

Side by side with responsive parents in the Care for Child Development intervention

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The World Health Organization (WHO) and UNICEF intervention on Care for Child Development (CCD) helps caregivers actively engage with children during their first three years, using play and communication activities to help them learn to move, talk, focus, manage emotions, solve problems, and develop other skills needed for school and adulthood. This article shares evidence on CCD's effectiveness for child development and health outcomes, including in resource-poor communities, and suggests ways to take it to scale.

Since the work of Bowlby (1951) and Ainsworth (Ainsworth *et al.*, 1974) on child attachment, we have been learning more about the critical role of caregivers' sensitivity and responsiveness in meeting the health, growth, and developmental needs of a child. Children need assurance that someone is watching over them, responding to them when they feel hunger or discomfort. These responses build relationships of love and trust. Children need to share their excitement with a caring adult as they explore and discover the world around them.

A caregiver must respond very frequently for a child to form a secure attachment, which serves as a foundation for how the child builds a capacity for human relationships and lifelong learning. Highly responsive caregivers contribute, for example, to the child's vocabulary, problem-solving abilities, and complex social interactions (Tamis-LeMonda *et al.*, 2001). They build the fundamental architecture of the infant's rapidly growing brain, and help infants to develop emotional control – all pieces of a strong start to learning the skills needed for life (National Scientific Council on the Developing Child, 2012).

Most parents easily respond to their children – smiling and making funny sounds, wiggling their hands and toes, comforting them when they cry, encouraging them when they try to do something new, and expressing joy when they succeed. Some adults, however, have difficulty responding to children in appropriate, timely ways.

For example, mothers separated from a child soon after birth may find it hard to bond when they are reunited. Mothers who are depressed – unfortunately common after the birth of a child – are unable to pick up social cues or see how and when an infant depends on their response (Patel *et al.*, 2004; Rahman *et al.*, 2004; Surkan *et al.*, 2011). Some low-birthweight babies are too weak to express

themselves, while children born with physical or intellectual disabilities can give parents confusing signs. Some parents simply may not know that, even with very young children, frequently interacting, touching and talking will help them learn.

Fortunately, there is growing evidence that caregivers can learn to be more sensitive and responsive to the child's cues (Landry *et al.*, 2008). Through Care for Child Development (CCD), the same play and communication activities that help a child learn critical developmental tasks also provide the context for more responsive caregiving (Yousafzai *et al.*, 2014).

CCD counselling: side by side with caregivers

Using the CCD approach, the counsellor meets with the parent or caregiver and the child and asks: 'How do you play with your child?', 'How do you talk with your child?', 'How do you get your child to smile?' (WHO and UNICEF, 2012). The counsellor listens to the caregiver and may encourage the answers with follow-up questions, such as 'Please show me how you get your child to smile'. For children over 6 months old, the counsellor asks how the caregiver thinks the child is learning, to identify any concerns. The counsellor also observes how the caregiver responds to the child: being aware of the child's movements, comforting and showing love, correcting or guiding. The information provides a platform for praising the caregiver, building the caregiver's confidence, and identifying the activities the caregiver and child do together at home.

The counsellor then coaches the caregiver in recommended play and communication activities appropriate for the age of the child. These include simple activities for newborns – 'Gently soothe, stroke and hold your child', 'Look into the baby's eyes and talk to your baby' – to stimulate early neurological development by touch, massage, and movement. As the child grows, recommended activities support new motor tasks, and cognitive, language and social skills: grasping objects, putting objects into containers, naming, telling stories, sorting similar and different shapes and colours, looking at a picture book or assembling a puzzle.

With the counsellor's guidance, activities strengthen the caregiver's ability to be sensitive to the child's cues, follow the child's lead, help sustain interest in more difficult tasks, and respond warmly to the child's efforts. For example, while a child learns the structure of communication, a caregiver learns to pay attention to a young child's cues: 'Get a conversation going by copying your child's sounds or gestures'. Playing 'peek-a-boo' with a cloth to cover their faces triggers active, laughing responses: the child learns that the caregiver is present, although hidden (object permanence), and the caregiver learns how to engage the child and help the child smile.

When both the caregiver and child are confident, the counsellor encourages the caregiver to commit to more play activities at home, using common household items.

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Delivering support for child development and responsive caregiving

In 2015, an inventory of places where CCD is being implemented identified 23 sites in 19 countries (Lucas, in press). In each site, CCD was integrated within an existing service, for example: child survival and health (Botswana, India, Kazakhstan, Kenya, Kyrgyzstan, Mozambique, Pakistan, and Tajikistan), nutrition rehabilitation (Mali and India), infant care and early education (Kenya and Brazil), services to families with developmentally disabled children (India and Turkey), and prevention of violence and child abuse (Australia). Different entry points might be used within the same country, as in Brazil, where CCD is included in parenting programmes for families of children in early daycare centres and services for families participating in a cash transfer programme.

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Instead of creating new workers specifically to deliver CCD services, providers already working with families have been trained in the methodology, including community health workers (Botswana, India, Mozambique, and Pakistan), social workers and daycare workers (Brazil and Kenya), child protection workers (Australia), and paediatricians and others working with disabled children (Turkey).

Only three countries have expanded CCD nationwide: in Kazakhstan, Kyrgyzstan, and Tajikistan, CCD has been well integrated, under different names, in the training of visiting nurses and doctors (Engle, 2011). The national expansion was facilitated by highly centralised health systems including pre- and in-service training; the devolution of more decisions to local and district units in most other countries makes national expansion more difficult.

Other countries have also adapted the CCD intervention and training materials to fit their specific delivery systems and providers. For example, PATH, an NGO in Mozambique, adapted the core materials for communities affected by HIV, translating the information into picture cards used by community health workers and nurses. The core guidelines (Counselling Cards, Participant Manual, and Facilitator Notes) have been translated from English into 17 languages: Armenian, Mandarin Chinese, Chichewa (Malawi), Farsi, French (West Africa), Hindi, Kinyarwanda (Rwanda), Kiswahili (Zanzibar), Lugandan, Mahrati, Portuguese (for Brazil and Mozambique), Russian, Sindh, Spanish, Tajiki, and Turkish. The inventory demonstrated that users found CCD recommendations to be appropriate across cultures, so cultural adaptations are minor.

Evidence of improved outcomes

Field research early in the implementation of CCD focused on the effectiveness of design components. A field test in Pelotas, Brazil, demonstrated that doctors and other health workers could conduct counselling and provide recommendations during consultations with sick children; and parents could recall and do the recommended activities at home (dos Santos *et al.*, 1999). In



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the 2001 trial in South Africa, health workers incorporating CCD counselling in their sick-child consultations improved, rather than distracted from, other IMCI (Integrated Management of Childhood Illness) assessment and treatment tasks (Lucas *et al.*, 2001).

A study in China in 2007 found that children in families who had received a counselling and follow-up session had higher development quotient scores than children in a control group. Families found the intervention to be understandable and acceptable (Jin *et al.*, 2007). In a case-control study in Turkey in 2008, CCD counselling by paediatricians during a single sick-child consultation improved caregiver practices, such as increased time reading to a child, and improved paediatricians' communication skills in assessing and treating sick children (Ertem *et al.*, 2006).

A large cluster-randomised factorial trial was conducted in Pakistan, on home visits and group meetings of mothers with young children (Yousafzai *et al.*, 2014). It found that the intervention, delivered at least monthly, increased family time with children in learning activities and language use; increased warm and responsive interactions; reduced harsh punishment; increased availability of learning materials in the home; improved measures of child development; and reduced the incidence of childhood diarrhoea, pneumonia and fever, with some improvements in growth.

Importantly, as maternal depression is considered by many experts to be one of the greatest risk factors in early childhood (Center on the Developing Child at Harvard University, 2009; Baydar *et al.*, 2014), the Pakistan study found a lower

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incidence of depression among participating mothers. The children are being followed up until they start school to determine whether the benefits of the early intervention are sustained.

Implications for scaling up

The Pakistan study demonstrated that CCD could be implemented within an existing service delivery system, in this case through the Lady Health Worker structure of publicly supported community services. Adding the CCD approach to scheduled home visits and mothers' groups was relatively cost-effective compared to other child and family services (Gowani *et al.*, 2014). In Kazakhstan, support for CCD spread nationally and became sustainable by institutionalising it into the pre- and in-service training of providers and including it within the required package of services for mothers and children.

The potential for full national scale-up of CCD depends on instituting policies that support child development as an integral part of existing programmes. Going to scale, therefore, involves finding compatible existing services for families – in health, education, family support, child protection, and other services able to provide a greater role in supporting child development and responsive parenting.

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