Mapping opportunities for ECD integration in the health system

Summary results from formative assessments in Kenya & Mozambique

Background

The foundation of a child's life is laid during the first 1,000 days from pregnancy to the second birthday. This is the period of most rapid brain development. Developmental delays that are not addressed during this critical window of opportunity may be irreversible and can have deleterious long-term health, education, and socioeconomic outcomes.

During the first 1,000 days, children and their caregivers come in contact with the health system on multiple occasions: antenatal care, childbirth, postnatal care, essential childhood immunizations, routine child health services, growth monitoring and promotion, peer support groups, home visits by community health workers, and services offered by community-based organizations. In fact, during this period, the health system is often the **only** practical means to reach children and their caregivers with essential services.

The education and social action sectors typically target older children and their caregivers.

A mother playing with her child in health facility waiting room, Mozambique. Photo: PATH.

Introduction

PATH's approach to integrated early childhood development (ECD) involves the integration of age-appropriate care and stimulation messages and activities into maternal and child health (MCH) service delivery points targeting children and their caregivers in the first 1,000 days. However, in spite of the growing body of evidence that underscores the impact of age-appropriate care and stimulation on a child's long-term health and well-being, health service providers in most low-resource settings rarely track developmental milestones, identify developmental delays, or counsel caregivers on ways to promote children's development.

In 2014–2015 PATH undertook a formative assessment to better understand the underlying reasons behind the poor quality—or often, complete absence—of integrated ECD service delivery, as well as map opportunities for integration of age-appropriate care and stimulation messages and activities into existing health service delivery structures, tools, and guidelines. The exercise was carried out in Kenya and Mozambique and involved observations of health services and interviews and focus group discussions with service providers and caregivers.

The assessment also included desk reviews of existing tools and guidelines, interviews with health managers at the national and subnational levels, interviews with specialists (physiotherapists, occupational therapists, and pediatricians), and collection and analysis of health indicators to better understand the way in which service providers are trained and supervised, how data is collected and reported at various levels of the health system, and what health programming priorities are indicated through the data.

Key findings

Tracking of developmental milestones and promotion of development are a recommended component of routine MCH service delivery in both Kenya and Mozambique. However, even though most nurses and facility-in-charges have received some sort of pre-service training in child development, there is little or no in-service

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training. Most facility-based service providers are also aware of the various developmental milestones, but few are familiar with one or more milestones at a specific age. In general, the term “children’s development” is also generally thought to denote physical development—both among caregivers and service providers. There is little or no awareness of cognitive or socioemotional development and associated milestones.

Health service providers only take action in cases of obvious developmental delays and disabilities in children. Referral mechanisms are quite weak, as specialists are typically only present in tertiary facilities. Counseling of caregivers to promote adequate development is not done in either facility or community settings.

The typical time taken to deliver various services varies widely across the health system. For instance, routine services, such as growth monitoring and immunizations, only take 3–5 minutes, while counseling of caregivers of HIV-exposed children/children-at-risk can take 15–30 minutes.

The formative assessment noted nutrition service delivery as an area of particular weakness. Nutrition is thought to be relevant only in special circumstances (e.g., severe malnutrition and nutrition in the context of HIV) and little emphasis is given to routine promotion of maternal nutrition and appropriate complementary feeding of children 6–23 months.

Caregivers practicing play activities with their young children. Photo: PATH.

Service providers do not generally mistreat their clients. However, service delivery is generally very procedural (often following the indicators that need to be reported) and done without much dialogue between service provider and client. Counseling is only carried out in response to a client’s expressed needs and is often cut altogether if time is short.

Peer educators, counselors, and mentor mothers supported by nongovernmental organizations are sometimes present in health facilities. They triage clients, offer psychosocial support, and supplement/complement services provided by government nurses and clinical officers/technicians.

Waiting times vary widely across different levels of health facilities and nature of service delivery points—although lengthy waits are often the norm. Waiting areas are not child-child friendly and there are no toys for children to play with during waiting periods and in the consultation room.

Counseling aids and reporting tools required for integrating care and stimulation content into MCH services are generally absent. The counseling materials that exist for facilitating MCH service delivery are often outdated or not used properly.

Lastly, supervision, mentorship, and in-service training structures are generally inadequate— especially in lower-level facilities. In tertiary facilities, on-the-job training and mentorship may be provided by peer service providers or by facility-in-charges.

Key recommendations

The following are some recommendations from the formative assessment:

- Given the differences in contact time with clients and in service content, it is important to have tailored ECD messages and training strategies for each service delivery point.
- Waiting rooms and waiting times can be used as an additional touchpoint for integration of ECD interventions (e.g., sensitizing caregivers on children’s development and setting up play areas).
- The quality of nutrition service delivery needs to improve and include promotion of optimal maternal nutrition and complementary feeding.
- In addition to building the “technical” capacity of service providers, it is important to improve overall quality of counseling (e.g., making it more participatory and responsive to client needs).
- Supervision and mentorship activities may be done by supervisors within the health facility.
- Existing quality improvement practices, such as goal setting and weekly performance reviews, can be used to strengthen the ECD component.
- It is important to engage peer educators, counselors, and mentor mothers, in addition to government service providers.