promote psychological development have even a greater effect than when carried out individually. A “critical link” has thus been established between physical and nutritional status of the child and his/her psychological development”.

“As the main source of physical and emotional care for young children is the family, parents need to be involved and provided with the necessary skills to feed their children adequately, stimulate their development and be responsive to their psychosocial needs. Of practical interest is recognizing that behaviours to improve nutrient intake and psychosocial support require just a few skills from child caretakers. Counselling families

to develop and strengthen those skills is therefore an approach to be undertaken. There is initial scientific evidence that counselling caretakers on child feeding, as promoted in the integrated childcare approach of IMCI, can ultimately result in weight gain and improved nutritional status. Large-scale early childhood care and development (ECCD) interventions in developing countries have resulted in improved short and long-term educational outcomes; to have long-term effects on development, interventions should be intensive and protracted for several years” (Pelto et al., 2000).

The module included recommendations to parents to support cognitive development (play), social-emotional and language development (communication), and responsive feeding, as well as breastfeeding and complementary feeding. One basis for the recommendations was derived from the WHO Mental Health and International Child Development Programme recommendations for good mother-child interaction, “Eight guidelines for good interaction” (WHO Mental Health, 1998), and critical care practices as summarized in *Care for Nutrition* (Engle PL, 1997).

The recommendations were based in part on the contextual psychology of Vygotsky (1978) and the attachment theories of Bowlby and Ainsworth that emphasize the importance of mother-child interaction patterns, emotional availability and responsiveness of the caregiver to the child for emotional and cognitive development (Bowlby, 1969; Ainsworth, 1978, 1989). These theories have now become the dominant explanatory models for developmental psychology that address cultural issues (e.g. Bornstein et al., 2008). Developing an early emotional connection to a caregiver, or an attachment, is critical for an infant's well-being (Isabella, 1993; de Wolf and van IZedoorn, 1997).

Care for Child Development encourages the experiences of positive contact between child and caregiver.

These dimensions are consistent with three aspects of parenting that Shonkoff & Phillips (2000) found to be

consistently related to young children's cognitive and social-emotional competence: (1) cognitive stimulation, (2) caregiver sensitivity and responsiveness to the child, and (3) caregiver affect (emotional warmth or rejection of the child). From the infant's perspective critical outcome dimensions are age-appropriate exploring and enjoyment and involvement, and the infant's interest and success in engaging the mother.

A marked deficiency in the early environment, both due to lack of stimulation and absence of attachment to a significant other, such as occurs in a poorly run orphanage, can have significant negative effects on cognitive functioning. Toxic stress, or “strong, frequent or prolonged activation of the body's stress management system,” can affect brain development and possibly later learning and memory (National Scientific Council on the Developing Child, 2005).

Researchers in South Africa evaluating the effects of the HIV/AIDS pandemic on young children reached somewhat similar conclusions (Richter, Foster & Scherr, 2006). They concluded that every child needs a continuing relationship with at least one person for whom that child is special. These researchers also emphasized two other basic requirements: that the mother-infant dyad has adequate sources of support (economic as well as social), and that they belong to a larger social group (Richter, Foster & Scherr, 2006). In many developing countries, access to resources and to the wider context of social support is absolutely essential to child survival and development.

Responsivity and sensitivity are also necessary for a young child's cognitive development. Numerous studies have demonstrated the effectiveness of stimulation for improved development in many developing countries (e.g. Walker et al., 2007). These studies demonstrate that children's cognitive development can be improved through adult support of children's cognitive capacities through a process called “scaffolding”, in which a child is encouraged to consider new options or extend her thinking through adult facilitation and joint attention

(both adult and child attending to the same task). The amount of language exposure, particularly language used meaningfully or in context, is strongly associated with later language development, which in turn affects school performance and success (Brooks-Gunn & Duncan, 1997). Learning materials that provide children with opportunities for manipulation and control, whether homemade or purchased, and books are important supports for learning in many societies (Bradley & Corwyn, 2005). For example, a recommendation for cognitive development (Play) for 6-12 months is to “give your child clean, safe household things to handle, bang and drop”. The recommendation stresses the child's control over the materials, and the experimentation that the child should do with them. It also shows that children do not need purchased toys for learning.

These concepts of sensitivity and responsivity underlie the recommendations in the **Care for Child Development** intervention. For example, the “communication” recommendation for 1-6 months to “get a conversation going with your child with sounds or gestures by copying your child's sounds or gestures” is an adaptation of one of the eight principles of good interaction and emphasizes sensitivity (reading the child's cues), responsivity (responding to the child) and emotional exchange. The recommendations are made more specific than the guiding principles based on piloting.

The CCD intervention approach is built on evidence shown as to the importance and benefit of guiding parents, family members and other caregivers in actions to prepare a safe and stimulating environment for young children – especially for the most disadvantaged. The present LAC modification process continues with this priority focus, but includes additional information to initiate increased support for parents and other family members with children with developmental delays and/or disabilities, along with highlighting elements that focus on including fathers, addressing violence against young children linked to physical punishment, and promoting more inter-sectoral efforts.

Within the growing international debate on the rights of persons with disabilities, recent publications have highlighted multiple issues and priority areas related to CRPD commitments. In addition to recent WHO, World Bank and UNICEF global publications on the topic of disabilities, two specific WHO and UNICEF documents provide important inputs to the topic of the importance of early intervention for children with developmental delays and disabilities and involving parent and other family members in addressing the rights and developmental needs of these children:

Early childhood Development and Disability: A discussion paper (WHO and UNICEF) and *Developmental Difficulties in Early Childhood – Prevention, early identification,*

assessment and intervention in low-and middle-income countries. (WHO). UNICEF and WHO highlight key areas that require attention: “Despite being more vulnerable to developmental risks, young children with disabilities are often overlooked in mainstream programmes and services designed to ensure child development. They also do not receive the specific supports required to meet their rights and needs. If children with developmental delays or disabilities and their families are not provided with timely and appropriate early intervention, support and protection, their difficulties can become more severe – often leading to lifetime consequences, increased poverty and profound exclusion”.¹

b. Operational decisions

Age groupings and multi-sector involvement

A number of decisions were taken in designing the most recent global recommendations. First, the decision was to provide guidelines for children from birth to 5 years old, with a particular emphasis on the youngest of that group, from birth to 3 years, because this is a critical period for effectively influencing the child’s development. Second, the intervention is often delivered through the health system, as the health system is the most likely service to reach the youngest children, starting at birth. Third, within the health system, the **Care for Child Development** intervention can fit within the preventive, promotive, and care services for mothers and children as well as a whole range of other services dealing with families.

With the modification process in LAC, actions will continue to focus on the birth to 3 years of age priority group, with a strong family/caregiver focus. However, efforts will be made to achieve an expanded “partnership” vision to promote the preparation and inclusion of other sectors and ECD programmes. In addition, emphasis will be given to include increased paternal involvement, while expanding inputs related

to a rights-based approach and initial family support for children with significant developmental delays or disabilities and/or facing other risk factors.

Developmental assessment

Health services in some countries have the responsibility of providing a developmental assessment at regular intervals in order to promote child development through family involvement and detect children in need of early intervention, especially with a family focus. In cases of developmental delay or disabilities, the earlier the intervention can begin, the more likely it is to be effective in ameliorating the risk and reducing the potential long term impact on the child’s development and on the confidence of parents and caregivers in terms of their parenting skills. Developmental assessment or screening should be part of a system of early intervention for children with disabilities and delay.

In numerous LAC countries, different forms of screening and/or developmental monitoring are underway, with ranging degrees and quality of follow-up services. For those countries without a system of early intervention, screening is not recommended especially on a national

¹ UNICEF; 2013 State of the World’s Children – Children with Disabilities and WHO – World Bank World Report on Disability

level. However, caution should be exercised against the justification of “inactivity” base on the assumption that services are not fully available. Children with developmental delays and/or disabilities will be identified with different levels of frequency – with or without a screening system - and families cannot be left on their own without orientation.

Screening is the early identification of possible developmental delay or disability in order for early intervention to occur to address the delay or disability through family involvement. The Care for Child Development (CCD) approach utilizes a counselling strategy which provides support, knowledge, and skills to parents and other caregivers in order to help them support their child's development. The CCD intervention can be incorporated into a variety of programs including more complex systems that include the assessment of child development skills, with the health worker observing and gaining a better understanding of the interaction between the caregiver and the child by asking the caregiver to, “show me how to get your child to smile.” While this assessment on smiling does not specifically identify the child's developmental level, if the caregiver expresses a concern, it will be discussed. At present, while certain countries have materials (e.g. growth cards) that contain developmental milestones without specific information as to how to encourage development through parental actions, nor provide cut-off points for developmental delay, others have advanced in developing and utilizing more detail instruments and parent centred materials for monitoring and stimulating development.

Which approach is most appropriate will depend on the circumstances and resources of health, rehabilitation, education and social protection systems and the operational capacity at the local level (health or ECD centre, community-based rehabilitation or early intervention). If a health or ECD centre has: the ability to deliver quality health care or ECD interventions to most children including family/caregiver involvement, trained staff to administer developmental scales tests, and referral options if a delay or disability is detected, screening of high-risk children would be recommended. The earlier the intervention for children with disabilities, the more likely it is to be effective. However, there are many countries that do not meet these criteria – there

are no referral services, and much of the delay observed is due to poverty or malnutrition. In cases where there are no resources for referral, the health-care or ECD worker who assessed the child and determined that there was a delay would simply recommend additional actions by the caregiver. In these cases, a counselling approach may be preferable as a starting point.

On the positive side, an emerging number of LAC countries are undertaking developmental monitoring actions and/or different forms of screening, combined with different levels and coverage of referral services. In these countries, trained personal are found in or working with the health sector to provide support for young children with developmental delays or disabilities and their families. Screening and other forms of early detection include some of the following strategies: newborn screening (NBS) for specific metabolic and genetic disorders; hearing and visual screening; implementing developmental monitoring actions; and undertaking community level disability identification (survey) processes. In all aspects, counselling and supporting parents, family members and/or other caregivers are critical elements.

Adopting a counselling approach should be seen as an appropriate strategy for all health and ECD support services working with young children and their families, no matter if screening is undertaken or not. It should not be seen as an either or situation. Steps towards strengthening parent, family and caregiver capacities and skills to promote the care and development of their child is appropriate for all systems – and extremely valid for all children, especially for those most disadvantaged.

Although the identification of young children with developmental delays and/or disabilities is an important step to guarantee these children with their right to achieve their optimal development, certain considerations should be given by countries when designing screening strategies. Some of the following are:

- With or without referral options after a screening process, the family has to deal with the child's disability and explore strategies to assist their child's development. Therefore, CCD interventions with additional parent and family support are critical.

- If a child appears to be developmentally delayed due to poor environmental conditions or inadequate stimulation, the most effective approach is to counsel the family to improve their responsiveness to the child's rights and needs and work towards strengthening their competency to guarantee a stimulating environment.
- The final outcome of a screening process may lead to a range of results. An incorrect assessment and "classification" at an early age and/or placing "a disability label" on the child can have long-term social consequences for the child and parents. Preparing all levels of health workers for initial parent/family orientation process is critical, to guarantee the essential motivation, appropriate attitude, and initiative to assist the child's development and inclusion.
- Developmental screening tests that are sensitive, specific and based on local norms is a major undertaking. In a range of LAC countries, efforts have been made to design developmental monitoring instruments and screening tests for infants and young children, based on undertaking the required research and validation efforts. However, for other countries and those with significant diversities within country borders, far more research is required to identify appropriate screening materials for infants and young children, as well as developmental standards that are relevant for children in different cultures and resource-poor environments.

c. Past and present changes in the new Care for Child Development materials

After 10 years, there was a need for a review and revision of the global Care for Development materials. Although a number of changes were recommended, a decision was made to undertake minor modifications based on a revision of the materials and the card, but no need was seen for a major overhaul of the basic approach. The changes and the rationale for the change to the core set of CCD materials are listed below, with additional comments pertaining to recent modifications suggested for the LAC region, based on a recent regional revision process:

Global changes undertaken

1. **Title.** The first change is to the title, which will now include the word Child in order to distinguish it from economic development.
2. **Newborn care.** There is an increasing focus on the newborn, and there needs to be specific recommendations for that age period. Therefore, the new card includes recommendations for the child from birth to one week, and then one week to six months rather than 0-3 months and 4-6 months. This has implications for the recommendations.
3. **New checklist for health workers.** In the initial Care for Development, the health worker recorded whether or not there was a recommendation given on the overall checklist, and this information was also recorded in the IMCI monitoring form. However, since this recommendation did not have any actions associated with it, or any indicators, it tended not to be used. The current module includes a guide for the health worker to record observations for the visit and suggests specific recommendations that the health worker can make. This form could be used for ongoing programme monitoring.
4. **Maternal depression, distress, and well-being.** Recent research suggests that maternal depression is much more common than previously believed, particularly in areas of poverty and social exclusion for women (e.g. South Asia), and that there are risks for infants when mothers are depressed (Patel V et al., 2004). The new Care for Child Development

incorporates recommendations for dealing with maternal depression.

5. **HIV and AIDS.** In order to address the increasing number of young children affected by HIV and AIDS, recommendations for children not living with their parents are included.
6. **Motivational statements.** Current research suggests that having a rationale for action linked to one's beliefs increases motivation for behaviour change. For that reason, more attention has been spent on explanations for actions, and there are suggestions to community health workers that caregivers need support and want the best for their children.
7. **Information on harsh punishment.** The previous version of the Card did not include any recommendations or problem issues related to punishment. However, there is increasing concern about the dangers of harsh punishment, and their wide usage in many countries. Therefore, a question on discipline has been added to address these concerns.
8. **Adding specific suggestions on toys and books.** The earlier version focused primarily on using home-based materials for playing and exploring. However, the increase in evidence on the importance of early exposure to books, and interactions around books and pictures, and the importance of learning materials has suggested that there can be specific suggestions to incorporate books and some toys into the Card.
9. **Father and family.** The earlier module used the term “mother” rather than specifying who the caregiver was. However, the increasing understanding of the importance of men's role with young children has led to specific suggestions for male involvement and use of the words Caregiver or Parent rather than just “mother”.
10. **Rights.** A Statement on Rights is in the beginning of [Counsel the Family on Care for Child Development](#).
11. **Allowing Care for Child Development to be a stand-alone module.** Many countries do not have IMCI, and there was a clear decision to create a module that could be incorporated into any primary health care rather than only IMCI. Therefore, the structure has been changed to be a stand-alone card and training manual. As part of that decision, it was decided to separate it from the nutrition component as well.
12. **Increase the number of components.** The original Care for Development module provided information and recommendations for families to help them provide cognitive stimulation and social support to all young children as part of the child health visit specified in IMCI. WHO prepared not only the Care for Development recommendations, as part of the Counsel the Family Card, but also prepared advocacy materials (video and newsletter), technical seminars, training materials for the trainers of health workers, a facilitator's guide for training of trainers, and videos for advocacy and training.

Proposed modifications for LAC version (in addition to the above modifications for future validation process)

1. **Titles for different documents:** The title for the original “Guide for Clinical Practice” was modified to “Guide for CCD Field Practice”, to reflect an expanded vision of training and material use, beyond the present health focus.
2. **Alternatives for Checklist:** For the LAC region, two alternative formats (to be validated) are proposed for use by health and ECD workers, maintaining the main components of existing content but expanding elements related to the following: (1) additional items have been included in the section of “child background information” for use by health and ECD workers to achieve a better understanding of related family and environment factors (2) in the short form, the backside/page is designed to include any existing developmental scale or monitoring instrument used in country to promote a more integrated approach; (3) in the long form, more space has been included for writing/ registering observations for two different appointments; and (4)

for both formats, a more detailed section has been included for scheduling follow-up appointments and for tracking referral processes.

- 3. Alternatives for Counselling Card:** Based on LAC revision recommendations, two alternative formats (to be validated) are proposed for the counselling card, including: (1) a short form based on the existing counselling card with minor changes to the cover page and section on counselling families about problems to CCD; and (2) a long form which includes two supplementary pages focusing on additional activity recommendations by age group and providing more detailed information for family/caregiver counselling on problem areas.
- 4. Father and family:** Additional visibility has been given to the important role and involvement of fathers, as part of the strategy to implement CCD interventions and to improve the home environment for learning.
- 5. Rights:** For the LAC version, additional references are included to emphasize a rights-based approach, in accordance with the CRC and CRPD.
- 6. Promotion of a multi-sector vision and CCD material use:** For the LAC region, suggestions are made: (1) to include the application of the checklist and counselling activities in other ECD settings and (2) to incorporate the involvement of multiple sectors in CCD intervention application, in addition to the initial focus on the health sector.
- 7. Children with developmental delays and disabilities, and their families:** Considering that children with disabilities and those with significant development delays are often the most disadvantaged and excluded, especially if they also face other risk factors, consideration has been given to include related CCD elements to expand parent and caregiver support and counselling. This is in line with emerging activities in the region to comply with both the CRC and CRPD.
- 8. Incorporation of CCD intervention within existing systems, and at all levels:** Throughout CCD documentation, emphasis is given to the incorporation of CCD interventions as part of existing systems as a complementary element – not as a stand-alone action.
- 9. Expanding menu of advocacy and training workshop options:** In addition to the proposed agenda presented in the Facilitator’s Guide for training CCD providers, an expanded menu of training topics (blocks) are included to support actions to incorporate CCD interventions as part of health and ECD systems.
- 10. Identification of additional components to consider for development, in future validation and review processes:** Although briefly mentioned, issues pertaining to the use of a wide range of communication strategies for expanded parent, family and other caregiver support should be strengthened to complement direct counselling actions. Strategies for implementing CCD actions with indigenous populations are missing, and should be discussed at a country and sub-national level, to identify culturally appropriate approaches for CCD interventions.

The list below shows all of the components that are currently available for the new and updated WHO/UNICEF **Care for Child Development**.

- Foreword – Acknowledgments
- Care for Child Development: Improving the Care of Young Children

Course materials:

Counsel the Family on Care for Child Development

- Care for Child Development: Participant Manual
- Care for Child Development: Checklist (2 alternatives) and Counselling Cards (2 alternatives)
- Care for Child Development: Facilitator Notes
- Care for Child Development: Guide for CCD Field Practice
- Framework for Monitoring and Evaluation
- Poster: Recommendations for Care for Child Development

CD-Rom:

Technical, Advocacy and Training Resources

- Care for Child Development: Guide for Monitoring and Evaluation
- Course Materials
- Presentations for Technical Seminars
- Reviews of the Evidence
- Training and Advocacy Videos
- Other Resource Materials



CHECKLIST for Counselling on Care for Child Development
(Short Form and Developmental Scale)

Child's name: _____ Family: _____

Address, Community: _____ Urban/Rural: _____

Caregiver's Name (Daytime): _____ Relationship: _____

Caregiver's Name (Nighttime): _____ Relationship: _____

Number of Siblings	Child name: 1st	Child name: 2nd
Father/Male Involvement	Yes/No	Yes/No
Family Income Source	Farmer	Other
Significant health conditions or other disability in family	Yes/No	Yes/No

1. Identify practices to support the child's development and counsel the caregiver and record any relevant observations.

Look	Praise the caregiver
How does the caregiver show he or she is aware of child's movement?	How does the caregiver show he or she is aware of child's movement?
Your dates: _____	Your dates: _____
How does the caregiver comfort the child and how long?	How does the caregiver hold the child and how long?
Your dates: _____	Your dates: _____
How does the caregiver protect the child?	Does the child have unmet needs with appropriate toy or activity?
Your dates: _____	Your dates: _____
How does the caregiver protect the child?	Stimuli: Child This caregiver doesn't talk to or play with the caregiver's child by giving alternative
Your dates: _____	Your dates: _____



Developmental assessment

Similar to the previous Care for Development materials, the new **Care for Child Development** materials do not assess developmental milestones, although all of the recommendations are developmentally based. Second, as before, one of the problem areas identified is the caregiver reporting that the child seems to be developing slowly. In this case, the health or ECD worker is provided with a series of simple screening questions for vision and hearing to help determine these potential problems. Screening questions for potential sensory problems should be complemented by suggesting to the health or ECD worker to observe any delays or problems for physical movement and manipulation skills of the child.

However, there is an increasing interest in incorporating some form of early detection or screening in health systems as part of a strategy to improve early child development. In general, the recommendation in this case is to use an instrument that emphasizes the partnership between the parent and the health-care provider, as described by Ertem et al. (2008). In low- and middle-income countries (LAMI), the caregivers of a child assess their concern with the child's developmental progress with a series of questions that help to develop an assessment. This instrument is specifically designed to function in lower resource settings. Numerous LAC countries have past and existing experiences in applying a combined early detection and intervention plan (e.g. Jamaica and Nicaragua, in the past use of the Denver and Portage, with Panama utilizing national instruments), while for an increased number of countries, developmental monitoring or screening instruments are already available and in use (e.g. Chile, Colombia, Brazil.).

A second option is the Ages and Stages Questionnaires mentioned above (Squires et al., 1997). Although these were originally developed for a US population, they have been used in a variety of countries and efforts are under way to validate their use in other countries. They contain more specific examples of behaviours, and the caregiver is asked to observe the child and make ratings as indicated. The battery includes a series of questionnaires divided by age group, and a scoring strategy for the parent to be able to determine if the child is at risk.

This instrument requires a higher level of literacy than the Ertem et al. instrument; it is supposed to require a reading competency equivalent to completed primary. It has been used in an interview mode, but not validated.

Both of these instruments have sensitivity and specificity ratings that are equal or superior to more standard clinic-based testing such as the Denver Developmental Screening Test (Oberklaid, 2005). They have the advantage of not increasing the time spent by the health worker, and providing new information about development to the caregiver. There may be few situations in which a system for intervention is in place, but the caregivers do not have the capacity to fill out the instrument.



Validation of the materials (for original CCD materials)

A. Pilot tests

Since the approach was relatively new, three different trials were undertaken to evaluate the effectiveness of the materials. In Brazil, the materials were used with health workers, and their understanding and recall of the concepts were assessed. In South Africa, a field trial assessed changes in health workers' behaviour in consultations, understanding of messages, and client satisfaction. Finally, in Ankara, Turkey, the impact of the evaluation on not only attitudes and behaviour, but also the quality of the home environment was assessed.

The Brazil Field Test (dos Santos, Gonçalves, Halpern, & Victora, 1999)

A small-scale field test was conducted to assess if mothers were able to understand the messages being delivered and if the messages resulted in changes in maternal behaviour regarding child stimulation. Five physicians were trained on the nutrition module and the Care for Development module, and six were controls. For each medical doctor (both groups), a trained anthropologist carried out structured observations of five clinical attendances of children under two years. These children's caretakers were interviewed soon after these consultations, to assess their recall and understanding of the counselling provided. Approximately half of the 109 caregiver/child pairs were in the intervention group. One group of 68 was observed in the session with the physician, interviewed at exit and one week later, and the other group of 41 was not observed but interviewed at exit only. Caregivers' memory of the message, and expectation of doing the activity were assessed.

The results suggested that all but one of the five intervention physicians made a recommendation for Care for Development, but more recommended communication (79%) than play items (60%). They were significantly more likely to praise the mother (70% vs 19%) and check her understanding (78% vs 32%) than controls. When Care for Development was used, the average session time increased from 20 to 27 minutes.

All observed mothers recalled some messages both at the exit interview and seven days later. The most commonly recalled messages were (from the most frequent): Get a conversation going with sounds or gestures; give child clean household things that are safe

to handle, bang and drop; have large colourful things for your child to reach for; play with child; and respond to your child's sounds. Although the physicians were less likely to give play messages than communication messages, four of the five most frequently recalled messages were about play. Interviewed, but not observed mothers, all remembered a message and recalled the same set of items. Among the intervention group, about 66% of mothers were already doing the activities and the remainder reported trying them.

The field test indicated that physicians can be trained to do this assessment (ask the questions) and give recommendations, mothers can recall them, and in this setting of southern Brazil, they are already being done. The physicians felt that the Care for Development training should be expanded with more exercises, they were less clear about the developmental levels, and felt more comfortable with the communication items than the play items. They recommended a training video.

South Africa Field Test (Chopra, 2001)

The purpose of this field test was to evaluate the implementation of the improved model of training for Care for Development with nurses, and its use within an IMCI sick child consultation.

A before/after design was used, with structured observation of consultations of the participants with eligible mothers and children, and exit interviews with the caregivers after the consultation. In the Western Cape, 21 nurses were trained on Care for Development and Feeding. A subgroup was observed a week before the training, and all 21 were observed during the training. In the training, the 14 nurses in the pre-test did not differ

from the seven who were not pre-tested, so the results were combined.

Trained nurses improved their general responsiveness to caregivers, increasing from 10% praise during the pretest to 58% during training, and 72% a week later. They also increased checking the caregiver's understanding (7% pre- to 58% during training and 67% later), and encouragement of the caregiver to talk (38% pre- to 64% during training). The authors conclude that “the modified IMCI training has been very effective in generally improving the performance of health workers in their communication and counselling for feeding and

care in the short term”. The authors recognize that a pretest/post-test design, with the supervisor observing the nurse in session, reduces the validity of the study. However, the behaviour changes were substantial; the problem is the ability to attribute these changes to the intervention. The authors commented that the group of trainees that was able to practice the feeding and care for development separately did perform better than those who did them together, but no reason was given. Finally, they comment on the relatively poor recall and responses of caregivers especially with respect to play and communication during the exit interviews, but again, data are not presented.

B. Efficacy trials

Ankara, Turkey (Ertem et al., 2006)

The first efficacy evaluation of the Care for Development module was performed in 2004 at the Department of Pediatrics, University of Ankara. The hypothesis tested was that the intervention group would have more play and communication activities in the home one month after an intervention than the control group, using the Home Observation Measurement of the Environment instrument, or HOME Scale. The design was sequential: two physicians saw 113 children for illness in the hospital and then in the home one month later. The two physicians were then trained, and they proceeded to see 120 caregiver/child pairs, of which most returned for a follow-up visit seven days later. They were also observed in their homes using the HOME Scale one month later. The sample was recruited from the Ankara Pediatric Outpatient Clinic, serving low- to middle-income families. Only those 24 months or younger, and with relatively minor illnesses or those who were coming for well-baby care were included. There were no differences between groups on any socio-economic status or illness measures.

The mean duration of the initial visits was 25.6 minutes (SD: 6.1) in the comparison group and 36.9 minutes (SD: 10.5) in the intervention group ($P < .01$), or 11 minutes more, which is slightly longer but quite similar to the Brazil estimates of seven minutes of increased time.

At the one-month home visit, 95.0% and 13.3% of caregivers in the intervention and comparison groups, respectively, stated that the paediatrician provided information on promoting their child's development. The two groups also differed significantly on their scores on the HOME Scale. Significantly more families had optimal HOME Scale scores (17.5% vs 6.2%), more homemade toys were observed (42.5% vs 10.6%), and more caregivers reported reading to their children (20.0% vs 3.5%) in the intervention than in the comparison group.

After the Care for Development training, physicians were observed to use two counselling skills more frequently: encouraging the caregiver to talk (observed in 45.1% and 99.2% of the visits before and after care for development training, respectively; $P < .001$) and encouraging the caregiver to ask questions (observed in 42.5% and 85.8% of the visits before and after care for development training, respectively; $P < .001$).

There was no apparent negative effect on health care. At the one-week follow-up, 88% of children had recovered. In fact, the intervention group provided significantly fewer incorrect medications. Moreover, patient satisfaction was high in both groups.

The authors conclude that the Care for Development intervention is an effective method of supporting caregivers' efforts to provide a more stimulating

environment for their children and can be used by health-care professionals during visits for acute minor illness. Whether such a brief intervention might have a long-term impact is a question that should be investigated.

Rural China (Jin et al., 2007)

A second efficacy trial was performed in rural China, using a child development measure as outcome. The Jin et al. study (2007) evaluated the efficacy of the Care for Development intervention in rural China using home visitors who visited twice with caregivers over a six-month period. In the study, 50 mother/child pairs were randomly assigned to each arm of the study for a total of 100 children. Children were aged below two years; the families were selected after an initial survey to assess basic knowledge and attitude about child health. Mothers were provided two sessions of face-to-face guidance about good childcare practices using WHO guidelines. The first session at the beginning of the six-

month period was followed by another after two months. Local village doctors were also trained using video, reading material and problem-solving exercises about child health care. At six months, the child's development was assessed using the Gesell Development Scale, and mother's knowledge and understanding of the recommendations were assessed using a questionnaire. Doctor's knowledge and confidence about managing the health of young children was assessed both prior to providing them training and one month after training. The mothers showed significant improvement in knowledge and skills about early childcare; the doctors showed increased ability to practice the learned skills; fine motor, speech and interpersonal communication among children in the experimental group were significantly higher than in the control group in adaptive skills, language development and cognitive development, but no differences were found in motor scores. A limitation of the study was that the person who tested the children was also the experimenter.

C. Programme evaluation

The only field trial located was an evaluation of the implementation of Care for Development in the field in Kyrgyzstan, Tajikistan, and Kazakhstan (Engle et al., 2010). These three country studies assessed the degree of implementation of the intervention in a random sample of -families living in the intervention districts, and in Kyrgyzstan and Tajikistan, assessments of child development using the Tajik Early Learning and Development Standards for children from 0-84 months, and the Ages and Stages Questionnaire in both (4-12 months in Tajikistan, and 4-36 months in Kyrgyzstan). The methodology was to compare districts that had received training in Care for Development with those which had not, matched by family asset and maternal education levels. An adaptation of the Health Facilities Survey was used, as well as a more in-depth assessment of family behaviours, and caregiver competencies. Approximately 100 health workers were interviewed, over 100 health visits were observed, and between 100-200 households were observed, with two thirds

in the intervention area and one third in control areas. Exposure to the training was assessed in all cases. In both Tajikistan and Kyrgyzstan, significant differences in assessed child development were found.

In Tajikistan, children from intervention districts scored significantly higher than the control on two subscales of the Ages and Stages Parent Report Questionnaire from 8-12 months, and scored higher on the child measure ELDS at both 0-12 months and 13-36 months, although not at older ages. In Kyrgyzstan, children 4-36 months in the intervention districts scored significantly higher than the control on two subscales of the Ages and Stages Parent Report Questionnaire: communication and personal-social development (Engle et al., 2010). In all three countries, there was evidence that health workers who had been through the training were significantly more likely to ask and make recommendations about Care for Development. Health workers who had been trained reported a greater

sense of competence in items related to children's development. The child's caregivers in the intervention areas were more likely to recall items about Care for Development than those in the control areas as well. Families in the intervention areas were significantly more likely to have seen the Care for Development

materials, but the differences between groups were not large. In two of the three countries, parents living in the intervention areas were significantly more likely to report having done a new activity with their child in the past week, with a trend in that direction in the third country.

D. Summary of the evidence

These pilot, efficacy, and effectiveness studies suggest that interventions to provide recommendations and problem solving to parents through a public health system can be effective in improving family stimulation behaviours and young children's development.

In order to implement this intervention, the time and investment of the health programme is relatively small; interventions added approximately 5-10 minutes per visit in the Ertem study and the Engle programme evaluation. The Jin study incorporated a 30-60 minute home visit two times over a six-month period – approximately the same intensity. The recommended IMCI training package is for 2.5 days, and is designed to include clinical experience.

In these studies, and in US studies that incorporate guidance on child development (Palfrey et al., 2005), the level of parental satisfaction with the health clinic is higher, suggesting that there may be additional benefits.

Ongoing studies investigating the longer term impacts of the Care for Development materials are underway in Pakistan, India and Australia which will provide more examples of local adaptations of materials, longer term impact on development and growth, delivery through community based agents and further data on integration within existing services of children less than 3 years of age.

Preliminary data from Sindh, Pakistan investigating the integration of **Care for Child Development** in the Lady Health Workers programme is promising. Local adaptation shows that combined group meetings and individual counselling through home visits are feasible if supported by regular training and supervision. Families and health workers accept the intervention.

Change in knowledge and practices on **Care for Child Development** and early benefits in growth and development are being observed (Department of Paediatrics and Child Health, Aga Khan University, Karachi, Pakistan).

Based on PAHO/WHO and UNICEF interest to “roll-out” the Care for Child Development intervention approach in the Latin America and Caribbean region, a first step was taken to prepare for initial implementation actions in select pilot countries. In November 2012, a regional meeting of ECD experts was held in Panama to identify and consider the required adaptations to the Care for Child Development (CCD) package for implementation in the Latin America and Caribbean Region, along with identifying potential follow-up pilot processes to validate modified materials in two or three regional countries. This present version reflects inputs and comments from the following workshop organizers and participants.

Guidelines for effective implementation and conclusions

The results from the intervention studies are quite consistent and a number of conclusions have emerged from them to guide effective interventions. In addition to global conclusions, initial observations and recommendations were provided for CCD material revision and implementation efforts in the LAC region.

Adequate training is a critical component of the success of the programme. This training should:

- Include all health workers, not just nurses or physicians
- Ensure that clinical practice is included in all training courses
- Have clear linkage with nutrition programmes
- Have a regular schedule of training combined with regular supervision for encouragement and feedback on intervention skills

Additional recommendations for the LAC region:

- In addition to health workers, other ECD workers should be included for training from such services as: early education, social protection, early intervention, and rehabilitation.
- In line with an expanded vision of CCD application, CCD field practice should be organized in ECD centres and community/home-based settings, in addition to health services.
- Multiple training levels and actions should be included as part of efforts to incorporate CCD interventions as part of health and ECD systems, including: “training of trainers”; training of supervisors”; initial and follow-up training actions for service providers (based on supervision results and staff turnover).

Adequate materials and strategies for working with parents should include:

- Adaptation to the local cultural context
- Value of local traditions, combining evidence-based processes
- Identification of local values related to child care and aspiration for the child that are motivational
- Maintenance of high quality, defined by structure and processes
- Cost effective and sustainable approaches
- Commitment and ownership at the local level through early engagement with health workers, families and communities
- Helping families use these recommendations at home, including giving them opportunities for practice with feedback
- Training community health workers to provide support to families
- Providing handouts that give specific recommendations
- Creating family demand through media and outreach

Additional recommendations for the LAC region (related to materials and implementation strategies):

- Material adaptations should be made for the local cultural context, including the preparation of counselling materials and family orientation guides in local languages.
- In addition to activity recommendations for parent/caregiver directed child development activities, family orientation materials should be prepared on how to best organize the home environment to promote other learning opportunities while parents are undertaking home tasks.
- Multiple formats and visual presentations of parent/caregiver orientation materials should be designed for use by families in the home, as well as for application in health and ECD settings.
- Coordinated efforts with community-based services should be explored to provide home-based following up and family support, especially for children with developmental delays or disabilities, and those affected by violence and abuse.
- Communication strategies aimed at unifying messages for families and caregivers should be considered, with an effort to reduce conflicting messages often provided by different sectors.
- For families with children with developmental delays and disabilities, initial counselling and encouragement should be provided by the health and ECD worker before undertaking a referral process – along with guaranteeing a follow-up appointment with the health or ECD service.

The policy and programming environment should:

- Have clear indicators and be part of a monitoring system
- Include child development in the health policy
- Have support of the government health system at local or wider levels
- Encourage partnership with local government, with education officials, and with community groups
- Benefit from funding mechanisms that allow local decisions

Additional observations and recommendations for the LAC region:

- Mainstreaming and implementation of CCD interventions should be undertaken as a complementary element of existing health and ECD system policies and services for young children and families.
- Initial steps for CCD implementation should include multi-sector advocacy and orientation workshops for decision-making and national technical levels (including health, education, social protection, and rehabilitation sectors).
- National multi-sector coordination is required to design, implement, support and monitor CCD implementation at national and local levels and to guarantee quality and sustainability of actions.
- In line with efforts to promote a rights-based approach (based on the CRC and CRPD) in ECD strategy development and implementation, CCD intervention actions should consider addressing the more specific problems areas of the most disadvantaged and excluded children, especially those with developmental delays and disabilities, experiencing violence and faced with the impact of significant family poverty.

A module to provide recommendations to families to promote the development of their young children and with suggestions for handling specific problems in child rearing has been shown to have an effect on parenting behaviours and to increase parent appreciation of the health-care visit.

Delivering the Care for Child Development intervention through community-based providers

The scaling-up of the intervention so that the benefits could reach the greatest number of disadvantaged children remains under-addressed. In order to achieve this, the implementation of the **Care for Child Development** intervention as a complementary strategy to existing health and ECD actions through community-based providers, who are the cornerstone of primary care in most low-income countries, needs to be expanded. Health (PHC), ECD and CBR workers at the community level are already concerned with the health, learning, early intervention and/or rehabilitation of young children, along with the well-being of mothers, and other family members. In many instances, community health workers are the only health professionals with whom families come into contact at the home or community level, in the early years of the child's life; they thus reach the majority of children in a community. Therefore if taken, the windows of opportunity within health-care and ECD encounters for young children are golden opportunities to help strengthen families' efforts to promote their child's development and may be the only opportunity available for health and ECD providers in developing countries to influence positively parents of young children, in a culturally appropriate manner. It would be important to integrate **Care for**

Child Development into the existing work of the community-based providers so that they do not see it as an extra burden. Globally, previous work with Lady Health Workers in Pakistan shows that this is possible, but the intervention would need to be developed in close collaboration with the existing community health worker programmes (Rahman A, 2007; and Rahman A, Roberts C, Husain N, 2009) with a focus on training, support and motivation provided to health-care providers. WHO, UNICEF and partners are promoting the integration of the Care for Child Development intervention into existing health systems in all countries with special attention to poorly resourced areas. For the LAC region, important opportunities exist to utilize **Care for Child Development** materials and strategies to complement and/or expand on existing community-based initiatives focusing on PHC, ECD, early intervention, community-based rehabilitation and follow-up to social safety net initiatives for the poorest of families. Such experiences as the Roving Caregivers in the Caribbean, early intervention and CBR actions in a wide range of LAC countries; ECD efforts linked to a multi-sector social protect initiatives in Chile ("Crece Contigo"), Brazil, Mexico, Colombia and along with others provide important entry points to apply CCD strategies.



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