TECHNICAL NOTE

Early Childhood Development, Nutrition and Health in Emergencies

WHO IS THIS NOTE FOR?

Nutrition and health staff in UNICEF and partners.

WHAT IS THE PURPOSE OF THIS NOTE?

To support nutrition and health colleagues own early childhood development (ECD) sensitive approaches as integral to nutrition and health activities in emergencies. This technical note extends the basic content included in UNICEF's *Early Childhood Development in Emergencies: Integrated Programme Guide* to help UNICEF staff and partners implement in emergency settings.

INTRODUCTION

The period of early childhood (conception to 8 years) is a critical time for brain development and establishing strong foundations that can last a lifetime. The plasticity of a human brain (capacity to learn and adapt) is tremendous in comparison to the adult brain – 80% of the brain structure is built in the first 3 years of life at a rate of up to 1,000 new neural connections per second.[1] Early childhood is the most formative period of life, as children are the most effective 'learning machines' when they have a strong attachment with adults in a nurturing and loving environment. Those attachments are absolutely necessary to complement nutrition and health inputs.

The brain needs nutrition and health inputs along with care, responsiveness and stimulation in order to grow and develop to its full potential. Without it, there is an increase in the likelihood of stress becoming toxic. Toxic stress is the continuous elevation of the body's stress responses that negatively affects children's development, including permanent physical changes in the body.[2] Those responses are often triggered by violence and neglect, which are circumstances that are frequently present in emergency situations. Adults are also affected by emergencies and this impacts their own capacity to support their children.

A landmark study of Jamaican stunted, malnourished children found evidence to support the combination of socio-emotional stimulation[3] (also called early stimulation, psychosocial stimulation) and nutritional supplementation. The study found that children who had both stimulation and nutritional supplementation developed faster and better than those with just nutritional supplementation.[4] Other research from Bangladesh, Pakistan, Uganda and other countries has also found similar results to the Jamaica study.[5] These research studies illustrate that food and vaccines are not enough for children's positive recovery from malnutrition, stunting and continued development. Understanding the need of an early childhood development lens and in particular socio-emotional stimulation for young children along with increasing the capacities of parents/caregivers to care for them, has been found to yield better results by saving more lives and helping malnourished children recover faster.[6]

In emergencies, nutrition and health spaces, such as temporary health tents, outreach therapeutic programs (OTPs), attract a lot of vulnerable young children so there is a unique opportunity to make an impact on children's lives. Health and nutrition professionals have in many cases limited understanding of the importance of socio-emotional stimulation and potential negative lifelong consequences when children do not receive this support.

HOW NUTRITION AND HEALTH PRACTITIONERS PROGRAMME ECD SENSITIVE ACTIVITIES

Nutrition practitioners target mostly children 0-5 years, pregnant and lactating women and parents/caregivers. While for health practitioners these population groups are a priority, they also include older children and adults. Targeting requires understanding ECD to comprehend the relevance and prioritisation of these populations beyond nutritional and health short- and mid-term indicators.

The **PREPAREDNESS KEY ACTIVITIES** *(p.3)* should be done as part of preparedness. If these are not completed prior to an emergency starting, they can also be done during an emergency.

The **RESPONSE KEY ACTIVITIES** *(p.4)* should be started during the onset of an acute emergency. These activities normally continue during the recovery phase. They can also continue in chronic crisis situations.

PREPAREDNESS KEY ACTIVITIES

- ☑ **Mapping of key community structures/services:** (i.e. health facilities, health/nutrition workers, mother support groups, community playgroups, parents' or caregivers' groups, formal and informal ECD spaces, etc). This can be done at a state, provincial or level appropriate in a country. It can use existing government data, if this is available, or develop a matrix/information that governments and key health/nutrition stakeholders can use.

- ☐ **Use existing coordination system or establish a new one.** First verify if a coordination mechanism exists (a cluster or sector coordination or other mechanism). If a coordination mechanism does not exist, ideally a multi-sectoral group for ECD can be established with involvement and co-leadership of various government ministries (ie. health, nutrition, wash, social services, education, finance). If this is not possible a coordination mechanism with the ministry of health/nutrition can be formed whilst coordinating with ministries leading child protection and education. This can ensure services are provided consistently and equally, gaps are identified and filled and there is no overlap of services.

- ☐ **Work with ECD, gender, child protection or education actors to adapt and prepare developmentally appropriate play materials** that can be used by health and nutrition workers. This can be an adaptation of the UNICEF ECD kit so the content is appropriate for the cultural context.

- ☐ **Work with ECD, child protection, gender or education actors to adapt and prepare monitoring tools** (i.e. programmatic, child and parent level)

- ☐ **Work with ECD, child protection, gender or education actors to adapt a parenting manual that is culturally relevant.**

- ☐ **Stockpile or make arrangements with local vendors for the rapid availability of temporary safe structures and materials** (i.e. tents, UNICEF ECD kits, infant kits, safe delivery kits) that can be used during an emergency. Map readily available community resources. When donations are sought or received, they cannot be from companies that provide breast milk substitutes, bottles, teats, or with graphics about these products as it could send the wrong message about breastfeeding.

- ☐ **Integrate ECD into government health/nutrition policy and budgets:** work with government to integrate services (including a budget and a focal point) within the department that will focus on children 0-5 years, pregnant mothers and parents/ caregivers.

- ☐ **Establish a plan for staffing ECD services in emergencies:** focus on the high-risk areas in the country (i.e. ECD staffing roster).

- ☐ **Conduct training for health and nutrition professionals** – this training could be on the UNICEF/WHO Care for Child Development package or a similar type of package that targets nutrition/health workers.

RESPONSE KEY ACTIVITIES

- ☑ **Conduct a rapid assessment** in collaboration with sector leads during the initial stages of an emergency to identify the impact on young children, their parents, families and caregivers and existing ECD related services in relation to nutrition and health (see sample questions provided on page 8).

- ☐ **Use existing coordination system or establish a new one.** First verify if a coordination mechanism exists (a cluster or sector coordination or other mechanism). If a coordination mechanism does not exist, ideally a multi-sectoral group for ECD can be established with involvement and co-leadership of various government ministries (ie. health, nutrition, wash, social services, education, finance). If this is not possible a coordination mechanism with the ministry of health/nutrition can be formed whilst coordinating with ministries leading child protection and education. This can ensure services are provided consistently and equally, gaps are identified and filled and there is no overlap of services.

- ☐ **Establish safe spaces for children 0-5 years, their primary caregivers and pregnant/lactating women** – in collaboration with child protection and education sectors. The spaces could either be where multi-sectoral services are provided or separate spaces for health/nutrition services (i.e. private spaces for breastfeeding). Unfortunately some health/nutrition clinics are often not child-friendly.

- ☐ **Mobilise and recruit nutrition/health staff** to support all activities for children of different ages, their parents/caregivers and pregnant women.

- ☐ **Train nutrition/health staff** on UNICEF Care for Child Development and similar types of packages.
- ☐ **Establish mentoring groups** where nutrition/health staff can work to improve their practice on how to support children 0-5 years, their parents/caregivers and pregnant women. Set up monthly or bi-weekly mentoring meetings/discussions.
- ☐ **Start nutrition/health services for children 0-5 years, their parents/caregivers and pregnant women** (i.e. breastfeeding and support, supplemental feeding, health check-ups, pre-natal care for pregnant women). WHO and UNICEF recommend a minimum of 6 months for exclusive breastfeeding. Breastfeeding is possible even during emergencies as long as babies have the opportunity.
- ☐ **Provide developmentally appropriate play materials for health/nutrition spaces** (i.e. adapted UNICEF ECD kit or similar) and relevant health/nutrition materials (i.e. weight scale, MUOC, child growth chart, safe delivery kits, infant kits, vitamins, key medicines).
- ☐ **Integrate early stimulation and play in nutrition/health spaces** where children and parents can use developmentally appropriate toys.
- ☐ **Form parenting groups** amongst those that attend nutrition/health spaces. Groups can be mixed with mothers-fathers, mothers only or fathers only based on the cultural norms. The role of the father is critical so efforts should be made to engage them.
- ☐ **Run parenting groups in health/nutrition spaces** in collaboration with ECD, education, child protection colleagues.

CASE STUDY – ECD AND NUTRITION/HEALTH IN EMERGENCIES: EXAMPLE FROM MALI

UNICEF and partners implemented a multi-sectoral ECD approach to address the nutritional needs of very young children in Mali in 2015, inspired by the Care for Child Development initiative and materials. The focus of the Handicap International / UNICEF partnership was to work with children who have been malnourished, through both clinic- and home-based activities. The novel ingredient was the introduction of physiotherapy into the therapeutic package, to more effectively manage the delays in motor development observed in malnourished children. Their objective was to bring the child back on target developmentally. The focus of the community-based BØRNEfonden-UNICEF partnership was to provide parental education that transfers key messages of good parenting practice. These messages, including psychosocial stimulation, cognitive stimulation and nutrition, were integrated into a life stage model of change and development intended to influence practices in pregnancy and infancy, as well as preparation for school.

The programmes were evaluated by using video to record the narratives of the beneficiaries' experience. At the heart of programmes observed was a reframing of the relationship between parents and their very young children, to strengthen the attachment process. The intervention included a variety of activities to promote the concept of holistic development through cognitive, motor and psychosocial stimulation, and better feeding practices.

CASE STUDY – EMERGENCY AS AN ENTRY POINT FOR INTEGRATED PROGRAMMING: EXAMPLE FROM INDONESIA

Before the 2004 Asia tsunami, the Indonesian government's various ministries were responsible for different aspects of ECD such as health and early learning with little integration. In Banda Aceh, the Tsunami devastated many village health posts and birth delivery centers. Plan International used the emergency as an opportunity to support the integration of the various government ministries' services such as helping the health ministry integrate socio-emotional stimulation and parenting support into the work at health posts and birth delivery centers. Previously, specific services and socio-emotional, child development and parenting support were not provided through these spaces. Plan International brought together the relevant government departments in Banda Aceh to ensure increased awareness about the benefits of socio-emotional stimulation and parenting within health/nutrition interventions. Plan International supported the health ministry in increasing knowledge and capacity about child development and socio-emotional support among staff in the village health posts, birth delivery centers and other spaces where heath support was being provided. Plan International also worked with the community and the Ministry of Education to start age-appropriate stimulation and early learning activities and parenting groups. The village health posts also began providing basic health and hygiene education and services as well as nutrition (including supplementary micronutrients) for young children in education spaces (i.e. temporary learning centers) and to pregnant and lactating mothers.

Through advocacy that began immediately after the Tsunami, Plan International worked closely with the Ministry of Health to draw up standards and guidelines for the health posts, which now include a multi-sectoral approach. Additionally, the District Health office agreed to increase its share of the budget to continue the birth centres so children, mothers and pregnant women could continue to have high quality multi-sectoral services.

INDICATORS

KEY QUESTIONS TO REINFORCE EXISTING NUTRITION AND HEALTH ASSESSMENTS WITH ECD APPROACHES

- # and quality of activities to support socio-emotional stimulation within nutrition/health facilities
- # of parents/caregivers engaged in parenting activities
- # of health and nutrition personnel trained in ECD
- # of young girls and boys showing symptoms of PTSD
- # of children 0-5 years with severe acute malnutrition and moderate acute malnutrition (disaggregated by sex and age 0-2; 3-5)
- # of children 0-5 years injured (disaggregated by sex and age 0-2; 3-5)
- # of non-breastfed children under 2 (disaggregated between <6m and >6m)
- # of under-5 girls and boys in the catchment area
- # of separated children or in situation of alternative care

SAMPLE INDICATORS RELATED TO YOUNG CHILDREN

Outputs

- # of children who participate in play and early stimulation activities in health/nutrition spaces
- # of parents who access parenting groups
- # of nutrition/heath staff trained in child development

Outcomes

- % of children with improved child development outcomes (based on baseline child development outcomes)
- % of parents with improved childcare practices
- % of pregnant women with increased knowledge about pregnancy, health, nutrition and child development
- % of lactating women practicing socio-emotional stimulation with babies whilst breastfeeding

TOOLS AND RESOURCES

AVAILABLE IMPLEMENTATION TOOLS

- UNICEF ECD kits
- UNICEF/WHO, *Care for Child Development package (CCD)*
- UNICEF ECD kit training manual
- Parenting manual

REQUIRED STAFF AND CAPACITY BUILDING OPPORTUNITIES

Staff

- Health and nutrition staff – either existing ones or new ones
- Parenting programme facilitators/officers
- Early stimulation/child development officers
- Monitoring officer
- Logistics officer
- ECD technical advisor

Training and capacity building

- Training on Care for Child Development package (3-5 days)
- Monthly mentorship meetings (for continued support in implementing the Care for Child Development package)
- INEE/UNICEF ECD in emergencies face-to-face training module
- World Bank, ECD online course
- Harvard University's Center on the Developing Child

RESOURCES FOR MONITORING

Child assessments

- Save the Children, IDELA (International Development and Early Learning Assessment)
- Bayley Scales for Infant and Toddler Development
- Ages and Stages Questionnaire (ASQ-3)
- Ages and Stages Questionnaire – Social and Emotional Difficulties (ASQ-SE 2)

Parent assessments

- The HOME Inventory (The Home Observation for the Measurement of the Environmental Inventory)

LEARN MORE

- UNICEF, *Early Childhood Development in Emergencies Integrated Programme Guide*
- UNICEF, *Early Child Development Kit: A Treasure Box of Activities*
- UNICEF/WHO, *Care for Child Development package*
- Plan International, *Early Childhood Care and Development in Emergencies: A Programme Guide*
- Plan International, *Investing in the Youngest: Early Childhood Care and Development in Emergencies*
- UNICEF/WHO, *Integrating ECD activities into Nutrition Programmes in Emergencies: Why, What and How*
- The Consultative Group on Early Childhood Care and Development/UNICEF, *Noteworthy Practices: Early Childhood Development in Emergencies*
- *Infant and Young Child Feeding in Emergencies guide*

ACKNOWLEDGEMENTS

This technical note was written by Sweta Shah and designed by Sandra Dudley and Danny Plunkett at Plan International. Special thanks to the UNICEF ECD team in NY for financing the publication of this note and for technical reviews – Eduardo Garcia Rolland, Mariavittoria Ballotta, and Arnaud Conchon. Thanks also to UNICEF Health and Nutrition teams.

CREDITS

Notes:

1. Conel, J.L. (1959). *The Postnatal Development of the Human Cerebral Cortex*. Harvard University Press: Cambridge, MA.
2. Shonkoff, J.P., Garner, A.S., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L. & Wood, D.L. (2012). *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*. Pediatrics, 129 (1), 232-246.
3. Socio-emotional stimulation includes when a parent or caregiver looks at the child in the eye, talks to him her, caresses and hugs him/her. Often parents do not talk to their children until they can talk back, but starting to engage a child in these and other ways is critical for their early brain and linguistic development.
4. Grantham-McGregor, S. et al. (1991). *The Jamaican early childhood home visiting intervention.*

Walker, S., Chang, S. Powell, C. and Grantham-McGregor, S. (2005). *Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study.* Lancet, 366:1804-1807.

5. Hamadani, J. et al. (2004). *Psychosocial stimulation improves the development of malnourished children in rural Bangladesh*, Journal of Nutrition, 136, 2645-2652.

Yousafzai, A. et al. (2014). *Effect of integrated response stimulation and nutrition interventions in the Lady Health worker program in Pakistan on child development, growth and health outcomes: a cluster randomized factorial effectiveness trial*, Lancet, 384(9950), 1282-1293.

Nahar, B. et al. (2009). *Effects of psychosocial stimulation on growth and development of severely malnourished children in a nutrition unit in Bangladesh*, European Journal of Clinical Nutrition, 63, 725-731.

Nahar, B. et al. (2012). *Effects of a community-based approach to food and psycho-social stimulation on growth and development of severely malnourished children in Bangladesh: a randomized trial*, European Journal of Clinical Nutrition, 1-9.

6. Ibid.

July 2016