The most common services that come in contact with children from birth to three years are the health services in most countries. Therefore, the health sector in partnership with other sectors has a unique role in young children's growth and development. The WHO Commission on the Social Determinants of Health in 2008 called on health systems to reduce health inequities in a generation by “building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development”.

From conception through the first few years of a child's life is the period of greatest risk as well as greatest opportunity for making a difference for children. Rapid brain development affects cognitive and social-emotional development, which is critical for long-term economic productivity, for meeting the challenges of globalization, and for ensuring every child's right to survival and development. It is estimated that globally over 200 million children under the age of 5 years are not developing their full potential, and many of these children (about 89 million) are in South Asia.

Investments in early child growth and development, particularly for children living in poverty will contribute to achieving the Millennium Development Goals and closing the gap between rich and poor. In the last two to three decades most countries in the South-East Asia Region have recorded significant declines in child mortality and impressive economic growth. The Region should be moving from a focus on child survival, to a broader concern for healthy development of children, economic productivity, and the reduction of disparities between rich and poor. WHO/UNICEF have developed a package of tools and a training manual, “Care for Child Development” that can be used along with “Care for Feeding” by primary health care and community health workers to assist individuals and families in promoting good nutrition and development, and preventing risks.

This strategic framework recommends developing programmes for children's growth and development that can be implemented in South and South-East Asia Region through the health sector with partners, and policies and plans to support these programmes. It outlines evidence-based, effective age-appropriate interventions that health facilities, communities and families can use to ensure optimal early child development through the health system. The Strategic Framework recommends that countries incorporate promotive, preventive and curative care for early child development into integrated primary health care and describes the steps each country could take to develop a plan for putting the programmes and policies into practice for promoting early childhood development.
Role of the Health Sector in Promoting
Early Childhood Development

A Strategic Framework
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Executive summary

From conception through the first few years of a child’s life is the period of greatest risk as well as greatest opportunity for making a difference for children. Rapid brain development affects cognitive and social-emotional development, which is critical for long-term economic productivity, for meeting the challenges of globalization, and for ensuring every child’s right to survival and development. High levels of adversity and stress during early childhood disrupts brain architecture, affects other organ systems, and leads to stress-management systems that establish relatively lower thresholds for responsiveness that persist throughout life, thereby increasing the risk of stress-related disease and cognitive impairment well into the adult years. It is estimated that globally over 200 million children under the age of 5 years are not developing their full potential, and many of these children (89 million) are in South Asia.

Children raised in poverty face formidable challenges to healthy growth and development, but effective interventions can make a significant difference. Yet, between about one year of age and entry to school, governments make few investments in young children, and families are often not prepared, or not aware, of the critical role they play in their children’s development in these first years of life. Investments in early child growth and development, particularly for children living in poverty will contribute to achieving the Millennium Development Goals and closing the gap between rich and poor.
The health sector in partnership with other sectors has a unique role in young children’s growth and development. The WHO Commission on the Social Determinants of Health in 2008\(^3\) called on health systems to reduce health inequities in a generation by “building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development”.

The timing for bringing development issues into focus while addressing child health is right for South and South-East Asia. In the last two to three decades most countries in the Region have recorded significant declines in child mortality and recently, impressive economic growth. The Region should be moving from a focus on child survival, to a broader concern for healthy development of children, economic productivity, and the reduction of disparities between rich and poor.

This strategic framework outlines evidence-based, effective age-appropriate interventions that health facilities, communities and families can use to ensure optimal early child development through the health system\(^6,8,86\). It describes guiding principles and the steps each country can take to define goals and objectives and develop a plan for putting these programmes and policies into practice. It recommends that countries incorporate promotive, preventive and curative care for early child development into integrated primary health care. This strategic framework recommends developing programmes for children’s growth and development that can be implemented in South and South-East Asia Region through the health sector with partners, and policies and plans to support these programmes.

WHO/UNICEF have also developed a package of tools and a training manual, “Care for Child Development” that can be used along with “Care for Feeding” by primary health care and community health workers to assist individuals and families in promoting good nutrition and development, and preventing risks.
The importance of Early Childhood Development for child survival, growth and development

From conception through the first few years of a child’s life is the period of greatest risk as well as greatest opportunity for making a difference for children. Rapid brain development affects cognitive and social-emotional development, which is critical for long-term economic productivity, for meeting the challenges of globalization, and for ensuring every child’s right to survival and development.

Poverty, poor health, undernutrition and lack of early stimulation undermine children’s development early in life when brain development is most rapid and the architecture of the brain is most sensitive to the influences of the external environment – prenatally through 3-5 years of age.

High levels of adversity and stress during early childhood also disrupt brain architecture, affect other organ systems, and lead to stress-management systems that establish relatively lower thresholds for immune responses that persist throughout life, thereby increasing the risk of stress-related disease and cognitive impairment well into the adult years.
As a result, it is estimated that more than 200 million children under 5 years fail to reach their full potential in cognitive, language, and socio-emotional development. Many of these children will do poorly in school resulting in lowered incomes and productivity. Given lower levels of education, they will be likely to provide their children with poorer quality health care, nutrition and stimulation, thus contributing to the intergenerational transmission of poverty.

Many of these children – 89 million – live in South and South-East Asia. Three of the ten countries that account for 145 million (66%) of the 219 million disadvantaged children in the developing world are India, Bangladesh, and Indonesia.

Even though children raised in poverty are challenged by malnutrition, morbidity and mortality, higher risks of injury and fewer learning opportunities, effective interventions can make a significant difference, including for children with developmental delays or disabilities.

1.1 The role of the health sector

In the last two to three decades most countries in South and South-East Asia have recorded significant declines in child mortality. In the past decade, the region has also witnessed impressive economic growth. Countries recognize children’s right to survive and develop, as well as the importance of human capital development for economic productivity. As the region moves from a focus on child survival to a broader concern for child development, the importance of investments to achieve these goals in the first few years of life are becoming increasingly clear.

The WHO Commission on Social Determinants of Health (CSDH) issued a landmark report, “Closing the Gap in a Generation (2008)” which examined the role of social factors such as poverty, social exclusion, and lack of health care facilities in explaining disparities and inequities in health among and within countries. The report emphasized that health disparities cannot be reduced by health facilities alone, but that social and economic differences play a major role in those disparities.
“The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.”

The commissioners concluded that these inequities are the result of a “toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.”

Because “Investment in the early years provides one of the greatest potentials to reduce health inequities within a generation” improving early child development (ECD) was identified as a key point for action. The first recommendation in the report is:

**Equity from the Start:** “Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development”.

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**Equity from the start: Early Childhood Development**

A comprehensive approach to the early years in life requires policy coherence, commitment, and leadership at the international and national level. It also requires a comprehensive package of Early Childhood Development and education programmes and services for all children worldwide.

Experiences in early childhood (defined as prenatal development to eight years of age), and in early and later education, lay critical foundations for the entire life course. The science of ECD shows that brain development is highly sensitive to external influences in early childhood, with lifelong effects.

Good nutrition is crucial and begins in-utero with adequately nourished mothers. Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life. Children need safe, healthy, supporting, nurturing, caring, and responsive living environments.
Preschool educational programmes and schools, as part of the wider environment that contributes to the development of children, can play a vital role in building children’s capabilities.

Early childhood development – including the physical, social/emotional, and language/cognitive domains – has a determining influence on subsequent life chances and health through skills development, education, and occupational opportunities because what children experience during the early years sets a critical foundation for their entire life course. Through these mechanisms, and directly, early childhood experiences influence subsequent risk of obesity, malnutrition, mental health problems, heart disease, and criminality.

Including early child development in health systems is consistent with the broad definition of health as a state of well-being, as mentioned in WHO’s Constitution. Health systems along with families and communities play a critical role not only in curative or therapeutic care for children with special needs, but also in preventive care for children at biological or social risk, and promotive care to support good parenting practices in caregiving and early stimulation for all children. The health sector has the greatest access to mothers and children during the critical first few years.

Figure 1: **Contribution of various sectors to early child development (from Ulkuer, 2009, and Britto, 2009, personal communication)**
All sectors need to contribute but the health sector may have the largest role to play for younger children. Figure 1 suggests the relative roles of a number of sectors across the age range, with examples of programmes that would apply. The chart suggests that not only health and nutrition, but also social protection, the environment ministries, economic investments, and education contribute to early child development. The chart suggests that some sectors have a continuing role, but that the roles of education and health will gradually change over the early childhood period. The 0-3 period includes health and nutrition, but as indicated here under ACSD, the prenatal period is even more heavily weighted toward health and nutrition.

1.2 Scope of the strategic framework

This strategic framework provides a basis for implementing in South and South-East Asia some recommendations of the Commission on Social Determinants of Health (CSDH). The CSDH had recommended among others:

- Set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on.
- Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay.

There are four steps to put these recommendations into action: 4

1. Advocate for early childhood development (ECD) as critical for the achievement of the MDGs.
2. Prioritize technical support for including ECD policies within national development policies and instruments.
3. Provide technical support for regions, countries, and partners for the integration of simple ECD interventions in health services and community health initiatives.
4. Oversee interagency collaboration on ECD through health systems.

This strategic framework provides the background on what is known about ECD, then proposes goals, objectives, and a series of evidence-based strategies for improving ECD through the health sector, families and communities. It also describes guiding principles and concludes with a roadmap for developing policies and implementation plans in each country.
1.3 What is Early Childhood Development?

Children’s development is the gradual emergence of capacities in the physical, sensory-motor, cognitive, language and social-emotional domains or areas. This development depends on the function and structure of the developing architecture of the brain. From conception through the second or third years of life, the brain develops rapidly and disruptions caused by illness, poor nutrition or high levels of stress can affect a variety of biological systems. These ontogenetic events occur sequentially and build upon each other. Thus, even small deviations in these processes can have long-term effects on the brain’s structural and functional capacity\(^1\). Maternal and child nutrition, maternal well-being, and the quality of parent-child interaction significantly affect the child’s growth and development.

1.4 ECD is necessary for achieving the MDGs

In order to achieve the Millennium Development Goals related to reduction of poverty, reduction of infant and maternal mortality, reduction of malnutrition, gender equality, and primary education for all, investments in the earliest years of life are essential. The quality of interaction between mother/caregiver and the child from birth onward affects the infant’s chances of survival as well as development. For example, the caregiver’s ability to recognize and respond to the infant’s cues, such as the danger signs of illnesses, is crucially important for child mortality and morbidity as well as for nutrient intake, growth, and development.

Support for caregivers and enhancing their knowledge, skills and responsiveness will increase a child’s chances of survival and contribute to its physical and mental health. These investments can also contribute to preventing loss of the child’s developmental potential. Evidence-based, recognized interventions can improve the quality of caregiver-child interactions and the environment through an integrated model of community engagement and primary health care services\(^5\).

Early opportunities for learning in combination with improved nutrition increase the chances that a child will attend and stay in school, will learn effectively while in school, and will be able to use the learning for becoming a more productive worker and caregiver of the next generation in adulthood.
On the other hand, poverty, low education of parents, social exclusion, gender discrimination, or conflict and stress can reduce children’s chances of developing their potential. When gender, poverty, different abilities, or social exclusion occur together, their combined impact is magnified.

1.5 Benefits of investing in ECD

Globally, stunted and/or poor children’s inability to reach their full potential is estimated to result in a 20% deficit in yearly adult income, costing nations billions in lost productivity. Thus, children’s early development has implications not only for the individuals but also for national economic development.

Interventions in early childhood can make a difference. Early child development interventions in the first 3-4 years have resulted in improved child outcomes, resulting in the long-term in benefits of between 3 to 17 dollars for every dollar spent, both in the US and in developing countries.

These effects on a child’s development result in improvements in long-term productivity. A child’s growth and development, particularly in the first three years, sets a trajectory for school performance, productivity, and participation in society. Reducing stunting in the first three years of life (but not later) in rural Guatemala was associated with a 46% increase in wage rates of men at the age of 30, and significantly more years of schooling for women. Interventions that address the most disadvantaged children and are initiated before the age of three years have the largest impact.

Stunting is often used as a rough proxy for child development, as the two tend to be correlated. Poor nutrition affects both stunting and development. One estimate was that as much as 40% of the effects of stunting on productivity are due to cognitive deficits. Stunted children also tend to have poorer learning environments, with less cognitive stimulation and opportunities for learning and these factors have independent effects on cognitive development. The early study in Jamaica by Grantham-McGregor et al. showed that both stimulation and food supplementation affected development. Stimulation in the home environment has effects on cognition even in a well-nourished population which is further evidence that stunting should be considered as a proxy for child development, but that multiple factors other than nutrition are also at play in a child’s development.
Improved adult health is another benefit of early childhood interventions. An extensive body of evidence links adult chronic disease to processes and experiences occurring decades before, in some cases as early as intrauterine life, across a wide range of impairments. For example, experiences with toxic stress in early childhood may result in heightened immune responses in adulthood that are known risk factors for the development of cardiovascular disease, diabetes, asthma, and chronic lung disease. Reducing the number and severity of early adverse experiences leads to a decrease in the prevalence of a wide range of health problems.

Nobel Laureate Heckman determined that the most cost-effective interventions for reducing disparities for disadvantaged children are those that occur prior to school entry. However, governments make few investments in children between the end of the child’s first year and entry to school. Yet families and communities may be ill prepared, or not aware, of the critical role they play in their children’s growth and development in these first years of life. This lack of investment results in a missed opportunity for children and for economic development – a mismatch between investment and opportunity.

**Figure 2: Rates of return on human capital investment**

![Mismatch between Investment and Opportunity](source)

Source: Heckman & Carneiro Human Social Policy, 2003, Voices for America and the Child and Family Policy Center. Early Learning Left out An Examination of Public Investment in Education and Development by Child Age, 2004
1.6 Early Childhood Development and child rights

The actions outlined in this strategy document are not only good economic investments, but they ensure children’s rights. The Convention for the Rights of the Child ensures every child the best start to life, to survive and develop (Art. 6). The child has the right to the highest attainable standard of health (Art. 24), and to develop his/her personality, talents, and mental and physical abilities to their fullest potential (Art. 29). Other rights important for young children include the right to name and nationality, to express their views and have them given weight according to the age of the child, to play and leisure, and to parenting by both mother and father. For children with disabilities, rights include special care and rights to a full and decent life.
Influences on Early Childhood Development

Figure 3: Conceptual model of how interventions can affect early child development

![Conceptual model of how interventions can affect early child development](image)
This chart outlines the overlapping domains of development, and the factors which influence it. There are direct effects of the central nervous system on development, direct effects of both psychosocial and biological risk factors on development, as well as indirect effects of risk factors through their influences on brain development. A major determining role is poverty and all of the economic and social policies which influence poverty. The chart outlines three goals for interventions: to promote good child development, to prevent risks for poor child development, and to reduce or ameliorate the negative effects of problems such as low birth weight, developmental delay, or poverty. These three themes are reflected in interventions for promotive, preventive, and curative care.

2.1 CNS (Central Nervous System) development and function

Brain architecture, the structure and function of the brain, play a major role in a child’s eventual functioning. Both brain architecture and developing abilities are built “from the bottom up,” with simple circuits and skills providing the scaffolding for more advanced circuits and skills over time. Brain architecture is built over a succession of “sensitive periods,” each of which is associated with the formation of specific circuits that are associated with specific abilities. The development of increasingly complex skills and their underlying circuits builds on the circuits and skills that were formed earlier. Through this process, early experiences create a foundation for lifelong learning, behaviour, and both physical and mental health.17

2.2 Biological risk factors

The prenatal environment accounts for significant amount of the variance in brain development, and the quality of that environment is directly related to maternal health and nutrition. Low birthweight due to small for gestational age or prematurity has significant long-term consequences for a child’s development although the size of the effects may decrease in adolescence and adulthood16. Iron status of the infant, strongly related to maternal iron status, has long-lasting effects on a child’s development. According to Beard19 and Rao et al20 iron deficiency in the first year of life occurs at a time of rapid neural development, and when morphological, biochemical, and bioenergetic alterations may all influence future functioning. The structures of the brain can become abnormal because of iron deficiency either in-utero or in early postnatal life because
iron is essential for proper neurogenesis and differentiation of certain brain cells and brain regions. This deficiency has a long-term, persistent effect on a child’s development\textsuperscript{21}.

The influences of nutritional intake on growth are well recognized, and an increasing body of research has documented the effects of nutrition on development\textsuperscript{6}. The best documented nutritional risks for child development include iodine deficiency, iron deficiency, and stunting (including low birth weight). Others that have an impact include zinc, breastfeeding and intrauterine growth retardation. The role of illness in child development is being explored\textsuperscript{6}. Combining improvements in nutrition including micronutrients with development will have an additive effect\textsuperscript{13,22,23}.

2.3 Psychosocial risk factors: lack of cognitive stimulation and opportunities for learning

Stimulation and responsive care, reflected in caregivers’ style of interactions with children, results in improved child development in many countries\textsuperscript{24}. For example, the amount of language exposure a child hears, particularly language used in a meaningful context such as a conversation with a child (rather than on TV), is strongly associated with later language development which in turn helps school performance and success in later years\textsuperscript{25}. Learning materials that provide children with opportunities for touching, manipulation, problem-solving, and control, whether homemade or purchased, exist in many societies and are important supports for learning. Books and pictures help children adapt to the written word and build vocabulary, as do playing with adults or older siblings\textsuperscript{26}. Children who do not have these learning opportunities are at risk for not developing their potential.

2.4 Psychosocial risk factors: emotional connections and attachment

Shonkoff and Phillips\textsuperscript{27} review of research found three key aspects of parenting consistently related to young children’s cognitive and social emotional competence:

(1) Cognitive stimulation.
(2) Caregiver sensitivity and responsiveness to the child.
(3) Caregiver effect (emotional warmth or rejection of the child).
Developing an early emotional connection to a caregiver, or an attachment, is critical for an infant’s well being\textsuperscript{26,29,30}. Emotional security develops through a child’s attachment or unique bond with at least one consistent caregiver, who responds to the child’s physical and emotional needs soon after they are expressed.

The lack of a close, emotional and trusting relationship (“attachment”) with at least one consistent caregiver can have significant negative effects on brain development and a child’s overall functioning\textsuperscript{31,32}. When these emotional deficits are severe, as in the case of early exposure to systematic abuse or poor quality non-paternal care, children are often stunted\textsuperscript{33}, developmentally delayed, and show dramatic differences in brain function on brain scans because they suffer from metabolic and connectivity deficits in the areas of the brain involved in higher cognition, emotion, and emotion regulation\textsuperscript{34,35}. As they get older, these children are more at risk of problem behaviours\textsuperscript{36}.

When children are removed from a hostile environment, and adopted into families, they show catch-up growth but do not reach normal height if the removal occurs after 12 months\textsuperscript{37}. Similarly, brain function tends to recover more the younger the child when placed in a more positive environment\textsuperscript{22}. It seems that there is a sensitive period requiring emotional and cognitive input in order for the infant’s brain to form normally\textsuperscript{39}. These findings have implications for protecting young children in emergencies who are separated from their families.

Maternal depression or depressive symptoms undermines this emotional connection with the infant, and can threaten normal development\textsuperscript{40}. A recent investigation from rural Bangladesh demonstrated that when maternal depressive symptoms occurred in conjunction with perceptions of infant irritability, infants acquired fewer cognitive, motor, and behavioural skills than when mothers had neither or only one condition\textsuperscript{41}.

Maternal depression varies with the conditions of women’s lives. It tends to be quite high in many parts of the world, and particularly in South Asia. For example, rates were 15-28% in Africa and Asia\textsuperscript{42}, 35-50% in Latin America\textsuperscript{43}, 50% in Bangladesh\textsuperscript{41} and 28-57% in Pakistan\textsuperscript{44}.

### 2.5 Poverty, social exclusion and marginalization

Poverty is associated with poor child development in research from all parts of the world. But what is less clear is what the mechanism is for this effect. The
quality of the home environment appears to be more important than the overall level of poverty\textsuperscript{26}. Thus the quality of interactions with caregivers, often affected by poverty, has an important role in explaining this relationship.

Recent evidence of the damage of toxic stress, often associated with poverty, on adult health, cognitive functioning and possibly brain development, raises new urgency to reduce the number of children raised in poverty\textsuperscript{1,39}. Even at a young age, conditions of conflict, exclusion, and loss appear to have long-term negative effects on children.

Shonkoff et al\textsuperscript{1} found that children from lower socioeconomic backgrounds have a heightened stress activation response system. They conclude that differences in parenting related to income and education — as mediated through parent-child interaction, exposure to new vocabulary, and stability of responsiveness — can alter the maturation of selected brain areas, such as the prefrontal cortex. These changes can persist into adult life and alter emotional states, decision-making capacities, and bodily processes that contribute to emotional instability, substance abuse, aggression, obesity, and stress-related disorders.

The size of the impact of poverty is illustrated by the WHO-SEARO investigation of inequalities in four countries: Bangladesh, India, Nepal, and Sri Lanka. Variations in stunting were predicted between 40% and 60% by poverty, with only a small percentage due to differences in availability of health services\textsuperscript{45}. 
3.1 Health, nutrition, education, and poverty of young children and families

The situation of children in countries also varies on many dimensions relevant to the health sector. Using data from UNICEF’s State of the World’s Children 2009 and the UNESCO database, Table 1 illustrates these differences. Not surprisingly, where U5MR is highest, stunting is also high and the outcomes for children’s schooling are lower. The currently collected data on both GNI (Gross National Investments) per capita and percentage of central government allocation to health, education and defence offer some suggestions about how expenditures might play a role.

Table 1 summarizes data from the Region on variables related to early child development as well as government investment patterns. At this point there are no globally comparable measurements of a child’s developmental
level that can be used to compare across or within countries. In order to assess children’s development, some proxies are used, or measures that tend to be positively associated with child development. The two used here are stunting and the quality of the parenting environment. A third measure that reflects a child’s experiences is the percentage of children attending preschool or pre-primary. Table 1 summarizes available data for the countries from the UNICEF State of the World’s Children of 2009 and the EFA Global Monitoring Report 2007.

Of countries with data, Timor-Leste has the highest rate of stunting (54%), and India, Nepal, and Bhutan all have rates of 40% or above. All countries except Sri Lanka (14%), Thailand (12%) and Indonesia (23%) have rates over 35% which is a serious source of concern for children’s developmental potential. No data were available in the State of the World’s Children (2009) for Maldives or Myanmar.

The quality of the learning environment contributes to the child’s development. Unfortunately, cross-national data on parenting is very limited. The Multi-Indicator Cluster Survey–3 (MICS3) parenting data were collected from only two countries in the Region, Thailand and Bangladesh. Almost half of the families in Bangladesh provided minimally appropriate levels of support for learning in Bangladesh (48%), and almost 80% did in Thailand (MICS 3 reports).

A more fine-grained approach showed that there are wide discrepancies within and between countries in the amount of support from parents, particularly fathers. Parenting was assessed as the number of activities out of six that the mother or father reported doing with a child less than five years in the three days prior to the interview. The only one that required any materials was to show a child a book or picture book. As Figure 4 shows, differences between countries were greater for fathers’ activities than mothers’ activities, but in both countries, there were substantial differences in the number of activities reported by families in the wealthiest quintiles from those in the poorest quintiles. Children in Thailand, whether rich or poor, are receiving more support for learning than their counterparts in Bangladesh, and wealthier children receive more support in both countries.

Adult education, and possibly literacy, tends to be associated with the quality of the learning environment for young children. Five countries show levels of literacy above 90% (Indonesia, Maldives, Myanmar, Sri Lanka, and
Thailand, and the remainder are either far lower or have no data (Timor-Leste). These data suggest that although some may have families that can support young children’s learning, others may need additional support.

Preschool attendance, both as measured in the MICS (aged 3-4) and from the UNESCO data set (ages 3-6) (Table 1), is much higher in Thailand than any other country (60-90%). Despite high rates of malnutrition, India and Nepal report preschool attendance above 35%. This is an achievement for both and increases the chances that children will develop their potential.

Countries in the Region differ greatly in the percentage of their central budgets that are allocated to health, to education, and to defence (Figure 5). They also differ in the Gross National Income (GNI) per capita. How are these expenditures related to two measures of child well-being, the percentage of children in preschool or the percentage of children stunted? Figures 6 and 7 below show the percentage of children not in preschool and those who are stunted, and finds, not surprisingly, that the same countries are low on both. In the five countries with data on both variables, higher preschool attendance is associated with less stunting. It is also important to note that many more children are not in preschool than are stunted.
Table 1: Comparison of child outcome and government investment indicators in the Member States of South-East Asia Region

<table>
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<td>36</td>
<td>40</td>
<td>37</td>
<td>43</td>
<td>23</td>
<td></td>
<td></td>
<td>43</td>
<td>14</td>
<td>12</td>
<td>54</td>
</tr>
<tr>
<td>Adult literacy</td>
<td>54</td>
<td>56</td>
<td>66</td>
<td>91</td>
<td>97</td>
<td>90</td>
<td>57</td>
<td>92</td>
<td>94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% family support for learning</td>
<td>48</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>% 36-59 months in early learning centres</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% in pre-primary *</td>
<td>12</td>
<td>36</td>
<td>22</td>
<td>48</td>
<td>2</td>
<td>36</td>
<td></td>
<td>90</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% in primary (net)</td>
<td>81</td>
<td>70</td>
<td>83</td>
<td>96</td>
<td>97</td>
<td>84</td>
<td>84</td>
<td>98</td>
<td>94</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>% poor using $1.25/day</td>
<td>50</td>
<td>26</td>
<td>42</td>
<td>21</td>
<td></td>
<td>55</td>
<td>14</td>
<td>0</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GNI per person</td>
<td>470</td>
<td>1770</td>
<td>950</td>
<td>1650</td>
<td>3200</td>
<td>220</td>
<td>340</td>
<td>1540</td>
<td>3400</td>
<td>1510</td>
<td></td>
</tr>
<tr>
<td>% central govt expenditure for health</td>
<td>10</td>
<td>14</td>
<td>7</td>
<td>5</td>
<td>23</td>
<td>11</td>
<td>18</td>
<td>6</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% central govt expenditure for education</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>% central govt expenditure for defence</td>
<td>17</td>
<td>13</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>13</td>
<td>18</td>
<td>10</td>
<td>20</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Note: All data from UNICEF State of the World’s Children, 2009 unless noted.
* Gross enrolment rate in preschool UNESCO Global Monitoring Report – children 3-6
Figure 5: **Percentage of central government expenditure on health, education and defence**

(Source: State of the World’s Children, 200946.)

Figure 6: **Percentage of children stunted**

(Source: State of the World’s Children 2009)
3.2 Global and regional experiences of health sector initiatives in ECD

Interventions through the health sector with partner ministries can be described in terms of promotive, preventive, and curative care, and by each age period. For each cell, actions are required by families, communities, and the health facilities, in combination with other ministries. In each column, the focus is somewhat different.

<table>
<thead>
<tr>
<th>Period</th>
<th>Promotive</th>
<th>Preventive</th>
<th>Curative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>Family focus</td>
<td>Outreach/family</td>
<td>Health facility</td>
</tr>
<tr>
<td>Intra-partum</td>
<td>Family focus</td>
<td>Outreach/family</td>
<td>Health facility</td>
</tr>
<tr>
<td>Newborn (1 month)</td>
<td>Family focus</td>
<td>Outreach/family</td>
<td>Health facility</td>
</tr>
<tr>
<td>One month to 36 months</td>
<td>Family focus</td>
<td>Outreach/family</td>
<td>Health facility</td>
</tr>
<tr>
<td>3 years-5 years</td>
<td>Family focus</td>
<td>Outreach/family</td>
<td>Health facility</td>
</tr>
</tbody>
</table>
**Promotive care.** The health sector has a unique role in supporting young children’s growth and development, labelled here as promotive care. The health worker is often the most trusted source of information and advice to families. Health care providers can give critical guidance such as how to communicate with infants and children, stimulate children, handle common developmental problems such as sleep, feeding, and discipline, and reduce injuries through alerting families to rapid changes in development that result in periods of increased susceptibility for accidents.

In 1999 WHO developed a module of Integrated Management of Childhood Illness (IMCI) for early child development, titled Care for Development. The module adapted recommendations for healthy mother-child interaction from the WHO Programme for Mental Health (1998). The module contains recommendations for age-appropriate activities that families can engage in with children as well as nutrition and responsive feeding behaviours. Sample problems and solutions were provided. The intervention was designed to include ECD into IMCI with a minimum of additional time and effort. Given changes in the last 10 years in both nutrition and development, the Care for Child Development and Care for Feeding modules were revised and updated in 2008-2009.

Family and community empowerment can also help in improving children’s growth and development. Promoting early child development is one of the 15 actions in the community component of IMCI. In Malawi, when community IMCI health workers encouraged families to talk with children and appreciate their attempts at learning, families reported using parenting behaviours that support development more often.

In Indonesia, the KKA programme was an early leader in incorporating information about children’s development on their health cards, and the Posyandu system incorporated group sessions for caregivers and young children on child development along with nutrition interventions. Initial results were encouraging. With decentralization, some of these programmes disappeared, but they are now emerging again as models of integrated care for young children.

**Preventive care.** The health sector’s role in preventive care includes identifying children in need of increased interventions (who are at risk of delay, deviance or disability) through accurate and timely diagnosis, and well planned and followed structured and child-centred interventions. If not facility based, these services could be family, home, or community-based. Children who are known to be high-risk for impaired development, such as those born premature
or with low birth weight (LBW), have achieved normal levels of development with supportive interventions\textsuperscript{52,53,54}. This has implications for South-East Asia where almost one-third of the babies are LBW. Programmes with higher intensity and longer duration have greater impact\textsuperscript{55,56}. The Nurse Partnership Programme with high risk families in the US found increases in school readiness, reduction in days hospitalized with injuries, reduced use of food stamps, and eventually greater economic productivity\textsuperscript{9}. The authors estimate a benefit/cost ratio of 5.7 to 1 for the programme of home visiting\textsuperscript{8}.

The negative impact of other risk factors can be reduced with intervention as well. Maternal depression is increasingly recognized as a risk for young children, and can be reduced through social support, although effects on infants were modest\textsuperscript{40,57}. Loss of family members, or illness of family members, particularly with AIDS, is associated with poorer cognitive performance\textsuperscript{58} but Potterton\textsuperscript{59} found significant differences between a group of HIV+ infants in a home stimulation programme in addition to ARVs, and a comparison group. It is less clear how to reduce the effects of other risks such as exposure to violence, conflicts, disasters, and excessive (or toxic) stress.

**Curative care.** Finally, the health sector’s role in curative care involves early detection of children with delays or disabilities, and overseeing and coordinating early interventions for children identified as developmentally delayed or with special needs. The health sector should work with families to help them help their children and give them a sense of empowerment with respect to interventions with their child. The health sector may deal with child mental health, behavioural disturbances or withdrawn behaviour. The health sector’s role is also in developing and coordinating multi-sectoral linkages with social welfare, nutrition workers, and preschool programme workers, and in increasing access to primary health care for children and their families who require multiple, ongoing and multidisciplinary interventions.

Given the critical role of the health sector, and its relationship with growth and development, a regional strategy for strengthening the role of ECD in the health sector is needed.

### 3.3 Country experiences

The 11 countries in the SEAR Region have all begun to develop programme strategies to improve children’s cognitive development and prevent risk. These examples illustrate the variety of platforms and strategies that can be used to improve young children’s development through the early years.
A number of countries have developed some form of ECD programme through the health sector. Nepal has a well-developed community-based child care programme plus home visits. Bhutan has initiated home visits with new parents. Indonesia uses parent/child groups with ECD as well as health and nutrition, and is beginning to revise its posyandu system of comprehensive care. Maldives and Bhutan have both used mass media. An evaluation of the TV based communication strategy in Maldives found it to be effective.

Maldives has also adapted a positive deviance approach for malnourished children to include developmental milestones. In a positive deviance approach, community members identify children who are prospering despite poverty, and try to identify key positive practices. Caregivers are empowered to try out these new practices (“if someone else could do it, then maybe I can too”). A similar programme in India was able to significantly reduce severe malnutrition and improve care practices through community empowerment and positive deviance sessions linked to the ICDS system.

India adapted the WHO/UNICEF Care for Development messages into its Mother-Child Protection Card for ICDS in 2002, and recently included it with all new growth monitoring charts as part of the Integrated Child Development Services. India has the largest model of a comprehensive approach to young children in the world through the ICDS. These programmes incorporate a number of different approaches, such as the positive deviance model above, parenting groups and home visiting models. The Community-Led Initiatives for Child Survival in Maharashtra, India, through the Mahatma Gandhi Institute of Medical Sciences uses parenting workshops for mothers and fathers to incorporate ECD into their health delivery system.

Sri Lanka has been a leader in the integrated approach for young children. A law supporting a holistic approach to young children was passed in 2004, supported by five ministries and organizations. The law built on existing programmes, such as the home-based early childhood development programme initiated jointly by the Family Health Bureau, Ministry of Health and UNICEF. The programme reaches the communities and the caregivers through its network of public health mid-wives (PHM) and the health volunteers. The PHM’s capacity is strengthened through comprehensive training on holistic child development with the focus on psychosocial development. The new law includes this model, as well as early assessment and intervention for children with special needs. Sri Lanka has incorporated ECD into all training programmes for health workers, and has a number of posters and media. Every child receives a Child Health Development Record, which includes a growth chart,
immunization record, child development checklist and recommendations for families from Facts for Life.

Bangladesh is developing a master’s degree in early child development, and has had a number of experimental programmes that have illustrated the effectiveness of ECD. Incorporating ECD into the Bangladesh Integrated Nutrition Project resulted in significant improvements in child development at little additional cost\textsuperscript{64,65}. Plan International improved its parenting programme by incorporating specific practice activities, and found significant improvements in learning and in some responsive feeding skills\textsuperscript{66,67}. Timor-Leste reports developing a set of parenting materials on ECD, and will put them into practice.

All Thai children receive a “Mother and Child Health Handbook” at birth, combining birth registration with information on pregnancy, breastfeeding, complementary feeding, dental care, and child development. The child development chart provides a list of milestones children should achieve, a place for the parent to indicate when the child has achieved it, and recommendations for things parents can do. Thailand developed a community-based comprehensive programme based on “six things every child needs” through the government, Save the Children, and UNICEF in the 1990s\textsuperscript{68}. Community-based activities included health, nutrition, water and sanitation, safety, and ECD interventions. The evaluation suggested that not only had parents changed, but also children’s cognitive development improved, particularly among the poorest. There was such a positive reception to the programme that it expanded rapidly to include more topics and address more age-groups, resulting in a programme that reached children 0-18 years and became too complex for the implementers to understand and communicate, and so it could not be sustained.

Capacity development and leadership in ECD is critical for success. A number of countries have university-level programmes, as well as training for health care workers in ECD. Bangladesh is developing a master’s degree in early child development, and has had experimental programmes to sensitize health districts about the importance of ECD. India has PhD-level courses in child development, and at the other end of the spectrum, six month certificate level courses for undergraduates offered through distance mode. Thailand has a National Institute for Child and Family Development at Mahidol University that provides training for preventive and curative approaches for children with disabilities, and strategies for working with families, as well as considerable research on the learning capacities of Thai children\textsuperscript{69}.
Goals, objectives, and evidence-based programmes to support child development are proposed in this section.

4.1 Goal and vision

To ensure that all children are able develop their full potential, recognizing that development is integrally related to child health and nutrition. Improving one without improving the other will not achieve the goal.

4.2 Objectives

In order to achieve this goal, the regional framework will guide Member States to achieve the following goals:

(1) All programmes for child and maternal health and nutrition will include support for child development and maternal mental health and links with other appropriate sectors.
(2) All policies relevant to health and nutrition will include support for child development and maternal mental health and links with other appropriate sectors.

(3) All health sector community mobilization will include support for early child development and maternal mental health and links with other appropriate sectors.

(4) All children at risk of poor development due to poverty and social marginalization will have the same access to support for survival, growth and development as all other children at all levels.

(5) Policies and programmes will be in place to support appropriate assessment, referrals and services for children with special needs as a package to the extent possible given the capacities of the country, and with links to other sectors.

(6) Communities and families will receive support for children with special needs.

(7) Monitoring and evaluation of actions to support early child development will be carried out by the health sector in facilities and in communities.

(8) Advocacy for ECD will be successful at all levels, including in influencing policy, in the health sector.

(9) Capacity building for ECD in the continuum of care will be in place throughout the health system in facilities and in communities.

For each objective, an indicator can be defined that refers to coverage, equity, access, and provides a timeframe for achievement. (e.g., by 2015 80% of all primary health care visits in both urban and rural areas will include counselling on child development).

### 4.3 Guiding principles

These guiding principles have been applied to the development of policies for health systems. They equally apply to the incorporation of a child development component into primary health care. Implications for effective programming are suggested for each.

- **Equity.** Interventions are particularly important for children raised in disadvantaged conditions, and can serve to reduce disparities in the life course if early interventions are followed with adequate
levels of services. Particularly in parts of South and South-East Asia, gender is a major source of disadvantage.

- **Disadvantaged children are most likely to show impact.** Although impacts of early stimulation programmes are normally seen at all levels, evidence suggests that they are greatest for children who are most disadvantaged.

- **Child rights.** Children have the right to develop as well as to survive, and to be free from discrimination in achieving this goal.

- **Achieving child rights** requires supportive laws and policies, strategic information, services, and strengthening collaboration with other sectors.

- **Integration of services.** In the critical prenatal period and the first few years of life, not only direct services, but a broader series of
support and interventions are needed to provide children with the best start in life.

- **Health services should advocate and provide an integrated approach to early child development.** This requires cognitive stimulation and support in a responsive, nurturing, and secure environment. Children need opportunities for play, fine and gross motor development, and to have their wishes taken into account to the extent possible.

- **Comprehensive models are more effective than single sector programmes.** Programmes that combine interventions to improve nutrition, health, and development tend to have greater impact particularly when levels of malnutrition and poverty are high.

**Life course approach.** Interventions should provide a continuum of support for children’s development including care for women prior to childbearing and delay in childbearing, care during pregnancy, and for the child through the first five years of life.

- **Mental health of women during pregnancy and postnatally is critical for both maternal and child well-being.**

- **Interventions for the poorest should begin as early as possible to be effective.** Early interventions are more likely to be effective than later. Interventions that begin within the first two to three years of a child’s life have been shown to be more effective than those that begin at ages 5 or 6, although the latter may show effects on specific school readiness skills.

- **ECD interventions should link with adolescent health and development.** Risk for young children is reduced if their mothers stay in school longer and are more educated, and if mothers are beyond adolescence at the birth of their first child.

**Community ownership and participation.** Interventions should be based on community planning and ownership and the socio-cultural context. **Families must be empowered** and enabled to be effective in their roles in caregiving, bonding and emotional attachment, and stimulation. Families are the child’s first teachers.

- **Community mobilization** should actively involve all dimensions of the social environment that impact a child’s development, not just health.
4.4 Evidence-based interventions for Early Childhood Development

Interventions for promoting early childhood development should become part of the regular primary health care package, and link with maternal and child health, breastfeeding and complementary feeding and newborn care. Health promotion and disease prevention must begin in the early years rather than in adulthood. Nutrition and prenatal factors have been shown to have a long-term impact on adult health and disease. A reduction in the number and severity of early adverse experiences e.g., child abuse and neglect, maternal postpartum depression, and maternal substance abuse will lead to a decrease in the prevalence of a wide range of health problems.

Evidence-based interventions to support children’s development can be categorized according to the period of development (prenatal, intra-partum, newborn (to one month), one month to three years and three-five years) and the purpose of the intervention: promotive, preventive, or curative. Promotive and preventive care may function through community mobilization and outreach, whereas curative care is centred in health facilities.

An approach to promotive and preventive care for early childhood development is WHO/UNICEF’s “Care for Child Development’ package. The package provides evidence-based, theoretically sound, and tested methods for supporting early child development, good nutrition and responsive feeding. It provides three-four recommendations for all children on play (cognitive development) and communication (language and social-emotional development) for each age group. It includes questions for health workers to use with parents, a checklist for observation by health workers and recommendations to use if a health worker observes problems such as lack of mother-child attachment, harsh discipline or maternal depression. It includes a list of potential problems with recommendations for action. Recommendations cover the first week of life through 24-36 months. A controlled trial in Turkey showed that use of the module could significantly improve parenting behaviours one month after the intervention (Ertem et al, 2006) with only about 10 additional minutes per visit.
The Care for Feeding Module (a component of Care for Child Development) provides recommendations on nutrition and responsive feeding across the same age range. It has been updated with the most recent recommendations on nutrient intake for the breastfed child, and includes a focus on the newborn. It also includes suggestions for responses when problems are identified, and a checklist for health care providers to use to identify, advise on and manage problems.

The Care for Child Development Module requires a 2.5 day training, and can be used with caregivers by health workers, nutrition workers, or community health workers. It can be used in groups or during home or clinic visits. Parenting materials that can be given to families to reinforce messages have been developed as well.

‘Care for Child Development’ module has subsequently been incorporated in a larger package ‘Caring for the Child’s healthy growth and development’ developed by WHO.

Table 2 summarizes interventions to support all children’s early child development and to ensure maternal and child mental health that are additional to health and nutrition interventions. An asterisk indicates where the Care for Child Development and Care for Feeding Modules are the recommended intervention. The evidence base for these interventions is described in the Annex 1.

**Table 2: Interventions for Early Childhood Development to complement health and nutrition and other primary health care interventions (Evidence provided in Annex 1)**

<table>
<thead>
<tr>
<th>Period</th>
<th>Promotive care</th>
<th>Preventive care (In conjunction with promotive care – previous column)</th>
<th>Curative care</th>
</tr>
</thead>
</table>
| Prenatal | • Social and emotional support from male partner  
• Information on child development for new mothers* | • Social-emotional support for mothers evidencing depression or stress | • Special care for women at risk for mental illnesses. |
<table>
<thead>
<tr>
<th>Period</th>
<th>Promotive care</th>
<th>Preventive care (In conjunction with promotive care – previous column)</th>
<th>Curative care</th>
</tr>
</thead>
</table>
| Intrapartum           | • Encourage bonding of mother/infant by skin to skin contact, allowing infant to find the breast, immediate breastfeeding;  
                         • father presence at birth                                                   | • Increased family and health worker support                             | • Counselling and support for families with high risk birth and/or infant      |
|                       |                                                                               |                                                                        |                                                                              |
| Newborn to one month  | • Age-appropriate recommendations for child play and communication to families and problem-solving for attachment difficulties, discipline, other care practices*  
                         • massage and gentle stroking*  
                         • show parents how newborns respond to stimuli                           | • Kangaroo mother care with skin to skin contact for premature or LBW infants | • Kangaroo mother care with skin to skin contact for hospitalized or very low birthweight infants promote mother, newborn and family bonding |
<table>
<thead>
<tr>
<th>Period</th>
<th>Promotive care</th>
<th>Preventive care (In conjunction with promotive care – previous column)</th>
<th>Curative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>One month – 36 months</td>
<td>• Age-appropriate recommendations for child play and communication to families and problem-solving for attachment difficulties, discipline, other care practices*&lt;br&gt;• guided practice for families in these recommendations (hold parent-child group sessions),&lt;br&gt;• increase access to books, learning materials&lt;br&gt;• inform parents of accident risks associated with developmental changes (e.g., walking)</td>
<td>• Consultation and assessment with parents regarding concerns if a risk of disability or delay;&lt;br&gt;• for LBW/premature children gradually increase responsive stimulation from family&lt;br&gt;• encourage responsiveness in feeding particularly for malnutrition or over – nutrition*&lt;br&gt;• provide women at risk of maternal depression social support&lt;br&gt;• Early recognition of children undergoing neglect, abuse, violence, or other high risk environments identify resources for supporting child</td>
<td>The previous column and:&lt;br&gt;• early intervention with family for children at risk of disability, delay, or learning and behavioural difficulties&lt;br&gt;• monitoring of women with maternal depression to be sure that they are accessing treatment&lt;br&gt;• Early intervention with families and communities for children experiencing neglect, abuse, violence, or mental health problems</td>
</tr>
<tr>
<td>37 months to 60 months</td>
<td>• Communicate the importance of family support for learning&lt;br&gt;• advice on family care and discipline&lt;br&gt;• Encourage play with other children, participation in early child development programmes</td>
<td>• Continued routine checks for child malnutrition, vision, speech and hearing, learning and behavioural problems, and developmental delays&lt;br&gt;• awareness of problems in interaction between family and child</td>
<td>The previous column and:&lt;br&gt;• early intervention for children at risk of disability or delay – interventions coordinated by the health sector&lt;br&gt;• linkages with preschool workers for early inclusion/rehabilitation in available educational settings within the community.</td>
</tr>
</tbody>
</table>

* These recommendations are in the WHO/UNICEF Care for Child Development and Care for Feeding Modules.
Planning for implementing ECD at scale and quality

This section outlines the components of an implementation plan for ECD within the health sector. Section 6 outlines steps to be taken in developing the plan and moving it forward.

An implementation plan includes goals, actions that key stakeholders and sectors should undertake, and a structure for ensuring that the actions take place such as laws, policies, and financial allocations. It may be explicit, as in a policy, or implicit, as part of governmental speeches or decrees. An ECD policy or plan refers to the actions to support the well-being of children before birth through transition to school.

An ECD implementation plan includes the following components:

5.1 Vision, goals, and objectives for Early Childhood Development

The vision and goals tend to be broadly stated, whereas objectives should be stated in a way that can be tested and have a timetable. Objectives may include inputs (activities to be done), outputs (results of the activities), outcomes
(changes in behaviour or actions of families, communities, or health care workers), and impacts (changes in child development). They should be stated in terms of achievable objectives within a time period.

5.2 Situation analysis of young children

This section discusses the current situation of young children’s development and trends or changes over time in the country. Disparities by rural/urban, gender, income level, and ethnicity (if applicable) should be examined. Given the relative lack of data on children’s development, it may be necessary to include proxies such as stunting and measures reflecting the quality of the home environment such as maternal education. It should include a review of child-rearing practices to identify beneficial practices to support, and possibly practices to discourage because they do not support child development. It should end with an assessment of problems and opportunities for investment in young children.

Second, it should review current policies and plans for young children in all relevant sectors (health, education, social welfare, and possibly others such as housing or the environment). Third, it should review the role of stakeholders (ministries, families, communities, and civil society) in young children’s development. Finally, it should define policy and programme gaps as well as opportunities and recommend policy and plan development.

5.3 Evidence-based programme strategies appropriate to the context

Key programme strategies to be applied should be based on both evidence for effectiveness in early child development and the specific problems the country is facing. A list of possible interventions is in Table 2, with evidence in Appendix 1. Ideally the evidence is from the country, but in the absence of relevant data from the country, others can be used judiciously.

An important part of a programme strategy is communication. Reaching families through many channels is often the most effective method for behaviour development. A broad communication involvement is likely to result in wider coverage and greater likelihood of attaining goals.
If the Care for Child Development Modules are adopted, recommendations already cover many of the areas outlined in Table 2 for promotive and preventive care.

5.4 **Structure of governance: supervision, administrative arrangements for coordination**

Roles and responsibilities should be defined, including systems for coordinating among ministries. It is helpful to have one ministry in charge of each area, with contributions from others defined. Definitions need to be provided at each level. Adequate supervision is important for programme quality.

5.5 **Monitoring and evaluation plan established with a system for accountability**

No component can be effective if it is left to the goodwill of workers. A system of feedback, accountability, and review for modification is important for the approach to become sustainable and to be sufficiently qualitative to make a difference in the lives of young children. Monitoring of health facilities, supervisors, and community health workers is particularly important for preventive care, often seen as a lower priority than curative care.

Given the difficulty in measuring child development with a simple indicator, a monitoring system should assess a) health worker capacities; b) whether recommendations have been given; c) parent/family knowledge, skills, and practices; and d) where possible, reports of child achievement of a few key indicators at the population level. In some cases, these have been developed within the country and can serve as proxies. Language and motor development for young children can be useful indicators. In others, either external measures could be used, or the country could rely on the proxy indicators. More work is needed in this area.
5.6 Capacity building: Pre-service and in-service training systems, tools, manuals, training schedules

Capacity development of practitioners and managers is needed at each level. All need to become aware of the importance of early investment in early childhood to close the gap in a generation. A number of examples have shown that training health workers without sensitizing their supervisors undermines sustainability, as their supervisors then may not value the work but wish to have them focus on something else.

Involving training institutions and academia for pre-service and regular in-service training is important for programme sustainability. These groups can be involved in the adaptation of the materials, development of training mechanisms, and review of the goals and objectives of the approach. Their ongoing research will continue to strengthen the programme and provide evidence for the importance of ECD.

If the Care for Child Development Modules are adopted in part or whole, many tools for implementing them are prepared:

- Training programmes for health workers and community providers (2.5 days training for Care for Child Development)
- Facilitator’s training
- Advocacy materials and video for policy makers and managers
- Common problems in providing good care to young children and advice.
- Models of materials for parents to take home to reinforce these messages
- Monitoring and evaluation framework.

Tools that are in the process of development include:

- Guidance for the integration of Care for Child Development into ongoing programmes and activities in health and nutrition facilities and in the community.
- Guidance for adaptation for local conditions.
- Posters and displays.
Other components that could be added include the new WHO Growth Charts, the Motor Milestones, or the Guide for Monitoring Child Development for low and middle-income countries developed by Ertem et al. (2008), a parent-report screening system. Early intervention for children with delays or disabilities has been shown to be effective. However, assessment of possible delay is useful only when early intervention is available to children and regularly accessible to parents. If not, a more effective use of funds is to provide all parents with basic information and skills to improve children’s development.

Linkages with maternal and newborn care packages are being developed. At this point, specific recommendations for injury prevention are not included but could be incorporated in country adaptations.

5.7 Costs defined and financing sources identified

An assessment of costs of the programme, and definition of sources of funds to support the new costs is important for scaling up the intervention. Stable funding allocations are often overlooked, and must be defined in the plan.

Having an estimate of existing costs and the cost of adding an additional component can be very helpful, and there are several programmes available to help with this first approximation. With this information, including coverage, it is possible to begin to consider sources of financing.

5.8 Partnerships

Given the extensive evidence that disparities in health will not be reduced by the health sector alone, and the need for cooperation among many sectors as well as families, communities, and civil society, identifying partners who will work with the Ministry of Health to develop and implement the plan is highly recommended. Their roles and responsibilities should be defined.

Partnership and coordination with community-based organizations and local bodies for implementation is critical for scaling up. Recent research suggests that community mobilization approaches leading to community empowerment may be important for achieving child health goals. Particularly with a cross-sectoral approach, the local governing bodies must be informed, involved and committed.
Communication partners can be valuable. Depending on the context, this could include television, radio, folk theatre, or a broad-based community volunteer outreach effort.

When children are identified as needing special support, linkages need to be made with other organizations and resources, such as community-based rehabilitation, or the WHO protocol for treatment for severe malnutrition.

5.9 Strategies for sustainability: Laws, policies, and the enabling environment

The keys to sustainability are an accepted policy, adequate funding, ongoing monitoring and improvement, and high-level support for the inclusion of ECD in a health system. Not only at the highest level, but at all levels, workers as well as families and communities need to recognize the critical role of early child development for the future of their children. Ongoing advocacy, research, and demonstration of effects can often increase sustainability. Involvement of academic and training institutions creates a cadre of leaders who will be able to renew the efforts.

Having a strong policy and legislation basis plus strong political commitment will help the process tremendously. In some cases a good place to start is to initiate a policy development process, but in other cases, policy should be pursued once a programme is underway. Having a policy and/or legislative basis for the intervention, including a funding source and a system for accountability should be a goal.
### 5.10 An activity chart template

The chart below can provide the structure for finalizing the elements of the plan and the next steps. It can be divided by objective, but also could be divided by level.

<table>
<thead>
<tr>
<th>Level or objective</th>
<th>Activities to be implemented</th>
<th>Month, Year when it will be completed</th>
<th>Partners</th>
<th>Expected results</th>
<th>Funds needed and source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/legislative base</td>
<td>1.</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>2.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Intersectoral</td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health system</td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary health facilities</td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community and family</td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
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<tr>
<td></td>
<td>3.</td>
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</tr>
</tbody>
</table>
The way forward: developing the strategic plan in countries

The previous section described the components of a plan for a comprehensive approach to early child development through the health sector. This final section outlines a process for developing and refining the strategic plan in each country. The amount of focus on policy and programme development will depend on the country situation. This section describes recommendations for first steps that will help to make a programme sustainable and attractive.

6.1 Advocacy with policy and programme decision-makers

Departments and units in ministries of health as well as other ministries, including education, finance, and planning need to be sensitized to the rationale for incorporating initiatives for early child development in existing primary health care programmes. Ministries of health can identify, advocate and partner with existing programmes which support early child development such as a ministry of child welfare, social welfare, commissions for child rights, nongovernmental organizations, universities, and professional organizations.
Depending on the country, reviewing existing policies, national plans, and legislation relevant to early child development can form the basis for a policy framework that brings these partners together to develop programmes for young children. The review can also identify policy gaps.

6.2 Create a working group to oversee the process

Countries can establish an ECD working group to develop an implementation plan for ECD. The working group should be appointed by a more senior level authority and it should be charged with preparing the plan. The working group will have representation from ministries of health, and related ministries like those responsible for nutrition, child welfare, social welfare, finance, labour, planning, education and information / broadcasting and consumers. It should use a wide participatory process. It is suggested that representatives of WHO, UNICEF, NGOs working with children, and multilateral and bilateral donors be included in the working group.

The suggested terms of reference for the working group are:

- Assess the situation of young children in the country, and identify ECD-related issues.
- Assess policies that are in place and need to be changed.
- List indicators that need to be considered in setting goals and objectives.
- Identify goals and objectives for early child development
- Assess the current interventions for pregnant women and young children for ECD, particularly through the health sector, and identify gaps.
- Assess the current policy environment and partnerships/funding sources that could be used for ECD.
- Make recommendations of interventions that would address the gaps identified, including gaps in coverage, access and equity.
- Make recommendations of actions required for preparing the implementation plan in the areas of policy and legislation, programmes, capacity building, governance structures, and monitoring to facilitate sustainability and quality.
• Piloting and re-vision of the programme.
• The group may want to identify champions who can assist in advocacy, awareness raising and communication of the plan.

6.3 Consultation with policy makers, civil society, communities and families

Results of the working group’s conclusions can be used as the basis for a broader consultation on the goals and approaches that might be introduced. Understanding the perceived need for support for children’s growth and development at all levels will help to guide the programme to sustainability. This assessment can also assist in the evaluation of the parenting approaches that may be most effective.

6.4 Pilot the programme model

Piloting should begin in areas where there is enough infrastructure to be sure that the new component of the programme will be implemented - start where you are likely to succeed. The best results will occur when the component starts where there is a perceived need – start where there is a need. You may not have all partners lined up when you start – begin and add links with providers as you go. Above all, let all participate and listen to all ideas.

6.5 Support a research programme

The situation of children’s growth and development in each country, the most effective strategies for improving children’s development, and an assessment of programme activities require ongoing research. Continuing to build a locally appropriate data base is important for sustainability and effectiveness.

6.6 Build the motivation of all stakeholders for sustainability

The inclusion of a new component into existing programmes requires a review of the motivation of all workers, the additional time and resources needed, and the linkages and benefits of the new approach for all workers. For example, linking
new nutrition interventions such as home fortification with ECD information may provide additional support for young children’s growth and development through increased interest and involvement of families when they see the benefits in their own children. This additional support of new approaches increases sustainability.

In order to create a sustainable system for promotive, preventive, and curative care for early childhood development in the health sector, five groups must play a part: Policy and decision-makers; Academics/trainers/supervisors; Service providers at secondary and tertiary care; frontline and community health workers; and communities and families. Table 3 summarizes elements required to increase stakeholders’ motivation and awareness of ECD, improve capacity to deliver interventions, and facilitate the process of implementation. Despite all the rationale for the importance of early child development, building a component into a health system will require commitment, motivation and strong partnerships.

Table 3: Actions for a sustainable policy support for ECD

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Motivation and raising awareness</th>
<th>Improving delivery capacity for ECD interventions</th>
<th>Facilitating the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/decision makers/ finance</td>
<td>Evidence-based advocacy and rights perspective on ECD</td>
<td>Training and skill building for policy analysis and planning for ECD in health system</td>
<td>Laws and legislation in place – resources leveraged, institutions and systems enhanced</td>
</tr>
<tr>
<td>Academia/trainers/supervisors</td>
<td>Increased awareness, and receptiveness for ECD in the health system</td>
<td>Pre-service and in-service training, systems development, leadership, M&amp;E</td>
<td>Increased incentives for the implementers, including financial benefits, research</td>
</tr>
<tr>
<td>Secondary and tertiary care</td>
<td>Perceived benefits for MoH</td>
<td>Accessible services for children identified</td>
<td>Policies and programmes in place</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Motivation and raising awareness</td>
<td>Improving delivery capacity for ECD interventions</td>
<td>Facilitating the process</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Frontline health workers and community health workers</td>
<td>Increased awareness and willingness to promote ECD as part of their routine work</td>
<td>Training of front-line health workers (Care for Child for Development training and implementation)</td>
<td>Additional benefits, recognition, and other incentives and support; requirement for incorporation</td>
</tr>
<tr>
<td>Families and communities</td>
<td>Perceived benefits to families and communities of children’s development</td>
<td>Parenting support programmes, training, counselling (Care for Child Development parenting materials)</td>
<td>Linked social services - social protection policies, communication strategies</td>
</tr>
</tbody>
</table>
Evidence for interventions proposed in Table 2

Prenatal

For a child’s development, the most critical prenatal interventions relate to reduction in possible developmental impacts related to nutritional deficiencies or cognitive consequences of teratogens such as smoking, excessive amounts of alcohol, or drug intake such as cocaine, all of which have been found to have significant effects on children’s development. Stress during pregnancy resulting in high cortisol levels has been linked with increased children’s difficult temperament, a risk factor for later psychological disorders⁷⁴. Maternal depression during pregnancy, and postnatally has been linked with poor child growth and development⁷⁵,⁷⁶. Low birth weight due to intra-uterine growth retardation has been associated with poorer development without additional interventions⁶.

Promotive Interventions should include a family-based approach encouraging male partners to support the pregnant woman emotionally.

Preventive. Strategies include interventions with pregnant women who are abusing drugs, alcohol, or tobacco, and social support for women who show symptoms of depression or excessive stress.
**Curative care.** Conditions such as maternal diabetes, maternal age over 35 or very young, drug or alcohol abuse, or multiple pregnancies have special risks for a child’s development, and require special interventions.

**Intra-partum care**

**Promotive and preventive.** Research supports the importance of mother-child bonding and skin-to-skin contact in the first 45 minutes or hour after birth for breastfeeding, quality of attachment, and possibly discipline strategies. Although this intervention appears to be important for all, it is particularly effective for high-risk mothers, such as very young mothers, those who may not have wanted the child, or with socio-economic risk. Putting the child on the mother’s chest and allowing the baby to find the nipple himself or herself has been shown to be effective for supporting breastfeeding.

**Curative.** An abnormal birth, a child disability evident at birth, or a very premature birth may increase risks for healthy development of the mother-child bond, resulting in a long-term risk for the child. Counselling with the family (not just the mother), and an honest discussion of the risks and possibilities is recommended. Strategies to keep the mother and father in as close contact as possible with a very low birthweight child are helpful.

There has been considerable discussion about the effects of C-sections on mother-infant bonding and attachment, particularly as the rates of c-sections continue to rise in many parts of the world. However, research suggests that the effects of C-sections on maternal-child bonding depends on prior experience with children and maternal depression. As noted above, this tends to be a larger problem with high-risk mothers or with low birth weight and less responsive infants.

**Newborn (birth to one month).**

**Promotive care.** In addition to interventions to increase the chances of a child’s survival, there is evidence that parental attachment and investment in newborns, by mother and father, increases if they are more aware of their child’s capacities early on. One strategy is to show families that children can see and hear from birth, which many do not know. This knowledge may improve patterns of interaction in the first days of life.

Demonstrating to families their newborn’s capacities can be even more effective than knowledge alone. A simple demonstration of these
abilities has resulted in improved interaction and subsequent breastfeeding behaviour\textsuperscript{50,51}.

Gentle massage in some cultures has been shown to increase weight gain and development as well\textsuperscript{82,83}.

**Care for Child Development.** A major tool to be used during the period of birth through 36 months is the WHO/UNICEF Care for Child Development package. It serves both as a guide for community health workers and facility workers, as well as a training package for them. Studies have demonstrated the effectiveness of the Care for Child Development intervention for improving the quality of the interaction with the caregiver. Three trials with the initial Care for Development intervention though primary health care suggested that it took relatively little time, was positively received, and in one trial, resulted in positive behaviour change. It was tested in Brazil\textsuperscript{84}, South Africa\textsuperscript{85} and a randomized controlled trial was performed in Ankara, Turkey\textsuperscript{86}. Interventions were delivered by trained physicians and health care workers. For all three experiments, the measured outcome was maternal recall and maternal satisfaction, and the third included the quality of mother-child interaction one month after the health care visit as well.

Using the Care for Development Module increased a primary health care consultation on average by seven minutes in Brazil and 11 in Turkey. There were no negative effects of the intervention on the child’s health status. One of the most consistent effects of these interventions in all three locations was increased satisfaction with these health care visits that included child development, and an increased participation in other visits. Ertem et al.\textsuperscript{86} in Turkey found an effect on the quality of the home environment one month later after only one health centre visit and a follow-up visit.

The modules were based on principles of effective interventions with parents\textsuperscript{87}:

- Clear, simple behavioural examples that caregivers can immediately use with children, including demonstration, practice, and feedback.
- Promote 1) a positive view of the child, 2) the caregiver as the person who has most to give to the child, and 3) importance of the caregiver for the child. For example, demonstrating to the caregiver how responsive the child is to her/him can be an effective illustration of these ideas.
- Improve the well-being of the caregivers through support, being aware of both personal and economic resources that may be limiting for intervention.
- Connect the caregivers to additional services, or engage other family members (e.g., father, mother-in-law) may be effective.

**Preventive care** could include routine neonatal screening and surveillance of high risk newborns (e.g., low birthweight, premature) and infants from high risk pregnancies or births on variables such as alertness, tone, or colour, in addition to the interventions listed above. Gentle massage could be recommended as an aid to both mother and child. For premature babies, positioning, with support, and vestibular stimulation can promote catch-up growth.

**Curative care.** For children who are significantly premature or very low birthweight, curative kangaroo care has been shown to be effective when other options are not available.

**One month to 36 months**

This period of life is absolutely critical for a child’s growth and development. The health sector, as the major service delivery agency during this period, plays a critical role in children’s development. For sensory and auditory development and for development of emotional security the first year is most critical. For language development, problem-solving ability and learning how to control emotions, the second and third years of life are most crucial. For broader cognitive development, development of social skills, and higher thinking processes, the timeframe is broader, with brain development continuing for months and even years beyond the first two – three years of life.

Maternal depression during this period is common, particularly in South Asia. Maternal depression in this region represents a risk factor for the child as well as for the mother. Identification of possible depression may be done clinically or through a brief inventory, and can be followed by recommendations for social support, for group support sessions, and possibly for medication.

From 24 through 36 months activity levels are higher than at any other period of time, and children have not yet developed a system of internal control or regulation of their behaviour. Discipline can be challenging particularly if families expect a high degree of obedience. Families should be encouraged to use positive discipline and avoid harsh discipline. For example, they can teach children limits and rules before unacceptable behaviour occurs. With this
method, they are informing children of what they can do beforehand rather than simply correcting them for unacceptable behaviour.

As noted in an earlier section, interventions can reduce the negative effects of low birth weight, developmental delay, physical disability, or speech and hearing problems considerably. Problems with vision should be corrected very early. Harsh discipline has been reduced through health-centre based interventions. In some cultures, traditional practices such as keeping children in unattended sleeping places for many hours without an opportunity for movement and seeing can undermine healthy development. Other cultural patterns, such as low levels of speaking with children, or high rates of physical discipline may have long-term consequences. Evidence is growing that toxic stress associated with conflict, extreme poverty, or multiple risk factors can result in long-term impacts on brain architecture and function.

**Promotive care** during this period includes providing families with information on what they can do to help their children develop their motor, cognitive, language/communication, and problem-solving abilities. Guidance on discipline, responsive feeding, developmental changes that may be associated with injury (e.g., special attention when a child begins to walk or climb, or develops fine motor abilities) should be a component of primary health care.

Care for Child Development, and the associated package on Care for Feeding, including responsive feeding messages, can be used during this period.

**Preventive care** requires identification of children who are at higher risk such as those living in extreme poverty, children who are low birthweight or stunted, show signs of developmental delay or physical deficiencies, without families, or whose families express concern about the child. Health care providers with simple guides can observe problems in the child/caregiver interaction, such as a lack of responsiveness of the caregiver to the child. In extreme examples, child abuse may be suspected.

In these cases, follow up with appropriate interventions is needed. The current recommendation for identifying children with possible delays or disabilities is to collaborate with parents in their concerns about their child’s behaviour rather than immediately testing the child. The advantage of this procedure is that rather than simply labelling a child, with families passively accepting the diagnosis, it is advisable to have families raise concerns and collaborate in the diagnosis of the child, at least to some extent. This avoids being stigmatized and parents being blamed, and sets the expectation that they will be
active partners in early intervention\textsuperscript{73}. The initial assessment should be followed by a more formal assessment that can also suggest appropriate interventions. For stunting and low birthweight, and for mild developmental delay, the recommendation is usually to increase responsive play and communication of the family with child, in addition to reduce the stunting.

\textit{Curative care} is required when a child is diagnosed with a disability, severe malnutrition, or evidence of neglect or abuse. The health worker’s role may be to refer the child for additional care and continue to monitor progress.

\textbf{Thirty-six months to 60 months}

During these months, children develop a wide range of school readiness capacities in preparation for school entry. In general, the role of the health sector during this period related to child development is ensuring nutritional adequacy, particularly for key micronutrients related to cognitive ability, monitoring for physical or mental disabilities, and providing ongoing support to parents. Micronutrients such as iron continue to be needed for adequate functioning. Although there has been considerable research on the impact of geohelminths on cognitive development, the results are not conclusive. Continuing family support for language and cognitive development, exposing children to a variety of experiences, positive discipline and giving them a sense of belonging are needed. The health sector can continue to provide this information.

Many disabilities are not identified until children are about to enter school or are in a preschool learning environment. In this case, a rapid response may need to be coordinated by the health sector.

\textit{Promotive care} during this period includes continuing encouragement to families to provide responsive care and stimulation, positive discipline, and nutritional advice especially for micronutrient adequacy.

\textit{Preventive care} is ongoing monitoring of children’s mental and physical health for disabilities.

\textit{Curative care} is the continuing coordination of services for children with some form of disability or severe malnutrition.
References


45. WHO Regional Office for South-East Asia (2009). Health Inequities in the South-East Asia Region: selected country case studies. Delhi, India: WHO.


84. dos Santos, I. et al. Pilot test of the child development section of the IMCI “Counsel the Mother” module: study results and comments. Pelotas, Brazil: report to WHO. 1999.


The most common services that come in contact with children from birth to three years are the health services in most countries. Therefore, the health sector in partnership with other sectors has a unique role in young children's growth and development. The WHO Commission on the Social Determinants of Health in 2008 called on health systems to reduce health inequities in a generation by “building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development”.

From conception through the first few years of a child's life is the period of greatest risk as well as greatest opportunity for making a difference for children. Rapid brain development affects cognitive and social-emotional development, which is critical for long-term economic productivity, for meeting the challenges of globalization, and for ensuring every child's right to survival and development. It is estimated that globally over 200 million children under the age of 5 years are not developing their full potential, and many of these children (about 89 million) are in South Asia.

Investments in early child growth and development, particularly for children living in poverty will contribute to achieving the Millennium Development Goals and closing the gap between rich and poor. In the last two to three decades most countries in the South-East Asia Region have recorded significant declines in child mortality and impressive economic growth. The Region should be moving from a focus on child survival, to a broader concern for healthy development of children, economic productivity, and the reduction of disparities between rich and poor. WHO/UNICEF have developed a package of tools and a training manual, “Care for Child Development” that can be used along with “Care for Feeding” by primary health care and community health workers to assist individuals and families in promoting good nutrition and development, and preventing risks.

This strategic framework recommends developing programmes for children's growth and development that can be implemented in South and South-East Asia Region through the health sector with partners, and policies and plans to support these programmes. It outlines evidence-based, effective age-appropriate interventions that health facilities, communities and families can use to ensure optimal early child development through the health system. The Strategic Framework recommends that countries incorporate promotive, preventive and curative care for early child development into integrated primary health care and describes the steps each country could take to develop a plan for putting the programmes and policies into practice for promoting early childhood development.