

Early Childhood Matters

2020



Advances in early childhood development



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EDITORIAL

Rising to the challenges of today by investing in the early years for the present and future

Cecilia Vaca Jones

Executive Director

Bernard van Leer
Foundation, The Hague,
the Netherlands

This world is plagued by injustice and inequities that have never been more evident as a global pandemic underlines the enormous gaps in society, from within local communities and cities to between regions and nation states. To shape a better future, investing in early childhood needs to remain a priority for all governments and societies. The earlier we invest in a human being, the greater the economic and social return on the capital invested. This investment must start from before birth to guarantee equal opportunities for all children to develop their full potential and, collectively, set the foundation for a healthy, creative and peaceful world.

This year's *Early Childhood Matters* is launched in a historical moment when our mission, 'ensuring a good start for all children', is more relevant than ever. We are particularly concerned about children with the greatest vulnerability, such as the 22 million children who have been displaced by various crisis situations and the 250 million children living in urban areas in developing countries who are at risk of not attaining their developmental potential. We have only a limited window of opportunity to take action while a child is a baby or toddler, and in the pandemic context this time pressure motivates us to work harder to find agile and creative solutions that can scale much faster. We hope this journal will provide inspiration for more good practices around the world to improve the well-being of societies.

'The future we want, of a healthier and fairer society, begins today with strategic investment in early childhood.'

This issue opens with testimonies from five extraordinary leaders – four of them women – who make a clear call to action to protect populations living through today's humanitarian crisis. In sharing their visions and experiences of having worked at different levels of government and organisations, these leaders highlight the importance of seeking to be more effective in acting across sectors, between different levels of government, and with varied strategic stakeholders to consolidate an effective system of social protection for children.

The 'Scaling' section explores the implementation of diverse early childhood policies and programmes in different parts of the world and the challenges that must be considered when working at scale. Articles describe the successes and challenges faced by various programmes with modalities such as home visiting and parent coaching in reaching the vast majority of the population while prioritising interventions in the most vulnerable populations and households.

This section also highlights the importance of incorporating mental health as a priority policy in early childhood health and care systems. In these difficult times it is vital to sustain the mental health of caregivers, since this enables positive interactions with children. The behaviour of caregivers has a defining impact on the early development of children. In addition, a unique article emphasises the importance of starting in early childhood to deal with identity as a determining factor to promote equity in our societies. Finally, you will find a comparative analysis of different interventions that the Bernard van Leer Foundation has made in four cities to ensure that urban design and planning incorporate actions that allow improvements in equity, inclusion and the well-being and quality of life of babies, toddlers and their families.

The 'Innovations' section gathers valuable experiences that explore the challenges specific to working with ethnic minorities and highly vulnerable groups in ways that promote fairness and inclusion. Many times the programmes and policies that work at scale do not make it possible to identify and respond to pertinent differences in how diverse populations should be assisted. Several articles discuss how service providers responded to the

Covid-19 pandemic by rapidly finding new solutions, including the use of new technologies, to minimise interruptions to vital services and gaps in access to information and knowledge.

Facing a crisis requires commitment, but also creative problem solving. Current times present a new paradigm of thinking to transform the scope of early childhood policy, and to see beyond immediate services to achieve a bigger impact. That is why the final section, 'Global impressions', shares critical actions to ensure children's well-being in today's context. Nurturing a healthier relationship between childhood and nature, recovering the streets as a public space for people, finding synergies between climate change and early childhood development, and recognising the care economy seem fundamental ways to sustain our societies and focus our collective action.

At this moment, the pandemic is making young children around the world more vulnerable and affecting all areas of their development. The pandemic has also showcased how quickly a range of stakeholders can adapt, with empathy, agility and creativity. We must now ensure continuous action to promote access to all opportunities that help young children thrive. The future we want, of a healthier and fairer society, begins today with strategic investment in early childhood.

➔ Find this article online at earlychildhoodmatters.online/2020-ed

Bold leadership – or, as we see it, the ability to mobilise people to solve important problems collectively – is crucial to achieving results for young children. In this section, leaders from local and national government, civil society and academia discuss meeting the challenges of today and using strategic foresight to shape the future of early childhood.





Leadership

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The Covid-19 pandemic and childhood in Latin America and the Caribbean

- ▷ *The indirect effects of the Covid-19 crisis on children are multiple and severe.*
- ▷ *They include intra-family violence and likely reductions in education funding.*
- ▷ *A survey identifies effective policy responses from the Latin America region.*

Laura Chinchilla Miranda

President of Costa Rica,

2010–2014

San José, Costa Rica

The medical consensus is that Covid-19 poses few direct risks to children and adolescents – with some exceptions, such as children who have specific comorbidities and, perhaps, babies in their first year. But the indirect effects on children – due to the social and economic crisis that has resulted from the pandemic – are multiple and severe, and they have been mostly overlooked.

The Alliance for Child Protection in Humanitarian Action, a global inter-institutional group supported by Unicef, has published an important brief on the protection of children during the coronavirus pandemic (Alliance for Child Protection in Humanitarian Action, 2020, online). It warns about harm to the environment in which children are growing up, through serious disruptions to family dynamics and daily routines. In more serious cases, these disruptions have provoked family separation, violence, mistreatment, educational problems, forced labour, and exclusion.

The economic effects of the pandemic are already visible around the world, and the outlook for the future is worrisome. In the case of Latin America and the Caribbean, there are predictions of a severe contraction: both the International Monetary Fund and the Economic Commission for Latin America and the Caribbean project a decrease in regional GDP of more than 5%. These projections also envisage a massive rise in the unemployment rate, increasing the number of people in poverty in the region from 185 million to 220 million.

This will undoubtedly have significant political and institutional effects, such as growing dissatisfaction with democracy potentially triggering political violence. We must also consider the likely effects of the economic crisis on child mortality, malnourishment, teen pregnancies, and learning quality – with the risk of deepening the region’s pre-existing educational crisis.

The closing of schools and childcare services increases stress on all families, especially single-parent households and those headed by women. The lockdowns have exacerbated the impacts of unequal pressure on women and girls to do care work. It is also worth remembering that half of the doctors and 80% of nurses are women in the Latin American and Caribbean region – the highest percentage in the world, according to the Inter-American Development Bank.

An increase in intra-family violence is a particularly worrying effect of the confinement due to the pandemic, as it is undoing recent progress in this field. Lockdowns have isolated many women at home, breaking their family support networks, friendships and links to civil society and the State. This has left them and their children more vulnerable to abuse, neglect, violence, exploitation, and stress (United Nations, 2020).

Not all countries in the region have considered support and care for women and children as essential services. For women and children experiencing physical and mental abuse, the lack of priority given to these services has added to their emotional suffering.

Children look to adults in their lives in order to find an example of how to behave when faced with new, complex and challenging situations. Already six out of ten children in the Americas are raised with violent methods that include corporal punishment and psychological aggression, according to the Inter-American Commission on Human Rights (2020). A generation of young Latin Americans may now grow up with additional psychological and emotional trauma due to their experiences during the pandemic.

Laura Chinchilla Miranda, President of Costa Rica from 2010 to 2014, visiting a public school while in office



In addition to these general challenges, specific groups of children have faced particular risks during the pandemic. For example, malnourished children have been deprived of the food they used to receive at school. Migrant children, and those living in dangerous social environments where organised crime is constantly present, have often been expected to continue to work and support their families.

Survey on policy responses

In response to the pandemic, I joined more than 60 leaders from 17 countries in Latin America and the Caribbean to create the *Convergencia para la Acción, Red de Líderes por un Comienzo con Futuro*, (Convergence for Action: Network of Leaders to Begin the Future) initiative. Between April 20 and May 1, this initiative conducted a pioneering survey¹ on early childhood development policy responses to Covid-19. It collated evidence on measures including:

- policies to ensure children's food security, especially for families without access to social protection
- strategies for maintaining educational programmes via the internet or television, bearing in mind that a third of the region's population does not have internet access
- special measures for migrant and indigenous children
- caring policies for sick children or children with a disability who, due to the emergency, could not continue their treatments in conventional health systems.

Interrupted healthcare is also a concern in terms of vaccinations: the United Nations projects that the demands placed by Covid-19 on health infrastructure and personnel will delay vaccinations for diseases such as measles for more than 117 million children in 37 countries around the world, some of them in Latin America.

The survey found multiple examples of specific initiatives that have shown efficacy in protecting children in the pandemic context. For example:

- In Chile, parenting guides have been published to help parents protect and promote the emotional well-being of their children through the crisis, and shield them from frightening messages (Pontificia Universidad and CUIDA, 2020, online). The CUIDA Centre (*cuida* means 'protect' in Spanish) systematises and shares knowledge and techniques so that parents, teachers, and governmental and non-governmental agencies can identify whether a child needs mental health support or a professional emotional intervention.
- In Colombia, a dedicated hotline is working 24 hours a day to enable children to seek direct support from social workers and psychologists. The project, implemented by the Health Ministry and Unicef, has been instrumental in reducing the risk of children suffering serious psychological damage.
- In Peru, educational materials are being donated on a large scale with the aim that students should have everything they need for their new online learning experiences, helping them to remain engaged and committed and reduce the risk of school dropout.

'Lockdowns have isolated many women at home, breaking their family support networks, friendships and links to civil society and the State.'

1 Convergencia para la Acción, Red de Líderes por un Comienzo con Futuro: *Medidas hacia la primera infancia adoptadas por los países de Latinoamérica en el contexto de pandemia*, May 2020.

- The ministries of education in both Costa Rica and the Dominican Republic, conscious of the importance of preventing child malnutrition, have implemented programmes to enable schools to continue delivering food rations to children at home during the pandemic.

The Covid-19 crisis has been unprecedented. Policy responses to help the next generation through the present crisis will be essential to build for their future. Latin America and the Caribbean countries offer a complex and challenging scenario, but also good practices in spite of economic and institutional weaknesses.

→ Find this article online at earlychildhoodmatters.online/2020-1

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Inter-sectoral work in public policy in Colombia as a poverty reduction strategy

- ▶ *Inter-sectoral coordination is necessary to address complex social challenges effectively.*
- ▶ *Colombia has made progress in reducing childhood-related poverty indicators since 2010.*
- ▶ *Remaining challenges include care for migrant children and closing rural–urban gaps.*

Constanza Alarcón

Párraga

Vice-minister of Basic and Middle Preschool Education

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Social issues are complex, with multiple, interdependent causes that exceed the responsibility of any single sector or actor. Understanding this, Colombia has faced its significant social challenges in recent decades by creating inter-agency coordination mechanisms that favour comprehensive approaches and connected actions. Little by little, these mechanisms have been able to go beyond coordinating sector efforts to develop unified management based on their own holistic perspectives.

The National System of Comprehensive Care for the Displaced Population (SNAIPD) is one example. As a result of a judgement by the country's Constitutional Court on rights violations in forced displacement¹, public policy was strengthened. This did not give more rights to victims, but improved the enforceability of their existing rights. Maximising the efficacy of state prevention actions, emergency humanitarian care, return, consolidation and socioeconomic stabilisation mitigated the adverse effects on this population.

The country has used a similar inter-sectoral mechanism on poverty reduction, 'Red Unidos' (United Network). Since 2006, it has facilitated the coordination of different entities to tackle the multiple dimensions of extreme poverty through a comprehensive response to improve living conditions and protect rights.

Until recently, policies addressing childhood in Colombia concentrated on preventing exclusion and violation of rights, and eliminating unjust circumstances that impact the full enjoyment of rights. This trend changed with the State Policy for the Comprehensive Development of Early Childhood 'De Cero A Siempre' ('From Zero to Forever'), under the responsibility of the Inter-sectoral Commission of Early Childhood (CIPI), which coordinates different sectors to generate the conditions for every child to achieve their potential.

Comprehensiveness is central to the Policy. Reductionist views of human beings, their realities and circumstances are easy to understand, but they fragment knowledge. New narratives need to make clear the multidimensional and systematic nature of the social support people need. This can form the basis of an inter-sectoral strategy for coordination between actors that maximises their harmonious synchronisation.

¹ Constitutional Court, Ruling T-025 dated 2004.

The State Policy covers actions related to care and upbringing, health, food and nutrition, primary education, recreation, and the participation in and exercise of citizenship. It aims to protect children's dignity, strengthen families and their links with those responsible for their care, and promote their self-determination and the construction of a sense of personal and collective identity in diversity.

Progress on poverty indicators

The sustained effort in comprehensive care during early childhood is demonstrated by improvements in measures of different dimensions of poverty since 2011. The Multidimensional Poverty Index (IPM) considers 15 variables grouped into five categories:

- 1 Educational conditions (low educational achievement and illiteracy)
- 2 Conditions of children and adolescents (truancy, falling behind in school, access barriers to services for early childhood care, child labour)
- 3 Employment status of household members
- 4 Health access and insurance, and
- 5 Housing conditions.

The IPM uses the household as the level of analysis: if one member suffers some shortage, this affects the whole home. For example, households are considered to fall short on the variable of access to childcare if at least one child aged 5 or under does not have access to comprehensive early childhood care services, even if other children in the household do have access. All those who constitute a household are considered multi-dimensionally poor if it falls short on at least

Constanza Alarcón Párraga, Vice-minister of Basic and Middle Preschool Education, at the final of the Supérate con el Saber, Bogotá, 2018



Photo: Courtesy of National Ministry of Education

five of the 15 variables. Multidimensional poverty decreased from 30.4% in 2010 to 19.6% in 2018 (National Statistics Administration Department (DANE), online).

Six of the 15 variables relate to children, adolescents and education. This means that policy actions in these areas have an essential role in poverty reduction. With *De Cero a Siempre*, Colombia increased the coverage of quality services for early childhood care from 566,429 children in 2010 to 1.1 million in 2018 (National Planning Department (DNP), 2010, 2019). The proportion of children attending the transition grade – a year of preschool to prepare for primary school – went from 61.8% to 64.06%. (Net coverage across all levels of the educational system increased from 89.8% to 92.3% during the same period.) These achievements reduced the number of households falling short on the IPM variable for barriers to early childhood care services from 11.8% in 2010 to 9.3% in 2018.

Comprehensive care actions also reduced chronic malnutrition, from 13.2% in 2010 to 10.8% in 2015, through nutritional monitoring, delivery of quality food, promotion of growth and development check-ups, and promotion of vaccinations (Ministry of Health, 2015). In addition, care for pregnant women through antenatal check-ups, adequate care during birth, promotion of breastfeeding and counselling in early education programmes all helped reduce mortality: maternal mortality from 71.9 per 100,000 live births in 2010 to 44 in 2018 (Instituto Nacional de Salud, 2019); infant mortality from 12.8 per 1000 live births in 2010 to 10.7 in 2017; and under-5 mortality from 15.7 to 13 over the same period (Ministry of Health, 2019).²

As part of the Policy's inter-sectoral efforts, the government's Families in Action programme was redesigned in 2011 to subsidise the enrolment of children in the transition grade. It is hoped that in the medium term this will reduce the number of children who enter the educational system late. Evidence among other age groups shows that the programme's cash transfers have direct effects on educational indicators: for example, the probability of dropping out was reduced by 0.8% in municipal centres. Positive effects in secondary education grades were demonstrated, with an increase in the probability of enrolment of about 16% in urban areas and 23% in rural areas and a reduction in child labour.

Upcoming challenges

Although the results indicate that the country is on the right path, there are three significant challenges for public policy in the coming years.

1 Care for the migrant population

With growing migration from Venezuela, Colombia needs to care for more migrant children and those who are born to migrants in Colombia. The challenges involve almost all sectors: the healthcare system needs to provide antenatal check-ups, vaccinations, and urgent care; the Colombian Institute of Family Welfare (ICBF) must ensure comprehensive early childhood care services for an estimated 68,340 children; and the educational sector needs to guarantee care for an estimated 314,736 students.

² This contributes to UN Sustainable Development Goal 3, to ensure healthy lives and promote well-being for all at all ages, whose main objective is to reduce maternal mortality and put an end to avoidable deaths in children under 5 years of age.

2 Closing urban–rural gaps

Against almost all indicators, the differences between large cities and rural areas are substantial, not only in the coverage but especially in the quality of services. These disparities are even greater in areas affected by the armed conflict. The country’s geographical characteristics make it hard and expensive to implement public policies in rural areas – but to advance social equality this is an urgent issue to tackle.

3 Adaptation in light of the Covid-19 pandemic

The educational system had to adapt quickly to deliver services through alternative learning methodologies at home, rising to new challenges in ensuring access, quality and the participation of families. In public administration, we need to be creative so that children can continue learning adequately. The decisions taken today will affect people’s lives for a long time.

When entities specialise in their mission, inter-sectoral work becomes more necessary. It is the most efficient way to address major challenges and promote well-being for all.

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Investing in evidence to achieve health equity for refugee children

- ▶ *The Covid-19 pandemic could reverse years of progress in refugee children's health.*
- ▶ *Non-communicable diseases, which often begin in early childhood, are on the rise.*
- ▶ *Research partnerships between countries along the migratory route are needed.*

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Across the globe, an estimated 800 million children live in fragile and conflict-affected areas. Around 30–34 million have been forcibly displaced, according to the report *Global Trends: Forced displacement in 2019* by the United Nations High Commissioner for Refugees (UNHCR, 2020). As the aftermath of the Covid-19 crisis continues to put pressure on societies and economies, these numbers are expected to grow – as will the health crises associated with being a child refugee, including pre-term birth, physical illness, and threats to well-being such as caregiver depression, neglect, hunger, psychological trauma, isolation, being out of school, early marriage, assault, or forced child labour.

There are added threats of food insecurity, cuts in healthcare and education, and stigma, stress and tensions with hosting communities globally. The experience of the pandemic could reverse years of progress made through humanitarian assistance, unless we take a step back to gain a deeper understanding of what it means to be a child refugee on the journey to achieving health equity.

Refugee communities are among the most marginalised and discriminated against in the world, and their health has long been politicised. At a moment of fragmented leadership, grassroots innovative partnerships can – through science – carve a way out of this pandemic and prepare for the next one by informing the systems and decision makers that allowed these vulnerabilities and disparities to emerge in the first place.

The growing burden of non-communicable diseases (NCDs) in refugee children, and the lack of existing health systems to respond to these needs in refugee-hosting countries, is a serious concern in the pandemic and beyond. For example, among the 57% of refugees who come from three countries in the Middle East – Syria, Afghanistan and South Sudan – it is estimated that more than 2000 children will be affected by cancer due to the collapse of previously adequate healthcare systems (Fouad *et al.*, 2017). Treatment of paediatric cancer – one of the most preventable causes of death among refugee children – is costly, and many refugee children are left behind due to lack of funding and prioritisation, as reported in *The Lancet* and elsewhere by Professor Richard Sullivan and colleagues (El Saghir *et al.*, 2018; Abdul-Khalek *et al.*, 2020).

While most NCDs tend to emerge in adulthood, they stem from contextual factors and behaviours from early childhood through to adolescence. Maternal health, unhealthy diet – including infant and young child feeding practices – air pollution, poor water quality, poor mental health and tobacco use are all growing concerns in humanitarian crisis settings and contribute to impaired development and health.

The low- and middle-income countries that host the majority of the world's refugees have limited resources, but are expected to bear most of the financial burden of dealing with growing NCDs among refugee children. Continued cuts in funding from the largest donors to the United Nations, such as the USA, will have dire impacts on refugees worldwide. The USA's recent decision to halt funding to the World Health Organization (WHO) will be especially catastrophic in dealing with Covid-19 globally and the overall health of refugees.

Limited research is hindering progress

Advances in population health science must include investigations into the health of refugees, an area where there has been little research globally. Data on refugee children is of variable quality, having been collected primarily in cross-sectional studies that record a situation at a single point in time and place, and do not allow for comparisons within and across refugee groups or in multiple geographic locations. Most research does not consider the factors affecting children's health before, during and after migration.

Her Royal Highness Princess Dina Mired of Jordan speaking on behalf of civil society as an 'Eminent Champion' of non-communicable diseases at the United Nations General Assembly Third High-level Meeting on NCDs in New York in 2018



Photo: Cia Pak, Bureau Chief, Scannews, United Nations, New York, USA

This lack of evidence exists because refugee health is still being treated as an 'acute' problem within the humanitarian crisis, with a focus only on treating symptoms rather than looking to solve bigger questions through carefully designed epidemiological studies that follow refugees over time. Questions that could be answered by such studies include:

- What types of exposures or trauma caused by war in early life increase the likelihood of developing specific types of paediatric or adult cancers and other NCDs in later life?
- Is malnutrition a problem in refugees and, if so, when in the migration process does it affect growth and development?
- How can we prevent such adverse outcomes?
- When can we intervene, and at what level, to prevent the worst outcomes associated with malnutrition?

'For other NCDs with more subtle outcomes and lengthy treatment processes, such as mental health and cancer, resources are seriously lacking and lives are being lost as a result.'

The lack of answers to these questions hinders progress in promoting the well-being of refugee children.

Traditionally, health research in refugee children has looked only at acute or emergency health concerns (such as nutrition or infections), neglecting NCDs including cancer. Resources have been allocated accordingly, and this has negatively impacted millions of children with NCDs. Recently, the issue of NCDs in refugees has started to gain more attention globally, but much of it has focused on cardiovascular diseases, hypertension, or diseases with severe, visible and immediate outcomes if treatment is disrupted, such as provision of insulin for type I diabetes or dialysis for kidney disease. For other NCDs with more subtle outcomes and lengthy treatment processes, such as mental health and cancer, resources are seriously lacking and lives are being lost as a result.

Only a few months ago, a population-based modelling study – the first of its kind focusing on refugees – showed that cancer among the Syrian refugee population represents a substantial financial burden for host countries, including Jordan and Lebanon, as well as humanitarian agencies such as the UN Refugee Agency. The study called for new ways to provide financial assistance that must be coupled with clear, prioritised pathways and models of care for refugees with cancer. Such pathways and models must be studied and the resulting evidence used to drive change and progress.

Epidemiological research can be used in refugee populations to detect, prevent and address health disparities that persist over generations even when people are resettled in high-income countries such as the USA. Analyses by the Migration Policy Institute found that more than half of refugees from Somali, Iraq, Burma, Bhutan and Liberia living in the USA have household incomes under half of the level that constitutes the federal poverty line. Breaking the intergenerational cycle of disadvantage to eliminate such health disparities can be done only by drawing on existing literature and experimenting with interventions that are informed by a deep understanding of the unique struggles that refugees face along the migratory route and across their lifespan.

Two- and three-generation approaches – whole-family approaches that acknowledge the primacy of the family in shaping health and developmental outcomes for children, starting in utero and the very first years of life – are proving effective in breaking the cycle of poverty (Cheng et al., 2016; National Human Services Assembly, online). Such implementation science strategies can be researched to inform interventions that would aim to achieve similar outcomes in refugee children, which would have a huge positive impact on their health and development.

Our team studied a small group of Syrian refugee youth who live in Zaatari camp and were offered an opportunity for higher education. Our study found that this group’s mental health, and their feelings of peace and security, were significantly improved one year into their studies, and much higher when compared to other young refugees in Zaatari camp who cannot pursue high education studies (Al-Rousan et al., 2018). Longitudinal research is needed to assess how indicators such as stress biomarkers can predict health over the long term.

Research links between countries along the migratory route

To mobilise resources and policies that can achieve long-term systemic changes and sustainable impact, it is key to build an evidence base that focuses accurately on the refugee experience.

First, the health of all refugees should be prioritised in the context of the Covid-19 pandemic, especially in academia. An expert group meeting at the World Health Summit in late 2017 concluded that while the UN Sustainable Development Goals principle of ‘leave no one behind’ is inclusive of migrants and refugees, the realisation of universal healthcare for refugees requires evidence-based, inclusive policies that balance the costs and benefits of ‘health for all’ from a public health and development perspective. The panel stated:

At present, there is a lack of effective global governance for public health and a need for new governance structures that are beyond the present capacities of WHO and may have to evolve from elsewhere, such as the grass roots.

(Matlin et al., 2018)

These grassroots should be organisations capable of producing strong science, such as academic institutions, and must step up strongly into this space.

Second, philanthropists have an opportunity to invest in advancing public health science to design a better and more prepared world. At the intersection of stress, trauma and resilience, the refugee population can teach the world a lot about recovering from the worst of hardships. Investments now can guide us in a post-pandemic era and achieve health equity for the millions of displaced children.

‘Breaking the intergenerational cycle of disadvantage to eliminate such health disparities can be done only by drawing on existing literature and experimenting with interventions that are informed by a deep understanding of the unique struggles that refugees face along the migratory route and across their lifespan.’

Such knowledge can be gained only if research productivity in low- and middle-income countries is boosted through partnerships with research and academic institutions in other parts of the world. In October 2019, through a gift from Atlantic Philanthropies, a scientific research team from the University of California in San Diego visited Jordan University for Science and Technology in Irbid to learn about the research endeavours by the Jordanian faculty on refugee health.

San Diego, which borders Mexico, is the second-largest refugee resettlement city in the USA (Morrissey, 2017), and Syrians are its fastest-growing foreign-born population (Wong and Sanchez, 2020). Irbid borders Syria and is home to the second-largest Syrian refugee population in Jordan – the country which hosts the second-largest number of refugees in the world per capita (United Nations Population Fund, online). Research links along the migration route between Jordan, which is usually the first stop for Syrian refugees, and San Diego – a final resettlement destination – can be very informative. It can be a way to redistribute wealth in research skills, financial resources and capacity building of hosting communities to produce top-notch science that serves refugees. The trip has enabled two regionally unique research institutions with lived experiences and deep roots within refugee and hosting communities, that would otherwise be unlikely to meet, to come together and learn from each other.

The goal now is that growing partnerships can be further nurtured to train future scientists to give refugee health the attention it deserves and produce groundbreaking science – science that can promote a structured dialogue on financing a refugee health system by leveraging data, research partnerships and resources as a key strategy to achieve better results for refugee children.

→ Find this article online at earlychildhoodmatters.online/2020-3

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Returning the city to children

- ▷ When elected Mayor of Tirana in 2015, Erion Veliaj found a city unfit for children.
- ▷ New playgrounds, car-free days and improved kindergartens have transformed Tirana.
- ▷ The city is using the Covid-19 lockdown to create more space for walking and cycling.

Erion Veliaj
Mayor
Tirana, Albania

This year Tirana marked its 100th anniversary as the capital of Albania. A city that is well known for its colours, contrast, diversity and cultural intersections, and with a rich history embodying Ottoman, Italian and Soviet influences. Immediately after the fall of the harshest Communist regime in Eastern Europe, Tirana looked like the capital of North Korea. It was a city of 170 thousand people with 170 cars, to which only elites and party cadres had access. The rest of the population commuted by walking or biking, not by choice but because of poverty.

The fall of Communism had a radical impact on the city's infrastructure and social life, deeply affecting its mentality and lifestyle. Tirana experienced a painful transition process with a chaotic urban transformation. Suddenly people rushed to the capital from every corner of the country, seeking new opportunities and a new life. In 30 years, since the fall of Communism, Tirana became a city of one million people and 170 thousand cars.

When we took office five years ago, we inherited a city full of cars, disordered traffic, pollution, illegally occupied public amenities and, above all, no play space for children. In 25 years of democracy, children had been forgotten and left out of any urban planning and policy agenda. Advocating for child-friendly infrastructure in a city that was experiencing rapid urban expansion and population growth under tight budget constraints sounded like madness. It required innovative, creative thinking to push forward such a salient issue.

Under these circumstances, options were limited. We commenced working on child-friendly infrastructure through 'urban acupuncture'¹ – pinpointed interventions that allowed us to spark small changes that could catalyse outsized social impacts. Attaching a sense of ownership to the city transformation process was a pivotal move to counteract the apathetic behaviour that was commonplace among the citizens of Tirana.

On day one at the office, we were all aware that infrastructure for children was poor, but we weren't able to gauge the real situation until we experienced for ourselves the conditions in kindergartens in the city. It was appalling. They looked like prison cells: no wonder we had so much violence, rudeness, and trash in the streets. We discovered that we had, unwittingly, been living in a city with no care or love for children.

¹ For a description of urban acupuncture, see www.arup.com/perspectives/urban-acupuncture

From ‘adopting a kindergarten’ to ‘days without cars’

Soon after this revelation, we organised a large ‘adopt a kindergarten’ campaign in our city. We called companies, designers, practitioners, students, and everyone with the energy and willingness to help. In record time, we succeeded in transforming our kindergartens into open spaces, full of colours, vivid decorations, and all the required amenities. The response was fantastic. Therefore we decided to push further by freeing all the occupied spaces within kindergartens and schools that people were using as car parks.

Keeping in mind that children’s growth and cognitive and behavioural development are connected to what happens outdoors, we decided also to focus on playgrounds and parks, and mobility to these destinations. This was an opportunity to improve children’s well-being by allowing them to experience the city and create a connection with the world around them.

We managed to build a state-of-the-art playground for kids at Lake Tirana, having unexpectedly encountered a great deal of resistance from citizens – and politicians – to constructing ‘inside’ a park. On the day the playground opened, the place looked like a rally – not with adults, but with children playing. This

The Mayor of Tirana, Erion Veliaj, in one of city's many new playgrounds



success motivated us to build more and more playgrounds in every part of the city, in every space previously occupied by cars. We went on to build 60 new playgrounds, and today almost every neighbourhood of the city has an area dedicated to children.

Interestingly, these playgrounds are now being used not only by children but also by elderly people and young parents. Older people use them as recreation spaces. Young parents take the opportunity to feel more relaxed than before, leaving their kids playing outdoors, while using the time for professional engagements.

Eager to see more changes in this regard, we went further, introducing the 'days without cars' and 'let's clean Tirana in one day' initiatives. Adults went ballistic again, complaining and resisting – but this time we knew what to do. We returned for support to our best allies: children. They didn't let us down. As always, they fully participated in these initiatives to enjoy a day without cars and help clean up the city. With a fascinating force for change, children became our top advocates in transforming Tirana into a child-friendly city.

Today, Tirana has much more to offer to children. We transformed Skanderbeg Square into an exclusively pedestrian square. What used to be 40,000 m² of roundabout, dedicated to cars, is currently Tirana's biggest playground, where children can enjoy a car-free day at any time in much cleaner air. We are also embellishing Tirana with a green belt of two million trees, which will be pivotal in addressing the environmental concerns of the city.

'During the pandemic crisis, people have come to realise that the air in the city is much cleaner and the city itself much quieter and safer without cars.'

A legacy for a resilient city

Four years ago, we joined the Green Cities Framework and, together with the European Bank for Reconstruction and Development, developed the Green City Action Plan for Tirana. Based on our measurements, cars in Tirana made 800,000 trips a day, of which 400,000 were within a distance of 500 metres. These astonishing figures increased our determination to beat the dominance of cars and use public space for more playgrounds, pocket parks, wider pavements, bike lanes, and days without cars.

This action plan laid the foundations for improving the quality of the surroundings, health, and well-being of our children and families. During the pandemic crisis, people have come to realise that the air in the city is much cleaner and the city itself much quieter and safer without cars. They have understood that in a city where there are no heavy industries, the most prominent pollutants are cars – real-life enemies not just to them but their children too. They also realised that it is actually possible and much healthier to reach destinations within a kilometre by walking or cycling together with their children.

People have learned another vital lesson from the coronavirus. What makes cities resilient during a crisis is not wealth and power, but knowledge and unity. Through our previous investments in kindergartens, playgrounds, wider

pavements, and bike lanes, together with our citizens the city of Tirana had already embarked on an extraordinary journey in transforming not only children's education infrastructure but their mindset too. What started as acupuncture interventions transformed into a road map for the future of the city. Suddenly, our mission to return the city to the people changed to returning the city to the children.

While the pandemic is not over yet and streets are still empty of cars, we are intensively working to seize this moment to reallocate more space to pavements and bike lanes. Tirana is also developing nine new polycentric areas to rebalance the city's density and supplement each area with new schools, kindergartens, parks and playgrounds. The aim is to agglomerate essential services within a kilometre – walking distance. The best part is that all urban projects in Tirana are embracing Urban95 and '8 to 80'² concepts to design infrastructure from the perspective of a child.

'In 2050, children born today will reach the age of 30 – ready to run our cities. How we raise and educate them will impact the resilience of Tirana in the next 100 years.'

Child-friendly infrastructure would have no value if children could not travel safely on foot or bike to their favourite destinations. Therefore we are working with the US National Association of City Transportation Officials (NACTO) Global Designing Cities Initiative, through the Streets for Kids programme, to design and build child-friendly streets. In cooperation with the Albanian-American Development Foundation, the Pyramid of Tirana – a symbol of Communism – is being transformed into an 'educational cathedral', one of the newest locations of the TUMO Center for Creative Technologies. This new centre will provide more public space for children to socialise and receive quality education through a range of programmes that will include teaching the basics of IT and coding.

Our ambition is to leave our children a city where they can be more healthy and energetic, thrive, and grow into adults who will carry on the transformation of Tirana for the next 100 years. We are aware that we cannot achieve this ambition alone without the help of parents. In this hectic world, it is essential that they stay focused on their priorities, balancing their responsibilities and identifying the real needs of their young children – we are working on this, too. We have already designed heartwarming initiatives turning parents into 'classmates' who help their little ones complete their assigned homework. The Municipality is also developing a 'good parenting' guide to help young parents with educating and raising their toddlers responsibly.

In 2050, children born today will reach the age of 30 – ready to run our cities. How we raise and educate them will impact the resilience of Tirana in the next 100 years. Building and designing our city for them is like sketching the blueprint of our future. I often say that the most significant infrastructure project to change in a city is not a boulevard, nor a big building; we know how to do those. It's the 10 cm between our ears – our thinking and mindset – that is the toughest of infrastructures to transform. The future belongs to the children.

² For further details, see: www.880cities.org/

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Boa Vista, the Early Childhood capital, faces prejudice and Covid-19

- ▷ Boa Vista is challenged by poverty, lack of resources, and a recent influx of refugees.
- ▷ The city has established a strong focus on services for babies, toddlers and caregivers.
- ▷ Covid-19 has added to pressure, but reinforced the need to focus on young children.

Teresa Surita

Mayor

Boa Vista, Brazil

The Covid-19 pandemic has put the world on hold. The SARS-CoV-2 virus has spread to all regions, forcing us to break our daily routines, interrupt major projects and direct all our energies to this tragic historic emergency. It requires from us a new perspective to see the present and the future. We are now asking every child, adult, young and elderly person to behave in a way that prevents rapid transmission and the collapse of health systems. From leaders we demand readiness, sensitivity, objectivity and competence to treat the sick, to search for a cure and a vaccine, and to support people's livelihoods, embracing their anguish, providing encouragement and guidance to move forward in the pursuit of a new tomorrow.

In my country, Brazil, the disease spread in an accelerated and alarming manner. Here the virus encountered a population with widespread suffering: 52.5 million people (25.3%) live in poverty and another 13.5 million (6.5%) in extreme poverty¹. Among the labour force, 11.6 million are unemployed (11%) and 38.4 million (41%) work in the informal economy (Moreira and Gaier, 2020; Garcia, 2020). Most of these families depend on today's efforts to ensure tomorrow's meal. Due to the pandemic, they have now been joined by millions more who lost their jobs or had their wages cut as a result of the need to stay at home to reduce the risk of infection in the streets.

Brazil has 18 million children aged 6 and under. Not only do 29% of them live in poverty, 23% live in precarious housing. For these children, staying at home does not necessarily offer the protection they require, although it was the only viable measure to tackle the pandemic. For 41% of these boys and girls, the lack of basic sanitation has always been a permanent threat. Now the risk is multiplied by the advance of a virus that, in less than two months², claimed the lives of more than 12,000 mothers, fathers, grandparents and siblings.

The response of the federal government to this huge challenge has, unfortunately, been characterised by denial and resistance to the implementation of crucial and urgent measures. It is unnecessary to mention here examples of this irresponsibility, as much of it has already been reported on by the media the world over, to the embarrassment of Brazilians. However, it is important to note a direct effect of this lack of leadership: where there should have been coordination and communication between the federal, state and

1 According to the World Bank's poverty line criteria, people who live on less than USD 5.50 a day are living in poverty, and those who live on up to USD 1.90 a day are considered to be living in extreme poverty (Nery, 2019).

2 It is very likely that this number is higher if one considers the underreported cases.

municipal spheres of public administration, we instead witnessed contradictory guidelines and, worse, the downright discouragement of social distancing policies. The inherently challenging task of constraining economic activities and keeping people at home becomes much more difficult when a central authority continually sabotages these attempts.

A challenging scenario

This scenario of scarcity and difficulties is especially gloomy in my state, Roraima, in the extreme north of Brazil, and especially in my city, Boa Vista. As the capital of Roraima, Boa Vista is home to 65% of the population of the entire state – and the remaining 35% also relies on its more specialised services. For Roraima's 600,000 inhabitants, there are just 30 intensive care beds in the only public hospital offered by the state government. There are more people below the poverty line (32.6%) and in the informal economy (47.1%) in Roraima than the national average (G1-RR, 2019; Garcia, 2020). Little can be expected from the state government, which is in the throes of a long-term crisis. Its compromised management capabilities increase the pressure on the municipal administration.

'On top of its existing challenges, Boa Vista has suffered more than the rest of Brazil from the humanitarian crisis that emerged in neighbouring Venezuela in 2015.'

On top of its existing challenges, Boa Vista has suffered more than the rest of Brazil from the humanitarian crisis that emerged in neighbouring Venezuela in 2015. Boa Vista has become home to 40% of the Venezuelans who have taken refuge in Brazil, increasing its population of 340,000, over just three years, by 60,000. These new residents – about 15% of the population – were fully welcomed as citizens of Boa Vista.

We have received the children with special care. Since 2013, Boa Vista has been designing and implementing integrated policies for early childhood, which are anchored in the idea that large-scale investment in children's development is one of the best ways to overcome historical social problems. Currently, the programme 'Familia Que Acolhe' ('A Family that Welcomes') is looking after 1746 pregnant women and mothers of children up to 2 years old, 777 of whom are Venezuelan. In the municipal public schools, 6101 (13.8%) of the 44,025 students are from Venezuelan families.

Even before the pandemic arrived, then, Boa Vista had become the stage for a unique challenge in Brazil. Having the smallest budget of all Brazilian state capitals – under USD 120 million, equivalent to the 2019 budget of the Roraima State Secretariat for Education – the city had to sustain overburdened public services, in particular the public health system. At the Hospital da Criança (Children's Hospital), under the municipal administration, between 2015 and 2019 the number of Venezuelan patients increased by a factor of 16, from 1719 to 28,196.

The first two cases of Covid-19 in Boa Vista were reported on 21 March 2020. Approximately 50 days later, the number of infected people exceeded 1400, with 31 deaths. Following the guidelines of the World Health Organization, in

the very first days we interrupted non-essential activities and adopted rigorous social isolation measures. We quickly noticed that, as expected, some people refused to comply with the restrictions, reinforced by the divisive message coming from the federal capital. The pandemic also fuelled xenophobia against Venezuelans, who were accused of ‘carrying the virus’ to the city after a baby was diagnosed in a refugee shelter.

Reflecting on children: the future of humanity

Just as it is across the whole planet, dealing with Covid-19 is a continuous battle in Boa Vista, and we do not know when life will return to normal. But we have a beacon of hope that boosts our confidence in these times of uncertainty. I have learned that reflecting upon children is a natural way of thinking about everyone, and that prioritising them also leads to benefiting the greatest number of people. When we decided to make our city the Early Childhood Capital, we improved its efficiency. Despite increasing pressures, the municipality was able to keep its expenditure balanced and continue offering its services (Prefeitura Boa Vista, 2020).

The Hospital da Criança increased its number of intensive care beds and can count on a staff trained to receive children and teenagers up to 16 years old. There is a specific ward for indigenous people, where the traditional habits of each ethnic group are respected. Since the first cases of Covid-19 were reported

The Família Que Acolhe programme provides support for pregnant women and mothers of young children



Photo: Fernando Teixeira

in Boa Vista, the hospital has treated 13 children, four of them indigenous and five from Venezuelan families. Another 237 professionals have been recruited to work in other health facilities.

A central element of the integrated policy for early childhood, the Família Que Acolhe programme continues to provide support to ensure healthy pregnancies and childcare. Face-to-face meetings with mothers have been suspended to avoid transmission of Covid-19, but contact continues through the visiting teams who deliver powdered milk and basic food, hygiene and cleaning products to 4500 families. The logic is simple: we take care of the caregiver and consequently the caregiver takes good care of the children.

The social assistance, education and health sectors are also using home visits to provide support and protection. Call centres have been set up to monitor and address vulnerabilities. With school closures, an online programme has been created – @Aprendendo em CasaBV ('Learning at Home Boa Vista') – to provide distance pedagogical activities via Instagram. Municipal teachers developed specific content for the programme for kindergarten, elementary schools, special education and indigenous education. At home, children complete

Mayor Teresa Surita in one of Boa Vista's public spaces designed to encourage playful interactions between children and caregivers



simple tasks focusing on learning and family social interaction. The programme instructs parents and caregivers on activities such as creating games and playing with household objects.

Before the pandemic, we were in constant conversation with society through neighbourhood meetings and social networks. We have cancelled face-to-face meetings, but intensified communication via online networks, giving priority to health information and guidelines. This interaction has also been important to embrace people's feelings at this difficult time. Uncertainties and fears often generate tension and the need to find 'enemies' to blame.

I try to share with people the vision that differences enrich us and drive us forward. I remind them of the courage and strength of health professionals, as well as the teams that take boxes of food and other supplies to the most vulnerable families, working for everybody with the same commitment. I remind them of the courage and determination of all the professionals who provide essential services in order to urge people to take good care of themselves and others, in particular our children – all children – so that they will love the land where they grew up.

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There are many pathways to scale – taking a successful small programme, and making it work for hundreds of thousands of children – but the challenges are complex. In this section, practitioners and policymakers explore issues such as coordination, financing, training, monitoring and learning, with many of the articles touching on the unique challenges and new opportunities created in 2020 by the Covid-19 pandemic.





Scaling

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Jamii ni Afya: using digital tools to scale integrated services to mothers and children in Zanzibar

- ▶ *Jamii ni Afya is a new programme for mothers and children under age 5 in Zanzibar.*
- ▶ *A digital platform simplifies training, service delivery, monitoring and management.*
- ▶ *National-scale implementation will generate learnings to inform work globally.*

Kim Wilson

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Umali smiles as she enters the family compound and sees one-year old Abdul playing 'pretend' with a home-made pull toy, a small tyre wheel on a rope. She had brainstormed how to make home-made toys with the boy's mother on her last home visit and is excited to see her advice being put into practice.

Umali, Abdul, and Abdul's mother settle down on a small rug. Using a mobile app as a guide, Umali checks in on important health issues, including screening for danger signs and malnutrition, updating Abdul's immunisation records, and advising on healthy behaviours for good hygiene and nutrition. Next on the visit agenda is a child development check-in. The digital platform continues to guide Umali through monitoring developmental milestones, coaching the family through age-appropriate interactive play, and introducing some communication and early learning activities.

Although the session targets Abdul and his mother, other children and adults begin to gather around as Umali sings songs and demonstrates how to use pots, spoons and even small rocks in toy trucks made from old bottles to promote positive, stimulating interactions between caregivers and children.

Umali is a CHV (community health volunteer) with Jamii ni Afya, a national community health programme in Zanzibar aiming to promote maternal and child health, well-being and optimal child development. Jamii ni Afya CHVs use a smartphone app to deliver integrated health, nutrition, and early childhood development services to mothers and children under 5.

During home visits, CHVs support antenatal care; encourage mothers to give birth in a medical facility; screen and refer for danger signs in pregnancy and early childhood; support breastfeeding; monitor immunisations and nutritional status; and coach on a wide range of health topics including dietary diversity, WASH (water, sanitation and hygiene), and supporting child development. The digital platform prompts screening questions, supports decision making, and guides coaching in health and development.

An evidence-based intervention

Jamii ni Afya officially launched in February 2020, when Zanzibar’s National Community Health Strategy 2020–2025 was released. The strategy now includes CHVs as an essential cadre to expand access to universal health coverage, reaching every household in Zanzibar. Promoting early childhood development is a new priority in Zanzibar’s community health strategy, with potential for significant impact.

In many communities in low- and middle-income countries worldwide, children are falling behind in development at an alarming rate. While detailed developmental data is limited, estimates based on poverty and stunting suggest that over 240 million children worldwide fail to reach their developmental potential (Black *et al.*, 2017). In Zanzibar, national household surveys conducted in 2018 found that one in five children was physically stunted and one in ten had significant delays in development (Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) *et al.*, 2018; Nelson *et al.*, 2019, unpublished data¹).

Common conditions that often have compounding impacts on children’s development include poverty, inadequate nutrition, birth complications, recurrent infections, limited caregiver stimulation and lack of early learning opportunities. The consequences for communities are significant, as deficiencies in child development lead to an estimated eventual 25% reduction in adult economic productivity (Richter *et al.*, 2017).

Jamii ni Afya’s approach to promoting optimal early childhood development is based on the World Health Organization (WHO) and Unicef’s Nurturing Care Framework. The Framework builds from the principle that children develop best in a safe environment that assures good health and nutrition, stimulating and interactive experiences with caregivers, and early learning opportunities (WHO *et al.*, 2018). The early childhood component of the digital platform is adapted from Care for Child Development, an intervention developed to promote child development within health services.

As part of the home visit, CHVs observe caregiver–child interactions, screen for concerns such as maternal stress, harsh discipline, or lack of play materials, and coach caregivers in age-appropriate play and communication activities. The programme is based on scientific evidence that early exposure to positive and responsive interactions with caregivers strengthens neural pathways in the developing brain, leading to stronger language, cognitive, motor and socio-emotional skills as children grow. Prevention of ongoing exposure to adverse experiences such as neglect or violence can avert lifelong and even intergenerational consequences.

‘Promoting early childhood development is a new priority in Zanzibar’s community health strategy, with potential for significant impact.’

1 This report is unpublished but available from the authors on request.

Success factors in national launch

In implementing Jamii ni Afya in Zanzibar, the Ministry of Health is partnering with D-tree International, a leading global health organisation with expertise integrating digital health and decision-support systems for frontline health workers. As of April 2020, Jamii ni Afya has been scaled to three districts with nearly 400 CHVs serving more than 40,000 households, including regular visits to 31,000 children under age 5. The government plans to scale the programme to all 11 districts, supporting a population of 1.6 million people, by early 2021.

Jamii ni Afya's approach to delivering integrated, comprehensive reproductive, maternal, newborn and child health and child development services in a national CHV programme is both innovative and ambitious. The strategy behind the programme's success illustrates some principles in planning to scale digitally supported community health programmes.

An important factor behind Jamii ni Afya's ability to launch nationally was the groundwork laid by prior programmes and partnerships. The Safer Deliveries programme, implemented from 2010 to 2019, was a partnership between the Zanzibar Ministry of Health and D-tree International, which successfully

A community health volunteer in Zanzibar, guided by a mobile phone tool, counsels a new mother



introduced digital platforms for maternal and newborn care in the community health system. CHVs worked with pregnant women and newborns to support antenatal and newborn care and promote timely delivery in medical facilities.

Safer Deliveries demonstrated the feasibility and advantages of digital healthcare. It increased the rate of pregnant women delivering in facilities from 50% to 75% among women participating in the programme, increased facility-based postpartum care visits from 20% to 80%, and increased referrals to facilities from 27% to 90% (Battle *et al.*, 2015, and based on D-tree programme data compared to a published study on referral completion, Peterson *et al.*, 2004). CHV performance and motivation improved, with 75% of CHVs meeting performance targets monthly.

As the Ministry of Health's priorities expanded to include child health and development, a decision was made to expand the digitally enabled programme for CHVs, and Jamii ni Afya was conceived. The Jamii ni Afya team held stakeholder workshops to identify local priorities for reproductive, maternal, newborn and child health and child development. A needs assessment, using data from the national nutrition survey and a baseline household survey, demonstrated significant gaps in child development and home environments. Adapting programme content from established national and international guidelines with a clear evidence base also helped facilitate consensus and a rapid launch of the programme.

'On the national level, the Jamii ni Afya programme will generate previously unavailable population-level data on child development that can inform both advocacy and policy decisions.'

Intervention design also contributed to Jamii ni Afya's successful launch. Its digital platform provides a simplified solution for managing the complexity of delivering integrated community health services. CHVs can easily learn to use the platform, and decision-making support and detailed coaching guidance then facilitate a high-quality and wide scope of integrated care delivery. The digital platform significantly reduces the initial CHV training burden, and allows for ongoing updates and refresher training remotely.

The digital platform also seamlessly generates data to inform programme management and quality improvement. Data on visit length, location and content can support CHV supervision, mentorship, workforce management and resource allocation. Data on client characteristics, service delivery, and health outcomes facilitates programme monitoring and evaluation.

Informing programmes globally

As the programme is implemented and evaluated nationwide, Jamii ni Afya is poised to generate learnings to inform early childhood interventions and innovation in low- and middle-income settings more broadly. Having client-level data at a national scale about biological, social, and environmental risks and outcomes will enable early childhood services to be tailored to individuals or communities at the highest risk – enabling a level of personalised care that could be groundbreaking in both efficiency and impact.

On the national level, the Jamii ni Afya programme will generate previously unavailable population-level data on child development that can inform both advocacy and policy decisions. Jamii ni Afya is also poised to address critical implementation research questions in the early childhood field globally. While not a controlled trial, implementation at scale will generate programme and outcome data from a wide range of family and care delivery circumstances. Analysing the impact of variables such as dose of intervention, duration of service, and level of paternal involvement may generate knowledge to inform service delivery more broadly. With ongoing implementation, there may be opportunities to address challenges such as appropriate services for families with children who have a developmental delay or disability, or mothers who are struggling with maternal depression.

The impact that Jamii ni Afya is already having in Zanzibar is cause for optimism: families are becoming empowered to help their children reach their full developmental potential. The scope to inform future work in low- and middle-income environments is equally significant. With a digitally enabled, holistic approach and integration at scale within the community health system, Jamii ni Afya is poised to provide population-level data on early childhood risks, outcomes, and programme impact that may serve as an impetus for future advocacy and programming.

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Perinatal depression in Chile: advances and challenges

- ▷ Chile has made progress in screening for and treating postpartum depression.
- ▷ Barriers to women accessing services include negative beliefs, fear and shame.
- ▷ Chile must act to tackle these barriers, improve processes and expand research.

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Perinatal depression is defined as a depression that occurs between the beginning of a pregnancy and the postpartum period. It is a significant public health issue that affects mothers, their children and all family members, but tends to go under the radar in terms of detection and treatment (Committee on Obstetric Practice, 2015; O'Connor et al., 2019). Chilean studies show that around 10% of pregnant women suffer depression during pregnancy, compared to 13% in international studies. However, this can increase to one in three if anxiety symptoms are also considered (Jadresic, 2010).

Perinatal depression is a common and disabling disorder that occurs during or after pregnancy. Postpartum depression (PPD) is the best-known form of perinatal depression. Studies in Chile have reported an incidence of between 8.8% and 9.2%, and a lifetime prevalence of 20.5% – that is, around one in five mothers will experience PPD after one of their births. There is an inverse relationship with socioeconomic means: women with lower income have about three times the risk of suffering PPD (Mendoza Bermúdez and Saldivia, 2015).

Perinatal depression can have lasting and even permanent consequences for the physical and mental health of the mother–child dyad. Such consequences can produce family dysfunction, higher risk of child abuse and neglect, delayed child development, perinatal obstetric complications, difficulties in breastfeeding, and more healthcare expenses. PPD can alter the interaction and bond between a mother and her child, which can provoke long-term physical, emotional, cognitive and social development issues in the child (Earls et al., 2010). PPD can also affect a couple's relationship and constitute a risk factor for paternal depression (Misri, 2018).

It is crucial to investigate perinatal depression in a timely manner because it is a disease that responds well to treatment, which can help to avoid the most severe consequences (Jin, 2019).

Investigating and treating PPD in Chile

Since 2000, Chile has had a National Programme for the Detection, Diagnosis, and Comprehensive Treatment of Depression (Ministry of Health, 2009). Since 2006, Chilean law has included depressive episodes in the list of conditions

for which timely care is guaranteed through the GES (*Garantías Explícitas en Salud*), a system which makes public health insurance available to all who do not have private insurance (Escobar and Bitrán, 2014). This means that, with a confirmed diagnosis, all beneficiaries 15 years of age and older will have access to treatment from a specialist within 30 days with a maximum co-pay of 20% (about 75 US dollars per year) (Superintendencia de Salud, online).

In 2009, the 'Chile Crece Contigo' ('Chile Grows With You', CCC) programme was institutionalised, with the aim of making inter-sectoral public policy to promote comprehensive child development. It comprises both universal services and special support focused on cases of greater vulnerability in pregnancy, birth, and childhood up to age 9. CCC works via the public health system, with children enrolled during the mother's first pregnancy check-up.

'Factors that encourage mothers to ask for help include having suffered prior episodes of depression and undergone treatment, the motivation to be healthy for the well-being of the child, and awareness of the sensation of psychological distress.'

Through CCC, primary care centres conduct psychosocial assessments of pregnant women and new mothers using a scale that measures nine risk factors, including depressive symptoms (Cordero and López, 2010). Primary healthcare teams use a manual developed by the Ministry of Health (MINSAL) to accompany women during check-ups through pregnancy, birth, and newborn care (Ministry of Health, 2008). It includes a flowchart for the detection and treatment of PPD, using the Edinburgh Postnatal Depression Scale to assess mothers at routine check-ups two months and six months after the birth (Ministry of Health, 2009; Alvarado *et al.*, 2015).

Pregnant women with a confirmed case of depression receive a house call which aims to evaluate the risk of suicide, encourage psychological and/or pharmacological treatment, and educate them about the psychology of postpartum depression and options for follow-up (Ministry of Health, 2009).

Screening for PPD achieves high coverage and is well accepted. Nevertheless, studies show that this does not necessarily translate into starting treatment, as mothers face multiple barriers to seeking help and accessing services (Rojas *et al.*, 2015). These include difficulty in defining psychological problems as a disease, lack of a support network, and fear of being categorised as 'crazy'.

The barriers are associated with negative beliefs about depression, maternity, and psychological care – for example: the belief that depression can be overcome with willpower; mental health problems and intra-family violence; mothers' fear of being rejected by their families, or the fear that their baby will be taken away; and shame in accepting their feelings of rejection of their child. Socio-cultural contextual factors also contribute to stigma.

Factors that encourage mothers to ask for help include having suffered prior episodes of depression and undergone treatment, the motivation to be healthy for the well-being of the child, and awareness of the sensation of psychological distress.

Some factors are specific to their doctor's practice. For example, they are more likely to access help if they feel confident in the personnel at the healthcare centre, and positive about the care they have received there; if the surgery's opening hours are convenient; and if they feel a sense of support when receiving the PPD diagnosis. Other factors relate to a woman's support networks: the support of loved ones, feedback from others about their mood, and suggestions from a close family member (such as a mother or sibling) that they seek help.

PPD challenges for Chile

Despite advances in recent years, Chile faces three main challenges to improving screening for and treatment of perinatal depression.

First, it is important to develop strategies to prevent and diminish barriers to accessing treatment. These could include:

- promoting and broadening early intervention strategies in children of mothers suffering from PPD
- improving the connection between positive screening of mothers with PPD and timely referral for diagnostic confirmation and follow-up
- improving the GES depression programme offer, emphasising evidence-based psycho-therapeutic treatment
- improving psychological education for mothers and their families in order to counteract social stigma and inform them about different treatments
- promoting inter-sectoral strategies that involve groups of working mothers to develop maternity-friendly work practices and timely PPD screening.

The health team educates mothers and screens for postpartum depression at Iquique Hospital, Chile



Photo: Courtesy of Iquique Hospital, Chile

Second, it is necessary to improve the detection of symptoms, including by educating people about PPD and the need for timely diagnosis and effective treatment, and by continuously training healthcare personnel.

Finally, domestic PPD research needs further investment to generate more knowledge. Specific areas for research include approaches to the investigation, care, and follow-up of teenage mothers, including validation of instruments for timely detection in this age group; and improvements to the use of domestic registry systems to organise timely action according to the local situation.

In conclusion, Chile is a regional leader in universal screening and the possibility of universal access to perinatal depression treatment, and its achievements deserve to be highlighted. Nevertheless, improvements are needed in processes and access to treatment for women with PPD in order to improve their recuperation and quality of life, for the benefit of mothers and the next generation.

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Mental health and learning: BRAC's response in Bangladesh during Covid-19

- ▷ The pandemic has demanded new ways to support caregivers' mental health and children's learning.
- ▷ BRAC adapted existing models through scripts for weekly phone calls to caregivers and children.
- ▷ The service reaches children and caregivers throughout Bangladesh including Rohingya refugees.

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In response to Covid-19, in March 2020 the Bangladesh government, like many others, issued measures to restrict movement, which dramatically changed the world as everyone knew it. Offices, workplaces, schools and most shops were closed temporarily. People had to adjust suddenly to the challenging new realities of working from home, temporary unemployment, home-schooling children, and lack of physical contact with extended family members, friends and colleagues. At the same time, people had to manage the fear that they, or vulnerable people close to them, might contract the virus.

Providing psychosocial support became absolutely crucial during this time. Children are among the most vulnerable due to prolonged school closure. According to UNESCO, the education of nearly 1.6 billion pupils in 190 countries has so far been affected. School dropout rates are expected to rise in the near future. Combined with the other stresses of living in lockdown, this may have serious long-term consequences, including delays to children's cognitive, emotional and social development. Since the poorest will be hardest hit by all of these effects, lockdowns are expected to widen existing inequalities across the globe, with repercussions for years to come.

BRAC, the world's largest NGO, is built on the principle of standing with the most vulnerable, particularly in times of crisis. We realised the urgency of providing opportunities to children so that they could continue learning at home. BRAC developed several initiatives in response to the pandemic, including a telecommunication model called 'P Ashe Achhi', which means 'Beside You' in Bengali. This model provides psychosocial support to parents and caregivers and engages with children through playful approaches to learning at home, aiming to mitigate the adverse effects of the situation on children and caregivers.

The P Ashe Achhi model

Before the pandemic, BRAC operated Play Labs for children aged 4–5 years in government primary school premises around Bangladesh. We also operated Humanitarian Play Labs for children from newborn to 6 years old in the Rohingya camps of Cox's Bazar. In both the mainstream and humanitarian settings, young women from the community – or Play Leaders, as they are known

– act as facilitators of a play-based curriculum that was created to promote children’s physical, cognitive, language, and social-emotional development.

In March 2020, as the government ordered educational institutions to be shut down, these face-to-face interventions could no longer operate. The mode of delivery had to be revised and adapted. Play Leaders and other frontline staff initially went door to door to spread awareness about Covid-19 and collect phone numbers, and then began to use mobile phones to stay in regular contact with families. BRAC soon learned that the children loved hearing from their Play Leaders, and these calls made caregivers feel more valued and safe.

In mid-April 2020, BRAC launched a nationwide telecounselling platform called *Moner Jotno Mobile E*, in collaboration with partner organisations Kaan Petey Roi and the Psychological Health and Wellness Clinic, to give psychosocial assistance to people who were affected by the pandemic situation. We then took the conceptual framework, ethical guidelines, safeguarding policies, scripts and call anatomy that we had developed to set up this service, and integrated it with our experience with play-based learning to create a remote curriculum for Play Leaders.

During the remainder of April, BRAC gathered 37 play-based curriculum developers and 37 psychologists to develop a curriculum integrating psychosocial support and play-based learning. Scripts were tailored to the learning needs of children of different age cohorts, both in the humanitarian setting of the Rohingya camps and in the mainstream setting in Bangladesh. The scripts were piloted with the different age groups, and refined based on feedback received.

The bond between the Play Leaders and the Rohingya children helps to keep the children engaged in playful learning



The team then trained frontline staff – in total 211 project assistants, project organisers and para-counsellors – who in turn trained Play Leaders, with the help of the scripts on audio files. It was important for trainers at all levels to understand the importance of empathy and actively listening to parents and caregivers. The training stressed that staff were not just going through calls with beneficiaries, but were there to listen to them and support them.

Training for all facilitators was conducted throughout Bangladesh over four days at the start of May, and the model was launched on 7 May. Play Leaders began to call families every week to engage in a 20-minute conversation based on the scripts developed, which are simple and do not change much week to week:

- For the birth to 2 years age cohort in the Rohingya camps, they give basic psychosocial support to mothers and caregivers as well as tips on how to take care of infants and stay safe from Covid-19.
- For the 2–6 age cohort in the Rohingya camps, the Play Leaders interact with children as well as mothers and caregivers. Children are engaged through activities such as reciting traditional rhymes called *kabbiyas*, while mothers and caregivers are given basic psychosocial support, health and hygiene tips, and child stimulation tips.
- For the 4–5 age cohort in the mainstream setting of Bangladesh, Play Leaders engage with children over the phone through activities such as reciting Bangla rhymes, and also give mothers and caregivers basic psychosocial support, tips on how to engage with children, and health and hygiene messages.

‘BRAC soon learned that the children loved hearing from their Play Leaders, and these calls made caregivers feel more valued and safe.’

The callers have been trained on maintaining transparency about the safeguarding and ethical guidelines they must practise. All staff making calls have to sign up to the safeguarding policies, and every person receiving the calls has the right to opt out. At the time of writing, the intervention has reached 80% of beneficiaries in the Rohingya camps and more than 90% of beneficiaries in the host community.

A research strategy is being developed for collecting data to ensure quality of delivery of the calls. The model is also being adapted to engage fathers, with the launch planned for the end of 2020. It is expected that the Pashe Achhi model will operate until the end of 2020 and beyond.

The importance of innovative solutions

As the pandemic puts the world in uncharted territory, it has been necessary to rapidly develop innovative solutions tailored to the needs of particular communities for psychosocial support and to meet the learning needs of vulnerable children. BRAC’s initiatives are simple, contextualised, and scalable. They aim to reach as many beneficiaries as possible, and show the need for individuals, institutions and countries to be flexible and creative as everyone adapts to the ‘new normal’.

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Scaling early childhood services in cities: lessons from four Urban95 case studies

- ▶ *Urban95 can help cities to overcome challenges in scaling early childhood services.*
- ▶ *Princeton researchers studied Urban95 programmes in Tel Aviv, Tirana, Boa Vista and Recife.*
- ▶ *Success factors include top-level support and study tours to see initiatives in action elsewhere.*

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Scaling early childhood development initiatives is challenging: costs often remain high; early childhood investments compete with other priorities; distrust or disruption may impede take-up in fragile communities; programmes may not reach the intended groups or neighbourhoods; there are not always enough staff members with the right skills and aptitudes; and streamlining can be difficult within different departments. Princeton University's Innovations for Successful Societies (ISS) programme developed case studies, reviewed by LSE Cities, that profile how four partner cities of the Bernard van Leer Foundation's Urban95 initiative – Tel Aviv (Israel), Tirana (Albania), Boa Vista (Brazil) and Recife (Brazil) – have addressed these coordination and delivery challenges.¹

Urban95 aims to integrate early childhood services and make it easier and safer for caregivers with babies and toddlers to reach delivery points, with convenient play areas along the routes. In this way, a city can improve access to early childhood development programmes; help private, non-profit and public providers reduce their costs and expand their reach; and enable families with infants and young children to take advantage of learning opportunities in the environment around them. More broadly, Urban95 gives children a 'voice' that can help to accelerate change in long-standing urban challenges, from air quality to the provision of public space.

This effort to integrate service provision with the kind of urban planning usually associated with the city's built environment requires capacity to promote sustained collaboration at multiple levels and across departments. Urban95 aims to develop the necessary leadership, strategic thinking and other skills needed to bring early childhood-focused initiatives to scale. It is about securing authorisation to make changes in both services and streetscape, setting goals collaboratively, making the case for wider social and environmental co-benefits associated with early childhood investment, building understanding and momentum among municipal staff members, working closely with communities, following up, and collecting the information needed for evidence-based policy.

Valuable ideas

The Princeton ISS case studies highlight some positive lessons learned during the past two years as well as some areas where progress has proven harder but where good ideas can make a big difference.

¹ To read case studies on the Foundation's partnerships exploring ways to take services for babies, toddlers and caregivers to scale, visit: <https://bernardvanleer.org/publications-reports/scaling-partnerships-case-studies/>

In all four cities, the mayor and city CEO played an important role, lending support and sometimes stepping in to persuade sceptical department heads or council members to cooperate. In Boa Vista and Tirana, the mayors led the programme's adoption and became its public face. In Tel Aviv, the change was more bottom-up. Municipal officers organised support across departments and mobilised results from early projects to help the mayor see the initiative's potential and strengthen his commitment. The mayors' motivations and theories of change varied, but in all instances their support was crucial.

Tirana created new structures to finance and deliver the programme, while Tel Aviv, Boa Vista, and Recife used experience from previous programmes and existing foundations or trusts as vehicles for receiving outside funds, bringing partners together, keeping an eye on results, and maximising the chances of the policy being sustained across changes of administration.

The four case studies provide further valuable ideas on embedding early childhood provision into integrated governance structures, helping to bring early childhood into the workstream of city departments. Effective collaboration and two different types of governance integration are essential for scaling urban early childhood services and initiatives: first, integration horizontally between departments; and secondly, but to a lesser extent, vertically across city and national levels.

The city governments usually coordinated Urban95 through a small team in charge of implementation monitoring, troubleshooting, and planning. In Recife, the mayor empowered a chief of staff to bring department heads together and continuously improve the programme through close monitoring of interventions. Tel Aviv vested similar responsibility in staff members who operated out of a department, instead of the office of the mayor. Mutual trust and strong networking between departments were an important way to strengthen horizontal integration in Tel Aviv with key individuals acting as the mediators between departments.

Recife and Boa Vista show how Urban95 projects can scale more effectively when national policies already support investment in early childhood. Tying the Urban95 programme to existing Brazilian national policies, as was done in Boa Vista, can help accelerate change. In Tel Aviv, the absence of a national policy initially slowed the city's response. However, the division of authority between local and national levels later shaped the programme that emerged.

Across the board, the city officials pointed to the positive impact of study trips and executive education workshops in overcoming scepticism among key staff members. Public works officials usually found it hard to understand the case for collaborating with NGOs or city health and education officers on projects serving children under age 3, so viewing an example on the ground brought abstract ideas to life. Workshops helped develop ideas and generate enthusiasm. In some instances, occasional check-backs with officials from other cities helped sustain momentum.

'Public works officials usually found it hard to understand the case for collaborating with NGOs or city health and education officers on projects serving children under age 3, so viewing an example on the ground brought abstract ideas to life.'

In all of the cases, leaders used pilots or an initial set of investments to help build public support. Both Tirana and Tel Aviv implemented their first playground investments in central parts of the city, which helped push early childhood interventions into the spotlight.

In fragile or distrustful neighbourhoods, city officials found it was helpful to work with existing non-profit organisations that had previously built knowledge and trust with citizens. In Recife, for example, a network of community peace agents proved invaluable in fostering understanding and conducting caregivers and children to a service centre, co-located in its own facilities.

Inculcating a sense of civic responsibility for maintenance of spaces and respect for traffic calming initially challenged some of the municipalities: no sooner had a 'pocket park' been created than vandals damaged equipment. Gradually the municipalities affected began to adapt, by trying to inculcate civic spirit, purchasing equipment that was less vulnerable, or some combination of the two.



Sticking points

The case studies reveal some shared difficulties and tentative solutions. The cities prioritised action over evaluation, which was understandable. However, without an initial effort to think ahead about how to evaluate performance, most cities lacked baseline data and had limited evidence of early-stage or intermediate impact to share with voters or to help with decision making.

When the city teams eventually settled on indicators, the next challenge was to induce frontline providers in NGOs or government offices to collect and share the necessary information. Many were too busy, and in most instances the innovation team did not follow up. There were some exceptions, however: Tel Aviv won the assistance of service providers in administering surveys to parents who used their services, and came up with creative ways to collect data, such as spot checks to count people using a playground or park. These experiences point to the future importance of building evaluation processes into programme design before the investments are complete.

Some of the cities engaged university knowledge partners and student volunteers to assist in data collection, but these collaborations often worked less well than anticipated. Although students proved helpful in conducting one- or two-day mapping operations using careful instructions, other forms of student participation were harder to manage as the students and their professors had competing demands on their time. Short, intensive, defined tasks with potential payback for research – or paid commitments to play specific roles – may hold greater promise.

Collecting evidence could have helped allay another problem: managing the risk of politicisation and improving sustainability. While mayors wanted to be able to point to compelling, concrete accomplishments, they also had to reduce the risk that the project would be identified too closely with their own political party and have no lasting effect if another party came to office. In some instances, vesting responsibility for some aspects of the programme in a city foundation or partnership helped improve sustainability by improving staff continuity and by providing a neutral forum for assessing results.

In some cases national statutes designed to minimise politicisation banned new investments or receipt of outside funds in the months leading up to an election. This created a planning challenge. To avoid delays in funds transfers or project execution, project teams had to prepare carefully and ensure that all operations scheduled to take place during the run-up to an election commenced before the start of this period.

Future scaling issues

Here at Princeton ISS, we considered it an innovative idea to use urban planning and service coordination to help scale services to under-served families

‘In all four cities, the mayor and city CEO played an important role, lending support and sometimes stepping in to persuade sceptical department heads or council members to cooperate.’

with young children. Whether it will work depends not only on municipal coordination – on which our studies focused – but also on timing, creativity, and aligning the programme to needs. Six issues need to be considered.

1 Changes to infrastructure

It is not easy or cheap to alter public works, such as pavements or roads. Opportunities arise during expansion or rehabilitation, so the success of this approach to scaling may depend in part on whether these opportunities coincide in time and place with programme priorities. That said, creative solutions are also possible: for example, while Tirana embarked on major overhauls of public space, Tel Aviv experimented with pop-up parks, traffic calming along streets parents often used, and conversion of small kiosks to educational toy sheds, which required far less investment in durable infrastructure.

2 Location of investments

The location of these investments, whether permanent pieces of infrastructure or pop-up parks, raises further challenges. Tirana and Tel Aviv initially invested in the most prominent or central public places in the city. One might refer to this strategy as ‘campaign urbanism’ where investments are situated to generate attention from both the public and the media. This approach can be a useful way to build initial momentum in the programme, as in the case of Tel Aviv, but it does come with the risk of public resistance, as in the case of Tirana. Further, while very visible investments in famous city locations may broaden the base of public support, they are also vulnerable to criticism that they neglect the neediest families. Balancing steps to build support with the need to extend services to deprived neighbourhoods is one of the hardest judgements Urban95 leaders have to make.

3 Human resources

The case studies did not address staffing costs and quality, which could become significant impediments to scale, depending on labour market conditions and service utilisation rates. One solution, in Tel Aviv, was to integrate the programme with other projects and plans that departments were developing, enabling more efficient use of resources. For example, project leaders realised that some of the intellectual stimulation required for early childhood development could take place without professional assistance in the context of the city’s parks and playgrounds, where they were already making investments. The city also encouraged new parents to install a smartphone app, Digitaf, that links caregivers with a variety of programmes and with each other, helping to lessen the need for staff by harnessing peer-to-peer assistance. This option may prove helpful in other countries where access to technology is broadly shared.

4 Optimising service provision

Only in a few instances did cities experiment comprehensively with grouping multiple services in ‘priority zones’ or modulating building hours and public transport routes. Co-locating services and using facilities such as schools as

‘Balancing steps to build support with the need to extend services to deprived neighbourhoods is one of the hardest judgements Urban95 leaders have to make.’

service points after hours have potential to increase access and decrease operating costs in the longer term. However, there are start-up costs. The cities we profiled pursued these options only on a limited scale, probably because of the upfront information required to plan and coordinate.

5 Reaching other sectors

Identifying co-benefits may help scale these types of early childhood development initiatives in the future. For example, adopting a child lens helps achieve improvements in walkability and air quality, while focusing on the latter issues will help improve life for children. Broadening the aims that Urban95 programmes serve expands the coalition of support and increases the probability that leaders will invest. The co-benefits approach is an increasingly popular way for city leaders to introduce new social and environmental endeavours that also improve the outcomes of other sectors in the city. It encourages collaboration over competition between departments in a city and specifically around financial resources shared between these departments.

6 Sustainability: from institutional change to behavioural change

Finally, scaling will depend on how well cities can embed the programme in municipal processes and services. One approach is through the law: Recife, for example, passed a law authorising the city to spend resources to support early childhood development in its activities, including investment in public space to mark the city's 500th anniversary. However, sustainability will require changing the culture by fostering broad public understanding of how the programme creates value for communities.

Success or failure on each of these six challenges and opportunities depends on the ability to collaborate across government departments and assess costs and benefits accurately, using evidence. In the next phase of their work, the cities profiled in the studies will help to inspire others.

‘The co-benefits approach is an increasingly popular way for city leaders to introduce new social and environmental endeavours that also improve the outcomes of other sectors in the city.’

➔ Find this article online at earlychildhoodmatters.online/2020-9

Supporting children to grow smarter, not just taller: here's how

- ▶ A new meta-analysis shows that responsive caregiving boosts infants' brain development.
- ▶ Parenting group sessions and home visits improve cognitive, language, and motor skills.
- ▶ Nutrition-only programmes have much less effect than comprehensive interventions.

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Ani's mother tells her a story each night before she goes to sleep. Her older sister sings songs and plays clapping games with her. She and her older brother play with a ball together, throwing and kicking it back and forth. Ani's father makes her a toy car out of wire and they play together. These simple activities change the shape of Ani's brain.

Researchers have been studying how an enriched environment changes the structure of animal brains for more than 70 years. In these experiments, some newborn rodents are placed in a large enclosure that contains colourful objects that they can smell, climb onto, push around and play with. They are raised together so they can interact with each other. Other newborn rodents are placed alone in empty cages. When their brains are compared, the rodents raised in the enriched environments have 10% higher overall brain weight, 20% higher dendritic branching, and 20% higher synapses per neuron (Kolb and Whishaw, 1998). Higher dendritic branching and synaptic density means that more connections between brain cells have been formed and can be formed.

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How do these changes in the brain relate to changes in children's abilities and behaviour? In human populations, structural characteristics such as brain weight and synaptic density are difficult to measure; however, we can measure children's cognitive, language, motor, and social-emotional skills. In a recent systematic review and meta-analysis, we found 75 early intervention programmes that enrolled pregnant women or children up to 5 years old, used a randomised controlled design, and reported children's height-for-age z-scores and developmental outcomes after the intervention (Prado et al., 2019a).

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Fourteen of these were caregiving programmes that encouraged parents to provide responsive care and learning opportunities to their children through activities such as talking to them, playing with them, telling them stories, singing them songs, and making them toys. These programmes were conducted through parenting group sessions or individual home visits, typically for a duration of 6–12 months. At the end of the programmes, compared to children in the control groups, children who received the interventions scored 0.48 standard deviations higher on cognitive scores, equivalent to 7 IQ points; 0.42 standard deviations higher on language scores, equivalent to 6 IQ points; and 0.38 standard deviations higher on motor scores, equivalent to 5.5 IQ points.

Five of the 14 studies measured the children's development again between one and two years after the programme ended, and three of them found sustained positive effects on cognitive, language, or social-emotional development.

These findings demonstrate that simple activities caregivers can do with their children have a profound impact on shaping children's brains. Community workers can support and promote these activities through behaviour change communication in individual and group settings.

Unicef and the World Health Organization (WHO) have published several resources to support early childhood development interventions, including the *Early Childhood Resource Pack* (Unicef, online) for programme planners



Photo: Elizabeth Prado

and managers, *Caring for the Child's Healthy Growth and Development* (WHO, 2015) for community health workers, and *Care for Child Development* (Unicef, 2012) for workers in health facilities. The Reach up and Learn curriculum has also been made freely available and is an excellent curriculum with a proven evidence base for effectiveness (Reach Up, online). Investing in these types of programmes will support the development of human capital among populations where children are at risk of not fulfilling their developmental potential.

Tackling stunting is not enough

In many countries, programmes for pregnant women and children under 5 focus on nutrition and prevention of stunted growth, rather than promoting responsive care and learning opportunities. The hope is that improved growth will coincide with better health and improved neurodevelopment. To test this idea, we also calculated the effects of nutrition programmes on children's growth and development in our systematic review.

'In many countries, programmes for pregnant women and children under 5 focus on nutrition and prevention of stunted growth, rather than promoting responsive care and learning opportunities.'

Of the 75 studies reviewed, 51 programmes provided nutritional supplements to pregnant women and/or children from birth to 5 years old. The effects of these nutrition programmes on child development were five times smaller than the effects of the caregiving programmes described above, with children who received nutritional supplements scoring 0.05 to 0.08 standard deviations higher on cognitive, language, motor, and social-emotional development compared to control groups, equivalent to about 1 IQ point.

Despite the limited gains in cognitive ability from nutrition interventions, we know that adequate nutrition is part of the essential needs of the developing brain. When rodents are fed inadequate diets, their developing brains are affected in some similar ways to the effects of a deprived environment described earlier. For example, iron deficiency results in reduced brain size, iodine deficiency in reduced synaptic density, and vitamin B6 deficiency in reduced dendritic branching (Prado and Dewey, 2014).

However, the findings of our review demonstrate that investment in nutrition alone will not be sufficient to nurture thriving individuals and communities. We can expect only small gains in child development from nutrition programming alone.

Focusing solely on reducing the prevalence of stunted growth will also be insufficient to support thriving populations. Stunted growth, defined as height for age more than two standard deviations below the mean of the WHO's norms, is consistently associated with poor child development. Thus, stunted growth is often used as a proxy for stunted development.

Across all of the 75 programmes that we reviewed, effects on height-for-age z-scores were not associated with effects on cognitive, language, or motor scores. This means that when programmes had positive effects on growth, they

did not necessarily have corresponding positive effects on child development, and vice versa. This contradicts the assumption that improvements in growth will correspond to improvements in neurodevelopment.

Stunted growth is a marker of an environment that constrains growth and development through partly overlapping mechanisms (Prado *et al.*, 2019b). Faltering in linear growth and in neurodevelopment share some causes, but also have some distinct causes. We need to implement programmes that address risk factors for poor neurodevelopment in the population, and not assume that improved growth alone will appreciably improve child development.

We also need to build on the resources cited above to create an evidence-based comprehensive intervention package that addresses the causes of faltering in neurobehavioural development. Critically, we need to determine what intervention packages and implementation platforms can be delivered at scale to most cost-effectively improve child development, thereby leading to not only taller, but more thriving populations.

➔ Find this article online at earlychildhoodmatters.online/2020-10

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Identity matters: addressing inequity starts in early childhood

- ▷ *Refugee children internalise a sense of otherness from a young age.*
- ▷ *Refugee Trauma Initiative works to help children feel valued and respected.*
- ▷ *Developing a sense of self-worth helps children heal their traumatic beginnings.*

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Evidence shows that race and identity heavily influence key life outcomes including physical and mental health and income (Pachter and Coll, 2009). Across the world, people from black and ethnic minority communities bear the brunt of growing inequity. It starts with how young children experience difference: children as young as 3 are shown to internalise a sense of otherness based on their identities (Connolly, 2009). The formative early years can build a strong foundation of self-worth and resilience, or set up a child for a life battling prejudice and discrimination.

Nowhere is this more apparent than in the experiences of refugee children. They spend their childhoods in exile, dislocated from their communities and often facing racist prejudice and discrimination, vilification by politicians, and aggressive behaviour from border agencies and the police. In the media, almost every image of a refugee is either threatening or depicts a victim without agency. Refugees are stripped of all other facets of their identity.

Refugee children internalise the experience of being ‘othered’ from a young age. I remember vividly the numerous times when landlords refused to rent my family accommodation because we were refugees. Grief would hang over my family for days. I would wonder in my child’s mind what we could do to repent for our circumstances. To dismantle the trauma of such experiences in adulthood requires difficult emotional work and regular psychosocial support that is rarely available.

Refugee children often grow up in contexts where their history, language and traditions are not understood, even purposely ignored. Families live under inhumane and arduous conditions, sometimes for years, lacking security, nourishment, education and healthcare. Women in the groups that my colleagues and I run often talk of the claustrophobia that their situation inflicts on them. When ‘I can’t breathe’ – the final words of George Floyd – became a rallying call for protests against racial injustice in 2020, I reflected that I had long heard similar sentiments expressed, metaphorically, about the experience of being a refugee.

Creating spaces to respect identity

At Refugee Trauma Initiative (RTI), an organisation I set up and run, we take care to create spaces where the identities of the families and children we work with are recognised, respected and celebrated. The practice of understanding and respecting where the children come from forms the foundation of our work.

'Baytna', our early childhood intervention, is value-based (*baytna* means 'our home' in Arabic). Our training focuses on building the skills of facilitators to embed and disseminate the intervention's values into the lives of refugee families. Our first aim when training new facilitators is to establish the sense of safety that is necessary to recognise and dismantle the unconscious bias that we all hold, and understand the ways in which it can impact practice with children.

These sessions are often incredibly emotional and unsettling, requiring an experienced trainer to hold the space safely and guide the trainees through the difficulties into a space of awareness and community. In one such session, a tearful facilitator shared her feelings of resentment and judgement towards the families of the children who came to her sessions. It was difficult for her to disclose these feelings, but it opened an opportunity for discussion with her peers. She was supported through her difficult emotions and the group helped her brainstorm strategies for managing her judgemental feelings when they arise.

Children can leave their own imprint in Baytna spaces



Our facilitators receive meaningful and continuous training, peer coaching and supervision, enabling them to run sessions for young children where there is authentic support and respect for children's identities, history and curiosity. They practise understanding when children bring difficult emotions into a session, always welcoming their feelings and helping the children to express them through play, art, movement and storytelling.

We emphasise lived experience and representation of the community when developing our programmes. Baytna was designed with the support of refugee parents and children, and we search for facilitators from the communities we serve so that the children can see themselves represented in those who take charge of the space. In Polycastro, for example, a small town on the Greek–North Macedonian border, a group of Kurdish mothers run a Baytna kindergarten with RTI providing training, coaching and financial support. Often sessions end with songs from the Kurdish community.

We encourage parents to participate, and to bring stories and songs from their own childhoods so that their children can grow up from a young age with a sense of connection to where they came from. When parents experience guilt and shame for not being able to provide for their children, we listen to them and remind them of the courage and resilience it took for them to make the journeys that brought their children away from violence.

Identity-informed practice helps families reconcile the culture and traditions of their country of origin with their country of asylum



Building a sense of self-worth and agency

My own family's journey from Kabul to London took four years. We faced countless instances of racism and discrimination – sometimes intentional, but often stemming from a lack of understanding of what we had endured and the colonial roots of violence in the history of Afghanistan. Being a refugee means battling powerful, dark forces for the sake of the safety of your community.

In developing my own practice of working with children and families who have faced similar journeys, I recognised how important my identity was to my resilience. Connecting to the history and storytelling tradition of Afghanistan – and understanding the courage and tenacity of my own parents, who brought up five children in the most difficult circumstances – has healed deep wounds and nurtured a sense of pride in where I come from.

RTI's work aims to help children feel valued and respected so that they can develop emotional literacy, a sense of self-worth and agency, which in turn supports healing from their often traumatic beginnings. Affirming the identity and history of children who have faced difficult beginnings, and will continue to face discrimination, can be an important foundation for healing and resilience for years to come.

➔ [Find this article online at earlychildhoodmatters.online/2020-11](https://earlychildhoodmatters.online/2020-11)

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- ▷ Low-income families in poorer countries often cannot afford quality foods for young children.
- ▷ Fortified porridges are one solution – but hard to produce safely at low cost.
- ▷ GAIN is working with partners to help manufacturers produce such porridges at scale.





Business matters: engaging the private sector to give young children a healthy start in life

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Getting nutrition right in the early years can have long-lasting consequences. During their first two years of life, children lay the foundation for their lifelong physical growth and mental development. To help their rapid growth, children need a diet that is rich in nutrients – especially given the small portions they eat. Exclusive breastfeeding is recommended for the first six months, at which point infants are introduced to complementary or ‘solid’ foods, alongside continued breastfeeding. Our first foods shape us. Introducing complementary foods is a crucial stage in a child’s development, and a fun one.

Parents want the best for their children, but they also need options that are easy to find, convenient to prepare, provide good value and that their children will want to eat. Wealthier parents in low- and middle-income countries can often afford more diverse, delicious and nutritious foods, as well as cooking fuel, and typically have more time to invest in cooking – or can afford to pay someone else to cook.

For parents with little income, nutritious foods are often not an option due to their price, availability and the parents' knowledge. Locally available and inexpensive foods may not offer all the nutrients a child needs. This contributes to significant gaps in the diets of young children (Global Alliance for Improved Nutrition (GAIN) and Unicef, 2019). In low- and middle-income countries, only one in four children aged 6 months to 2 years eats a diet diverse in all the food groups needed to grow and develop (Unicef and GAIN, 2019).

'Families may also be reluctant to pay for foods that only one family member will eat when financial resources are scarce, so young children end up eating the same food as the rest of the family.'

Manufacturers in the food sector have responded to this need by producing specialised foods for young children, called 'fortified complementary foods'. These are grain-based porridges that are blended with vitamins and minerals and are designed to fill some specific nutrient gaps in the diet of children aged between 6 and 23 months. These porridges are easy for caregivers to prepare, often just requiring added water, and easy for a young child to eat. However, they are not a medicine, nor a 'fluoride-in-the-water'-style panacea for childhood malnutrition. They do not fill all nutrient gaps. But they can help decrease micronutrient deficiencies among young children and are an available food option that is appropriate for parents to choose.

Unfortunately, these fortified porridges are often expensive and available only in urban areas. If low-income households use them at all, it is only very occasionally, in finite amounts and sometimes as a remedy when a child is sick. Families may also be reluctant to pay for foods that only one family member will eat when financial resources are scarce, so young children end up eating the same food as the rest of the family.

Scaling-up provision of fortified food by SMEs

Multiple models exist to help those most vulnerable to malnutrition to gain access to fortified porridges. In its work alongside governments and the private sector, the Global Alliance for Improved Nutrition has been an advocate of market-based delivery models and has supported local small and medium-sized enterprises (SMEs) to bring nutritious and safe foods to all children, especially those living in low-income households. This approach tests the feasibility of the private sector to reach low-income groups, whether families will purchase such products and, in this case, whether fortified complementary foods can be sustainable without external funding.

There is appetite among a large number of local SMEs to produce low-cost fortified complementary foods, yet many face challenges reaching scale

commercially. Safety is key – especially with foods for young children – so the highest standards of product quality are required, which involves expense. Complementary foods are highly regulated, and compliance with both global and local regulatory requirements can place additional demands on manufacturers. Keeping the retail price low enough for low-income families therefore means low profit – and with slim margins SMEs cannot generate enough capital to grow and invest in promoting their products.

In 2015, GAIN began working with the Federation of Women’s Self-Help Groups in Bihar to set up and operate two production units to manufacture a fortified porridge, ‘Wheatamix’. Bihar is one of the most densely populated Indian states, and also has some of the country’s highest levels of child malnutrition (Government of Bihar, no date).

This pilot was a semi-subsidised model, with the government of India making regular orders and distributing Wheatamix to children and to pregnant and lactating women as part of its Integrated Child Development Services (ICDS) programme. The start-up capital for the production units was funded by a grant, and the working capital covered by a bank loan and owner contributions. The units started generating profit within a month of receiving orders from the ICDS programme. The project has supplied fortified porridges to 26,000 children and pregnant and lactating women suffering from malnutrition.

While the positive impacts of this pilot are clear, significant steps need to be taken to move from semi-subsidised models such as Wheatamix, with governments as the main customer, to market-based delivery models with caregivers as the customer. Behaviour change interventions promoting the use of fortified porridges such as Wheatamix could improve the distribution and uptake, and technical expertise in branding, packaging and labelling is also needed to make fortified porridges more appealing and user-friendly.

A second challenge is that fortified porridges require a specific blend of vitamins and minerals, or ‘premix’, that is safe and appropriate for children – and procuring high-quality, low-cost premix is a substantial barrier for many SMEs. To address this challenge, GAIN has established a premix facility (Protein Kissée-La, online) that offers SMEs an easier, more cost-effective way to procure high-quality vitamin and mineral premix suitable for young children.

Making fortified porridges more desirable, affordable and available must go hand in hand with strong rules and regulations. Marketing any products to children is very delicate. For that reason, GAIN also works with governments to ensure regulatory environments that are safe for children and also reduce risks and costs for businesses. GAIN supports and participates in multi-stakeholder alliances to translate global evidence into robust regulatory guidelines (GAIN, 2015), and to build trust and transparency in the process through the SUN (Scaling Up Nutrition) Business Network (SUN, online).

‘While the positive impacts of this pilot are clear, significant steps need to be taken to move from semi-subsidised models such as Wheatamix, with governments as the main customer, to market-based delivery models with caregivers as the customer.’

Making markets work for low-income families is difficult and takes time. Most fortified porridges are cereal-based and non-perishable, but there are opportunities to innovate further, looking beyond grains to include other locally available foods which infants consume. Providing low-income families with more food options allows parents to give their children the chance to start on the best path in life.

GAIN's ongoing work on fortified complementary foods around the world will be summarised in a working paper, which will be available on the GAIN website: <https://www.gainhealth.org>

→ Find this article online at earlychildhoodmatters.online/2020-12

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Sugira Muryango: scaling home visits in Rwanda through implementation science

- ▷ Implementation science can help early childhood programmes to achieve scale.
- ▷ Rwandan home visit initiative Sugira Muryango is scaling by learning and adapting.
- ▷ The flexibility to pivot quickly became critical in adapting to the Covid-19 crisis.

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It is challenging to scale-up any social programme quickly while maintaining its quality and effectiveness. Early childhood development services are particularly difficult to scale because of their multi-sectoral nature: buy-in, coordination, joint planning, and frequent communication are needed from actors in health and hygiene, nutrition, child protection, and early learning. These challenges are amplified when working to expand services through already stretched government structures.

Momentum is growing in low- and middle-income countries to improve the quality of early childhood services and broaden access, particularly for vulnerable children (Engle *et al.*, 2011). The global early childhood development community can capitalise on this momentum through deeper engagement with the principles of implementation science – defined as ‘the scientific investigation of factors associated with effective implementation’ (Halle *et al.*, 2013).

Even when a programme or practice is based on evidence, it can be challenging to implement in systems that are characterised by high complexity. Implementation science looks at the iterative, nonlinear nature of aspects of implementation. The early childhood community has not paid enough attention to observing, studying, learning and sharing knowledge about these aspects.

An implementation science approach entails a focus on coaching, training, and technical assistance, as well as quality assurance and quality improvement. It encompasses not only the evidence-based practice itself, but also each organisation involved and the environment in which they operate. Effectively implementing this approach requires all stakeholders to understand its value and to budget for the time, money and leadership required.

In Rwanda, implementation science is guiding a high-functioning, multi-actor partnership to adapt, scale, and sustain Sugira Muryango (‘Family Strengthening’) – a targeted home visiting programme that supports Rwanda’s most vulnerable families to practise responsive and positive parenting.

Sugira Muryango is unusual in the number and breadth of multi-level stakeholders that have participated in its creation and expansion. The co-

creators – François-Xavier Bagnoud (FXB) Rwanda, a local non-governmental organisation, and a combined team at the Research Program on Children and Adversity at Boston College School of Social Work and the University of Rwanda – built a high-level management relationship with critical stakeholders across sectors in the government of Rwanda (Ministries of Gender and Local Government), and invited active co-creation from their multilateral (World Bank), bilateral (USAID) and private funders (Network of European Foundations, The ELMA Foundation).

This multi-faceted partnership has been working to design, deliver, iterate, and measure the impact and cost of the Sugira Muryango home visiting programme, a 12-week intervention that works through community-based coaches to improve parent–child interactions. Sugira Muryango comprises five core components:

- providing education on children’s development, nutrition and health, and hygiene promotion
- coaching male and female caregivers to engage in play and early language learning with young children
- reducing family violence and improving conflict resolution and parental emotion-regulation skills
- strengthening problem-solving skills and social support through access to available informal and formal resources
- building skills in positive parenting, alternatives to violence, and coping skills to promote healthy family functioning.



Scaling through learning and adaptation

The Sugira Muryango partnership has been guided from the start by learning and adaptation. The home visiting curriculum was created based on global best practices, WHO's Care for Child Development, and a prior parenting curriculum that had been tested in Rwanda for families facing adversity due to HIV. The programme was then adapted, through a series of small-scale early pilots, for families with a child under 3 years old who are affected by extreme poverty. It was specifically designed for both dual- and single-caregiver families, and to layer on top of Rwanda's national social protection programme.

Designed with sustainability in mind, Sugira Muryango worked rapidly with local stakeholders to identify and recruit families and link to referral networks through existing government structures at national and local levels. At the same time, Sugira Muryango provided enhanced support to the most vulnerable families eligible for the Vision 2020 Umurenge Programme, a government-led initiative on poverty and social protection; built the capacity of specific community-based workers through training, monitoring and supervision; generated data; and evaluated implementation impact, process, and outcomes related to child development and violence.

A cluster randomised trial in 2017–2018 enrolled 1049 families, of whom 549 received the Sugira Muryango intervention. It was found to yield promising results such as improved dietary diversity, more help-seeking for health problems, better socio-emotional and cognitive development outcomes, and reduced violence against intimate partners and children (Betancourt et al., 2020).

At around the same time, early childhood development was emerging as a national priority in Rwanda. In 2017, the government strengthened the policy and institutional framework, including establishing the National Early Childhood Development Program (NECDP) under the Ministry of Gender. NECDP became responsible for coordinating all interventions supporting the development and growth of children aged under 6, including relevant ministries at central level and the implementation of activities at different administrative levels: district, sector, cell and village (the National Early Childhood Development Program strategic plan).

The Sugira Muryango partnership became an active participant, working with NECDP to plan for an expansion phase (2019–2022) to reach over 10,000 children in three districts. As a sign of confidence in the programme, home visiting will be conducted through existing Friends of the Family (*Inshuti Z'Umuryango*), a community-level child protection volunteer workforce. During this phase, ownership will shift further from the creators to FXB Rwanda and local officials, as they establish cross-site learning teams to improve quality using 'plan–do–study–act' cycles to generate home-grown solutions to programme challenges.

'An implementation science approach entails a focus on coaching, training, and technical assistance, as well as quality assurance and quality improvement. It encompasses not only the evidence-based practice itself, but also each organisation involved and the environment in which they operate.'

The Sugira Muryango partnership conducted a rigorous analysis to shed light on what it would cost to expand the programme entirely through government structures. Because of this emphasis – and the programme’s continued commitment to measure and monitor results for families – NECDP invited the partners to collaborate in developing national minimum standards and join technical working groups to guide other programmes transitioning to scale. The expansion phase also attracted further support to the Sugira Muryango partnership, from the LEGO Foundation, Echidna Giving, and Oak Foundation.

Adapting to Covid-19

The Sugira Muryango partnership’s focus on learning how to integrate the services into government structures proved to be critical during the Covid-19 disruptions. Project stakeholders immediately pivoted and adapted processes and materials: testing, adjusting, and progressing.

For example, training protocols were immediately adapted to use the WhatsApp platform, while partnership meetings continued with the government and other stakeholders through remote conferencing facilities. Direct home visiting was put on hold until social distancing restrictions could be eased, but the partnership continued a robust training and preparation agenda remotely to adapt programme delivery. Currently, multi-level strategies are being tested in three districts for scaling to all families with children under age 3 who are eligible for social protection programmes due to extreme poverty. Should they prove successful, they will provide a platform for expanding and sustaining high-quality services at greater scale.

→ Find this article online at earlychildhoodmatters.online/2020-13

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Improving child outcomes in Egypt through blended training and community awareness

- ▶ *Our Dream Initiative is training family counsellors and changing wider attitudes.*
- ▶ *The blended training model was rebalanced to online learning during Covid-19.*
- ▶ *Local centres are scaling by charging higher-income parents to subsidise others.*

Abla Al-Alfy

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Egypt is a young country, with 35% of the population aged below 18 and 2.5 million births a year. Yet it has among the world's highest incidences of malnutrition, stunting, obesity, unnecessary Caesarean section, premature birth, perinatal mortality, and genetic diseases. Beyond the country's economic challenges, the main reasons for these problems are lack of awareness among communities about the importance of the early years, and lack of training among health system professionals in early childhood development.

Our Dream Initiative is working to tackle both problems. Over the last five years we have trained 2200 family counsellors, who have reached over 600,000 mothers across 11 governorates. We also trained 250 health service professionals working in neonatal intensive care units, focusing on promoting early breastfeeding and Kangaroo Mother Care – that is, encouraging mothers to maximise skin-to-skin contact with their infants, a technique which has proven benefits in health outcomes for premature babies.

During this work we have explored the most effective ways to change ideas among both medical staff and the general public. This includes the need to overcome some deep-seated religious and cultural barriers. For example, we learned that the name 'Kangaroo Mother Care' was a problem because kangaroos are not well-known in Egypt and many mothers resisted the idea of being asked to emulate an animal. We rebranded the technique as 'Warm Hug Care', and this increased its acceptability.

For mothers to move around while practising Warm Hug Care requires a fabric wrap to hold the baby securely in place. These were not available locally at an affordable price, so we worked with suppliers to make the wraps more accessible. We are also producing a doll for children representing a baby in the Warm Hug Care position, to help change cultural expectations – children's dolls in Egypt currently tend to come with a toy bottle, which reinforces the norm of bottle feeding rather than breastfeeding.

Working with professionals at neonatal intensive care units, we identified factors linked with pre-term delivery, the most important cause of neonatal mortality.

The most significant include unnecessary lower-segment Caesarean section, maternal malnutrition, drugs and smoking, overuse of ovulatory drugs, early age of marriage and pregnancy, and large family size with short gaps between each birth. We launched several community campaigns to raise awareness about these issues.

In particular, our approach encourages parents to have smaller families so that they can put more caregiving resources into each child. This is in line with a long-standing state campaign to encourage family planning, using the message that two children are enough. However, that message struggles to overcome strong cultural norms in favour of large families and a religious belief that every child is a gift from God. Our approach is instead to stress the benefits of dedicating care during the first 1000 days to only one child, ideally then with a further gap of six to twelve months for the mother to get ready for a second baby.

Mothers demonstrating warm hug care during World Prematurity Week 2018



Blended training and Covid-19

To train counsellors cost-effectively to meet international certification standards, we developed a blended form of training in which online modules supplement face-to-face interactions. The training covers nutrition, health, child development, positive parenting, psychology and education. The trainee counsellors are primarily educated parents and community activists, from both medical and non-medical backgrounds. They work in hospitals and community centres, and through home visits to new mothers.

For training in remote areas, we developed a 'tele-health' model which connects local health centres, staffed by more junior medical professionals, with specialist consultants based centrally. It also enables us to provide counselling services via video links while the local medical staff perform routine well-baby checks. Trials in 2019 in three governorates – New Valley, Aswan and Matrouh – proved successful, and the model has been taken up by the government for scaling across the country.

Having these established online systems for training and consultations proved valuable during the Covid-19 pandemic, when in-person interactions had to be minimised and in some cases stopped altogether. We were able to continue reaching parents via video-conferencing, and adapt our blended training format to move more of the training online.

Before the pandemic we had established four 'centres of excellence' where parents can come with their young children for in-person activities with family counsellors. Based in Cairo, Giza, Dakahleya and Demietta, these centres are funded partly through donations from the private sector, and partly by charging higher-income parents for the services provided. This enables us to subsidise access for lower-income parents. We are developing a database to identify and contact low-income parents in the catchment area who have not yet used the centres. This model should allow us to continue to scale these centres in future, once the pandemic situation enables face-to-face activities to resume in full.

We are in the process of forming a network with seven other countries to scale up regionally.

→ Find this article online at earlychildhoodmatters.online/2020-14

Scaling-up mother tongue-based multilingual preschool education in Odisha

- ▶ Odisha scaled-up mother tongue-based early learning for 180,000 children.
- ▶ Thousands of frontline workers, supervisors and officials were trained.
- ▶ Early learning in their mother tongue helps children succeed at school.

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Phulamani Jani always wondered if she was doing the right thing in teaching young children in Kuvi, the language of the Kondh tribe, rather than Odia, the official language of the Indian state of Odisha. Phulamani works at the anganwadi centre in Putsil, a remote village in Koraput district comprising just 78 households, over 12 hours by road from the state's capital, Bhubaneswar. Anganwadis, or childcare centres, are run by the Indian government's Integrated Child Development Services scheme. Early childhood education for children aged 3 to 6 years is part of their mandate.

Phulamani had observed that the children were more engaged and learned more effectively when she spoke in Kuvi, the language they speak at home with their families. But would it be better to speak in Odia, the language the children would encounter when they started primary school? Some community members thought so.

Between 2016 and 2020, the state of Odisha implemented a four-year programme to scale-up mother tongue-based early childhood education and parenting. The Mother Tongue-based Early Learning and Parents+ (MTELP+) programme is a partnership between the government of Odisha's Department of Women & Child Development, Mission Shakti and the Bernard van Leer Foundation, which established a Programme Management Unit to provide technical support.

The collaboration aimed to strengthen the skills and capacity of workers at 7202 *anganwadis* – along with supervisors, managers and policymakers – to deliver high-quality mother tongue-based early learning and parenting programmes to 180,000 children across 12 of the state's 30 tribal districts. Phulamani was among the participants in one of the first training sessions held under the programme, during the summer of 2017. 'That is where I got to know and understand the scientific concepts, rationale and validity of transacting in mother tongue at preschool level,' she says.

Linguistic diversity

Odisha is home to 8 million people from tribal communities, including 1.4 million children under the age of 6. Each tribal community has its own language,

rich customs and lifestyle. As a result the state is highly linguistically diverse, with a total of 72 mother tongues. The literacy rate among tribal communities is 37%, compared to 63% for the state as a whole (data from the Multi-Lingual Education Policy and Implementation Guidelines for Odisha, Government of Odisha, 2014).

The poor educational performance of children from tribal communities is linked to the language barrier they encounter when they begin formal education. Children from tribal communities grow up speaking with their peers and families in their mother tongue. When they start preschool or primary school, they find that the teachers are speaking the official state language, Odia. This means that tribal children are initially unable to understand much of what teachers say.

Research shows it takes children nearly three years to comprehend the language of the teachers and textbooks. Their parents often do not persevere with their children's formal education, putting them at risk of dropping out of school early.

Training supervisors to develop locally relevant teaching and learning materials for young children



Mother tongue-based bilingual programmes allow children to learn in their first language, promoting understanding and participation in the classroom setting. Later they can gradually transfer skills from their familiar language to the unfamiliar one. Studies show that such programmes make children more likely to succeed in school (Kosonen, 2005) and develop greater literacy in other languages (National Council on Educational Research and Training, 2011), while their parents are more likely to communicate with teachers and participate in their children's learning (Benson, 2002).

India's government explicitly recognises the benefits of mother tongue-based education, for example in the National Curriculum Framework 2005 and the Right to Education Act 2009. Following consultations with the national government in 2005, the government of Odisha adopted multilingual education in 2006 and constituted a state tribal advisory committee. It introduced 10 of the state's most widely spoken tribal languages as a medium of instruction in over 500 public schools.

'The poor educational performance of children from tribal communities is linked to the language barrier they encounter when they begin formal education.'

In 2011, the Odisha government's primary education authority attributed the poor educational performance of tribal children to the language barriers they encounter in preschools, focusing attention on pre-primary education and the *anganwadi* system.

Building on these experiences in schools and early childhood pilot programmes, the government and Foundation worked together to scale-up mother tongue-based learning through the MTELP+ programme.

Scaling up

Challenges to scaling were manifold. The first was to decide which languages to prioritise from the 72 spoken by the state's varied tribes – ten were chosen. Next it was necessary to find people with the right linguistic and cultural backgrounds to develop the early years curricula in the ten languages, and source content from the relevant communities, such as stories, lullabies and cultural practices, to create appropriate teaching and learning materials.

Staff with the right skills also had to be found for the 16-person unit that was set up to implement the programme. Programme design had to overcome barriers of language and geography, as many tribal communities are in remote, hard-to-reach areas. Many of the workers at *anganwadis* lacked intensive training in early childhood care and education, so the programme had to focus more widely than mother tongue-based aspects.

As well as training 7202 frontline workers, the programme needed to strengthen monitoring and mentoring capacities at all levels. During the four years, MTELP+ also trained 1200 supervisors in the 12 intervention districts on mother tongue-based early learning and parenting. It provided specialised training to child development officers from all 30 districts, and trained over

200 state- and district-level master trainers and officials from the Integrated Child Development Services with the aim of institutionalising training capabilities in existing government systems.

Working closely with government personnel and early childhood experts, the programme consulted with community members and parents in the remote tribal districts. It held community workshops to gather information to inform developing the training modules, low-cost and culture- and context-specific teaching materials, and communications materials with appropriate messaging for tribal communities.

Both qualitative and quantitative data bolstered MTELP+ throughout. A baseline survey of the 7202 *anganwadis*, conducted by the Centre for Early Childhood Education and Development (CECED) at Ambedkar University, informed the programme's design. Day-to-day coordination with officials in the intervention districts allowed mentoring support to be tailored to local requirements.

Programme unit coordinators fed back observations from remote districts during regular meetings with top officials in the Department of Women & Child Development in Bhubaneswar. This helped to identify opportunities, challenges, bottlenecks and actions that could help.

Leaders at all levels of government were invested in the successful implementation of MTELP+. Officials and representatives visited the training sessions in Bhubaneswar and the districts, and travelled to far-flung *anganwadis* to see the programme in action. Regular visits by the government's child development project officers and supervisors and the programme unit's district coordinators – along with monthly monitoring and mentoring – helped frontline personnel to feel supported and perform their duties better.

'Mother tongue-based bilingual programmes allow children to learn in their first language, promoting understanding and participation in the classroom setting. Later they can gradually transfer skills from their familiar language to the unfamiliar one.'

Results and next steps

An endline study, conducted by the Centre for Early Childhood Development and Research at Jamia Millia Islamia University, New Delhi, found significant improvements compared to the baseline in a range of areas. For example:

- After the training, nearly four-fifths of the *anganwadi* workers reported engaging children by using songs and stories from their cultural background.
- Over half the *anganwadis* had 'activity corners' where children could access learning materials whenever they wanted, compared to just one in ten in the baseline study.
- Almost a third of *anganwadi* workers used materials from the local socio-cultural context in their teaching, compared to under one in ten before the training.

The evaluators noted higher attendance, improved learning environments, more engagement of children and the community, better language proficiency

and more successful transitions to primary schools. Supervisors and workers themselves also commented on these improvements. There was more storytelling, free or guided conversations, contextually relevant play and pre-reading activities.

Best practices from MTELP+ are now being institutionalised. The department's website includes all learning materials developed under the programme. Government training and job courses for *anganwadi* workers and supervisors include parenting, brain science, and mother tongue-based learning in the curriculum. Current deliberations in the department include how to further scale-up the programme to all the 72,587 state *anganwadis* and strengthen existing government training. The department is looking to further expand the parenting components of the programme in all *anganwadis*, which can serve as effective platforms for parental and community engagement.

Sustaining the programme's improvements will require follow-up and refresher trainings. It will also be necessary to find ways of reaching tribal children whose mother tongue is not among the ten initially covered, or who live in areas where tribal communities are more scattered. The government of Odisha is planning to

Ensuring regular hand washing as part of *anganwadi* teacher training and field monitoring



expand the programme to develop curricula in five further languages, as many *anganwadis* have children from multiple linguistic backgrounds.

Back in Putsil, after the training Phulamani Jani ensured that her *anganwadi* had all the required teaching and learning materials, purchasing some from the market and preparing others using locally available resources. She began to compose songs herself in the Kuvi language. One community member remarked: 'Our children who have been cared by Phulamani are doing better in schools. They have been performing well. We could not have expected any better.'

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Before good practices can be taken to scale, we first need good ideas. In this section, we focus on innovations – new or emerging programmes, policies or services which have the potential to meet the needs of young children and their caregivers in a wider range of contexts.





Innovations

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CanalCanoa: strengthening indigenous values to improve early childhood development

- ▶ CanalCanoa films share indigenous people's songs, stories, and child-rearing practices.
- ▶ Communities that discuss the films show improved child development outcomes.
- ▶ Strengthening caregivers' social support networks is an unexpected impact.

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In a wooden house in a poor neighbourhood of São Gabriel da Cachoeira, one of the most remote towns in the Brazilian Amazon, 15 indigenous women had come together to watch and discuss short movies. While the older children slipped out to play in the street, many mothers still had babies and toddlers in their laps.

'What that Tukano woman says is right,' said one. 'When we lived in the jungle, we had such healthy food for our children. Fish, manioc, so many fruits! And here in the city, what do they eat? Chips and soda pop. Chicken and rice and beans sometimes.'

'It's not just the nutrition. It's also a loss of culture,' contributed a grandmother.

One mother organised a time to show other women how she had made her small yard into a garden. Another turned to a friend and said, 'Lívia, I'm worried about the school. You know what they eat there ...'

Lívia did know: not only did she have two young children in school, she worked in the government procurement office for school lunches. The meeting inspired her to act. She examined federal rules favouring local producers, sought out local indigenous rural cooperatives, evaluated their capability to produce and deliver their goods, and taught them how to apply for government contracts. Today, children in São Gabriel get local produce in their school lunches and snacks.

Four years ago, when the Brazilian NGO Usina da Imaginação (Shine a Light) founded CanalCanoa, the idea was for indigenous people to document their songs, stories and child-rearing practices on digital media; starting in 2016, a team of indigenous educators showed the resulting films to dozens of small groups, to stimulate discussion, reflection, and cultural action for early childhood. These *ajuris de conhecimento* (roughly 'barn-raising sessions for knowledge') serve as a kind of cultural video coaching, in which larger communities and ethnic groups can look at themselves in the mirror of the camera and movie screen to evaluate and adapt their own child rearing. Some 1186 adults and 1148 children participated in the project, with an additional 44,000 indirect beneficiaries through network effects, shared films, and cultural impact.

Amazonian culture is pragmatic. In traditional villages, the whole community comes together early every morning, talks about current issues – lack of fish or game, a proposal to clear a new manioc field, a pack of peccaries running wild – and develops collective strategies. The *ajuris* served the same purpose: a space for parents to come together with their neighbours to think about child rearing and solve common problems. The results of the project extended far beyond the original proposal, including dozens of issues important to indigenous parents and grandparents.

Lívia's work in the school lunch programme is only one example of the pragmatic results. Other groups constructed new *malocas* (a kind of communal living space), developed collective fishing and fish-farming projects, shared fields to increase crop yields, created three new children's theatre groups, documented dozens of traditional children's stories and indigenous paediatric techniques, and formed almost a dozen new childcare collectives.

Sandriele Silva (Tukano) records stories for children



Indigenous values meet child development science

In dozens of interviews with participants in all but one of the 32 *ajuri* groups, we also evaluated the project in quantitative terms, based on criteria shared by the science of early childhood development and indigenous values. The results were fascinating.

'After participating in seven *ajuri* sessions, parents and grandparents dramatically increased their multilingual stimulation of babies and young children.'

1 Language acquisition. The upper Rio Negro region – where São Gabriel is located – enjoys extraordinary linguistic wealth, with 27 ethnic groups speaking 22 languages (Lasmar, 2005). Kinship rules of many groups (Tukano, Aruwak, and some Baré) demand intermarriage with groups that have a different mother tongue, so children speak at least two, and often four or five, languages. Research shows that native multilingualism builds metalinguistic awareness, cognitive flexibility, and executive function (Center on the Developing Child, 2016). Sadly, as families move from villages into the city – and as village children integrate into the school system – fewer and fewer children speak native languages, even if many continue to understand them.

After participating in seven *ajuri* sessions, parents and grandparents dramatically increased their multilingual stimulation of babies and young children. Every interviewed participant changed the way they interacted linguistically with children or grandchildren, including four-fifths who began to speak more with them in native languages and three-fifths who began to tell them more stories. In 30% of the groups, parents and grandparents sang more to their children and, in another 30%, children began to request stories and songs, and tell or sing them to each other, young siblings and cousins.

2 Health and nutrition. In 56% of the urban *ajuris*, participants began to plant food at home. Three-fifths of participants said they had learned how to complement traditional and western medicine. In 70% of the *ajuris*, participants used more herbal and home remedies. In more than half of the groups, older women began to sell or distribute herbal remedies. The process also re-emphasised traditional shamanic focus on early childhood, with two groups motivated to document their own herb lore and two young men inspired to study as shamans.

Stronger social networks

The most important result, however, was not these pragmatic actions in themselves, but the improved social networks that emerged from them. As families move from villages to the city, they lose the strong intergenerational support networks necessary to raising children. By bringing parents and grandparents together – often with shamans, midwives, nurses and public health agents – CanalCanoa re-created this informal social safety net.

We had not even planned to document this result, but every single interviewed participant spontaneously cited it as important: over three-quarters mentioned increased respect for the knowledge of elders, while over two-thirds pointed to better dialogue with young people. Older participants explained that after the *ajuris* younger people welcomed traditional childcare techniques; younger people said that they felt more respected, more able to ask advice and to request support from their parents, grandparents, uncles and aunts, and better able to understand the advice. Relatives and neighbours participated more in childcare. This support network reduced the toxic stress that is common in the life of urban indigenous families.

These findings demand more research into the intervention's long-term consequences: has it stimulated a cultural change? Will participants continue to pass these practices on to their peers? Direct research with children could show whether the Rio Negro – a context so different from most studies of early childhood development – bears out findings from elsewhere that connect language teaching, nutrition, support networks, and stress reduction to improved development results. Despite these caveats, we believe the CanalCanoa model is an important tool for NGOs and public policy directed towards improving the context of care for young indigenous children.

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NOTE

For more information about the CanalCanoa project, visit <https://shinealight.org/project/canal-canoa/>

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A pragmatic approach to expanding access to quality early learning for South Africa's poorest children

- ▶ *South Africa plans universal access to quality early learning services by 2030.*
- ▶ *Strict requirements on land and buildings exclude many quality service providers.*
- ▶ *The poorest children are most likely to miss out if the regulations remain in place.*

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South Africa is demonstrating a firm commitment to early childhood development. The South Africa National Development Plan and the National ECD (Early Childhood Development) Policy (2015) commit to universal coverage of the full range of services by 2030. In 2019, President Ramaphosa announced that the mandate for early childhood development would shift from the Department of Social Development to the Department of Basic Education, signalling a recognition of early learning, and committed to adding a mandatory year of additional schooling prior to Grade R (pre-primary).

Meeting the goal of universal access to quality early learning services by 2030 would mean enabling access for roughly 2.5 to 3 million children aged 3–6 years. Currently an estimated 1.1 million children aged 3–5 are not accessing early learning services, with the poorest children being the most excluded (Hall et al., 2019).

Early learning services for children aged 3–5 are currently provided by the non-profit and private sectors. The government provides limited subsidies to providers, based on children's family income. In 2016 the government increased spending on early learning by creating an early childhood development conditional grant, which added ZAR 400 million per year earmarked for early learning to the estimated ZAR 2.5 billion already allocated to early learning through other mechanisms. In 2019 the grant was increased to around ZAR 3.1 billion for 2020 to 2023, enabling the government to increase the amount of the subsidy, and to marginally increase the number of children accessing it from roughly 612,000 currently.

Despite this progress, the gap in access has not significantly decreased over the past five years. The wealthiest children are still twice as likely to be accessing early learning services as the poorest children, and there remains a dearth of national data on the quality of services (Hall et al., 2019: 37–8).

Infrastructure requirements

One of the most significant barriers to increasing access for the poorest children is that the early learning services they are most likely to be able to access are least likely to qualify for the government subsidy. To receive the per-child-per-day subsidy, early learning services have to meet registration requirements set by the government. These are meant to protect the best interests of the children, but in practice they result in many children being excluded from financial support.

The most significant barrier is physical infrastructure standards, which are regulated by national, provincial and municipal laws and are difficult to meet without sufficient access to capital. Only centres with sufficient income from parent fees or donations can meet them. While even the poorest families often contribute small amounts, it is not enough for service providers to purchase or build the required infrastructure. In informal urban settlements, lack of land is another barrier to meeting the requirements.

While it is clearly important for government to regulate the quality of early learning services, a more developmental approach is needed. Global evidence identifies five key components of a high-quality early learning programme:

- 1 a competent workforce
- 2 appropriate curriculum and materials
- 3 a safe and child-friendly space
- 4 appropriate caregiver–child ratios
- 5 a connection to parents/home environment

(Whitebread et al., 2015).

In other words, there is consensus that early learning services must be provided in a safe and child-friendly space – but there is no consensus on what this implies for building or land requirements. The subsidy regulations need to allow for services which can demonstrate they are delivering quality early learning that builds social, emotional, cognitive and executive function capacities in a variety of physical settings that are safe, available and accessible in the areas where the poorest children live.

Non-centre-based services

Over the last few years a number of child-focused South African NGOs – including Ilifa Labantwana, SmartStart Early Learning and Kago Ya Bana – have launched a vigorous evidence-based advocacy effort to demonstrate how early learning services outside of centres can be delivered and quality-assured, and how to change the regulations to enable subsidy for these services.

A key element of this strategy is demonstrating outcomes for children who participate in ‘non-centre-based’ services, using the Early Learning Outcomes Measure (ELOM), an easy-to-administer preschool child assessment tool that is rigorously standardised and culturally fair in the South African context (ELOM, 2020, online).

‘SmartStart is one example of an early learning platform that uses a social franchise mechanism to scale services that are affordable and accessible for the poorest children.’

SmartStart is one example of an early learning platform that uses a social franchise mechanism to scale services that are affordable and accessible for the poorest children. It demonstrates how the quality of those services can be effectively assured, even though few franchisees meet the regulatory requirements (SmartStart, 2020, online).

In establishing a new early learning service, every SmartStart practitioner undergoes competency-based training and accreditation, is provided with start-up support, works with a coach and a peer-support network, and operates as a micro-enterprise. Each practitioner is provided with a standardised, structured daily programme and participates in monitoring and ongoing quality assurance systems. Practitioners also engage parents and caregivers to participate actively in their children's education.

Like many other programmes supporting non-centre-based services, SmartStart has taken a developmental approach to physical infrastructure, enabling its franchisees to deliver their services in any venue SmartStart certifies as child-safe. An initial outcomes evaluation, using the ELOM tool, found that across SmartStart franchisees children improved their performance in all domains¹ above the expected age progress (Horler et al., 2019).

1 The ELOM domains are: Gross motor development; Fine motor coordination and visual motor integration; Emergent numeracy and mathematics; Cognition and executive functioning; and Emergent literacy and language.



Photo: C.L. Thoma

The way forward

While SmartStart and other programmes supporting early learning services outside of early childhood development centres are increasing access for the poorest children and demonstrating initial evidence of quality, most of the practitioners offering these services remain unable to access government financial support as they are unable to meet the current physical infrastructure registration requirements.

The Department of Basic Education should shift the focus on quality away from physical infrastructure requirements, and instead prioritise inputs that lead to improved child outcomes. Quality assurance systems that are developmental and supportive need to be adopted to include every child. Funding mechanisms and processes need to be established for non-centre-based services. NGOs working in early childhood need to be supported to continue to build delivery platforms that can implement quality-assured early learning programmes at scale for the poorest children.

Hard-won increases in government funding for early learning need to be directed to services that can both expand access and improve child outcomes for the poorest children. Any other approach will take too long and will cost too much. The poorest children are the ones who will pay the price.

→ Find this article online at earlychildhoodmatters.online/2020-17

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- ▷ *New research shows that maternal depression affects critical caregiving behaviours.*
- ▷ *Researchers studied behaviours linked to child health and development outcomes.*
- ▷ *Evidence-based, low-cost interventions can effectively treat maternal depression.*





How maternal depression and behaviours impact child health and development

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Maternal depression in the early stages of a child's life can have long-lasting effects on the child's cognitive and physical health. Preliminary findings of a recent study of 1200 Ugandan mothers experiencing depression provide new insight into the impact of depression on the uptake of commonly promoted health and nutrition behaviours. Use of a low-cost, community-based treatment can treat maternal depression. This evidence can help health and early childhood development practitioners around the world to support mothers' mental health and children's early development through household-level behaviour change.

'Maternal mental health is often ignored in the global conversation among health, nutrition, and early childhood development practitioners – despite the strength of the evidence that caregiver depression impacts children's growth, development, and well-being.'

One in five mothers experiences depression after birth in low- and middle-income countries, where there is often increased vulnerability to depression due to factors such as war, gender-based violence, and extreme poverty (World Health Organization (WHO), online). More generally, one in ten individuals worldwide needs mental health support at any given time (WHO, 2018a). Low-income countries do not have nearly enough specialists to meet these needs: there may be as few as two mental health workers per 100,000 people, compared with 200 times more providers in high-income countries (WHO, 2018b). Community-based, low-cost interventions are crucial.

Caregiver mental disorders are treatable through interventions delivered by well-trained, non-specialist providers. However, maternal mental health is often ignored in the global conversation among health, nutrition, and early childhood development practitioners – despite the strength of the evidence that caregiver depression impacts children's growth, development, and well-being. One meta-analysis, for example, found that eliminating maternal depression could reduce stunting globally by about 27% (Surkan *et al.*, 2011).

The international relief and development organisation Food for the Hungry ran a three-year randomised controlled trial between 2016 and 2019 in northern Uganda to see if the Interpersonal Therapy for Groups (IPT-G) approach – a community-based, attachment-focused approach to psychotherapy – could reduce depression in mothers and increase their ability to adopt life-saving health, nutrition, and responsive caregiving actions for their children. Endorsed by the World Health Organization, IPT-G has been implemented globally since the 1960s and validated as a low-cost approach to treat depression in low-resource settings. The study was conducted in conjunction with Columbia University, Johns Hopkins University and World Vision International, and with financial support from the Eleanor Crook Foundation.

Half of the 1200 mothers in the trial were randomly assigned to receive three months of weekly IPT-G treatment, followed by 15 months of peer-to-peer health education through Care Groups. Care Groups are an evidence-based behaviour change model using community-based health volunteers. These volunteers, often mothers, educate their peers in topics such as toddler nutrition needs, and engage them in improving behaviours such as proper breastfeeding, the use of boiled water, and having their children vaccinated. These mothers in turn train more mothers, resulting in a cascade effect of peer-based training, learning and encouragement. The other half of the 1200 mothers in the trial, the control group, participated in the Care Groups but did not receive the IPT-G intervention.

The study found a strong connection between depression and the ability to fully engage in behaviours that impact child health and nutrition outcomes. For 10 out of 12 of the indicators studied, non-depressed women were significantly (between around three and 20 times) more likely than depressed women to adopt important health, nutrition, sanitation and hygiene behaviours.

IPT-G treatment reduced depression quickly: six weeks after IPT-G treatment, a lower rate of depression was recorded among women in the treatment group than in the control group, and significantly better functionality and perceived social support. By the end of the trial, however, depression among participants in both groups had declined to similarly low levels. This may be due to the Care Group intervention itself having a therapeutic effect: understanding the potential impact of Care Groups on depressed mothers will be important for further research.

These early findings show that caregiver depression can be addressed quickly and at low cost. IPT-G and Care Group interventions can be initiated by national governments or non-governmental organisations, and then sustained by the community. Currently, few government ministries or international NGOs integrate mental health into their health programmes. This study emphasises that addressing caregiver mental health is a critical component in improving children's achievement of health, nutrition and development milestones.

Food for the Hungry is launching a Caregiver Mental Health Knowledge Sharing Series in the USA, in sub-Saharan Africa and online with the support of the Eleanor Crook Foundation and the Implementer-led Design, Evidence, Analysis and Learning (IDEAL) Small Grants Program of the United States Agency for International Development.¹ It aims to promote the exchange of knowledge, evidence and resources; identify opportunities for increased attention to and funding for integration of mental health interventions into global policy and programming; drive future research and advance implementation of best practices to fill gaps; and form mutually beneficial collaborations and partnerships.

1 To learn more, visit www.caregivermentalhealth.org or contact caregivermentalhealth@fh.org

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The ‘Village’ project: towards early learning communities

- ▶ *The Village provides access to quality early childhood services in disadvantaged areas.*
- ▶ *Caregivers are directly involved with children in development-focused activities.*
- ▶ *Results show that families include more reading, play and music in their home routines.*

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‘Educational poverty’ is a lack of opportunities to learn, experiment, develop and freely nourish capacities, talents and aspirations (Save the Children Italia, 2014). It is a growing concern in all countries (UNESCO, 2010). Educational poverty coincides substantially but not completely with economic poverty; it is among the key determinants of the early onset of social inequity, and an important contributor to social conflict and loss of human capital (Marmot, 2005). For young children, educational poverty reduces the ability to grow and thrive within a nurturing environment – it implies lack of access to early care, learning opportunities, and safe and responsive relationships, services and communities (World Health Organization et al., 2018).

‘Un Villaggio per crescere’ (A Village to grow together) is a country-wide project designed to address this challenge by improving the accessibility and quality of early child development and education services in economically, socially and culturally disadvantaged communities. The project builds on the ecological theory of child development (Bronfenbrenner, 1979) in providing its services with a focus on the home learning environment around children as much as on the ‘village’ around families. This approach embraces the vision of an early learning community in which multiple actors and systems connect to provide nurturing opportunities to families and their young children (Rodrigues et al., 2019).

The activities offered at the Village project’s centres are meant to be easily replicable within the home environment. They were selected based on solid evidence of their impact on responsive parenting and early learning: the evidence base covers the whole sequence from the general type of intervention to its specific content, as summarised opposite. Adopting a universal, area-based approach, Village spaces are open to all families living in the communities served by the project. Together with engagement of local actors to disseminate information and contribute to activities, this facilitates the creation of new networks among families and services, nurturing shared community values, social inclusion and sustainability.

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The evidence base – a selection from the literature*

GENERAL TYPE OF INTERVENTION: *Caregiving and early learning interventions*

- *Improving Early Child development: WHO guidelines* (World Health Organization, 2020)

SPECIFIC DELIVERY FEATURES: *Professional-led parent groups with children*

- Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old, *Cochrane Database of Systematic Reviews* (Barlow et al., 2010)
- The effectiveness of parenting programs: a review of Campbell reviews, *Research on Social Work Practice* (Barlow and Coren, 2017)
- Effects of early parenting interventions on parents and infants: a meta-analytic review, *Journal of Child and Family Studies* (Mihelic et al., 2017)
- *Parental Beliefs, Investments, and Child Development: Evidence from a large-scale experiment*, IZA Discussion paper No. 12506 (Carneiro et al., 2019)

GENERAL CONTENT OF THE INTERVENTION: *Development-focused activities*

- Inequality in early childhood: risk and protective factors for early child development 1–2, *The Lancet* (Walker et al. 2011)
- Advancing Early Childhood Development: from Science to Scale 1–3, *The Lancet* (Black et al., 2017)
- *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential.* (World Health Organization et al., 2018)

SPECIFIC CONTENT OF THE INTERVENTION

Shared reading

- The impact of dialogic book-sharing training on infant language and attention: a randomized controlled trial in a deprived South African community, *Journal of Child Psychology and Psychiatry* (Vally et al., 2015)
- Randomized controlled trial of a book-sharing intervention in a deprived South African community: effects on carer–infant interactions, and their relation to infant cognitive and socioemotional outcome, *Journal of Child Psychology and Psychiatry* (Murray et al., 2016)
- Shared picture book reading interventions for child language development: a systematic review and meta-analysis, *Child Development* (Dowdall et al., 2019)
- *Parent–child Reading to Improve Language Development and School Readiness: A systematic review and meta-analysis*, Final Report. (Law et al., 2019)

Musical experience

- Music therapy with children and adolescents in mainstream schools: a systematic review, *British Journal of Music Therapy* (Carr and Wigram, 2009)
- Music training increases phonological awareness and reading skills in developmental dyslexia: a randomized control trial. *PLoS One* (Flaugnacco et al., 2015)

Interactive play

- The benefits of play for children’s health: a systematic review. *Arquivos de Ciências da Saúde* (Gomes et al., 2018)

* Full citations for these resources appear in the References at the end of this article.

The Village model

The project started in 2018 in low-income communities in ten Italian cities, serving populations ranging from 10,000 to 40,000. Over three years, the project plans to reach up to 4000 families. A central secretariat provides funding, guidelines, training, and monitoring tools, and supports local Village teams, including with communication materials. At local level infrastructure is offered by public or private entities providing health, educational and community services. Each 'Village' operates for an average of 10–12 hours per week. Activities are facilitated by three or four professional educators who have been trained on the project's rationale and content, including effective communication with caregivers. Educators from all centres meet twice a year to receive further training and exchange experiences.

Attendance for caregivers is free, with no requirement other than to bring their children (newborn to 6 years old) and remain engaged in the activities (see Figure 1), which are planned in agreement with families and tailored to different age groups and developmental needs.

FIGURE 1

Content of activities at the Village project



The project reaches out to families – and seeks to retain their interest and participation – through strategies including flexible home visiting, use of social media, and involving the wider community network. Among the services involved are family health centres, immunisation clinics, child rehabilitation clinics, preschool services, community social services, parish and local associations, and commercial entities such as bars and shops.

To strengthen the coherence of messages and facilitate pathways to care, the project collaborates with local service providers across sectors through co-planning, continuous exchange on both organisational issues and individual cases, and multi-professional training. This engagement of local stakeholders

– including for-profit and non-profit entities – also aims to increase local ownership and build the foundations for sustainability. For example, a local confectioner donated cakes and another shop fruit for a summer party organised by the Village for the whole community, and volunteers are available for logistical support.

By getting involved in the Village, caregivers – and particularly mothers – get to know each other and soon establish new friendships, which extend into their life beyond the Village. Mothers and other family members get together to have a coffee or share activities such as shopping. They are guided by educators to discover the public library, which they can then attend independently, or a public beach. The Village is designed to target disadvantaged communities, so its centres serve mainly at-risk families – but they also encourage social mix, as diversity of experiences promotes social cohesion and helps to avoid the risk of participants becoming ghettoised.

At the time of writing, the Covid-19 pandemic has necessitated changes to how the Villages conduct activities with families. They are working online, using both individual and group-based contacts, to provide support, advice, and readings. The Villages have also worked to make electronic tablets available to families who need them, as well as children’s books and pencils.

‘The project reaches out to families – and seeks to retain their interest and participation – through strategies including flexible home visiting, use of social media, and involving the wider community network.’

Village model: key features

- Universal, area-based approach
- Open access and proactive strategies for outreach and retention
- Joint participation of parents and children from birth to age 6
- Easily accessible spaces with timetables adapted to parents’ needs and seasonality
- Evidence-based activities for child development and responsive caregiving
- Facilitation of activities by professional educators
- Inter-sectoral collaboration (health, education, social services, libraries) through co-planning, co-location and multi-professional training
- Involvement of all community actors (public services, commercial, non-profit, religious, etc.) for ownership, shared values and sustainability
- Mixed-method impact evaluation

Impact evaluation and preliminary results

The impact evaluation is based on the project’s logical framework and theory of change. It adopts a mixed-methods approach to assess outcomes, including measures of parental knowledge of child development, awareness of parental role, parental stress, parental self-efficacy and changes in the home learning environment. It also looks at retention as an indicator to assess

impact on caregivers and children, and considers the extent and functioning of community networks and collaboration among services and families to evaluate the wider impact.

Preliminary data across the ten centres, after an average of 12 months of activities, show that the project involved more than 1600 children and 1400 caregivers, in line with the target objectives of 5000 and 4000 respectively by the end of the third year. Several new agreements have been established among public services, civil society organisations and for-profit entities.

Preliminary analysis of a sample of families showed that 100% of parents feel more aware of children's developmental needs and empowered in their parental role, and almost all have introduced or strengthened activities such as reading, play and music in their family routines and feel more supported by services and other families. Observations made by project educators confirm that engaging parents in development-focused activities with their children, rather than just offering parenting classes, is an effective way to promote responsive parenting skills (Carneiro et al., 2019) and that benefits are likely to be greater for families with a low educational level (Engle et al., 2007).



In conclusion, the Village project responds to a variety of needs: for children, the need to enjoy activities with their parents; for parents, the need to discover ways to spend quality time with their children, to make friends with other parents and help each other; and for the whole community, the need to feel that something new and promising is happening – starting from improved social cohesion and smoother functioning of inter-sectoral collaboration. The dramatic implications of educational poverty on life trajectories can be effectively tackled if the ‘whole village’ is involved.

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OneSky: blended learning for home-based childcare providers in Vietnam

- ▶ Around 1.2 million migrant factory workers' children live in Vietnam's industrial zones.
- ▶ OneSky piloted a blended learning approach for training home-based care providers.
- ▶ Vietnam's government has invited OneSky to scale-up this training to 19 provinces.

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A growing body of research shows that blended learning produces better overall educational outcomes than online or classroom learning alone (Means et al., 2009, 2013). OneSky's innovative blended learning approach leverages the power of digital technology to improve the effectiveness of in-person training, create an online learning community, and provide continuing professional development for home-based care providers serving the children of factory workers in the industrial zones of Vietnam.

Over the last decade, millions of Vietnamese have migrated from rural to urban areas as climate change decreases agricultural productivity (General Statistics Office (GSO) and United Nations Population Fund, 2015). Many of these migrant workers, 80% of whom are women, find employment in factories in industrial zones (Unicef, 2017). Unfortunately, Vietnam has no public childcare system for children under the age of 3 years. For children aged 3 to 6 living in industrial zones, public preschools are often out of reach due to lack of residency status, as are private preschools due to cost.

A home-based care (HBC) industry has emerged in response to high demand for and limited supply of childcare in industrial zones. The vast majority of HBC providers are women who receive no formal training. There is little, if any, government oversight of their HBC centres. Under the regulations, as many as 49 young children in one group may be looked after by untrained caregivers for over 12 hours a day in these home settings (Ministry of Education and Training (MOET) et al., 2016). An estimated 1.2 million children of low-wage factory workers live in these industrial zones, and they are not receiving the stimulation and learning opportunities they need in their formative early years (GSO and Unicef, 2015).

Innovation through blended learning

In 2018, OneSky launched HBC provider training in the Hoa Khanh Industrial Zone in Da Nang, a growing city in central Vietnam. The HBC providers undergo an 11-month programme focused on responsive caregiving and fostering a safe, nurturing learning environment that supports the developmental needs of young children from birth to the age of 6.

The OneSky curriculum is inspired by the Reggio Emilia principles of child-centred learning, informed by the global evidence base on early childhood development, and adapted to serve the specific needs of children and caregivers in Vietnam. It centres on establishing responsive relationships between caregivers and children, promoting age-appropriate communication, and stimulating healthy cognitive, physical, language and social-emotional development.

The HBC training programme consists of 20 in-person classroom sessions delivered every two weeks, individual in-person and virtual group home visits by trainers to coach HBC providers twice a month, and an online learning platform suited to mobile access called *1GiaDinhLon* (1GDL) – meaning ‘1BigFamily’ in Vietnamese. HBC providers are invited to participate by their provincial Department of Education and Training and receive a certificate, signed by the Department and OneSky, on completing the training.

The training is delivered through an innovative blended learning approach, which combines online education with the in-person elements: the classroom sessions with peers and home-based individual support from trainers. The online platform increases participants’ engagement during and after training, and supports their motivation for lifelong learning.

Teacher and child at OneSky Early Learning Centre



Building 1BigFamily of caregivers online

HBC providers are introduced to 1GDL, the online learning portal, after the second classroom session. As trainers are able to do home visits only twice a month, 1GDL allows them to expand their teaching reach and give each HBC provider the ongoing support and individualised guidance that she needs.

1GDL is integrated with the classroom curriculum so the topics HBC providers learn in person can continue to be reinforced through discussions, follow-up practice instruction, related resources, photos, videos, and specialist support. Through a peer exchange forum, 1GDL connects HBC providers to learn from each other's experiences. This online community of practice is the first of its kind for HBC providers in Vietnam.

'A home-based care (HBC) industry has emerged in response to high demand for and limited supply of childcare in industrial zones. The vast majority of HBC providers are women who receive no formal training.'

1GDL has multiple skill-building features and resources to support continuing education long after the classroom sessions have been completed. Resources in the online library include various play activities, research articles, and guides for homemade toys. Longer distance-learning e-courses will also be accessible soon for specialised skills development.

Use of the 1GDL portal has increased over time: at the time of writing it has 492 HBC users, 214 content posts by trainers, over 9200 photos and videos uploaded by HBC users, and over 12,200 total comments. It has become even more relevant during the Covid-19 pandemic: while their childcare centres have been closed, HBC providers have logged into 1GDL to stay connected to each other and continue their learning.

With the 1GDL online platform, OneSky is transforming the way HBC providers are trained and supported in Vietnam. The OneSky blended learning approach is:

- enhancing the impact of in-person training on student engagement, knowledge retention, and skills proficiency through digital learning and teaching aids
- providing on-demand content accessible on mobile phones, including interactive, visual resources that enable caregivers of all educational levels to understand and apply concepts immediately
- cultivating collaboration through peer support, online community, and the exchange of best practices and resources
- driving greater scale by reducing the cost of training and continuing education that requires personnel, travel, and meeting expenses
- improving monitoring and evaluation by empowering trainers, equipped with tablets and online engagement data, to better assess skills gaps and improve programme quality.

Scaling up for systems change

OneSky is measuring progress through HBC provider surveys at the midpoint and endpoint of training. By digitising data collection using the KoBoToolbox app – which functions offline – and analysing the data through impact

dashboards on Tableau, our data analytics and visualisation software, frontline trainers equipped with tablets are able to contribute to rapid feedback loops for programme improvement. Concurrently, Professor Aisha Yousafzai at the Harvard T.H. Chan School of Public Health is conducting a pioneering impact evaluation on the HBC training, along with Vietnam's Research and Training Center for Community Development. It will be the first study on home-based childcare in industrial zones in Asia and the largest outside the Global North.

Since 2018, we at OneSky have trained 320 HBC providers in the industrial zones of Da Nang to improve the quality of care for 10,424 children. We recently expanded our training to a neighbouring province, Quang Nam, where we are now training 147 HBC providers to reach an additional 3675 children of factory workers.

The innovation's success so far has led Vietnam's Ministry of Education and Training to formally invite OneSky to scale-up the HBC provider training to 19 provinces. Our systems change strategy now involves creating regional training clusters for northern, central, and southern Vietnam, driving stronger government partnerships to advance quality childcare across the industrial zones. We aim over time to tie comprehensive training to licensing – upskilling the HBC provider workforce to ensure that an entire generation of factory workers' children gains the early developmental foundation they need to thrive in primary school and beyond.

➔ Find this article online at [earlychildhoodmatters.online/2020-20](https://www.earlychildhoodmatters.online/2020-20)

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Strategic foresight and the post-Covid future of early childhood

- ▶ The pandemic is deeply affecting families – but also creating policy space for new ideas.
- ▶ Strategic foresight involves investigating future possibilities to help chart a forward path.
- ▶ A late-2019 report explores how the early childhood sector could look in ten years' time.

Joe Waters

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Capita, Greenville SC, USA

How might the impacts of the Covid-19 pandemic continue to affect children and families in the years to come? Possible implications include caregivers struggling to provide responsive care to their young children because of stress over losing their livelihoods; further deterioration of trust in the governmental institutions on which families depend for social services; and reduced travel leading to a rise in inequalities between places.

Yet the period of flux created by the pandemic has also opened policy space to accelerate trends and bring forward new solutions. For the last two years, my organisation, Capita, has partnered with KnowledgeWorks to use 'strategic foresight' to explore global transformations in society and their impact on the well-being of young children and their families.

In October 2019, we published *Foundations for Flourishing Futures: A look ahead for young children and families* (KnowledgeWorks Foundation and Capita, 2019), which offers insight on issues ten years into the future that may impact children everywhere. The forecast also now provides decision makers with ideas for future directions to follow once the pandemic subsides.

The aim of strategic foresight is to investigate possibilities for the future, and support stakeholders to use those possibilities to chart a forward path. It involves examining assumptions, exploring current trends and trajectories and creatively considering alternatives, pushing the boundaries of what is currently plausible.

This was the first time the team at KnowledgeWorks had applied the strategic foresight methodology to early childhood. Building on their previous ten-year forecasts on education, they found they needed to scan a broader range of literature and interview experts from more varied fields, including paediatrics, sociology, demography, early childhood education, public policy, and the philosophy and ethics of technology.

Artefacts from the future

The report identifies five broad trends that must be engaged with to help young children and their families to flourish over the coming decade:

- 1 Health by the Numbers:** Emerging technologies and new understandings of community-level health are reshaping how young children's and families' well-being are measured and supported.
- 2 Learning in Flux:** Social and economic uncertainty and new research into the importance of relationships are influencing approaches to early learning.
- 3 The Autonomy Gaps:** New notions about young children's autonomy, along with increasing inequity, are creating cultural and generational tensions and are widening disparities among children's access to free expression.
- 4 Stretched Social Fabric:** Shifting support structures and information sources are changing the ways in which increasingly diverse families navigate and access resources.
- 5 Care at the Core:** New economic and employment realities and the ageing of the population are creating tensions related to caregiving structures and values.

Within these domains, the report imagines multiple 'artefacts from the future'. The purpose of imagining these future possibilities is to ask ourselves if we want to expedite the process of making them a reality – and what challenges would have to be tackled. Three selected 'artefacts' from the report illustrate the idea.

First, imagine a job advertisement for a 'Paediatric Urban Designer'. The role involves helping municipal decision makers to translate the science of young children's development and well-being into practical proposals in areas such as public transport and remodelling public spaces.

Second, consider a universal home visiting programme, funded by the state but delivered by a range of certified entities – governmental, non-profit, private, or medical – with varying areas of expertise. All parents are entitled to choose which provider they sign up to receive home visits from, and each provider has to find creative solutions to build trust with parents.

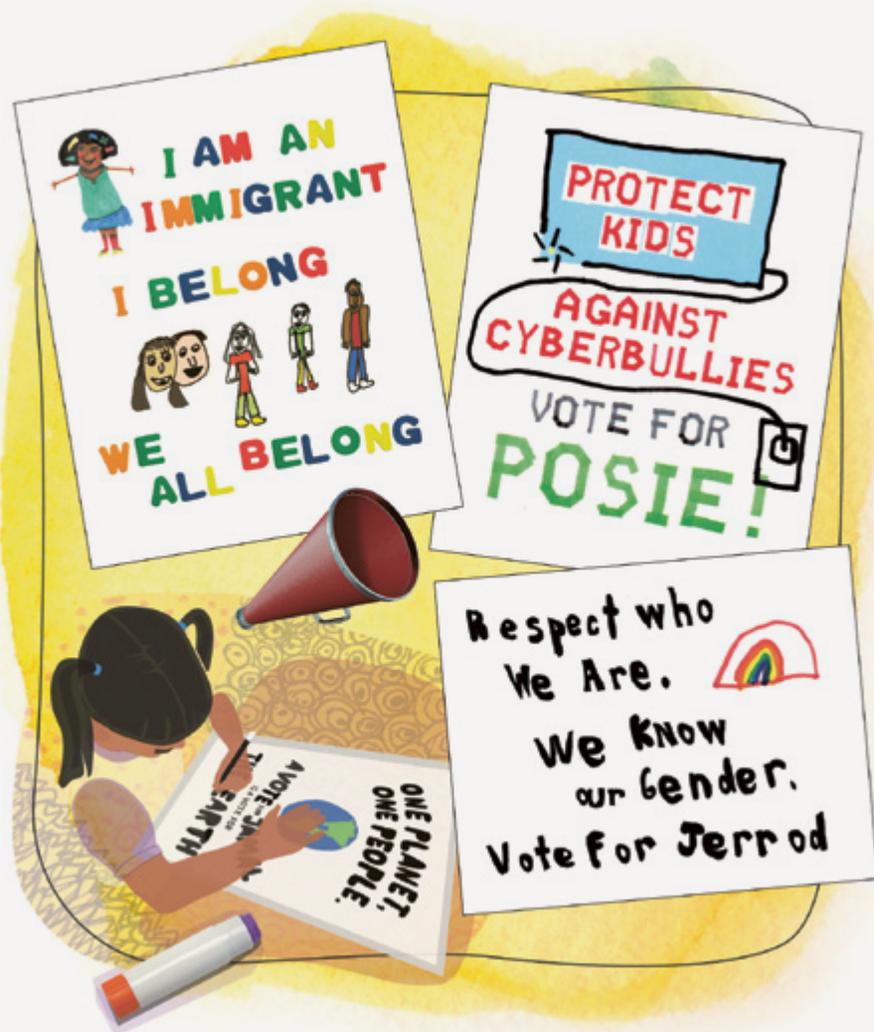
Third, envisage 'care co-ops', through which groups of neighbours come together to organise affordable and flexible caregiving services. Member families compare their schedules, caregiving needs and ability to pay, and figure out solutions that work for them all – even if that means not every family pays the same or puts in the same amount of time. People who have the ability to work from home coordinate their schedules to take turns caring for their own and others' children during the working day, while members with irregular working hours can work out flexible arrangements to leave their children at neighbours' homes.

'The pandemic has also made clear how profoundly the global economy depends on the availability of care for young children – in schools, homes, creches and childcare centres.'

Post-Covid opportunities

Returning to normal after the pandemic would be a defeat. For all its difficulties, the situation also opens the door to many new opportunities. It has, for example, taught us that our lives – individual, communal and global – depend on the health of people, communities and nations on the other side of the world. Educating our children for solidarity will be an urgent task in the years ahead – part of what we at Capita have termed a ‘relational revolution’ (Capita, 2019, online).

Artefacts from the future: children’s councils were formed to promote civic engagement and awareness and to ensure that children’s needs and voices were considered in public decisions



Many people's new experiences of schooling at home have heightened their appreciation of educators and childcare providers. Alongside the heroic actions of healthcare providers, this creates the opportunity to move all forms of caregiving towards the core of future economies as a high-status career choice.

The pandemic has also made clear how profoundly the global economy depends on the availability of care for young children – in schools, homes, creches and childcare centres. Growing interest in the concept of 'stakeholder capitalism' (Samans and Nelson, 2020) creates an opening to nudge corporate decision making towards giving greater prominence to the needs and concerns of employees, shareholders, or customers with young children.

Finland may provide an example to other nations of creating a post-Covid road map through the use of strategic foresight. The National Foresight 2020 Project is helping the country to map out its next decade. As a team of futurists at the think tank Demos Helsinki wrote recently (Minkkinen *et al.*, 2020):

It can be said that the crisis has momentarily opened up the future: at the moment, the future does not seem like a self-evident continuation of the past, but instead many things are now open to us as uncertain and possible.

➔ Find this article online at earlychildhoodmatters.online/2020-21

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- ▷ Many children who miss out on vaccinations live in poor households in urban slums.
- ▷ In Haiti and DRC, weekend services and marketplace-based outreaches increased uptake.
- ▷ Lessons can be learned by other, non-health services for young children or caregivers.



Early morning in Kinshasa: a health worker transports the day's vaccines from the health zone's central bureau to the health facility. Most facilities here do not have their own cold storage so health workers have to make this trip frequently



Adapting service delivery to reach marginalised women and children in urban areas

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Reaching young children with vaccines is critical for their survival. Covid-19 has disrupted vaccination programmes around the world in 2020. Even before the pandemic, though, globally we failed to fully vaccinate about 19.4 million children in 2018. Some 13.5 million did not receive even initial vaccines, and missed opportunities for other health services (World Health Organization, 2019).

Most of those not reached are from poor households, with mothers who have little or no education. They often live in very remote locations, conflict zones and urban slums. By 2030, about 60% of the world's population will live in urban areas, with over one billion people living in slum environments.

While aggregated administrative data generally show better health outcomes (including vaccination rates) in urban areas as compared to rural areas, they hide a significant wealth divide within the urban setting: the health outcomes of the urban poor are often worse than those of their rural counterparts (Nandy *et al.*, 2018). The lack of disaggregated data affects the ability to introduce new services to reach underserved vulnerable groups and close health equity gaps.

Two specific cases – from the Democratic Republic of Congo and Haiti – are described below and provide practical examples of neighbourhood-level understanding, design and implementation of flexible services for marginalised children. These experiences showcase common lessons: the need to understand the users of the services and their daily activities, identifying preferred hours and the barriers they face in accessing and using services. This information forms the basis for remaking plans, adapting existing services, or designing new services to better serve the local community's needs.

A retrospective study of over 6 million clients who received vaccinations at a national community centre in the USA found that 30.5% of vaccinations were provided during off-clinic hours: 17.4% at weekends, 10.2% during evenings, and 2.9% on holidays. The clients who had their vaccinations during these times were mostly urban dwellers (Goat *et al.*, 2013). Similarly, weekend services at public health facilities in Zambia yielded positive results for improving integrated counselling, testing, and family planning programmes (Malama *et al.*, 2020).

'Using neighbourhood-level data, and engaging and co-designing with the service users, communities, service providers and health managers are essential elements for success in increasing immunisation rates and the use of basic health services.'

DRC: vaccinations in marketplaces

Routine immunisation services in the Limete and Kimbanseke health zones of Kinshasa, DRC, are offered through health facilities that are very limited in number relative to the dense population. An initial baseline situational analysis suggested that conducting vaccination sessions in public spaces – such as marketplaces – may be more convenient and frequently accessed by caregivers, increasing uptake among the urban poor (John Snow Inc., 2020).

Vaccination sessions were planned by Zonal EPI and district health representatives and conducted by vaccinators from nearby health facilities. A total of 2139 children and 75 pregnant women were reached with all routine vaccinations over the course of 42 sessions at seven sites across the two health zones from August to October 2019. Social mobilisation by district chiefs, market administrators and representatives of the community, coupled with the use of local radio broadcasting, was an integral part of generating demand for and awareness of these services.

In Kimbanseke, from August to October 2019, doses administered in marketplaces accounted for 34.2% of all vaccinations delivered in the commune, and 8% of all doses in the zone as a whole. Offering vaccinations and vaccination cards free of charge was a major factor contributing to caregivers' participation, as this cost still presents a major obstacle at static facilities. This is now a key strategy in the country's immunisation road map, the Mashako Plan.

Haiti: weekend vaccinations

Vaccination coverage in Cité Soleil commune, on the outskirts of Haiti's capital city Port au Prince, had remained below 30% for several years. Detailed situation analysis and examination of the underlying reasons for the low coverage identified factors including lack of vaccines at health facilities, long waiting times, poor experience with service providers, fear of side-effects, and insecurity (JSI Research & Training Institute, 2017).

These interrelated service delivery and individual factors provided the basis for redesigning the services. Weekend vaccination services were planned together with the caregivers, communities, service providers and district managers, in line with co-designing practices, to increase service uptake in inner cities (Davie and Kiran, 2020). Most of the caregivers in Cité Soleil work in markets, factories, or as artisans in the capital city throughout the week. The weekend vaccinations provided a flexible time for caregivers to obtain vaccination services and information. The system was also adapted to ensure that children who had not completed their vaccinations had access to services that aligned with their caregivers' schedules.

Monitoring data from Haiti's national coordinators of the vaccination programme (UCNPV) on the initial seven months' implementation of weekend vaccinations showed that the average number of Penta 3 vaccinations increased to 749 per month compared to 417 in the preceding seven months. Vaccination at weekends increased by 41% the total number of children completing their vaccinations. It also contributed to 71% of new vaccinations (infants receiving their first dose of pentavalent vaccinations, Penta 1) administered in Cité Soleil.

Towards scaling up

Adapting services to reach marginalised populations of children living in urban areas will be critical to reduce health inequities and prevent outbreaks of vaccine-preventable disease. Using neighbourhood-level data, and engaging and co-designing with the service users, communities, service providers and health managers are essential elements for success in increasing immunisation rates and the use of basic health services. Key to achieving this is having simple tools for data collection, training local personnel to collect the data, and involving them in simple data analysis and interpretation. This then informs problem solving with the community stakeholders and local civic authorities through established review sessions and action tracking.

'Adapting services to reach marginalised populations of children living in urban areas will be critical to reduce health inequities and prevent outbreaks of vaccine-preventable disease.'

Future learning from this programme will be needed to understand the long-term impact of flexible immunisation services, in order to inform the scaling-up of these approaches, particularly to catch up on missed vaccinations caused by disruptions in children’s health services as a result of the Covid-19 pandemic. To ensure equity in accessing immunisation and other essential services in urban areas, it will be critical to secure increased investments in using local data, capacity building including de-stigmatisation skills, community engagement, adequate planning and realistic budgeting for vaccines and supplies.

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Rotterdam research will inform decisions on future pandemic lockdowns

- ▷ *Generation R researchers are studying how Covid-19 and lockdown have affected families.*
- ▷ *Policymakers had no clear evidence to guide decisions to close schools and childcare facilities.*
- ▷ *Learning how these measures affected children is critical to inform future policymaking.*

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Covid-19 is a novel disease with some unusual features, and it has forced policymakers to make quick decisions without good data. In particular, they could only guess at the benefits and costs of the decision to close schools and childcare centres. They had no good understanding of the extent to which children play a role in transmitting the coronavirus, and the extent to which children’s well-being would be damaged by these closures and the impacts on caregivers of wider economic shutdowns.

We urgently need better understanding on both issues with a view to potential future waves of Covid-19. We also need better understanding on the second issue to inform cost–benefit analyses in the event of future pandemics, when societies will again face the question of whether to lock down.

Generation R Next is a longitudinal research programme with young children in Rotterdam. We have been recruiting mothers-to-be since 2017, and currently have around 4000 enrolled, with almost 2000 babies born so far. Recruitment is ongoing, with an ultimate target of 5000 children. This programme is a follow-up to Generation R, which began to recruit in 2002 and now has a cohort of children aged between 14 and 17. By studying factors that affect children’s development, Generation R and R Next aim to inform strategies in public policy. We are now using these programmes to study how the coronavirus and the ensuing government measures affect both children and their families.

It has been clear since very early in the pandemic that children and young people are at very low risk of being seriously affected by Covid-19. This was unexpected, as viral illnesses typically affect disproportionately both the very young and the very old. However, it was not clear to what extent children were less likely than adults to be infected or less affected by infection, and what factors protect them. It was similarly unclear to what extent infected but asymptomatic children could pass on the virus to other children or to adults.

At the time of writing, there are some suggestive small-scale studies on these questions, but the evidence is not strong enough to make conclusive policy recommendations. A clearer understanding will be crucial to inform decisions about the risks and costs of allowing schools and childcare facilities to remain open in the event of future waves of Covid-19.

Studying within-household transmission

The Generation R Study will contribute to understanding the role of children in transmitting the Sars-Cov-2 virus, which causes Covid-19. We will start with antibody tests on the participating families and children. At the time of writing, it is estimated from other studies that around 6% of the Netherlands population has antibodies – although it is not yet known whether infection with the virus always results in antibodies, or if the absence of antibodies always implies susceptibility. Antibody studies often do not look at children, due to the logistical challenge of collecting blood.

‘The Generation R Study will contribute to understanding the role of children in transmitting the Sars-Cov-2 virus, which causes Covid-19.’

Antigen testing – that is, a test for whether someone has the virus now, rather than whether they have had the virus in the past – will be more critical for studying how the virus is transmitted within households. We will send around 250 families a weekly short questionnaire to ask about any symptoms. Once a family member reports symptoms, we will check in daily to ask about their symptoms and those of other family members. Each month we will take swabs to check for the presence of virus, and perform blood tests to check for antibodies.

The possibility that people can be infectious without ever developing symptoms complicates the task of tracing how the virus passes from one household member to another, but the combination of regular testing and symptom trackers should allow us to gain useful information. Ironically, we are reliant on there being a second wave of infections to be able to learn from this study, as the level of new infections at the time of writing is low enough to make it unlikely that a significant proportion of the families will be infected soon.

We will also be able to add to the evidence base on what factors make it more or less likely that a case of Covid-19 will be severe. Factors we will study include genetics; underlying diseases such as obesity, asthma and mental health problems; socio-demographic variables such as ethnicity and income level; lifestyle factors such as diet and smoking in the household; and environmental variables such as air pollution and access to green spaces.

The impact of lockdown measures

Like many countries, in response to the Covid-19 pandemic the Netherlands implemented a range of measures that had the effect of shutting down large parts of the economy and society. These included the closure of schools, childcare facilities, youth clubs and sports clubs, and the shuttering of many industries, leading to loss of income and uncertainty about future job prospects. As older people were among the vulnerable populations advised to self-isolate, parents could no longer ask grandparents to provide support with childcare.

The lockdown in the Netherlands was nonetheless less severe than in some other European countries: parks and playgrounds remained open, for example, and there were no limits on outdoor exercise.

With both cohorts – the teenagers of Generation R, and the babies and toddlers of Generation R Next – we will look at the impacts on their physical and mental health, and at lifestyle and socioeconomic impacts. As well as quantifying these effects, we will look for factors that could explain any differences in effects between individuals. These could include length of school absence, caregiver mental health, the ease with which caregivers were able to balance working from home and parenting, and differences between socio-demographic subgroups – for example, children living in houses with gardens versus small apartments with no outside space.

The decisions to close schools and childcare facilities were not evidence-based, because this was an entirely new situation and there was simply no evidence on which to base them. It is clearly vital that we now gather evidence to inform future policymakers who will need to decide whether the various costs of lockdown justify the benefits of slowing the spread of a virus. Whether in the event of further waves of Covid-19 or an unknown future pandemic, societies will inevitably face such decisions again sooner or later.

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Planning play for 1.1 million babies: Istanbul95

- ▶ Architecture firm Superpool designed playgrounds for young children in Istanbul.
- ▶ Four district municipalities agreed to pilot new ideas in playground design.
- ▶ Istanbul's new mayor is interested in scaling-up successes across the city.

Selva Gürdoğan

Partner

Superpool, Istanbul,
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Istanbul is a city with 15.5 million inhabitants where 47.5% of households include children, of whom 1.1 million are under 5 years old. The Bernard van Leer Foundation's Istanbul95 programme launched in 2017 with the ambition to increase public spending for the benefit of young children and their caregivers.

Istanbul consists of 39 districts, each with its elected mayor and municipal body, and a larger metropolitan municipal institution. The pilot phase of Istanbul95 created partnerships with four district municipalities – Sariyer, Maltepe, Sultanbeyli and Beyoğlu – to test new services and improved public spaces, with an ambition from the outset to carry the learnings to the metropolitan level within two years. This timeframe coincided nicely with 2019 local elections.

Superpool joined Istanbul95 to help the partner municipalities build a playground for young children in each district. This modest goal was the first step in introducing a young children's agenda to new departments in the district municipalities. While some departments, such as social services, were aware of services they could provide for young children and caregivers, others – such as public works, or parks and gardens – did not necessarily see a role for themselves in making better cities for babies and toddlers. Istanbul95 created two resources to help them start imagining: maps and a catalogue of ideas.

Istanbul is not without playgrounds; in recent decades many have been installed across the city, and each of the four districts have 50–100 playgrounds within their boundaries. Maps developed by Kadir Has University and the Turkish Economic and Social Studies Foundation (TESEV) positioned all of these playgrounds onto background maps that showed the number of children in each neighbourhood, to help evaluate whether the services provided were meeting the actual needs.

The maps differentiated the age groups of children, based on census data, into birth–4 years, 5–9 and 10–19. Did the neighbourhoods with the largest population of young children have playgrounds that met their needs? Not necessarily.

In general, playground equipment is designed for children aged 5 years and older who have already developed gross motor skills. However, the need for play and play spaces starts much earlier. Research shows that every new skill a baby acquires, from lifting its head to sitting, to crawling, is perfected through play, establishing the foundations for more complex skills to develop.

Playgrounds for children from birth to age 3

The first task Superpool took on was creating a book of ideas for play spaces for children and their caregivers. The publication explored how play opportunities could be created in public playgrounds for each skill that children developed during the amazing first five years of their lives.

Play in early childhood does not require expensive equipment to be installed in public spaces. It requires a more subtle configuration of space and elements such as sand, water, shade and simple equipment for activities such as balancing, climbing and jumping. And giving design attention to caregivers' comfort and well-being is as important as the play itself.

The most important challenge we encountered in implementing the pilot playgrounds was the procurement process of partner municipalities. We learned that their parks and gardens departments have a fairly systematised approach to the design and maintenance of playgrounds. Tenders are handed out at

A playground designed for children from birth to age 3 and their caregivers



Photo: Courtesy of Engin Gerçek/Studio Majo

regular intervals in large contracts. These contracts are then subcontracted to companies that are responsible for each component of a conventional playground, including plants, flooring and equipment. These subcontractors coordinate efficiently, installing equipment from catalogues with a wide range of price options.

Working outside of existing product catalogues, and wanting to achieve anything other than a flat floor created problems. Even with the district mayors' direct orders to get these playgrounds built, we met resistance from technical staff at different levels.

Safety is the most important argument in resisting any 'non-conventional' play space design. For example, is it safe to include a fallen tree trunk as a play element? When left to individual preferences, safety can become a very difficult subject to tackle. It was of utmost importance that we established EN 1176 Standards for Playground Equipment and Surfacing as the baseline document to refer to when in conflict. This European standard – adapted to the local context as TS 1176 – is known in Turkey, but not rigorously followed. Agreeing to follow its guidance made it possible to experiment.

More than a playground

Through building pilot playgrounds, we built trust and a collective vision. The process embarked on together with our partners was supported by study trips to Denmark and the Netherlands, and many workshops with different stakeholders. Academic partners such as Boğaziçi University and Kadir Has University were mobilised to train staff both in early childhood development and in urban design.

As we built trust, we were also able to bring forward new agendas such as pop-up play activities for young children in existing playgrounds that do not have provision for babies and toddlers, or testing the accessibility of playgrounds with 'stroller audits'. Each new experience helped the larger team of partners to become more confident that there is a lot we can do to make a better city for babies, toddlers and caregivers.

In the 2019 local elections, children's needs in the city featured in the campaigns of both of the main candidates for Mayor of Istanbul. Today Istanbul has a mayor who has gone on record many times saying he wants to work for the city's children, especially its youngest. And all the partners in Istanbul⁹⁵, who have tested many different aspects of what it takes to make a city serve its youngest, have established protocols to transfer their know-how. The stage is set for amazing things to happen.

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'Play in early childhood does not require expensive equipment to be installed in public spaces. It requires a more subtle configuration of space and elements such as sand, water, shade and simple equipment for activities such as balancing, climbing and jumping.'

How Covid-19 accelerated change: innovations in working with parents in Israel

- ▷ At Tipat Halav centres, nurses promote positive parenting.
- ▷ The Israeli Nurse Leadership Program fostered innovation in response to Covid-19.
- ▷ Local-level experiments with online services will inform national scaling plans.

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The Covid-19 pandemic seemed to have caught the Israeli Nurse Leadership Program at the worst possible time. We were just finishing the first phase of a multi-year collaboration with the Ministry of Health to strengthen the capacity of the 'Tipat Halav' service (early childhood health centres) to meet parents' needs and promote positive parenting behaviour. The programme aimed to establish a group of champions who could pioneer innovation and change in the service.

The second phase of the programme was due to be an 'innovation lab', in which we would work with the group of nurses using Design Thinking methods to develop innovative ways for Tipat Halav to promote positive parenting behaviours. As the pandemic forced the cancellation of face-to-face meetings, we were confronted with a dilemma. On the one hand, we felt that maintaining momentum and continuity was crucial. On the other hand, we felt that the innovation lab meetings needed to be done in person. It was difficult for us to imagine them working as well online.

We were also conscious that the participants, as public health nurses, would be in the eye of the Covid-19 storm and would find it difficult to get into the right frame of mind to focus on the programme. Tipat Halav centres remained open throughout the lockdown, while most community-based services were closed. Nurses were instructed to shorten face-to-face appointments to the minimum of neonatal screening and immunisations, and to use other forms of communication and outreach as needed.

We decided instead to start a series of webinars for the nurses on topics related to the unique challenges of their work during the pandemic. How to engage effectively with parents when the visits are short and parents are stressed out and isolated? How to manage stress and uncertainty? How to practise self-care? How to address managerial challenges? In these meetings we combined knowledge and skills with space for reflective practice and peer support. Participation was voluntary – either during work hours or in the evening – and both participation rates and engagement were high.

Zoom meetings for parents

Having experienced these online meetings, one of the nurses thought it could make sense to use a similar platform for the mothers' groups she would usually run in the centre. She held a series of online meetings for young mothers, which received warm and positive feedback. Isolated from their families and community support systems, the participants were particularly in need of connection, guidance and support.

Within a few weeks, other nurses from the district joined the initiative, as well as nurses and managers from other areas. The expansion of the online parent groups was part of a wider movement of online webinars, meetings and therapy. The meetings usually had some structure and covered a wide range of topics such as parent-child bonding, breastfeeding, promoting children's development through play, introducing solid foods, and even first-aid training.

As the nurses talked in our webinars about their experiences of conducting parent groups via Zoom, we sensed an opportunity to promote something potentially important for the service beyond the pandemic. We discussed the idea of scaling the local initiative, and got the blessing of the foundations that support the programme and our partners in the Ministry of Health. We invited any nurse from the programme to join the initiative, and over 20 did so. We offered them short training in how to lead an online group, and ongoing technical support, content development and supervision.



There have been some bumps in the road, and plans have changed several times, but we have been working with the nurses on content development and they are now conducting online parent groups routinely. If the results of this pilot continue to prove successful, it will strengthen the case for government investment in telehealth as a complementary service in Tipat Halav.

Lessons in managing change

Plans to digitise some services in Tipat Halav have been on the Ministry's agenda for a long time, in response to requests from parents, but it had always proved difficult to overcome the political, bureaucratic and technological obstacles. Some of the centres do not have broadband internet, for example, so most of the nurses working via Zoom during the pandemic did so from their homes. The programme funded tablets for the nurses in the pilot as a short-term technological solution, while the Ministry of Health works in parallel to connect the centres and develop a longer-term solution based on an online platform used by other health organisations in Israel.

By forcing experimentation at the grassroots level, the Covid-19 crisis is unexpectedly accelerating change that had been planned for the long term. In doing so, it is teaching us how to manage change and innovation.

We saw differences between districts and areas in terms of available resources, flexibility and innovative spirit. We learned that it is easier and more effective to work locally with the most innovative and capable districts rather than to start by working nationally. The grassroots were ahead of the headquarters – but in order for local innovations to be successful on a wider scale, leadership needs to work centrally. People on the ground can pave the way for those higher in the hierarchy to join.

Looking more broadly, the first-phase success of the Israeli Nurse Leadership Program was also a significant factor in creating the conditions for change. Within a relatively short period, we had established a highly motivated, strong group. By learning together they had developed a common language, history and agenda. They were enthusiastic, dedicated and keen to keep connected even through the difficulties of isolation and lockdown restrictions. Just as importantly, the programme had also succeeded in earning the trust of the public health services and nursing administration, so they were happy for us to work independently. This is a good demonstration of how investing in building relationships can also build resilience for times of crisis.

Finally, we have learned not to underestimate what can be achieved. At the beginning of the Covid-19 period, we found it impossible to imagine the programme working in an online format – but not only is it working well, it sparked further innovation in developing new solutions to promote positive parenting behaviours.

'As the nurses talked in our webinars about their experiences of conducting parent groups via Zoom, we sensed an opportunity to promote something potentially important for the service beyond the pandemic.'

➔ Find this article online at earlychildhoodmatters.online/2020-25

The articles in this section highlight initiatives, resources and approaches that have inspired us over the last year, which we believe deserve a wider audience.





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Building early childhood systems

- ▷ New research findings identify strategies for countries building early childhood systems.
- ▷ Researchers examined six countries where early childhood education and care is advanced.
- ▷ Lessons include the need to respect contextual variations when addressing systemic elements.

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Many countries are rapidly expanding programmes for young children and families, but often these programmes are not high quality, equitably distributed, efficient or sustained. The USA's National Center for Education and the Economy supported scholars to carry out a comparative analysis of six countries with advanced early childhood education and care (ECEC) systems – Australia, England, Finland, Hong Kong, Singapore, and South Korea – to identify practices, strategies and mechanisms that can help leaders plan and implement contextually appropriate systems for their countries.¹

The findings, published in a series of *Early Advantage* studies, identified four key lessons.

1 Different contexts, different systems

In all the studied countries, ECEC systems reflect and affect two types of context:

- socio-cultural (values, beliefs, heritages, religions), and
- econo-political (demographics, social thinking/movements, government leadership, funding).

The socio-cultural context helps shape the design and pedagogical orientation of services. For example, when commitments to valuing, trusting, and providing for children are embedded in country ideologies – and sometimes reflected in their constitutions – services tend to be more universally available, and are accompanied by less governmental accountability. The econo-political context influences the availability of funding for ECEC systems and the trajectory and nature of their implementation. For example, in times of social crises when women are needed in the workforce, funding for childcare may increase dramatically.

The studied countries differed markedly based on their context. Finland, for instance, offers most services via large public-sector provision, so ECEC is almost fully subsidised by governmental funds; in contrast, the three Asian countries, which function under a market-driven fiscal strategy, rely more on private provision.

¹ Principal investigators of the project include Rebecca Bull (Singapore), Sharon Lynn Kagan (USA), Kristiina Kumpulainen (Finland), Mugyeong Moon (Republic of Korea), Nirmala Rao (Hong Kong), Kathy Sylva (England), and Collette Taylor (Australia). The six countries were chosen based on the OECD Programme for International Student Assessment (PISA) performance rankings for mathematics and the Economist Intelligence Unit's *Starting Well* report (2012).

2 Many services, many strategies

Services for young children and their families are plentifully provided in the studied countries; these include home visiting programmes, paid family leave policies, subsidies for healthcare, parenting support, childcare, pre-kindergarten, teacher training, aid for at-risk families, and transition efforts.

Service provision in the countries shares three main characteristics. First, it starts early: most countries provide pre- and perinatal care to mothers and families. Second, provision continues throughout children's development, with age-appropriate programmes and transition efforts supporting infants, toddlers, preschoolers, and children in their earliest years of school. Third, the services are overseen by multiple ministries and typically diversely funded using both demand-side and supply-side strategies.

There are also notable differences in service provision. Some countries give more priority to children's earliest years, others to the years immediately preceding entry into formal school. The method and pace of organising, delivering and evaluating programmes and policies also vary.

Paid family leave is one of the services provided in the studied countries



3 Clear, common building blocks

Context matters: no country can adopt another country's system wholesale. Nonetheless, high-quality systems share common structural and functional elements. *The Early Advantage* (Kagan, 2018; Kagan and Landsberg, 2019) identified 15 systemic 'building blocks' and organised them into five pillars:

- strong policy foundations that recognise the unique context and needs of stakeholders and the public
- comprehensive services, sufficient funding, and coordinated governance mechanisms
- knowledgeable and supported teachers and families who can foster community through engagement and effective leadership
- informed, individualised and continuous pedagogy that promotes child-centred learning experiences
- effective data collection and utilisation to improve policies and programmes.

4 Plan for synergy

Most importantly, successful countries are strategic in their efforts to create structural and functional alignment among their ECEC services. They understand that work on one pillar or building block affects others, so they plan for synergies that strengthen the system as a whole.

For example, each of the studied countries has a national curriculum framework – a mandated policy or adopted guidance document outlining how and what children should learn. These frameworks align curricula across programmes, and often drive policies and practices associated with different building blocks or pillars (such as shaping professional development standards, establishing criteria for programme monitoring, and providing fiscal incentives). By planning for synergy among the pillars and essential building blocks, countries achieve greater philosophical and practical ECEC integration. Moreover, they achieve systemic outcomes – service quality, equity, sustainability, and efficiency – far more effectively and efficiently than by focusing on a single building block or pillar individually.

In conclusion, by sharing these four lessons and addressing the essential pillars and building blocks, countries can gain helpful and strategic insights into creating the kinds of effective ECEC systems their societies need and their children deserve.

➔ Find this article online at earlychildhoodmatters.online/2020-26

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Stigmatised and unsupported: the double tragedy of children with incarcerated parents

- ▷ Children of incarcerated parents globally often experience violations of their rights.
- ▷ New research in Kenya adds to understanding of the challenges for mothers and children.
- ▷ Many children of imprisoned mothers are stigmatised and do not receive enough support.

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When a parent is incarcerated, the sentence is served not just by a single individual but by an entire family. Across the world, parental incarceration has been linked to long-term effects on children’s emotional and social development. My recent qualitative research in Western Kenya contributes to understanding these issues.

In Kenya, when a pregnant woman or the mother of a young child is sentenced to prison, she usually may choose to have her child stay with her up to age 4. Prison is not a good environment for babies and toddlers: food supplies are often inadequate, leading to child malnourishment; conditions are overcrowded; sanitation is poor, with lack of clean water and healthcare; and there are shortages of clothing, bedding, and materials for learning and play. Prisoners are also frequently mistreated, causing psychological trauma that affects their children.

Despite all this, the majority of the imprisoned mothers I talked to in two correctional facilities in Western Kenya preferred to keep their child with them. They feel more comfortable being able to spend time and bond with their child, even in these difficult conditions, than placing their child with an alternative caregiver.

If the mother is still in prison when the child’s fourth birthday approaches, however, she must propose an alternative care arrangement – typically asking a family member to agree to take her child in. Social workers must approve the proposed arrangement. If they are not satisfied, or if the mother has no family member willing to care for her child, the child is usually placed in a facility run by a non-governmental organisation.

My research looked at what happens to children who are placed in alternative care with a family member (Opiyo, 2019). I interviewed 12 children aged between 9 and 13, many with younger siblings. Most were being cared for by grandparents – although many also had to assume adult responsibilities, providing emotional and caregiving support for their younger siblings and financial support for the household.

The children and grandparents told stories of things lost: connections, income, jobs, homes, and hope. Some girls found themselves pulled into early marriage or sex work, while boys joined criminal gangs. Children of incarcerated parents are frequently stigmatised, enduring shame, guilt, bullying, and social exclusion. Parents of other children may stereotype them as being dangerous, like their offending parent, and forbid their own children from associating with them. This manifests in low self-esteem, behavioural problems and poor school grades.

Support is available in principle, coordinated by the Ministry of Gender, Children, Youth and Social Services. However, there are significant gaps in data on the numbers of children affected, and the support provided to them. My research shows that children of incarcerated parents are, in practice, often forgotten by schools, community support agencies and policymakers.



Kenya is taking an increasingly tough line on criminal justice, incarcerating more parents and consequently pushing more households into financial difficulties. My study recommends a national effort to map the population of prisoners' children and examine how their rights are affected. This work is needed to inform the development of multi-sectoral policies – engaging schools to connect children with assistance in areas such as finance and housing, and creating the community resources needed to protect these children's welfare.

→ Find this article online at earlychildhoodmatters.online/2020-27

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The Beginning of Life 2 – Outside: new documentary promotes children’s engagement with nature

- ▷ Urban children’s development is being held back by lack of contact with nature.
- ▷ A new sequel to the film *The Beginning of Life* shows why children need nature.
- ▷ An outreach campaign accompanying the film will target a variety of audiences.

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Until two or three decades ago, childhoods were spent mostly outdoors, in the street, in parks or on the empty patches of land that existed on the outskirts of neighbourhoods and cities. In a gradual exercise of exploration – which began in the backyard of houses and expanded into public spaces in the open – girls and boys lived experiences that sharpened their senses, fed their imagination and challenged their physical limits.

Research increasingly shows that contact with nature is essential for children’s healthy development in other ways. It offers countless possibilities to learn about the world and each other. However, as urbanisation gathered pace, childhood changed. The natural world is increasingly less present in the lives of babies and urban toddlers. The consequences are significant: for example, studies have linked lack of access to urban parks with higher rates of childhood obesity (Wolch *et al.*, 2011).

We need to create incentives for the emergence of a culture that values children’s contact with nature. We at Alana Institute believe in the power of entertainment to create awareness that can change the way people think about the world. Our experience has shown us that documentaries are effective in catalysing changes in culture: powerful and inspiring stories can be tools of empathy and transformation.

In 2016, we joined with the Bernard van Leer Foundation, Maria Cecília Souto Vidigal Foundation, and Unicef to develop the film *The Beginning of Life*¹. As of June 2020, more than 8.7 million people around the world have seen its dramatic depiction of the importance of relationships in the first years of a child’s life.

We are now launching a sequel, *The Beginning of Life 2 – Outside*². The new film explores how children experience the natural world, and follows initiatives in several countries that promote reconnection with nature. These include the *Boa Praça* Movement in Brazil, which mobilises citizens and other stakeholders to occupy city squares and reclaim them for their original purpose of inclusive leisure³; and *Asociación para la Niñez y su Ambiente* (ANIA), a non-profit association in Peru that creates tiny areas – just half a square metre – for children to nurture and observe biodiversity⁴.

1 Directed by the production company Maria Farinha Filmes and distributed by Flow, the film can be viewed via the website: <https://mff.com.br/en/films/the-beginning-of-life-the-series/>

2 Again in partnership with Maria Farinha Filmes and Flow, and with additional sponsors including Boticario Group Foundation, UN Environment, Maria Cecília Souto Vidigal Foundation, and the Children and Nature Network.

3 Details of *Movimento Boa Praça* are available at: <https://www.facebook.com/movimentoboapraca>

4 Information about *Asociación para la Niñez y su Ambiente* (ANIA) can be found at: <https://www.aniaorg.pe/tini>

The film will be accompanied by a behaviour change campaign for families, youth, doctors, educators, environmentalists, urban planners, activists, and public managers. We are currently building a series of interventions to support a clear call to action for each of these audiences: for example, this could include asking families to download an infographic of outdoor things to do and tick them off after doing them; or asking paediatricians to display a poster in their waiting room with the message that contact with nature helps to improve children's health.

Our strategy includes tailored short clips and other content; media engagement; a distribution strategy that combines movie theatres, festivals, video-on-demand, television channels and Videocamp, a platform that enables the organisation of free public screenings; promoting debates among policymakers; and engaging influencers and celebrities. We will draw on our outreach experience with *The Beginning of Life*, which included Unicef using the film as the centrepiece of one of their global campaigns, and partnering with São Paulo's court system to use the film to raise awareness about children's legal rights.

➔ [Find this article online at earlychildhoodmatters.online/2020-28](https://www.earlychildhoodmatters.online/2020-28)

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Still image from *The Beginning of Life 2 – Outside* movie that explores how children experience the natural world



- ▷ *Aligning the early childhood and climate change agendas could strengthen both.*
- ▷ *Research into the health co-benefits of climate mitigation provides a precedent.*
- ▷ *Policies on air pollution, urban greening and transport are among possible links.*





Climate change and early childhood development: finding the synergies

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Children born today are likely to live until 2100, when – based on the current trajectory of greenhouse gas emissions – temperatures will have risen by up to 4 °C (Collins *et al.*, 2013), rising sea levels will have flooded coastal areas, and extreme weather will have dramatically affected agricultural production and water scarcity. Any agenda for early childhood development should work to limit the impacts that climate change will have on children throughout their lives. But can the climate agenda also strengthen the case for improving early childhood development?

We believe this is possible, but there is a need to clarify the pathways, connections and causal links between climate policies and drivers of nurturing care and child development – mapping out, documenting and developing research where necessary.

For example, evidence is mounting on the role of urban planning and the physical environment in promoting child development, from availability of parks and play spaces to how children and caregivers travel to facilities such as preschools and health centres (Brown *et al.*, 2019). This is relevant to policies being considered on climate change adaptation and mitigation, relating to issues such as land use planning; clean energy and sustainable transport; greening of cities; and energy efficiency and ventilation of buildings.

Air pollution, which affects children’s cognitive and physical development, is an especially notable link with climate change. It has many of the same sources as greenhouse gases, but it can be more easily measured by citizens and used for local accountability. Potential connections also exist between climate change and early child development through extreme weather events, droughts, floods, forest fires, heat, changes in vector-borne and infectious diseases, and changes in access to food and water.

‘In other words, richer countries are simultaneously protecting young children today and failing to protect their long-term future.’

Further work to link climate change and early childhood would follow up on two landmark analyses. The first is the Office of the United Nations High Commissioner for Human Rights report on the right to a clean and healthy environment for children (OHCHR, 2018), which presents the case for engaging with a broad range of sector policy decisions from a child rights perspective. The second is the report from the *Lancet* Commission on the future of the world’s children (Clark *et al.*, 2020); this shows a disconnect between actions for climate change mitigation and levels of nurturing care, with richer countries doing well on a composite ‘Thrive Index’, but poorly on CO₂ emissions commitments. In other words, richer countries are simultaneously protecting young children today and failing to protect their long-term future.

Moving this agenda forward will require unpacking these analyses and pathways, to engage a wide range of stakeholders around specific policy options. To take just one example, a linked agenda on climate change and early childhood development could add weight to policy objectives such as stopping fossil fuel subsidies.

Health and climate change

There is a precedent for efforts to link climate change to another agenda, strengthening them both: the integration of health into the climate debate, specifically the issue of non-communicable diseases.

The evolution of this discourse and evidence base can be observed through reports from the Intergovernmental Panel on Climate Change (IPCC). The first

report, in 1991, did not mention health. The second referred to direct impacts of climate change on health from heat and extreme weather events. The third added indirect health impacts through disease vectors – mosquitoes, water quality, air quality and food quality and quantity. The fourth, in 2007, added health vulnerability and adaptation.

However, there was resistance in climate circles to connecting health with climate change mitigation. In particular, non-communicable diseases – such as heart disease, strokes and cancers – were mostly seen as unconnected with climate change, and preventable only through changes in diet, smoking or physical activity. But a concerted effort to synthesise evidence about how climate mitigation policies in sectors such as transport, energy, agriculture and waste management could prevent non-communicable diseases made it possible to establish a link with climate action.

Consequently, the fifth report, in 2014, included health benefits from mitigation actions (Smith *et al.*, 2014). This new frame was supported by a series of World Health Organization (WHO) scoping reviews of evidence, mapping the health benefits and risks of various policies aimed at mitigating climate change (WHO, 2011, 2012). They aimed to identify the mitigation measures with most health benefits, as well as those that created the most health risks – for example, support for diesel engines, which emit lower amounts of greenhouse gases than petrol engines but still damage health.

A *Lancet* series helped consolidate the term ‘health co-benefits’ in relation to actions to mitigate and adapt to climate change (Costello *et al.*, 2009). The *Lancet* Countdown on climate and health, published yearly since 2017 (Watts *et al.*, 2017), includes indicators on the drivers of non-communicable diseases and climate change in a range of sectors, in addition to tracking infectious diseases and extreme weather caused by climate change.

The research agenda

Neither the *Lancet* Countdown nor the latest IPCC health report, however, makes reference to early childhood development. The same remains true of many other mainstream groups arguing for health and climate change actions. Three types of research are needed to bridge the current knowledge gap:

- 1 validated indicators for the development of children from birth to age 3 (Richter *et al.*, 2019) that can be used to research links with climate policies, intermediary risk factors and other interventions
- 2 a mapping effort to establish the evidence-based pathways between early childhood development and policies to tackle climate change; that would facilitate the development of narratives, and identification of action points and research gaps
- 3 mechanisms to enable continuing engagement of populations and stakeholders with this evidence – for example, to facilitate information gathering, the development of context-specific analyses and accountability

‘There is a precedent for efforts to link climate change to another agenda, strengthening them both: the integration of health into the climate debate, specifically the issue of non-communicable diseases.’

measures, and the use of results for framing policy and supporting action; urban observatories or laboratories would serve to catalyse and test this action-research agenda.

Establishing a collaborative network of groups committed to both early childhood development and climate change mitigation would help to support and communicate about the above efforts. It would be especially timely at a moment where the world is debating post-Covid economic recovery (Attali, 2020); the argument for economic models that promote early childhood development would be strengthened by better evidence on the links between early childhood and sustainable climate policies.

→ Find this article online at earlychildhoodmatters.online/2020-29

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Streets as assets in the Covid-19 pandemic response and recovery

- ▷ Covid-19 has changed cities, prompting urban residents to see their streets in a new light.
- ▷ Cities around the world have found quick, low-cost strategies to respond to pressing issues.
- ▷ Streets for Pandemic Response & Recovery is a new resource sharing ideas for action.

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Cities around the globe have experienced unprecedented times in 2020 as Covid-19 drastically changed every aspect of urban life. The closure of schools, daycare centres and playgrounds challenged the work of NACTO's Global Designing Cities Initiative, through the Streets for Kids programme, to improve how cities meet the needs of babies, young children, and their caregivers.¹ However, it is also prompting a widespread reimagining of where and how play, learning and social connection occur for the youngest members of society.

While there are many unknowns about the long-term impacts of the pandemic on streets and public spaces, we know they will remain the lifeblood of our communities and the conduits to accessing cities. Our streets can and should be reimagined and redesigned. The need to allow for physical distancing has forced us to rethink how we move within cities. It has emphasised the importance of neighbourhood planning – ensuring that key destinations and critical services are provided within close proximity to people's homes, which is especially important for caregivers with babies and toddlers.

The pandemic has also highlighted systemic inequities, with the most vulnerable communities bearing the brunt of suffering. Cities cannot afford to return to the inequitable, dangerous and unsustainable patterns of the past. As city leaders, transportation officials, planners and designers, our mission must be to help shape a better future for the next generations. The need for change is urgent. But change can be hard and scary, and take a long time.

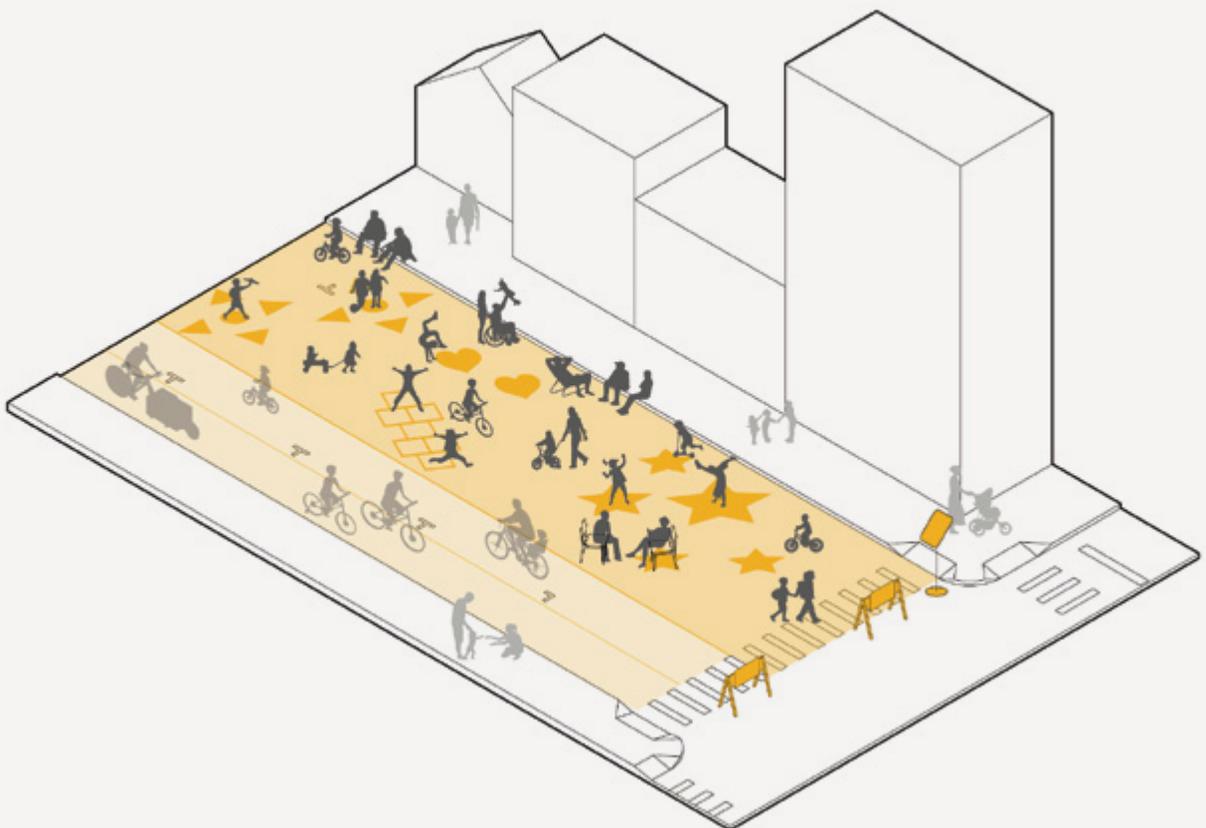
That's why our team at NACTO and the Global Designing Cities Initiative created *Streets for Pandemic Response & Recovery*, to collect emerging practices and actions that cities have taken in response to the pandemic (NACTO, 2020). Drawing experiences from Milan to Bogotá, Amsterdam to Auckland, this new resource offers cities quick, easy, low-cost strategies to respond to the most pressing issues of the Covid-19 pandemic and, when ready, to help the city begin to recover in a more resilient way. It will enable cities to learn from their peers and plan what might work best for them based on their local context, regulations and resources.

1 To find out more about the Streets for Kids programme, visit: <https://globaldesigningcities.org/publication/designing-streets-for-kids/> or see the article in *Early Childhood Matters* 2019: <https://earlychildhoodmatters.online/2019/designing-streets-for-kids-possibilities-for-children-in-the-built-environment/>

Many of the actions will improve cities for babies, young children and caregivers in particular. For example, tools such as paint, cones and barriers – alongside political will and local action – can help cities quickly create widened pavements and new bike-and-roll lanes that allow safer walking and cycling in a physically distanced way. The resource explains how 'Slow Streets', 'Open Streets' and 'School Streets' can offer new opportunities for daily exercise, recreation, learning, play, and physically distanced social connection.

As economies slowly reopen, restaurants and local businesses can temporarily expand into the roadway to operate within physical distancing requirements. In vulnerable communities, the street can provide a place for delivering critical services to families, such as food, water, sanitation, and medical testing or treatment. Dedicated transit lanes and improved stops and service frequency can support essential workers to use public transport safely, with speed reduction strategies ensuring vehicles are moving at safe speeds to minimise danger to caregivers crossing the road with young children.

Open/Play Streets with barriers at entry points provide safe space for physical activity, play and distant socialising



Now, more than ever, urban streets need to serve more people and support more functions within the same limited space. Our hope is that cities can see their streets in a new light. They can help fight the simultaneous crises of climate change, road safety and systemic inequities. They can promote physical and mental health, well-being and caring for each other. They can support our local economies and communities to recover sustainably. And they can invite social connections, learning, love and joy – especially for young children, but for others too. It’s time for our streets to facilitate a new normal that we can be proud to pass on to the generations to come.

➔ Find this article online at earlychildhoodmatters.online/2020-30

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Help or hindrance? The impact of gig work on caregiving

- ▶ A new study looks at the implications of gig work for caregivers in South Africa.
- ▶ Unpredictable schedules, early starts and long commutes create childcare challenges.
- ▶ Strong public action is needed to promote investment in accessible, high-quality childcare.

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'I had to wake up early at 4 a.m. ... I drop my child next door in her sleep and go to the train station. I have to take the early trains because trains delay and I end up being late for my booking. This is why I ended up leaving my child next door because no crèche opens at 4 a.m.'

Interviewer: 'What happens if your neighbour is not available on that day?'

'Ahhh unotorega kuenda kubasa kwacho [you end up not taking any booking at all]. This is why it's difficult to have my child live with me.'

(Akumzi, Cape Town)

Akumzi works through an Uber-style digital platform in South Africa, which connects workers to households seeking to purchase domestic cleaning services. Proponents of 'gig work' argue that such platforms provide jobs, and may offer better working conditions in comparison to alternative prospects in large informal economies. They argue that gig work offers flexibility, enabling women, in particular, to balance paid work and unpaid care¹. Our recent study of women's experiences of on-demand gig work in Kenya and South Africa probed this claim (Hunt *et al.*, 2019). It provided insights into the implications of gig work for caregiving.

We found that although many workers viewed gig work as more flexible than other paid work available to them, caring for young children proved challenging – not least given unpredictable schedules, early starts and long commutes². The women we surveyed through a domestic work platform in South Africa³ employed numerous strategies to meet this challenge. In a context characterised by constraints to accessing formal care and fragmented family structures, they relied heavily on informal care networks, notably relatives (Figure 1).

The most worrying strategy in widespread use was to leave young children at home without adult supervision. Overall, 24% of our respondents reported having left a child under 5 years old alone for more than an hour in a given week, while a further 9% had left their child in the care of another child under 10 years old⁴.

- 1 '[W]omen handle a disproportionate share of household work, child care, and care for elderly dependents, so flexible independent work helps them juggle these other responsibilities' (Manyika *et al.*, 2016: 43).
- 2 The need for early starts and long commutes may be especially acute for gig workers. Early starts were necessitated by clients' wanting to meet an (unknown) domestic worker prior to leaving for their own workplace, while commuting times were amplified where workers had to travel to undertake more than one gig on a given day.
- 3 N = 327. See Hunt *et al.* (2019) for details of our method – which included both a nine-round Automated Voice Response Survey with several hundred gig workers and in-depth interviews and focus group discussions with a small number of workers and other key informants.
- 4 There are no directly comparable data for the South African population. The only related information we identified is from the 2017 General Household Survey, which asks respondents where children under 6 are 'during the day for most of the time', if not in early education or formal childcare. Fewer than 0.5% of this group were reported to have been left with a person under 18 (computed from STATS SA, 2018).

Women who reported that they usually cared for their child themselves were most likely to leave a child without adult supervision, followed by those who engaged formal childcare or paid help. This points to shortcomings in formal care options as a high risk factor. Our interviews with workers reinforced this: they suggested that children were more likely to be left alone at times when these more formal options were not available, such as early mornings. Gig workers with unpredictable schedules also regularly chose not to use formal childcare services, such as a crèche, where fees were paid monthly.

There is also a high rate of children being left alone among those who might otherwise be cared for by a partner/spouse or another male child, suggesting that these options may not be consistent or reliable. The rate of left-alone children appears to be lowest for those reliant on: neighbours, friends or others; relatives; and other children (notably female children). These findings are limited by small sample sizes: the results are suggestive rather than indicative⁵. However, coupled with our qualitative fieldwork, they point to the importance of informal networks and family to support childcare – and the associated risks posed to children when these are not available.

5 A Kruskal-Wallis H test did not reveal statistically significant differences in whether a respondent was likely to leave a child alone in a given week, based on who usually cared for her child or children, $X^2(7) = 7.085$, $p = 0.4201$.

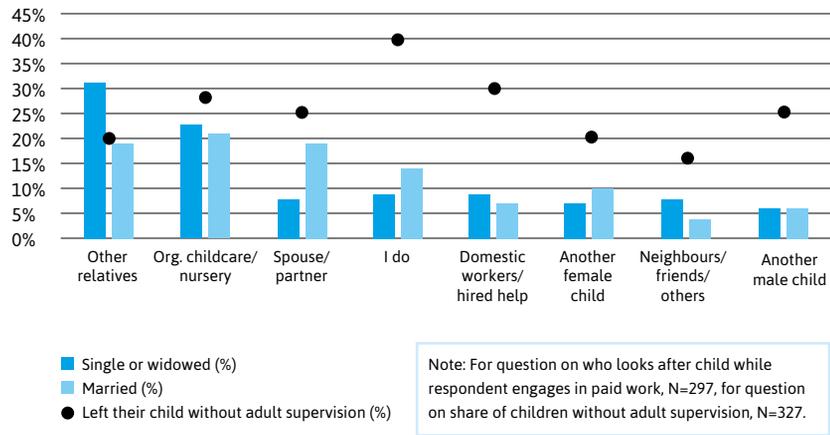
Digital platforms in South Africa connect workers to flexible domestic work options



FIGURE 1

Who looks after South African platform workers' children while they engage in paid work and share of children left without adult supervision in a given week

Source: Hunt et al., 2019: 60



These findings are clearly worrying and reinforce the need expressed by study participants for accessible high-quality childcare. They also sound a clarion call for a strong public action to promote public investment in care infrastructure and to insist that private companies, including those that argue that they are not employers, contribute their fair share.

→ Find this article online at earlychildhoodmatters.online/2020-31

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Towards a feminist childcare recovery

- ▷ The USA will need to reimagine its childcare sector after the Covid-19 pandemic.
- ▷ Hawaii is calling for free childcare to be part of a 'feminist economic recovery'.
- ▷ An explicitly feminist approach to childcare could help both mothers and children.

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The Covid-19 pandemic has been like an earthquake striking a rickety US childcare system. A sector that already didn't work for anyone involved – enormously expensive for parents, incredibly low wages for practitioners, highly questionable quality for children – has been brought to its knees (Mongeau, 2020). Based on survey data, interest groups such as the National Association for the Education of Young Children (NAEYC) estimate that the USA may permanently lose between one-third and one-half of its childcare supply.

As a result, many organisations have begun to talk about rebuilding a new, better system; as the CEO and the managing director of policy and professional advancement of NAEYC wrote:

If our economy is to recover, it will require a reimagined approach to financing and structuring the systems that support high-quality child care. (Allvin and Hogan, 2020)

One state, Hawaii, has taken an innovative angle to this question: the Hawaii State Commission on the Status of Women has published a plan that explicitly calls for a 'feminist' economic recovery, with an effective and equitable childcare system as a key component. The plan – *Building Bridges, Not Walking on Backs: A feminist economic recovery plan for COVID-19* – states:

The road to economic recovery should not be across women's backs. COVID-19, and the measures being implemented to contain it, are deeply affecting our social and economic relationships here in Hawai'i and beyond ... The cheap value of caregiving is not natural, but has political origins. Caregiving, associated with and expected of women, is necessary for economic production to take place and yet it is split off from economic production, thereby structurally subordinating women in society. ... Rather than rush to rebuild the status quo of inequality, we should encourage a deep structural transition to an economy that better values the work we know is essential to sustaining us. (Hawaii State Commission on the Status of Women, 2020)

The plan calls for childcare to be universal, free, and publicly provided, with pay parity between early childhood educators and public school educators. It also calls for complementary programmes such as paid family leave. Given that no US state has anything approaching a universal, free childcare system – and of the 2020 Democratic Presidential primary candidates, only Senator Bernie

Sanders called for such an approach – this is a welcome and bold goal. While the report doesn't go into detail, such as how such a system would be funded or how quality would be ensured, it moves the conversation towards a new way of thinking about what society owes women and children.

Taking a feminist approach to rebuilding a quality childcare system, while righting gender inequities, can support child development and school readiness in three ways:

- 1 Research clearly shows that parental stress levels are deeply correlated with child outcomes. As an article in the *New York Times* noted:
Parents in the United States have nearly doubled the time they were spending on education and household tasks before the coronavirus outbreak, to 59 hours per week from 30, with mothers spending 15 hours more on average than fathers, according to a report from Boston Consulting Group.
(Cohen and Hsu, 2020)
The increasing strain on mothers' shoulders from childcare responsibilities is not conducive to the goals of early education.



- 2 Lack of access to childcare keeps women out of the workforce – and many families on low-to-moderate incomes cannot afford to enrol their children in quality programmes. A 2019 report from the Center for American Progress found that:

Mothers who were unable to find a child care program were significantly less likely to be employed than those who found a child care program, whereas there was no impact on fathers' employment.

(Schochet, 2019)

- 3 More than 90% of childcare workers are female, and many are mothers to young children themselves (Becker, 2020). Given that an estimated one-third of childcare workers have already lost their jobs as a result of the pandemic, and the sector had more than 2 million practitioners, hundreds of thousands of families have been impacted. As these tend to be low-paying jobs, an approach to childcare that increases the salaries and status of childcare workers will benefit the same families.

It is nearly impossible to separate out childcare and women's issues, yet often the field does not take an explicitly feminist approach in strategy or language. Hawaii offers a promising example of how free, quality childcare can be a keystone policy in finally valuing care work and ensuring equity for mothers.

→ Find this article online at earlychildhoodmatters.online/2020-32

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