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# Preface and Acknowledgements

Recent neuroscience research has revealed the primacy of early brain development and the importance of supporting parents and other caregivers to ensure all children, including those with developmental delays and disabilities, achieve their full potential (Black et al., 2017). Two major and complementary fields are at the center of this effort: inclusive early childhood development (IECD) and early childhood intervention (ECI) (See Annex 1; Glossary of Terms).

The 2017 Lancet ECD Series presented an estimate that 250 million children (43%) under 5 years in lower- and middle-income countries (LMIC) were at risk of not reaching their developmental potential (Black et al., 2017). A recent study on developmental disabilities among children under 5 years in 195 countries and territories finds that 52.9 million have developmental disabilities, and 95% of them lived in LMIC (Olusanya et al., 2018). IECD and ECI programs are urgently needed to address this global crisis for infants and young children with at-risk situations, developmental delays, disabilities or behavioral or mental health needs.

Yet very little is known about existing IECD and ECI programs across the globe. To learn more about the current status of IECD and ECI programs, three international organizations collaborated to conduct this global survey: RISE Institute; UNICEF; and the Early Childhood Development Task Force (ECDtf), which is within the Global Partnership on Children with Disabilities (GPcwd).

We greatly appreciate the collaboration of the following organizations, which helped us identify IECD and ECI programs throughout the world: UNICEF headquarters and regional specialists in ECD, disability and child protection; UNESCO headquarters and regional specialists; International Bureau of Education; World Health Organization; Open Society Foundation's Early Childhood Program; International Society on Early Intervention (ISEI); European Association of Service Providers for Persons with Disabilities (EASPD); European Association on Early Childhood Intervention (EurlyAid); GlobalPartnersUnited (GPU. LLC); International Step by Step Association (ISSA); ASIA-Pacific Regional Network for Early Childhood (ARNEC); Pacific Regional Council for Early Childhood Development; Red Primera Infancia; African Early Childhood Network (AfECN); Association for the Development of Education in Africa (ADEA); Arab Resource Collective (ARC); Partnership for Early Childhood Development and Disability Rights (PECDDR); Plan International; Center for Disease Control and Prevention (CDC); several national ECD networks; and many national and international non-governmental organizations.

Our Advisory Board included: Anna Burlyaeva (UNICEF); Megan Tucker (UNICEF); Lilia Jelamschi (UNICEF); Evelyn Cherow (Global Partners United LLC); Yoshie Kaga (UNESCO); Paul Lynch (University of Birmingham); Vidya Putcha (Results for Development); and Camille Smith (Centers for Disease Control and Prevention). We thank early childhood specialists Rocío Gómez Botero, Kristel Diehl, Paola Vergara, Natalia Mufel, Eveline Pressoir, Paula Santos, and Emily Vargas-Barón for translating the survey, cover letter, glossary and open-ended responses from English to French, Portuguese, Russian and Spanish, and from those languages to English.

We are especially grateful to our respondents who provided information on 426 programs in 121 countries in all world regions. A complete list of respondents is available upon request.

This Final Report is dedicated to devoted front-line workers of IECD and ECI programs around the world. We work for you and we honor you!

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# Executive Summary

Globally, a majority of countries has ratified international mandates such as the United Nations Convention on the Rights of the Child (CRC) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD). An increasing number of countries also have adopted and promoted an array of inclusive early childhood policies and developed and expanded many early childhood development programs in response to a growing awareness of the importance of providing all children with supportive and nurturing care across home and learning environments (Black et al, 2017). Yet, despite a broad adoption of these conventions and the development of policies and programming, we know little about the extent to which Inclusive Early Childhood Development (IECD) and Early Childhood Intervention (ECI) programs and support services are being developed and implemented globally.

## Defining IECD and ECI services

IECD services and supports foster the physical, cognitive, language, and social-emotional development of children with delays and disabilities as well as their typically developing peers in early childhood programs that are accessible, equitable, and enable participation from, and support for, all children. ECI is a system of services that provides support to the families of children with developmental delays, disabilities, social-emotional difficulties, or children who may develop delays due to biological or environmental factors. Effective ECI systems are: (a) individualized; (b) intensive; (c) family-centered; (d) transdisciplinary or interdisciplinary; (e) team-based; (f) evidence-informed; and (g) outcomes-driven. ECI, a social and child rights model, replaces traditional approaches to service provision, such as the medical model. Whereas traditional deficit-focused approaches involve an “expert” providing the child with intervention services typically delivered in a clinical setting, a contemporary ECI approach involves the provision of individualized, family-focused and child-centered services delivered in the least restrictive natural environment of the child. Rather than being “expert driven,” ECI service delivery is “family driven.” The family is a partner in the provision of services and makes all decisions regarding the child and family.

## Global Survey of IECD and ECI services

The RISE Institute hosted the global online survey and worked jointly with UNICEF and the ECD Task Force (ECDtf) of the Global Partnership on Children with Disabilities (GPcwd) to create and distribute it in English, French, Portuguese, Russian and Spanish. This large survey was designed in 2016, was conducted in 2017, and the report was prepared in 2018. The main objectives of the survey were to:

- Map current implementation of IECD and ECI programs and related activities;
- Describe key IECD and ECI program features;
- Identify gaps and challenges in providing accessible IECD and ECI services;
- Document factors associated with successful implementation and scale-up; and
- Generate recommendations to inform future policy and program development and national planning and implementation efforts.

The online survey targeted a range of programs, and activities including IECD and ECI services; rehabilitation and habilitation services; humanitarian, emergency, and child

protection services; advocacy campaigns; and research and evaluation projects. The survey solicited a broad range of information from respondents including implementing sectors, scope and geographic focus of program, target population, policy support, and program approach and objectives. Respondents also provided information on screening and referral services; program contents and characteristics; barriers to program development, expansion, demand, and quality; factors that enhanced program success; and information on program funding.

## Survey Respondents

Program respondents, identified via a two-step non-probability sampling procedure, provided information on 426 programs that were implemented in 121 countries. Most respondents (88%) reported on a program in the country in which they resided. The majority of respondents completed the survey in English 335 (79%); though a small percentage completed surveys in Spanish 45 (10%), French 15 (4%), Portuguese 18 (4%), or Russian 14 (3%). The majority of respondents (62%) reported working for a national organization. The remaining participants worked for either an international non-governmental organization (NGO; 27%), or government (12%). Respondents were primarily subject matter specialists (49%), program directors or government managers (34%), or technical specialists (16%) working in a range of fields including health, nutrition, inclusive education, ECD, ECI, child protection services, the social sciences, policy, management, administration, and advocacy.

## Program Regions and Countries

The largest number of IECD and ECI programs identified was located in Sub-Saharan Africa (SSA; n = 115) followed next by Europe and Central Asia (ECA; n = 108). Programs in East Asia and the Pacific (EAP; n = 69) and Latin America and the Caribbean (LAC; n = 63) made up nearly 15% of the sample each. Programs from South Asia (n = 36), North America (n = 21), and the Middle East and North Africa (MENA; n = 14) each made up less than 10% of the sample.

Overall, 77% of identified programs were implemented in low- or middle-income countries (LMIC) based on World Bank income categories. Nearly 17% were implemented in low-income countries (n = 72), more than 36% were implemented in lower-middle-income countries (n = 154), and an additional 24% were implemented in upper-middle-income countries (n = 103). Additionally, 119 of the 426 programs (28%) were implemented in countries affected by humanitarian crises.

## Main Survey Findings

***Program type*****.** Programs reported providing both IECD *and* ECI services (40%) or primarily IECD (26%) or mainly ECI services (11%). Some programs also developed advocacy campaigns (14%), provided rehabilitation or habilitation services (12%), or mainly conducted research and evaluation activities (12%). There was some regional variation in the types of services provided (see Table 3). Within EAP and SSA, programs combining IECD *and* ECI services were the most frequent with a much smaller percentage of programs offering IECD or ECI only services. In ECA and South Asia, the percentages of programs offering combined IECD *and* ECI services were comparable. Respondents in

Latin America and the Caribbean reported almost no “ECI only” services and had a lower frequency of combined IECD *and* ECI programs than other regions.

***Policy dimensions.*** To ensure program official status and sustainability, it is essential to have one or more legal or normative frameworks supporting IECD and ECI programs. In 72% of the countries in which IECD and ECI programs were implemented, respondents reported the development of one or more policies, strategic plans, legislation, and/or normative instruments. Many regional differences exist with regard to policy development. Program protocols, regulations, bylaws and/or standards were most frequently found in approximately a third of the countries in South Asia, North America, Europe and Central Asia, and Latin America and the Caribbean. Sub-Saharan Africa and East Asia and the Pacific registered much lower rates of use of regulations (see Table 8).

**Program objectives.** The provision of training for professionals, teachers, caregivers and others in IECD, ECI or related services was reported most frequently (66%) as a program objective. More than half of the programs developed services with and for parents (59%); advocated for child and parental rights and services (54%); provided ECI services such as assessments, individualized family support plans (IFSPs), or home visits (53%); ensured provision of inclusive and accessible pre-primary and primary school services (53%); or worked to improve child health, nutrition, and development (51%). Respondents reported that only 40% of programs conducted screening, surveillance, and monitoring as a program objective despite the central role these services play in the implementation of IECD and ECI services (see Table 9).

***Sectoral Involvement.*** Fifty-six percent of programs reported multisectoral leadership with the remaining programs reporting a single lead sector for the program. The education sector was the primary lead for programs reporting a single sector (68%) and for programs reporting multisectoral leadership (91%). A majority (77%) of IECD and ECI programs featured multisectoral engagement.

***Program participants.*** The most frequently served age range was from 37 to 60 months (79%). Some 74% of the programs served children during the critically important period of brain growth from birth to 36 months (see Table 18). Nearly two-thirds of the programs (62%) reported targeting all children, including children with disabilities (see Table 19). Almost 75% of programs targeted parents and caregivers (see Table 20). Teachers, caregivers and other educational personnel were targeted for service (79%) more frequently than health professionals (57%) or child protection and social protection professionals (49%).

***Service provision.*** Services for preconception education and care were found in 19% of IECD and ECI services. Only 20% of IECD and ECI programs provided delivery and/or neonatal services. Most IECD programs serving children birth to 36 months (82%) provided parent education and family support (see Table 25). For children birth to 36 months, center-based services (66%) were more frequent than home visiting services (59%), and relatively less attention was given to child protection (33%) and child health and nutrition services (32%). Only 9% of programs reported providing respite care to parents of children birth to 36 months.

IECD and ECI programs were found to provide a high level of continuous services. For example, eighty percent of programs reported providing continuous IECD services for children 3 to 6 years. Some 77% of these programs reported they offered continuous

services from birth to 8 years of age. The remaining 23% reported only serving children from 3 to 8 years. Services for inclusive pre-primary education or the kindergarten transition year ranked second in frequency of provision (58%).

In total, 241 programs (57%) reported providing ECI services to children and families in 98 countries of all world regions. Some ECI programs (see Table 28) were found in low-income countries (15%), and lower middle-income countries (38.2%). Programs providing ECI services reported offering (see Table 29) parent education and support (66%), community outreach services (56%), developmental screenings (56%), comprehensive developmental assessments with parental participation (54%), case management and referrals (46%), parental participation in interdisciplinary or transdisciplinary teams (45%) as well as developmental surveillance and monitoring (44%). The programs reported less frequent provision of therapy services (41%); IFSPs (35%); exit and transition plans (37%); and other core ECI approaches.

Almost half of the 426 IECD and ECI programs (47%) provided some type of inclusive health or nutrition services. Health and nutrition promotion, education and counseling were the most frequent type of service (85%) as well as attention to special health services for children with disabilities (51%). Just under half of the IECD and ECI programs (47%) provided rehabilitation or habilitation services. WASH services were found in almost one third (29%) of the IECD and ECI services. Within this topic area, home hygiene (69%), general WASH services (44%), and clean water provision (44%) were the main services (see Table 33). Inclusive child and social protection services primarily sought to foster policy, training and support for these services (78%), and to provide (78%) these services (see Table 34). Little support (26%) was found for child and social protection services to prevent institutionalization and promote deinstitutionalization.

***Financial Support.*** Financial support for IECD and ECI programs was mainly provided in the following order by international organizations (279 mentions), national, regional and local governments (209), private organizations (107), local fundraising (107), and non-governmental organizations (84). Taken together, national non-governmental and governmental sources of funding (515 mentions) outweigh international support (279 mentions), suggesting that national support is key to the development and expansion of IECD and ECI programs. More studies are needed on financial support and costs of IECD and ECI programs.

***Parent Involvement.*** The vast majority (93%) of IECD and ECI programs reported enabling at least one program role for parents, grandparents and legal guardians. The most frequently reported role (see Table 35) was “participation in identifying child needs” (n = 240, 56%). Overall, two-thirds of the programs involved parents in program services in some capacity (see Table 36), and parents supported services in over half of the programs (56%).

***Barriers.*** The most frequently reported **barriers to program development** (see Annex 28) were:

- inadequate funding (50%);
- lack of national administratively collected data on childhood developmental delays and disabilities (32%); and
- lack of policies, plans, legislation or regulations supporting their program (28%).

Frequently reported **barriers to program growth** (see Annex 29) included:

- insufficient services for children with at-risk, developmental delays, disabilities and behavioral or mental health needs (61%);
- lack of community outreach to identify children with at-risk situations, delays, disabilities or atypical behaviors (41%); and
- lack of universal developmental screening for children (38%).

Respondents reported the top three **barriers to program demand** (see Annex 30) were:

- lack of capacity to meet demand and program has waiting lists (47%);
- absence of advocacy for program services and for children and families served (43%); and
- caregivers are not empowered (41%).

Major **barriers to program quality** (see Annex 31) included:

- lack of properly trained and qualified personnel (46%);
- lack of research opportunities (32%), and
- lack of supervisory services, including mentoring, coaching and reflective supervision (31%).

***Achieving program success.*** The most frequently mentioned factors for enhancing program success (see Table 39) included (in rank order): program and external expertise; pre- and in-service training; parent and caregiver empowerment; enabling policy environment and policy and political support; and networking and collaboration. These factors aligned closely with the most frequently referenced factors for creating, improving, and expanding IECD and ECI programs (see Table 40): expanded investment; increased advocacy and social communications; improved service coordination; improved and expanded parent education and support; development of policies, plans or laws for IECD and ECI services; improved pre- and in-service training and workforce certification systems; and establishment of universal screening and referrals for assessments.

## Recommendations

1. ***Develop, improve and scale up IECD and ECI Services.*** In general, IECD and ECI services should be greatly expanded to ensure all children in at-risk situations, developmental delays, disabilities and behavioral or mental health needs have access to appropriate services. Priority should be given to developing and expanding IECD and ECI programs in humanitarian crises, including conflicts and national disasters. More specifically, consideration should be given to the following:

    a. Services for child protection were found in only 36% of these programs, and services for child health and feeding were similarly low (25%). Both types of intersectoral services should be greatly expanded to ensure good child nutrition and growth as well as safe child development;
    b. Although home visiting services appear to be increasing, only 59% of IECD programs provided home visiting services. Many more IECD and ECI home visiting programs are needed in all countries;

c. Services for inclusive pre-primary education or the kindergarten transition year ranked second in frequency of provision (58%). A major effort is needed to ensure all initial education and care for infants and toddlers, and pre-primary education becomes inclusive;
d. Fewer than 30% of IECD and ECI programs included the provision of WASH services. Given that high rates of chronic illness and developmental delays are related to non-potable water, poor sanitation and inadequate hygiene, more attention should be paid to the provision of accessible and inclusive WASH services in IECD and ECI programs;
e. Only 9% of IECD and ECI programs provided respite care services. Respite services should be greatly expanded to ensure parents and caregivers of children receiving IECD and especially ECI services have a break from child care and development activities;
f. Although many IECD and ECI programs reported they serve rural areas (66%) and towns and semi-rural areas (51%), many more such services are needed, with a priority placed on ensuring rural and ethnic groups are served in culturally and linguistically appropriate ways;
g. ECI programs should include and expand available services for children with autism spectrum disorder (ASD), attention deficit and hyperactivity disorders (ADHD), and communication and other behavioral conditions. They should also address the needs of children with mental health conditions, such as trauma from severe stress, depression, and other situations;
h. In all world regions, nations should expand the development of specialized programs focused on improving child access to services and the quality of life of children with disabilities through the provision of accessible infrastructure and assistive products. Special attention should be given to WASH infrastructure in both development and humanitarian contexts (UNICEF, 2017). IECD and ECI programs should promote the affordability and availability of assistive devices for children with disabilities.

2. ***Greatly increase investment in IECD and ECI programs to scale up services rapidly.*** Expanded national and international investment in IECD and ECI systems and services is vital to their future expansion and success. National governments at central, regional and local levels should provide the bulk of funding to meet annual recurrent expenses of IECD and ECI services; whereas international funding should be used mainly for developmental, training and other innovation expenditures linked to achieving program quality, equity, and accountability. Additionally, international donors should focus more funding on the development and expansion of ECI services at national, provincial and municipal levels. IECD and ECI programs should cultivate and secure diversified sources of funding to ensure financial sustainability.

3. ***Invest in communication for development (C4D).***[1] Individuals and communities should be engaged to create positive behavioral and social change to address stigma and discrimination and shift social norms towards girls and boys with

[1] C4D is "an evidence-based process that is an integral part of programs and utilizes a mix of communication tools, channels and approaches to facilitate dialogue, participation and engagement with children, families, communities, networks for positive social and behavior change in both development and humanitarian contexts." (UNICEF, 2018, p. 4). For more on C4D: https://www.unicef.org/cbsc/

disabilities. Families of children with disabilities, Parent Associations, and Organizations of Persons with Disabilities (OPDs) should be consulted at every stage of the communication process, from design of the strategy to evaluation.

4. ***Expand advocacy efforts.*** Advocacy efforts for IECD and ECI programs and the children and families they serve should be developed or improved and expanded in order to build, strengthen, and increase support for these vital services. In particular, expanded advocacy campaigns are needed to address stigma, lack of inclusion, and inadequate awareness among governmental leaders, communities and families. In all world regions, international advocacy campaigns should be mounted to: (a) spur national and international investment in IECD and ECI systems of services; (b) develop national policies, strategic plans, legislation and regulations for IECD and ECI services; (c) scale up and improve IECD and ECI services; (d) promote universal developmental screening, surveillance, and monitoring in all countries; (e) increase dedication to preventing institutionalization and achieving deinstitutionalization; and (f) encourage the establishment of essential respite care services for parents of children receiving ECI services.

5. ***Promote the regional development of IECD and ECI services.*** All regions require more, larger and better IECD and ECI programs. Countries of Latin America and the Caribbean and Europe and Central Asia should give greater emphasis to developing, expanding and/or improving ECI programs. Nations of the Middle East and North Africa, Sub-Saharan Africa, South Asia, and Southeast Asia and the Pacific should place stronger emphasis on scaling up and improving both IECD and ECI programs. The ECD Task Force for Children with Disabilities (ECDtf), in collaboration with the ECD Action Network (ECDAN), UNICEF, UNESCO, WHO and other agencies, should help to develop low cost but effective regional, national and network initiatives to promote, design, and implement IECD and ECI services.

6. ***Prioritize scaling up IECD and ECI services in low- and middle-income countries.*** Although many LMIC have already developed considerable numbers of IECD and ECI programs and some have established national ECI systems, many more large-scale IECD and ECI programs are urgently required to meet the developmental and support needs of children and families living in poverty and other difficult situations.

7. ***Ensure all countries affected by humanitarian crises receive IECD and ECI services.*** To support families whose children have developmental delays and disabilities due to (or exacerbated by) trauma and deprivations caused by humanitarian crises, greater priority should be given to developing and expanding IECD and ECI programs in all such countries.

8. ***Promote multisectoral, transdisciplinary and interdisciplinary service coordination.*** Given the multidiscip/inary nature of IECD and ECI services especially in LMIC, multisectoral coordination among education, health, nutrition, WASH and child protection services sectors is essential. The strong leadership and participation of the education sector is of central importance; however, greater attention to inclusion of child protection and child health and nutrition sectors, in particular, will help ensure all children in IECD programs will be able to access child protection, health, and nutrition services. International donors, rather than

designating a single sector for IECD and ECI services, should encourage countries to select the lead sector for IECD and ECI services in accordance with their institutional strengths and policy contexts. All ECI programs should be multisectoral, transdisciplinary or interdisciplinary, and integrated to ensure their services will be high in quality and cost-effective.

9. ***Integration within existing administrative systems.*** To provide affordable, flexible and responsive services, ECI programs should use **one integrated administrative system** that plans and integrates the contributions of all participating sectors at municipal, regional and central levels. Furthermore, it will become increasingly important for national ECI programs to work with Ministries of Finance and Ministries of Planning as well as Ministries of Education, Health and Protection to develop strong support for, and assist with the scale-up of IECD and ECI systems and requisite accountability systems (e.g., monitoring, evaluation, and reporting).

10. ***Increase geographical program coverage.*** Most IECD and ECI programs that responded to the survey (55%) were found to be large in scale (international, regional or national in coverage) rather than medium-sized or small pilot initiatives. If external evaluations reveal good program outcomes, special attention should be given to stimulating the improvement and expansion of smaller- and medium-scale IECD and ECI initiatives to complement larger-scale programs and increase geographical coverage, especially in rural and remote areas. Valuable programs with complete program development processes of all sizes should be given technical and financial support to go to scale as important parts of national IECD and ECI systems. Priority should be placed on serving ethnic groups in culturally and linguistically appropriate ways. In this regard, external evaluations should be conducted on successful IECD and ECI programs serving ethnic groups to identify, assess and disseminate effective program methodologies and lessons learned.

11. ***Give priority to IECD and ECI policy planning.*** Policy planning processes must be expanded and intensified to establish the legal basis, strategic frameworks, and regulations for national IECD and ECI programs. National plans for ECI program development, innovation, training, quality assurance, equity, accountability, and phased expansion are urgently needed. Regulations, such as ECI program guidelines and procedures, are required to ensure key elements of quality ECI programs, including developmental screenings and assessments, IFSPs, program completion and transition plans, eligibility guidelines, and other core elements are in place. Additionally, greater attention should be given to developing policies for the provision of continuous services from preconception to transition to inclusive primary schooling.

12. ***Promote key objectives for IECD and ECI programs.*** Objectives for IECD and ECI programs should include:

    a. Improve birth outcomes through adding preconception, prenatal and immediate post-natal education and care or linkages with programs providing these services;
    b. Conduct community outreach and universal developmental screening as well as medical surveillance and monitoring;

- Provide ECI programs with all of their evidence-based key attributes, such as formation of transdisciplinary or interdisciplinary teams, developmental and family assessments, eligibility determination, individualized family service plans, and visits in the natural environment of the child; and completion and transition services to inclusive education programs;
- Offer parenting services and case coordination support, combined with ensuring child and parental rights;
- Ensure multisectoral coordination, continuous programming, and interagency agreements among education, health, nutrition, WASH, and child protection services;
- Develop an effective professional and paraprofessional workforce, including continuous pre- and in-service training systems, certification/recertification, career ladders, and salary scales;
- Establish regulations and guidelines for the registration and accreditation of services that are well aligned with and meet service and personnel standards;
- Prevent institutionalization and support the deinstitutionalization of young children; and

c. Implement national systems for program monitoring, internal and external evaluation, and reporting.

13. ***Expand service coverage for preconception, pregnancy, and early years.*** Although 30% of IECD and ECI programs reported providing prenatal education and care, more programs should be encouraged to focus on improving birth outcomes through the provision of preconception and prenatal education and care, essential micronutrients, neonatal health services, and continuous parenting education and support. Emphasis should continue to be given on serving families with children from birth to 36 months of age in order to prevent and overcome developmental delays and improve the status of children with disabilities. IECD and ECI programs and activities should continue to be family-centered and place emphasis on serving parents, caregivers, and program personnel.

14. ***Promote and scale up developmental screening services in all nations.*** Due to current low levels of neonatal screening and developmental screening, there is a growing need to increase outreach for, and access to, developmental screening from birth to 36 months of life to ensure the timely and efficient identification of children with developmental delays, disabilities, behavioral and mental health needs, and to ensure prompt referrals to ECI services. This necessitates the development and expansion of universal developmental screening and referral systems in many countries as well as the expansion and improvement of developmental surveillance and monitoring systems in all health systems. It will also be especially important to expand the number and types of neonatal screenings in LMIC as soon as possible to prevent and detect a wide variety of disabilities and delays before they become difficult or impossible to overcome.

15. ***Provide comprehensive and continuous IECD programs.*** Continuous services should be provided by IECD programs from preconception and prenatal education and care to services for children from birth to 36 months of age in line with the *Nurturing Care Framework* (WHO, 2018). Greater attention should be given to the provision of home visits to increase program effectiveness and emphasize the essential roles of parents, other family members and caregivers. Continuous

services should continue to age eight, with a strong focus on inclusive initial, pre-primary, kindergarten and primary school services as well as on continuous health, nutrition and child protection services.

16. ***Encourage parent and caregiver involvement.*** Parent participation and empowerment is essential for all effective IECD and ECI programs. Although parental and family involvement was found in 93% of IECD and ECI programs, every effort should continue to be made to include parents, grandparents and legal guardians in a wide variety of roles in these programs. In addition, efforts should be made to empower parents to seek, join, and participate in developing the IECD and ECI programs they and their children require.

17. ***Establish sustainable national IECD and ECI systems with training and supervision.*** Improvement of the IECD and ECI workforce through the development and expansion of continuous pre- and in-service training services, supervisory systems, and workforce certification systems constitutes the number one priority for achieving program quality. Pre-service teacher training or continuing professional development on inclusive education skills for teachers, principals and parents was provided in only 35% of the programs. In-service teacher training on inclusive education skills for teachers, principals and parents was found in 55% of the programs. Although these findings are positive, much more pre- and in-service training for inclusive pre-primary education and all ECI components is needed. International donors, national governments and academic institutions should place far greater priority on helping to develop, improve and expand national systems of pre- and in-service training and supervision for IECD and ECI personnel at all levels. There is a need to (a) create, adapt and field test educational, training, and program materials; (b) establish personnel qualifications; and (c) improve supervision, mentoring, and coaching methods.

18. ***Develop effective inclusive child and social protection services.*** To ensure full social equity, nations should greatly expand the provision of inclusive child and social protection services. Child and social protection services should be formally linked to IECD and ECI services. They should place priority on preventing the institutionalization of children, enabling the deinstitutionalization of those in institutions, and ensuring the placement of deinstitutionalized children with families. Countries should also study options for using conditional cash transfers to fund ECI programs that are linked with child and social protection, health and nutrition services.

19. ***Achieve full program accountability through monitoring, evaluation and research.*** As IECD and ECI systems and services develop and expand, national monitoring and evaluation systems are increasingly needed. Although almost half of the IECD and ECI programs identified in this report indicated that an external evaluator had assessed their program, these programs and new ones should be encouraged to develop and expand their internal and external evaluations, with findings and annual reports linked to parental oversight activities and annual program planning and budgeting. Additionally, more IECD and ECI programs should conduct external evaluations, support and collaborate fully with the development of national systems for monitoring and evaluation, and use culturally appropriate and validated developmental screening and assessment instruments.

Expanded support and capacity for research and targeted research is needed in all LMIC. Specifically, additional research is urgently required on the financing of IECD and ECI services including cost studies and budgetary analyses to prepare projections and simulations for annual program planning and budgeting. A clearer understanding of the relationship between program demand and fees is needed to ensure that cost is not a significant barrier to accessing IECD and ECI services and to guarantee services are affordable for families of all income levels. Further research on the prevailing patterns of parental participation and their relationships to IECD and ECI program success and sustainability are needed. More research is also required on inclusive practices to promote children's learning and development within IECD and ECI programs, with special attention given to cultural dimensions, gender, and developmental delays and disabilities.

Given that 78% of IECD and ECI programs of all types reported the use of internal monitoring and evaluation (M&E) procedures, future surveys should focus on their functioning, structure, instruments, training, reporting, and their use of findings in annual program planning. Case studies should also be conducted on selected programs to identify good practices, lessons learned, and effective uses of findings. This information can be used to help programs establish strong M&E systems and thereby improve internal accountability mechanisms. External evaluations should be conducted on successful IECD and ECI services with indigenous populations in order to identify, assess and disseminate effective program methodologies and lessons learned. As well, external evaluations will help inform the expansion of smaller- and medium-scale IECD and ECI initiatives to complement large-scale programs.

20. ***Provide more technical support*****.** Targeted and individualized technical support is needed across all world regions. In South Asia, and the Middle East and North Africa additional technical support to develop, improve and scale up both IECD and ECI services is necessary. For Latin America and the Caribbean, substantial technical support is needed to develop national ECI systems that will complement their general ECD services.

    This survey demonstrated that countries at all income levels are providing more intensive and individualized services for children with at-risk conditions, developmental delays, disabilities and behavioral and mental health needs. A major international effort is required to provide technical support to these programs as well as guidance for developing comprehensive, good quality, and sustainable national ECI systems. Additional technical support is also needed for national policy development, strategic planning, and to help countries consider their options regarding the contents of IECD and ECI normative instruments including program guidelines and procedures as well as service and personnel standards. Currently many ECI programs provide parent education and support; community outreach services; developmental screenings; comprehensive developmental assessments with parental participation; case management and referrals; and parental participation in interdisciplinary or transdisciplinary teams; however, these programs need additional technical support to expand other dimensions of their programs, such as individualized family service plans, transdisciplinary or interdisciplinary teams, comprehensive internal monitoring and evaluation systems, and completion and transition plans for children and families as they enter inclusive education and other social services. Finally, it is important that

international agencies expand and improve the competence of their personnel in IECD and ECI planning and programming in order to help nations meet their technical as well as funding needs for program development.

Finally, we issue a **Call for a Global Agenda for Inclusive ECD and ECI Programs.** The Call presents the following strategies and initiatives:

### Call for a Global Agenda for Inclusive ECD and ECI Programs

1. Expand and improve national leadership for IECD and ECI programs.
2. Conduct expanded advocacy and communications for development campaigns.
3. Assess the development of IECD and ECI programs in each nation.
4. Strengthen multisectoral involvement.
5. Place top priority on developing policies, strategic plans, and laws for IECD and ECI systems.
6. Establish universal developmental screening and referrals.
7. Improve the quality of IECD and ECI programs and encourage parent involvement.
8. Increase investment in IECD and ECI programs.
9. Provide high quality and fully accountable IECD and ECI services in each nation.
10. Expand networking and coordination for IECD and ECI services.

# Acronyms

| | |
|---|---|
| ADHD | Attention Deficit and Hyperactivity Disorder |
| ASD | Autism Spectrum Disorder |
| C4D | Communication for Development |
| CBO | Community-Based Organization |
| CBR | Community-Based Rehabilitation |
| CCD | Care for Child Development |
| CEDAW | Convention for the Elimination of Discrimination Against Women |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of Persons with Disabilities |
| DPO | Disabled Peoples' Organization |
| EAP | East Asia and the Pacific |
| ECA | Europe and Central Asia |
| ECD | Early Childhood Development |
| ECDAN | Early Childhood Development Action Network |
| ECDtf | Early Childhood Development Task Force |
| ECE | Early Childhood Education |
| ECI | Early Childhood Intervention |
| EFA | Education for All |
| FBO | Faith-Based Organization |
| GPcwd | Global Partnership on Children with Disabilities |
| ICF-CY | International Classification of Functioning, Disability and Health for Children and Youth |
| IDP | Internally Displaced Persons |
| IDPO | International Disability Peoples' Organization |
| IECD | Inclusive Early Childhood Development |
| IFBO | International Faith-Based Organization |
| IFSP | Individualized Family Service Plans |
| INGO | International Non-Governmental Organization |
| LAC | Latin America and the Caribbean |
| LMIC | Lower- and Middle-Income Countries |
| MCHN | Maternal Child Health and Nutrition |
| M&E | Monitoring and Evaluation |
| MENA | Middle East and North Africa |
| NCF | Nurturing Care Framework |
| NGO | Non-Governmental Organization |
| NICU | Neonatal Intensive Care Unit |
| ODI | Overseas Development Institute |
| OPD | Organizations of Persons with Disabilities |
| SA | South Asia |
| SDG | Sustainable Development Goals |
| SPSS | Statistical Package for the Social Sciences |
| SSA | Sub-Saharan Africa |
| UDL | Universal Design for Learning |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| WASH | Water, sanitation and hygiene |
| WB | World Bank |
| WHO | World Health Organization |

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# 1 Introduction and Survey Objectives

The Global Survey identified programs and activities for inclusive early childhood development (IECD) and early childhood intervention (ECI). For purposes of the survey, we focused on issues of inclusion related to child status and development. Although we are always interested in inclusion with respect to ethnicity, language, and gender, these were not our primary focus.

We used the following general definitions for IECD and ECI:

**Inclusive early childhood development services** include children from birth to eight years with delays and disabilities in early childhood programs, together with their peers without delays and disabilities. These services hold high expectations and intentionally promote participation in all learning and social activities, facilitated by individualized accommodations; and use evidence-based services and supports to foster children's development (cognitive, language, communication, physical, behavioral, and social-emotional), friendships with peers, and sense of belonging. This applies to all young children with disabilities, from those with the mildest delays and disabilities to those with the most significant disabilities. Early childhood systems that are inclusive consider the principles of access, equity, participation and support.

**Early childhood intervention services** are multi-sectoral, integrated and transdisciplinary or interdisciplinary, and are designed to support families with young children from birth to three years[2] who are at risk of or have developmental delays, disabilities or behavioral or mental health needs. ECI programs include a range of individualized services to improve child development and resilience, and strengthen family competencies and parenting skills to facilitate children's development. They often also involve advocacy for the educational and social inclusion of these children and their families.

(For additional definitions, including ECI systems, please see Annex 1: Glossary of Terms.)

## 1.1 The right to early inclusive early childhood development and early childhood intervention services

The *Salamanca Statement and Framework for Action* adopted by the World Conference on Special Needs Education in June 1994 by UNESCO and Spain's Ministry of Education and Science, reaffirmed the 1948 Universal Declaration of Human Rights and also called for inclusive education (UNESCO, 1994; Kiuppis & Hausstatter, 2015). The Statement manifested pledges made at the 1990 World Conference on Education for All; the Action Plan for the implementation of the World Declaration on Survival, Protection and Development of the Child, at the World Summit for Children, in 1990; and the 1993 United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities.

The Salamanca Statement prioritized Early Childhood Education (ECE): "The success of the inclusive school depends considerably on early identification, assessment and stimulation of the very young child with special education needs" (p. 33). The Statement called for pre-service and in-service teacher training to improve inclusion, and for the

[2] In a few countries, the age range for ECI programs is from 0 to 5 years.

expansion of programs through fund mobilization and pilot projects to model and disseminate new approaches.

The ratification of the United Nations Convention on the Rights of the Child (UNCRC, 1989) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) firmly acknowledged the rights of all children to access educational services and learn together in non-discriminating settings with reasonable accommodations (Articles 9, 24 CRPD).

Some have described the UNCRPD as a major paradigm shift. According to Arsenjeva (2013), the CRPD "firmly and unequivocally rejects the medical, or welfare, model of disability, whereby persons with disabilities were seen as weak recipients of charity and/or medical treatment, often responsible for their own condition. Instead, it reaffirms the social, or human rights, model that defines disability as the result of 'the interaction between persons with impairments and attitudinal and environmental barriers." (p. 6).

In 2015, Member States of the United Nations adopted the 2030 Sustainable Development Goals (SDGs), which includes 17 goals. Of these, Goal 4 for educational development calls on States to "ensure inclusive and quality education for all and promote lifelong learning." SDG Target 4.2 states, "By 2030 ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education."

Later, SDG Goal 4 stipulates that access be provided without respect to gender and with equal access for those considered vulnerable, including "persons with disabilities, indigenous peoples and children in vulnerable situations. As well, States shall increase the supply of qualified teachers, including those in developing countries, upgrade their education facilities so that they are disability and gender sensitive and provide safe, nonviolent, inclusive and effective learning environments for all." Thus, ALL young children unequivocally have the right to quality, early and inclusive education.

## 1.2 International expansion of IECD and ECI programs

The roots of the development of IECD and ECI programs are found in the early 1970s in the United States and Colombia. However, the major international expansion of IECD and ECI programs began in the 1990s, in part as a result of the first world Conference for Education for All (EFA) that was held in Jomtien, Thailand in 1990. This was the first time a global education conference declaration stated that early childhood development was an essential part of basic education. This declaration inspired many countries and some international agencies to invest in ECD program development.

The growth of ECI programs in LMIC began in the 1990s, reflecting advances in improving and expanding ECI services in high-income countries as well as in reducing child mortality and morbidity in LMIC. These advances were paralleled by an increased identification and reporting of developmental delays and disabilities, especially in LMIC (UNICEF, 2005; WHO and World Bank, 2011; WHO, 2012; WHO and UNICEF, 2012; UNICEF, 2013; and others).

The watershed decade of 2000 to 2010 coincided with the establishment of the Millennium Development Goals in 2000 that focused on overcoming child mortality and stunting,

among other related goals, and the Second Conference for Education for All held in Dakar, Senegal in 2000 (United Nations, 2000; UNESCO, 2000). In the Dakar conference, focused attention was paid to ECD, and nations were asked to develop ECD policies and focus on providing ECD services for the most vulnerable children (UNESCO, 2000). The publication of From Neurons to Neighborhoods in 2000 and three Lancet ECD series also brought increased attention to the need to serve at-risk children, although these series have not focused fully as yet on children with developmental delays, disabilities or behavioral or mental health needs (Shonkoff & Phillips, 2000; Lancet ECD series, 2007, 2011 and 2017).

## 1.3 Estimating the need

Global rates of disability prevalence are increasingly available, but they are rarely reliable. The World Health Organization's World Report on Disability (2011, p. 25) estimated that approximately 15% of the world's population has some form of disability, with variations ranging from under 1% to over 30% of the population depending on the approach and instrument used.

While the CRPD states that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others" (Preamble), there is no consensus on how and what aspects of disability (i.e., participation, environment, health) should be measured (Cappa, Petrowski, & Njelesani, 2015).

The first International Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1994) approached disability from a medical, disease model. Subsequently, WHO developed the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) representing a biopsychosocial model of human development. The more recent, International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) (WHO, 2007) provides documentation of health, disability and child characteristics and the surrounding environment of the child. Currently, WHO is preparing a new document that will bridge the previous two classification systems. It promises to be more streamlined and comprehensive, addressing all aspects of functioning across the lifespan. In addition, the updated DC-0-5 has recently been published allowing for a complementary system for classification in early childhood (Zero to Three, 2018).3

A multitude of instruments are available for detecting, screening and assessing developmental delays and disabilities (Fernald, Prado, Kariger, & Raikes, 2017). These instruments, however, are not widely available in all nations nor have sufficient studies been carried out to determine cultural and contextual appropriateness (Peña, 2007; Small, Hix-Small, Vargas-Barón, & Marks, 2018). This is particularly true for infants and very young children. Developing countries often use census and household surveys to document disability rates. According to the World Report on Disability (2011), this has yielded substantially lower rates of disability than in countries applying measures that document restriction in participation and activity limitations.

If we include children experiencing adverse conditions and children with developmental delays, the percentage of children in need of ECI and IECD programs approaches 40-

[3] https://www.zerotothree.org/our-work/dc-0-5

50% in some LMIC. The 2017 Lancet ECD series stated: “New estimates, based on proxy measures of stunting and poverty, indicate that 250 million children (43%) younger than 5 years in low-income and middle-income countries are at risk of not reaching their developmental potential.” (Black et al, 2017)

### A Global Crisis

**This high rate of children with at-risk status, developmental delays, disabilities or behavioral or mental health needs constitutes a global crisis. It also reveals a major gap in the provision of high quality inclusive early childhood development (IECD) and early childhood intervention (ECI) services for the families of those children.**

In order to serve all children in need of ECI and IECD programs, culturally and linguistically appropriate measures with strong evidence of reliability, validity, and feasibility in terms of both economics and application are urgently needed to document the prevalence of developmental delay and disabilities in all nations. Additional developmental screening and assessment instruments are required to identify and evaluate all children who require ECI programs. Finally, developmental instruments at the population level are necessary to plan ECI programs and accurately measure national program outcomes over time. Major efforts are currently underway to fill these gaps as quickly as possible.

## 1.4 Our lack of knowledge about the global availability of IECD and ECI programs

Various evaluation research projects conducted on IECD and ECI programs have revealed their effectiveness (Vargas-Barón & Janson, 2009a; Guralnick, 2011). Thanks to child development and neuroscience research and to extensive program development experience, we now know a great deal about what to do and how to do it.

However, little is known about the global status of IECD and ECI programs for the 43% of the world’s children not reaching their developmental potential as well as their parents, legal guardians, and caregivers (Black et al., 2017). These children and their parents require additional support along with individualized and intensive attention to prevent delays and disabilities, overcome them to the extent possible, and improve their development to achieve their full potential.

A few national case studies and sub-regional reviews of service provision exist but they do not give us a global overview of services in these fields (Carpenter, Schloesser, & Eggerton, 2009; Levy, Messner, & Wertlieb, 2014). General ECD studies routinely overlook or exclude children with developmental delays and disabilities (Wertlieb & Krishnamurthy, 2015).

In response to this need to document IECD and ECI practice, RISE Institute, UNICEF, and the GPcwd and its affiliated ECDtf, collaborated to conduct a global survey to identify,

document and better understand existing initiatives that address the rights and needs of children and their families.

## 1.5 Survey purpose and objectives

The general purpose of the Global Survey was to identify and learn about programs and activities in the fields of IECD and ECI.

The main objectives of the Global Survey were to:

- Provide an overview of the current implementation of IECD and ECI programs and related activities in all regions, countries of different income levels, and various contexts.
- Identify and describe key features of service programs and activities for IECD and ECI for children with at-risk situations, developmental delays, disabilities or behavioral or mental health needs, including preventive programs for preconception and prenatal periods.
- Identify gaps and challenges in providing accessible IECD, ECI and related programs, with an emphasis on low- and middle-income nations and countries with conflicts and/or natural disasters.
- Identify factors associated with the successful implementation and scale-up of IECD and ECI programs.
- Generate recommendations to advance the development and implementation of programs for IECD and ECI programs and to promote global exchange and learning.

To achieve these objectives, we obtained an extensive data set on IECD and ECI program characteristics, including implementing sectors, scope and geographic focus of program, target population, policy support, and program approach and objectives. Respondents provided information on screening and referral services within the country, program contents and characteristics, barriers to program development, expansion, demand, and quality, as well as factors that have enhanced program success and program funding.

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# 2 Methodology

# Survey organization and design

Senior Fellows and Fellows of the RISE Institute and the Coordinator of ECDtf structured and designed the Global Online Survey in collaboration with three principal UNICEF specialists in disability, early child development and child protection. Members of the Advisory Board reviewed and helped refine the initial draft of the survey. This large survey was designed in 2016, was conducted in 2017-2018, and the report was prepared in 2018. The online survey was provided in English, French, Portuguese, Russian and Spanish.

## 2.1 Survey structure and content

We asked respondents to provide information on IECD or ECI programs or activities in their home country or a country in which they were working. The survey targeted a range of programs, and activities including:

- IECD programs;
- ECI programs;
- Rehabilitation and habilitation programs;
- Humanitarian emergency, and child protection programs;
- Advocacy campaigns; and
- Research or evaluation projects;

The survey solicited a broad range of program information from respondents including:

- Existence of relevant national policies or strategic plans within the country;
- Lead sectors implementing the program (e.g., health, education, social welfare);
- Scope of program (e.g., local, national, regional);
- Geographic focus of program (e.g., urban, peri-urban, rural)
- Developmental stages covered;
- Target population;
- Approach and types of services;
- Program objectives;
- Roles of parents, grandparents, or legal guardians.

Additionally, we obtained information on: screening and referral services; barriers to program development and expansion; barriers to service demand; barriers to quality; factors that enhanced program success; program finances; and recommendations for creating, improving, and expanding services. The survey instrument is available upon request from RISE Institute.

## 2.2 Types of survey participants sought

We identified survey participants using a two-step, non-probability sampling strategy. First, we employed an “expert” sampling design to identify participants. We chose this sampling approach because it provided the highest likelihood of identifying respondents with the requisite knowledge of inclusive early childhood programming. Specifically, we sought to reach the following professionals: program directors, policy planners, supervisors, trainers, consultants, and specialists in the fields of IECD and ECI, education, child

protection, disability, health and therapies, research and evaluation, and advocacy. To solicit responses, we sent an invitation and link to the survey via e-mail to directors and managers of IECD and ECI programs worldwide and contacted all known international agencies and regional and national ECD and disability networks. We then used a chain sampling method to obtain referrals to other professionals. As a result, many agencies and organizations generously collaborated with us by sharing their mailing lists (unless they had a statutory limitation on sharing their lists for any reason). In total, we distributed the survey to 1,664 professionals representing approximately 288 organizations. Respondent characteristics are described in detail in Chapter 3.

## 2.3 Survey translation

As recommended by the WHO, we used a forward and back translation process to translate the Global Survey, its cover letter, and glossary of terms from English into French, Portuguese, and Spanish (WHO, n.d.). A subject matter specialist in IECD and ECI translated the survey and accompanying materials into Russian using a forward translation process.

## 2.4 Data collection and analysis

We collected data using an online survey design and data collection platform.4 When appropriate, we clustered responses to simplify results and facilitate additional sub-analyses by region, national income level, and status as a "humanitarian crisis country" – those impacted by conflict or natural disasters. For this analysis, UNICEF provided a list of countries with humanitarian situations.5 We conducted all data formatting and analyses in SPSS 24.

[4] https://www.surveymonkey.com/
[5] http://www.educationcannotwait.org/wp-content/uploads/2016/05/Education-crisis_map-with-list-1.pdf

UNICEF/UN0249397/Franco

# 3 Survey Respondents and Countries Represented

In total, we collected data from 121 countries on 426 programs that respondents reported as examples of IECD or ECI practice. (A complete list of respondents is available upon request.) Given our use of a non-probability sampling procedure, the programs included in this report are not representative of all IECD and ECI programs available within the 121 represented countries. The sampling procedure may have resulted in overrepresentation from some participating organizations and underrepresentation from others. Despite these limitations, the programs included in this report represent all world regions and economies and, therefore, provide a rich "global snapshot" of current IECD and ECI programming.

## 3.1 Responses by languages

Using several ECD and disability regional and national networks, agencies and governmental units, every effort was made to secure responses from countries where the following languages – often in addition to other languages – are commonly spoken: English, French, Portuguese, Russian and Spanish. The majority of survey responses were in English (80%). Respondents also completed surveys in Spanish (10%), French (4%), Portuguese (4%), and Russian (3%).6 We lacked the capacity to translate the survey to Arabic, and this limited our outreach to several countries. Nonetheless, some predominantly Arabic-speaking countries are represented in the survey.

## 3.2 Country of residence of respondent

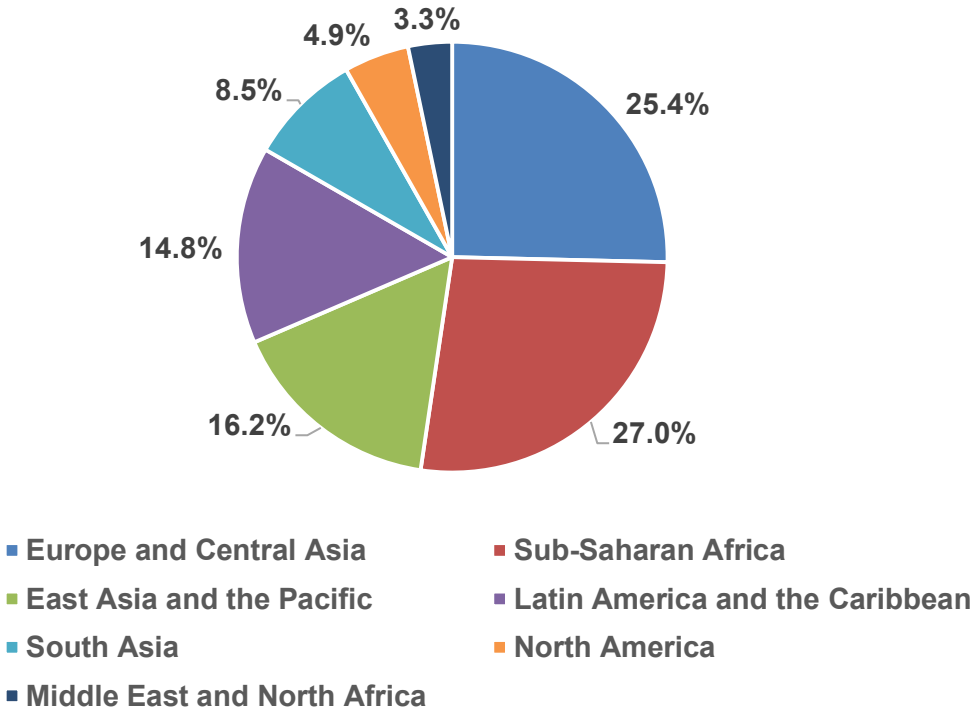
Most respondents (88%) reported on a program located in the country in which they resided. In other words, the majority were in-country respondents providing information on a program being implemented within their current country of residence. The remaining respondents provided information on a global or regional program or on a program implemented outside their current country of residence.

## 3.3 Program regions and countries

The largest number of IECD and ECI programs identified was located in Sub-Saharan Africa (SSA; n = 115) followed next by Europe and Central Asia (ECA; n = 108). Programs in East Asia and the Pacific (EAP); n = 69) and Latin America and the Caribbean (LAC; n = 63) made up nearly 15% of the sample each. Programs from South Asia (n = 36), North America (n = 21), and the Middle East and North Africa (MENA; n = 14) each made up less than 10% of the sample. Figure 1 below summarizes the percent of programs reported on by region.

[6] Here and throughout the document percentages may not sum to 100% due to rounding.

**Figure 1. Percent of reported programs by region**




On average, we received responses on four programs per country (M[SD] = 3.5[3.4]) although the actual number ranged from 1 to 18 programs per country. For 29 countries, respondents reported five or more programs. For 8 of the 29 countries, we received information on 10 or more programs: Colombia (n = 18), Croatia (n = 13), Myanmar (n = 10), Nigeria (n = 15), Philippines (n = 14), South Africa (n = 10), United States (n = 16), and Zimbabwe (n = 13). For a complete list of countries by region, see Annex 2.

## 3.4 Countries by national income levels

We used data from the World Bank (WB) to categorize participating countries according to gross national income level.7. Table 1 below provides a breakdown by income level for the 426 programs.

***Table 1: Survey Countries by Level of Income***

| Income group | N | % |
|---|---|---|
| Low-income | 72 | 16.9 |
| Lower middle-income | 154 | 36.2 |
| Upper middle-income | 103 | 24.2 |
| High-income | 92 | 21.6 |

[7] For details on WB categories, see https://datahelpdesk.worldbank.org/knowledgebase/articles/378832-what-is-the-world-bank-atlas-method

| Income group | N | % |
|---|---|---|
| Not available[8] | 5 | 1.2 |
| Total | 426 | 100.0 |

More than 60% of the programs were implemented in middle-income countries. Overall, 77% of the programs were implemented in low- or middle-income countries. See Annex 3 for a breakdown of income level by world region.

## 3.5 Countries affected by humanitarian crises

We used information from the Overseas Development Institute (ODI) to identify and categorize countries affected by conflict and natural disasters. Respondents reported on 22 of the 35 (63%) countries reportedly affected by humanitarian crises in 2015 (ODI, 2016).

In total, 119 of the 426 programs (28%) were being implemented in countries affected by humanitarian crises. For the SSA region, respondents provided data on 48 programs in 11 countries affected by humanitarian crises. For the remaining world regions, respondents reported on the following number of countries and programs: MENA (countries = 3; programs = 5); EAP (countries = 2; programs = 24); LAC (countries = 2; programs = 19); South Asia (countries = 2; programs = 13); and ECA (countries = 2; programs = 10). All countries categorized as affected by humanitarian crises were contacted but many did not report any IECD or ECI programs. See Annex 4 for a more detailed regional breakdown of the countries affected by humanitarian crises.

## 3.6 Respondent professional characteristics

The majority of respondents (62%) reported working for a national organization. The remaining participants worked for either an international non-governmental organization (NGO; 27%), or a government (12%). Annex 5 provides a more detailed breakdown of the organizations for which respondents reported working.

As detailed in Table 2, respondents reported work in a range of fields. For additional information of respondents' professional fields, see Annex 6.

*Table 2. Professional Fields of Respondents*

| Professional fields | N | % |
|---|---|---|
| Health, nutrition, and therapies | 95 | 22.3 |
| Inclusive pre-primary and special education | 86 | 20.2 |
| Early Childhood Development (ECD) | 79 | 18.5 |
| Social science field and humanities | 62 | 14.6 |
| Early Childhood Intervention (ECI) | 47 | 11.0 |
| Policy, management, administration, and advocacy | 35 | 8.2 |
| Child Protection or Social Services | 22 | 5.2 |

[8] Since the WB only calculates income groups for WB member economies and economies with population exceeding 30,000, the following countries did not have a corresponding WB income level: Cook Islands (2 programs), Palestine (2) and Niue (1).

| Professional fields | N | % |
|---|---|---|
| **Total** | **426** | **100.0** |

Almost half of the respondents were subject matter specialists (49%). The remaining respondents served as program directors or government managers (34%) or leading technical specialists. A small percentage of respondents (1%) reported a non-professional role, such as a parent or paraprofessional. Annex 7 provides a further breakdown of the primary role respondents reported.

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# 4 Survey Findings and Conclusions

In the following section, we present findings on the 426 programs identified through this global survey under the following headings. Conclusions are marked in bold throughout this chapter.

4.1 Types of Programs
4.2 Policy Dimensions
4.3 Program Objectives, Development and Sectors
4.4 Program Participants and Contents
4.5 Services Provided: by Age Ranges and Types
4.6 Parental Participation and Program Accountability
4.7 Barriers and Challenges Faced by IECD and ECI Programs
4.8 Achieving Program Success
4.9 Investing in IECD and ECI Programs

First, the types of IECD and ECI programs and activities are presented as a basis for addressing key elements of policy and program development.

## 4.1 Types of Programs

Respondents were asked to characterize their programs according to the categories in Table 3.

***Table 3: Program Type***

| Program type | N | % |
|---|---|---|
| Both ECD and ECI | 169 | 39.7 |
| ECD only or mainly | 109 | 25.6 |
| ECI only or mainly | 48 | 11.3 |
| Advocacy campaign | 58 | 13.6 |
| Research or evaluation project | 52 | 12.2 |
| Rehabilitation or habilitation (center-based service) | 51 | 12.0 |
| Humanitarian crisis emergency, or protection service | 30 | 7.0 |
| Other[9] | 21 | 4.9 |

Of the 426 programs, 315 (74%) reported only one program type. For the remaining 111 programs, respondents reported two program areas. The largest percentage of programs included both ECD and ECI activities (40%). “ECD only or mainly” was the next largest category (26%).

Although respondents reported that only 12% of programs provided ECI services “only or mainly,” as stated in Section 4.5.6, a total of 241 (57%) programs reported providing ECI services. This coupling of ECI with IECD services reveals that ECI programs in many

[9] Of those reporting ‘other’ for program type, 7 programs were described as academic or training programs and 2 were described as community-based rehabilitation. For the remaining 12 programs, no description was provided.

countries followed a twin-track approach. Generally, many ECI programs served at-risk children as well as those with identified developmental delays and disabilities.

**Essentially, many programs provided a continuum of comprehensive services for children and families, from non-individualized and less intensive IECD services to more individualized and intensive ECI services.**

Respondents reported a small percentage of rehabilitation or habilitation services (12%). More programs with community-based rehabilitation (CBR) services were noted but they were combined with other programs and initiatives.

In Annex 8, program types were further clustered. This clustering revealed that 100 (24%) of the IECD and ECI initiatives did not provide direct services but rather focused on advocacy, research and evaluation, and training.

**This suggests that national governments should anticipate supporting initiatives for advocacy, research and evaluation, and pre- and in-service training. These support activities contribute to IECD and ECI systems development and enable the development of well-functioning early childhood systems and programs** (Vargas-Barón, 2013).

In Table 4, the types of programs are arrayed by region.

*Table 4: Type of Program by region*

| Region | Both ECD and ECI (%) | ECD only or mainly (%) | ECI only or mainly (%) | No ECD/ECI services (%) |
|---|---|---|---|---|
| Europe and Central Asia | 34 (31.5) | 32 (29.6) | 22 (20.4) | 20 (18.5) |
| East Asia and the Pacific | 30 (43.5) | 16 (23.2) | 11 (15.9) | 12 (17.4) |
| Sub-Saharan Africa | 57 (49.6) | 24 (20.9) | 8 (7.0) | 26 (22.6) |
| Latin America and the Caribbean | 24 (20.9) | 17 (27.0) | 1 (1.6) | 21 (33.3) |
| South Asia | 13 (36.1) | .11 (30.6) | 1 (2.8) | 11 (30.6) |
| North America | 5 (23.8) | 3 (14.3) | 4 (19.0) | 9 (42.9) |
| Middle East and North Africa | 6 (42.9) | 6 (42.9) | 1 (7.1) | 1 (7.1) |

These results reveal notable regional variations. Latin America and the Caribbean (LAC) and South Asia lack “ECI only or mainly” services, and they have fewer combined ECD and ECI programs than other regions. This result may be due to limited sampling; however, national laws and children’s codes in Latin America focus on the provision of center-based rehabilitation services that use a medical model (UNESCO, 2010).

Rehabilitation centers abound in the LAC region. This result stands in contrast to nations of Western and Eastern Europe, Central Asia, North America and East Asia and the Pacific, where participating respondents reported the presence of relatively more ECI programs.

**It is notable that Sub-Saharan Africa, a region with many at-risk children, has begun to develop several ECI programs as well as twin-tracked IECD and ECI programs. It appears that countries of the Middle East and North Africa had very few IECD and ECI programs; however, this might have been due to receiving relatively fewer responses from countries in these regions.**

In Table 5, where program types are arrayed by country income level, respondents reported the implementation of fewer "ECI only or mainly" programs in low-income countries as compared to other income categories; however, it is clear that low-income countries are beginning to develop ECI programs.

As anticipated, high-income countries had the largest percentage of programs offering "only or mainly" ECI programs. For combined ECD and ECI programs, percentages of programs were comparable across income levels; however, low- (46%) and lower-middle-income (43%) countries reported the highest percentages of combined programs.

*Table 5: Type of Program by income level*

| Region | Both ECD and ECI (%) | ECD only or mainly (%) | ECI only or mainly (%) | No ECD or ECI services (%) |
|---|---|---|---|---|
| Low-income | 33 (45.8) | 15 (20.8) | 2 (2.8) | 22 (30.6) |
| Lower middle-income | 66 (42.9) | 45 (29.2) | 16 (10.4) | 27 (17.5) |
| Upper middle-income | 37 (35.9) | 30 (29.1) | 10 (9.7) | 26 (25.2) |
| High-income | 29 (31.5) | 18 (19.6) | 20 (21.7) | 25 (27.2) |

Table 6 provides a breakdown of program type by countries affected and not affected by humanitarian crises. In countries affected by humanitarian crises, respondents reported a lower percentage of combined ECD and ECI programs (33%) and programs providing "only or mainly" ECI services (8%) as compared to countries not affected by humanitarian crises (42% and 13%, respectively).

**Although some IECD and ECI programs are underway in countries undergoing a wide range of crises, given high levels of childhood trauma and developmental delays and disabilities found in young children, many more programs are urgently needed.**

*Table 6: Type of Program by countries affected by humanitarian crises*

| | Both ECD and ECI (%) | ECD only or mainly (%) | ECI only or mainly (%) | No ECD or ECI services (%) |
|---|---|---|---|---|
| Countries affected by humanitarian crises | 39 (32.8) | 31 (26.1) | 9 (7.6) | 40 (33.6) |
| Countries not affected by humanitarian crises | 130 (42.3) | 78 (25.4) | 39 (12.7) | 60 (19.5) |

## 4.2 Policy Dimensions

### 4.2.1 Presence/absence of a legal or normative policy framework

To ensure that IECD and ECI programs have a legal basis, official authorization, and long-term sustainability, they must have one or more legal or normative policy frameworks. As presented in Table 7, respondents reported that over 70% of programs were authorized by an official legal or normative policy framework. A larger percentage of "ECD only or mainly" programs (90%) reported alignment with a national framework as compared to "ECI only or mainly" programs (58%).

*Table 7: Program Authorized by a Legal or Normative Policy Framework*

| Type | Total (n = 426) | Both ECD and ECI (n = 169) | ECD only or mainly (n = 109) | ECI only or mainly (n = 48) | No ECD or ECI services (n = 100) |
|---|---|---|---|---|---|
| Yes | 306 (71.8) | 116 (68.6) | 98 (89.9) | 28 (58.3) | 64 (64.0) |
| No | 72 (16.9) | 31 (18.3) | 5 (4.6) | 12 (25.0) | 24 (24.0) |
| Do not know[10] | 48 (11.3) | 22 (13.0) | 6 (5.5) | 8 (16.7) | 12 (12.0) |

**Greater emphasis should be placed on conducting policy and strategic planning to establish a legal basis for all national ECI systems. Each country's ECI and IECD programs should have full legal authorization and official normative program guidelines and procedures to ensure quality as well as sustainability.**

### 4.2.2 Official national legal or normative policy frameworks

Among the 306 programs implemented in countries with an established national legal or normative IECD or ECI policy framework, 163 programs reported one framework and 132 programs reported from two to five frameworks.11 Most respondents (n = 278, 65%)

[10] Some 11% of respondents lacked information on their program's legal status at the national level.
[11] Missing data = 11 programs.

reported from one to three legal or normative national frameworks in place in the program country.

For the 163 programs reporting **only one framework,** the breakdown by framework type is as follows:

- 67 (41%) reported there was *a national policy or section of a policy*
- 38 (23%) reported there was *a national law/act or section of a law/act*
- 37 (23%) reported there was *a national strategic plan and/or an action plan*
- 15 (9%) reported there was *a program protocol, regulations, bylaws and/or standards*
- 3 (2%) reported there was *some other legal or normative framework*
- 3 (2%) reported there was *a state or regional law*

Countries in this sample mainly established national policies or sections of policies rather than legislation.

**Very few programs with only one normative instrument (9%) reported they were guided by national-level protocols, regulations, bylaws and standards, revealing the importance of creating policies, strategic plans or laws first.**

For the 132 programs reporting more than one policy framework, the breakdown was as follows:

- 99 (75%) reported there was *a national policy or section of a policy*
- 93 (71%) reported there was *a national strategic plan and/or an action plan*
- 65 (49%) reported there was *a national law/act or section of a law/act*
- 57 (43%) reported there was *a program protocol, regulations, bylaws and/or standards*
- 25 (19%) reported there was *some other legal or normative framework*

After policies and sections of policies, nations in this sample of 132 programs usually established national strategic plans and/or action plans. However, only 43% of the programs had national program protocols, regulations, bylaws and/or standards. Of those programs with more than one national framework to guide them, over half (71 of the 132 programs, 54%) had both a national policy and a national strategic plan. (See Annex 9 for a summary of the combinations of frameworks for programs reporting more than one national framework.)

Many regional differences exist with regard to policy development. Although some regions use one form of legal instrument over another, Table 8 shows that globally IECD and ECI national policies and strategic plans are used more than laws or sections of laws. Most nations with protocols, regulations, bylaws or standards also tend to have national policies and strategic plans, and relatively fewer have laws.

***Table 8: National Legal Policy Framework by Region.***

| Legal framework | ECA | EAP | SSA | LAC | SA | NA |
|---|---|---|---|---|---|---|

| Legal framework | ECA | EAP | SSA | LAC | SA | NA |
|---|---|---|---|---|---|---|
| a. A national policy or section of a policy | 23 (31.9) | 26 (63.4) | 65 (73.9) | 34 (69.4) | 13 (54.2) | 1 (9.1) |
| b. A national strategic plan and/or an action plan | 36 (50.0) | 17 (41.5) | 47 (53.4) | 13 (26.5) | 11 (45.8) | 1 (9.1) |
| c. A national law/act or section of a law/act | 36 (50.0) | 13 (31.7) | 16 (18.2) | 17 (34.7) | 10 (41.7) | 8 (72.7) |
| d. Program protocol, regulations, bylaws and/or standards | 24 (33.3) | 4 (9.8) | 15 (17.0) | 14 (28.6) | 9 (37.5) | 4 (36.4) |
| e. Other legal or normative framework | 8 (11.1) | 2 (4.9) | 5 (5.7) | 8 (16.3) | 3 (12.5) | 1 (9.1) |

ECA = Europe and Central Asia; EAP = East Asia and the Pacific; SSA = Sub-Saharan Africa; LAC = Latin America and the Caribbean; SA = South Asia; NA = North America.

Strategic plans and/or action plans were more prevalent in Sub-Saharan Africa, Europe and Central Asia, East Asia and the Pacific, and South Asia. Latin America and the Caribbean reported a reduced use of these types of instruments.12 Program protocols, regulations, bylaws and/or standards were most frequently found in only about one third of the countries in South Asia, North America, Europe and Central Asia, and Latin America and the Caribbean. Sub-Saharan Africa and East Asia and the Pacific registered much lower rates of use of regulations.

**In most LMIC, in addition to policies and plans, national level protocols, regulations, bylaws and standards need to be developed and officially adopted for IECD and ECI programs.**

## 4.3 Program Objectives, Development and Sectors

### 4.3.1 Program objectives

The 15 program objectives offered to respondents are listed in Table 9. On average, respondents selected approximately six objectives. (M[SD] = 5.7[3.3]).

*Table 9: Program Objectives*

| Objective | N | % |
|---|---|---|
| Provide training for professionals, teachers, caregivers and others in IECD, ECI or related services | 283 | 66.4 |
| Develop services with and for parents, parent education and support | 250 | 58.7 |

[12] The numbers of countries represented in the Middle East and North Africa were too few to include here.

| Objective | N | % |
|---|---|---|
| Advocate for child and parental rights and services | 229 | 53.8 |
| Provide early childhood intervention services (i.e., assessments, IFSPs, home visits) | 224 | 52.6 |
| Ensure provision of inclusive and accessible pre-primary and primary school services | 224 | 52.6 |
| Improve child health, nutrition and development | 216 | 50.7 |
| Conduct research or evaluation services | 176 | 41.3 |
| Identify children requiring services: screening, surveillance and monitoring | 172 | 40.4 |
| Improve child safety and protection | 169 | 39.7 |
| Provide rehabilitation/habilitation services for young children | 136 | 31.9 |
| Achieve service development goals, such as policy planning and SDGs | 130 | 30.5 |
| Improve child hygiene and home sanitation (WASH)[13] | 103 | 24.2 |
| Improve birth outcomes: low birth weight, preterm birth, fragile infants | 54 | 12.7 |
| Deinstitutionalize young children and prevent their institutionalization | 54 | 12.7 |
| Other | 14 | 3.3 |

The objective most frequently mentioned was, “Provide training for professionals, teachers, caregivers and others in IECD, ECI or related services” (66%; n = 283). This emphasis on workforce development reflects the importance of pre- and in-service training in the fields of IECD and ECI.

“Develop services with and for parents, parent education and support” (250, 59%), and “Advocate for child and parental rights and services” (n = 229, 54%) were also frequently mentioned, and they are fully in line with the Convention on the Rights of Children and the Convention on the Rights of Persons with Disabilities.

Over half (53%) of the programs were reported to: “Provide early childhood intervention services (i.e., assessments, IFSPs, home visits).” Similarly, 53% of respondents noted their program sought to “Ensure provision of inclusive and accessible pre-primary and primary school services.”

**These results demonstrate a major interest in ECI, inclusive education, health, and nutrition services for children with at-risk situations, developmental delays, disabilities or behavioral or mental health conditions. They also reveal a pervasive commitment to using both education and health sectors to serve children, parents, and caregivers.**

The result “Conduct research or evaluation services” (n = 176, 41%) reveals that many programs place importance on providing evidence-based services that will have a measurable impact on children. However, only 172 programs (40%) reported “screening, surveillance and monitoring” as a program objective, despite the central role these services should play in implementing IECD and ECI programs. (For definitions of developmental screening, surveillance and monitoring, see the Glossary of Terms.)

**The objectives least frequently mentioned were “deinstitutionalization” and “improving birth outcomes.” These areas urgently require more attention, especially in LMIC. Major international efforts are underway to prevent the**

[13] WASH is used throughout the report to refer to water, sanitation and hygiene.

**institutionalization of children with and without disabilities from birth to three or five years of age as well as to deinstitutionalize those already placed in institutions. However, much more must be done. This result reveals the need to expand advocacy for the establishment and expansion of ECI and related multisectoral services required to prevent institutionalization and support deinstitutionalization.**

**The lower priority given to "improving birth outcomes" is of concern. Without intensive ECI program services, many survivors of preterm birth face a lifetime of disability, including learning disabilities and visual and hearing problems. Failure to provide preconception and neonatal education and care can result in increased rates of child mortality, morbidity, and disability as well as lost developmental potential, and the increase of non-communicable diseases.**

### 4.3.2 Year program was founded

As noted in the Introduction, the major international development and expansion of large-scale IECD and ECI programs began the 1990's. In Table 10, study results reveal that most of the long-term IECD and ECI programs that began in the years before 1990 were developed in Europe and Central Asia, Latin America and the Caribbean, North America, and South Asia. Subsequently, in the 1990s and 2000s, an overall rapid rise of IECD and ECI programs was identified, and most especially in East Asia and the Pacific and Sub-Saharan Africa.

Overall, IECD and ECI program development appears to be regularly increasing over time. However, many more programs are needed in all nations, and most especially in lower and middle-income countries and the Middle East and North Africa region.

*Table 10: Founding Year of Program by Region*

| Region | 1950s N | 1960s N | 1970s N | 1980s N | 1990s N | 2000s N | 2010-present N |
|---|---|---|---|---|---|---|---|
| Europe and Central Asia | 0 | 0 | 1 | 0 | 14 | 34 | 58 |
| Sub-Saharan Africa | 1 | 1 | 2 | 2 | 9 | 36 | 61 |
| East Asia and the Pacific | 0 | 1 | 1 | 5 | 11 | 18 | 33 |
| Latin America and the Caribbean | 1 | 0 | 5 | 4 | 4 | 16 | 33 |
| South Asia | 0 | 0 | 0 | 3 | 5 | 14 | 13 |
| North America | 0 | 2 | 3 | 5 | 3 | 6 | 2 |
| Middle East and North Africa | 0 | 0 | 0 | 1 | 1 | 4 | 8 |
| Totals | 2 | 4 | 12 | 20 | 47 | 128 | 208 |

In Annex 10, the founding year of programs is arrayed by national country income. Unsurprisingly, early leadership for IECD and ECI programs originated in high-income nations with extensive university systems and greater resources. However, in the 1990s,

the growth of programs in LMIC has been notable, and since 2000, program expansion has been impressive.

In Annex 11, founding years are arrayed for countries affected by humanitarian crises. In the 1990s, and especially from 2000 to the present, increases in the numbers of IECD and ECI programs in these countries appear to parallel the growth of community and regional conflicts as well as natural disasters. As noted before, although all of these countries were contacted, many of them did not report any IECD or ECI programs.

**It is essential to strengthen IECD and ECI programs for children and families affected by conflict and natural disasters because they are even more vulnerable and at risk of trauma, malnutrition and chronic illnesses. The numbers of refugee, internally displaced, and migrant children have increased significantly. Greater attention should be given to establishing and expanding IECD and ECI programs in countries with or affected by humanitarian crises.**

### 4.3.3 Lead sector for programs

The selection of the lead sector for IECD and ECI programs has been hotly debated at national, regional and global levels, with some agencies recommending leadership by the health sector. However, the survey reveals that education is usually the lead sector, with strong participation also by health, nutrition and social and child protection.

IECD programs are often found under various arrangements in education, health/nutrition, child protection, and sometimes in special multisectoral sectors (such as women, gender, children and youth). Of necessity, ECI programs must be integrated in order to be cost-effective and efficient. They are usually placed under one lead sector with strong multisectoral participation and coordination.

Of the 426 programs surveyed, 180 (42%) reported only one lead sector and 238 (56%) reported that multiple sectors led the program.14 Below is the breakdown of the lead sector for the 180 programs reporting a single lead sector:

- Education: n = 123 (68%)
- Health: n = 34 (19%)
- Social protection: n = 21 (12%)
- Nutrition: n = 2 (1%)
- WASH: n = 0 (0%)[15]

**These results may be linked to education's roles in leading parenting programs and inclusive initial, pre-primary and primary education for children with delays and disabilities. Health/nutrition/WASH and social protection registered much lower rates.**

As can be seen in Table 11, education is the lead sector for IECD and ECI programs in all world regions.

[14] Eight programs (2%) did not respond to this question.
[15] WASH is used throughout the report to refer to water, sanitation and hygiene.

*Table 11: Lead Sector by Region for Programs Reporting One Lead Sector*

| Region | Education (%) | Health (%) | Social Protection[16] (%) | Nutrition (%) |
|---|---|---|---|---|
| Europe and Central Asia | 25 (53.2) | 11 (23.4) | 11 (23.4) | 0 (0.0) |
| Sub-Saharan Africa | 35 (74.5) | 8 (17.0) | 3 (6.4) | 1 (2.1) |
| East Asia and the Pacific | 25 (83.3) | 4 (13.3) | 1 (3.3) | 0 (0.0) |
| Latin America and the Caribbean | 14 (60.9) | 5 (21.7) | 3 (13.0) | 1 (4.3) |
| South Asia | 11 (73.3) | 2 (13.3) | 2 (13.3) | 0 (0.0) |
| North America | 10 (71.4) | 3 (21.4) | 1 (7.1) | 0 (0.0) |
| Middle East and North Africa | 3 (75.0) | 1 (25.0) | 0 (0.0) | 0 (0.0) |

Table 12 provides a breakdown of lead sector by income group, and education remains the leader. Some 47% of high-income countries (n = 42), 51% of upper middle-income (n = 51), 40% of lower middle-income countries (n= 61), and 35% of low-income countries (n = 24) reported one lead sector.

*Table 12: Lead Sector by Income Group for Programs Reporting One Lead Sector*

| Region | Education (%) | Health (%) | Social Protection[17] (%) | Nutrition (%) |
|---|---|---|---|---|
| Low-income | 18 (75.0) | 5 (20.8) | 1 (4.2) | 0 (0.0) |
| Lower middle-income | 48 (78.7) | 7 (11.5) | 5 (8.2) | 1 (1.6) |
| Upper middle-income | 28 (54.9) | 13 (25.5) | 9 (17.6) | 1 (2.0) |
| High-income | 28 (66.7) | 8 (19.0) | 6 (14.3) | 0 (0.0) |

Most of the programs reporting education as the lead sector were found in lower middle-income (79%) and low-income (75%) countries.

Table 13 presents data on lead sector by countries affected by humanitarian crises for programs reporting one lead sector. The percentage of programs reporting one lead sector was comparable across countries affected and not affected by humanitarian crises (41% and 44%, respectively). Like the overall sample, the education sector most frequently led programs implemented in countries affected by humanitarian crises.

*Table 13: Lead Sector by Humanitarian Crisis Country Status for Programs Reporting One Lead Sector*

[16] Social or child protection or social welfare
[17] Social or child protection or social welfare. Note: N reported in table = 178; two programs reporting one lead sector were not included in World Bank income group categorization.

| | Education (%) | Health (%) | Social Protection (%) | Nutrition (%) |
|---|---|---|---|---|
| Countries affected by humanitarian crises | 34 (72.3) | 6 (12.8) | 5 (10.6) | 2 (4.3) |
| Countries not affected by humanitarian crises | 89 (66.9) | 28 (21.1) | 16 (12.0) | 0 (0.0) |

Similarly, education is the lead sector for most of the countries with multisectoral arrangements. Below is a breakdown of sectoral involvement for the 288 programs reporting more than one lead sector:

- Education: n = 216 (91%)
- Social protection: n = 187 (79%)
- Health: n = 183 (77%)
- Nutrition: n = 93 (39%)
- WASH: n = 57 (24%)

For programs with multisectoral leadership (56%), once again education led with participation in 91% of the multisectoral arrangements. Social protection (79%) and health (77%) showed they also participate highly in multisectoral arrangements.

Table 14 shows that health and social protection as well as nutrition and sanitation/WASH sectors also play important roles in multisectoral arrangements.

***Table 14: Programs Reporting Multiple Lead Sectors***

| Lead sector | a | b | c | d | e |
|---|---|---|---|---|---|
| a. Education (n = 216) | -- | 163 (75.5) | 168 (77.8) | 85 (39.4) | 55 (25.5) |
| b. Health (n = 183) | 163 (89.1) | -- | 137 (74.9) | 75 (41.0) | 47 (25.7) |
| c. Social protection (n=187) | 168 (89.8) | 137 (73.3) | -- | 71 (38.0) | 49 (26.2) |
| d. Nutrition (n = 93) | 85 (91.4) | 75 (80.6) | 71 (76.3) | -- | 46 (49.5) |
| e. WASH (n = 57) | 55 (96.5) | 47 (82.5) | 49 (86.0) | 46 (80.7) | -- |

Health and social protection rise in importance for multisectoral IECD and integrated ECI programs, and Nutrition and WASH also emerge as valuable sectors. However, education continues to retain its leadership.

As shown in Table 15, in Europe and Central Asia, multisectoral involvement was divided more equally between education, health, and social protection; whereas in most of the other world regions, multisectoral involvement seems to be driven more by education. Nutrition and WASH played more leading roles in Sub-Saharan Africa, Latin America and the Caribbean, and the Middle East and North Africa in comparison to Europe and North America. In comparison to the other regions, there was relatively less involvement of the health sector in multisectoral leadership in Latin America and the Caribbean.

*Table 15: Programs Reporting Lead Sector by Region*

| Region | Education (%) | Health (%) | Social Protection (%) | Nutrition (%) | WASH (%) |
|---|---|---|---|---|---|
| Europe and Central Asia | 74 (68.5) | 59 (54.6) | 58 (53.7) | 6 (5.6) | 1 (0.9) |
| Sub-Saharan Africa | 96 (83.5) | 65 (56.5) | 55 (47.8) | 33 (28.7) | 20 (17.4) |
| East Asia and the Pacific | 62 (89.9) | 39 (56.6) | 30 (43.5) | 18 (26.1) | 12 (17.4) |
| Latin America and the Caribbean | 48 (76.2) | 18 (28.6) | 35 (55.6) | 25 (39.7) | 12 (19.0) |
| South Asia | 29 (80.6) | 19 (52.8) | 18 (50.0) | 7 (19.4) | 9 (25.0) |
| North America | 17 (81.0) | 9 (42.9) | 3 (14.3) | 1 (4.8) | 0 (0.0) |
| Middle East and North Africa | 13 (92.9) | 8 (57.1) | 9 (64.3) | 5 (35.7) | 3 (21.4) |

**These findings regarding lead sectors and multisectoral participation in leadership demonstrate that in the future, it is likely that education will continue to play a major leadership role. For the multisectoral development of IECD and ECI programs, all three sectors should continue to participate as fully as possible. Institutional cultures, policy contexts, and systems of governance differ greatly from country to country. In the foreseeable future, it is likely that nations will continue make independent choices regarding their lead sectors for IECD and ECI programs.**

### 4.3.4 Overall sector Engagement

In contrast to sectoral and multisectoral leadership, this section addressed sector engagement and involvement in IECD and ECI programs. Of the 426 programs, 95 (22%) reported involvement from only one sector; whereas, 327 (77%) reported multisectoral engagement.18

Below is a breakdown of sectors for the 95 programs reporting engagement from only one sector:

- Education: n = 69 (73%)
- Health: n = 18 (19%)
- Social protection: n = 7 (7%)
- Nutrition: n = 1 (1%)

For the 22% of programs conducted by only one sector, education (73% of programs) was the main sector. This was most likely due to the provision of inclusive education programs. However, many inclusive education programs were found to be multisectoral, including health care, feeding and social protection services.

[18] This information was missing for 4 programs (0.9%).

In Annex 12, the regional breakdowns for the 95 programs with single sector involvement revealed that once again education predominated in all regions. Sub-Saharan Africa had the lowest rate at 57% for education and the highest rate for health (30%).

With respect to the 327 programs with multisectoral engagement, the following breakdown reflects the primacy of education; however, health and social protection also played major roles in IECD and ECI programs.

- Education: n = 307 (94%)
- Health: n = 286 (88%)
- Social protection: n = 269 (82%)
- Nutrition: n = 148 (45%)
- WASH: n = 106 (32%)

Annex 13 presents the combination of sectoral involvements in IECD and ECI programs with multisectoral engagement. The strong engagement of health, social protection, nutrition and WASH in education programs was notable. However, the involvement of nutrition in health programs was relatively low (50%). This finding merits special attention since high levels of child malnutrition and developmental delays are found in most LMIC.

As may be seen in Annex 14 regarding sectoral engagement per region, the participation of education, health, and social protection in IECD and ECI programs was uniformly high in all regions. However, nutrition and WASH were less frequently involved in high-income regions (Europe and Central Asia, and North America). Similar results were found when sectors were arrayed by country income level and by the presence or absence of humanitarian crises. (See Annexes 15 and 16.)

**These results also demonstrate that multisectoral approaches can and usually are achieved in services requiring the participation of two or more sectors. Those who have advocated a sectoral approach to IECD and ECI programs should reflect on these results, and search for positive ways to ensure the provision of strong multisectoral planning; effective coordination; interdisciplinary program standards, contents and methods; cross-sectoral and interdisciplinary pre- and in-service training; and joint supervision as well as coordinated systems of accountability, reporting and planning.**

### 4.3.5 Scope of program in terms of international, regional and national coverage

Of the 426 programs included in the survey, the following levels of program coverage were reported:

*Table 16: Program Coverage*

| Scope | N | % |
|---|---|---|
| Nationwide program | 152 | 35.7 |
| Some country regions or districts | 87 | 20.4 |
| International or multi-country regional program | 83 | 19.5 |

| Scope | N | % |
|---|---|---|
| One region or district in country | 59 | 13.8 |
| A few communities | 36 | 8.5 |
| One community | 9 | 2.1 |

In Table 16, large-scale, nationwide and international or multi-country regional programs were in the majority (n = 235, 55%). Small-scale and medium-sized program composed 45% of the services.

**Although some hypothesized that most IECD and ECI programs were mainly small pilot efforts, respondents reported that 55% were large-scale nationwide, international, multi-country or regional programs. It is important to note that small-scale programs (24%) often provide important innovations; however, unless they are well designed and have complete development processes, it is challenging to take them to scale. (Vargas-Barón, 2009b)**

### 4.3.6 National geographic service coverage

Many IECD and ECI programs include more than one type of geographic coverage area. It has been posited that these programs are mainly found in urban and peri-urban areas. However, in Table 17, the findings reflect that programs have made major efforts to serve semi-rural areas, towns and rural areas. However, only 21% of programs served indigenous populations.

*Table 17: Geographic Coverage*

| Scope | N | % |
|---|---|---|
| Urban | 293 | 68.8 |
| Rural | 282 | 66.2 |
| Semi-rural or town | 215 | 50.5 |
| Peri-urban | 173 | 40.6 |
| Indigenous | 90 | 21.1 |
| Other | 8 | 1.9 |

Over two thirds of the programs in the sample (76%; n = 322) targeted either an urban or a peri-urban setting. Of the 426 programs, only 85 (20%) focused exclusively on urban or peri-urban areas. Of these 85 programs, 69 targeted urban areas only, 8 targeted peri-urban areas only, and 8 targeted both areas.

The remaining 237 programs that targeted urban or peri-urban settings also targeted rural (90%) or semi-rural (73%) areas. A smaller percentage of programs targeting urban or peri-urban settings also targeted indigenous communities (28%). Overall, 275 of the 426 programs (65%) focused on two or more geographic areas. Additionally, 189 programs (44%) targeted three or more geographic areas. The mean coverage was 2.5 geographic areas.

**In general, IECD and ECI programs are larger and cover more semi-rural and rural areas than expected. Case studies of semi-rural, rural and indigenous IECD and ECI programs should be conducted to gain a greater understanding of the processes and methods they use to provide their services.**

## 4.4 Program Participants and Contents

### 4.4.1 Child development stages served by programs

IECD programs included services in all or part of the age range from preconception to 72 months of age. ECI programs usually extended from birth to 36 months of age, and in some countries up to 60 months.

*Table 18: Developmental Stages Addressed by IECD and ECI Programs*

| Stage | N | % |
|---|---|---|
| From 37 to 60 months of age | 336 | 78.9 |
| From birth to 36 months of age | 316 | 74.2 |
| From 61 to 72 months of age | 275 | 64.6 |
| From 6 to 8 years of age | 246 | 57.7 |
| Neonatal (birth to 1 month) | 170 | 39.9 |
| Prenatal | 107 | 25.1 |
| Delivery | 84 | 19.7 |
| Preconception | 62 | 14.6 |

As noted in Table 18, the most frequently served age range was from 37 to 60 months (336, 79%). However, the number of programs offered to younger children during the critically important period of brain development extending from preconception to 36 months was comparable to this rate of services (74%). Nearly all IECD and ECI programs (92%)19 offered services at some point between preconception and 60 months. IECD and ECI programs reported serving an average of 3.8 of the categories of developmental stages.

A frequently stated policy goal for IECD programs is to develop continuous services from preconception and/or prenatal education and care up to 60 or 72 months of age. However, most countries were far from achieving this goal. Only 45 (11%) of the programs surveyed targeted every stage between preconception and 36 months. When expanded to include services up to 60 months, only 44 programs (10%) included every stage within this range.

**While 74% of the programs were found to serve children during the critically important period of brain growth from birth to 36 months, only 10% of the programs in the sample served children continuously from preconception to 60 months. IECD services have made major efforts to develop continuous services; however, more work needs to be done to ensure all children and parents requiring continuous support will receive it.**

[19] A few initiatives (8.5%) supported service programs through advocacy, training or research and did not provide services or they only served children from 6 to 8 years of age.

### 4.4.2 Types of children targeted

Inclusion is a central tenet of IECD and ECI programs. Usually, a major goal of IECD programs is to receive children with typical development as well as with at-risk situations, (i.e., severe poverty, conflicts, natural disasters, domestic violence, minority ethnic and language groups or difficult situations, such as the children of prisoners, commercial sex workers, etc.); developmental delays, disabilities or behavioral or mental health needs.

As presented in Table 19, nearly two-thirds of the programs (62%) targeted all children. Additionally, nearly half of the programs targeted children with disabilities and more than 40% targeted children with, or at risk of, developmental delays. Far fewer programs reported targeting children with behavioral or mental health needs (29%).

*Table 19: Types of Children Targeted*

| Types of children | N | % |
|---|---|---|
| All children (including those with disabilities) | 265 | 62.2 |
| Children with disabilities | 212 | 49.8 |
| Children at risk of developmental delays or disabilities | 180 | 42.3 |
| Children with developmental delays | 172 | 40.4 |
| Children with behavioral or mental health needs | 125 | 29.3 |
| Children living in severe poverty | 120 | 28.2 |
| Children in other difficult situations | 103 | 24.2 |
| Children of minority ethnic or language groups | 68 | 16.0 |
| Children in emergency situations | 60 | 14.1 |

As shown in Annex 17 in this global sample, most IECD and ECI programs focused on children with typical development, disabilities or behavioral or mental health needs (93%). In contrast, only 62% of programs were devoted to serving children with developmental delays or at-risk status.

**Greater attention should be paid to serving children with at-risk status, developmental delays, and behavioral or mental health needs.**

### 4.4.3 Types of adults served

Respondents noted a wide array of adults targeted by IECD and ECI programs. Table 20 shows that IECD and ECI programs targeted many different types of professionals, paraprofessionals and unpaid volunteers.

*Table 20: Types of Adults Served*

| Adults targeted | N | % |
|---|---|---|
| Personnel | | |
| Teachers, caregivers, and other educational personnel | 336 | 78.9 |
| Health professionals | 242 | 56.8 |
| Local community or council members | 234 | 54.9 |

| Adults targeted | N | % |
|---|---|---|
| Child and social protection professionals | 209 | 49.1 |
| Volunteers | 185 | 43.4 |
| Parents | | |
| Parents or caregivers only | 318 | 74.6 |
| Adoptive parents, foster parents or legal guardians | 145 | 34.0 |
| Adolescent parents | 141 | 33.1 |
| Future parents | 91 | 21.4 |

Teachers, caregivers and other educational personnel were targeted (79%) more than health personnel (57%) and child and social protection personnel (49%). Teachers, caregivers, other educational personnel (79%) as well as parents or caregivers (75%) were both frequently targeted. When examining the data across groups of adults served, most programs targeted both parents and personnel (78%) as opposed to only personnel (11%) or only parents (9%).

The emphasis upon training and supporting IECD and ECI personnel reveals these programs' commitment to quality improvement. Strong parental support is excellent; however, given the importance of deinstitutionalization and preventing institutionalization, greater attention should be given to serving adoptive and foster parents as well as legal guardians.

### 4.4.4 Use of specialized program approaches

For the survey, a few specialized program approaches were selected to explore the extent to which they were used globally.

*Table 21: Specialized Program Approaches*

| Specialized approaches | N | % |
|---|---|---|
| Early Childhood Intervention | 249 | 58.5 |
| Integrated ECD services for the holistic development of the child | 243 | 57.0 |
| Inclusive pre-primary or primary school services | 212 | 49.8 |
| Community-based rehabilitation (CBR) | 138 | 32.4 |
| Universal Design for Learning (UDL) | 84 | 19.7 |
| WHO/UNICEF Care for Child Development Package | 77 | 18.1 |
| Other | 24 | 5.6 |

As noted in Table 21, ECI services (59%), integrated ECD services (57%), and inclusive pre-primary or primary school services (50%) were found to be the predominant forms of specialized approaches. Fewer programs included CBR (32%). Inclusive education programs in high-income countries were reported to use Universal Design for Learning (20%); however, LMICs used UDL less frequently.

Similarly, relatively few IECD programs reported using the WHO/UNICEF Care for Child Development Package (CCD) (n=84, 18%). This package was found to be integrated with health and nutrition services and was used especially with low-income populations.

Nearly one-third of the programs reported only one approach (31%), with another 26% of the programs reporting two approaches. The remaining programs (43%) reported three or more approaches.

Annex 18 presents the combination of approaches used by programs reporting three or more approaches. Of the 70 programs using UDL, 91% did so in conjunction with inclusive education approaches. Of the 63 programs implementing the CCD program, 84% of them also used an integrated ECD approach. Nearly three-quarters of these 63 programs coupled CCD with ECI program services (71%), and with inclusive education programs (71%). CBR services were usually coordinated with ECI programs (84%), which is a notable finding. CBR was also combined with Integrated ECD and inclusive education (77%), but relatively little with CCD (27%) and UDL (36%).

**For inclusive education, UDL should be considered for use especially in LMIC. CCD, one of the programs of the Nurturing Care Framework, might be considered for use in more IECD programs.**

## 4.5 Services Provided: by Age Ranges and Types

The global survey reviewed the following IECD and ECI services by age ranges and types:

4.5.1 Preconception education and care
4.5.2 Prenatal education and care
4.5.3 Delivery and neonatal services
4.5.4 Inclusive ECD services for children (0 to 36 years)
4.5.5 Inclusive ECD services (3 to 8 years)
4.5.6 ECI services
4.5.7 Developmental screening services
4.5.8 Inclusive health and nutrition services
4.5.9 Rehabilitation or habilitation services
4.5.10 Inclusive water, sanitation and hygiene (WASH) services
4.5.11 Inclusive child and social protection services

### 4.5.1 Preconception education and care

Increasing attention is being given to the importance of providing services for preconception education and care to adolescents and prospective parents. By planning for a healthy pregnancy and a good delivery, birth outcomes for mothers, infants and future generations are greatly improved (Division for Early Childhood, 2018).

Of the 426 IECD and ECI programs, only 82 (19%) provided preconception services. The following types of preconception services were reported:

***Table 22: Types of Preconception Services Included in Programs (n = 82)***

| Type of services | N | % |
|---|---|---|
| Referrals to health and nutrition services | 50 | 61.0 |
| Identification of deficiencies and improving maternal nutrition | 41 | 50.0 |
| Discussion of family planning and child spacing | 37 | 45.1 |
| Provision of folic acid, iron, or other micronutrients, if needed | 30 | 36.6 |
| Discussion of family disability history | 29 | 35.4 |
| Discussion of maternal weight issues | 28 | 34.1 |
| Genetic counseling | 16 | 19.5 |
| Other | 7 | 8.5 |
| Not reported[20] | 4 | 4.9 |

Services for referrals, nutrition assessments, family planning and child spacing, the provision of micronutrients, family disability history, and maternal weight issues were frequently included in preconception services. However, genetic counseling remained very low at only 19%. Programs reported providing, an average of nearly three types of preconception services (Mean = 2.9). When the types of services for preconception education and care were clustered (See Annex 19), the percentage of programs endorsing health and nutrition referrals, nutrition services, and health services and counseling were comparable.

**Preconception services are urgently needed in LMIC due to their high rates of poor birth outcomes. In coming years, the percentage of IECD and ECI programs providing or linked to preconception education and care is expected to increase. It is of concern that relatively scant attention has been paid in IECD and ECI programs to ensuring the provision of folic acid, iron and other micronutrients, conducting discussions of family disability histories; addressing maternal weight issues; and providing or referring families to genetic counseling.**

### 4.5.2 Prenatal education and care

Of the 426 programs, almost one-third of them (30%, n = 126) offered prenatal education and care services. Table 23 clusters the services listed in Annex 20 by type. Only 64% focused on preventing poor birth outcomes, and fewer than 25% of programs reported micronutrient provision as a part of their IECD and ECI programs.

*Table 23: Types of Prenatal Education and Care*

| Type of services | N | % |
|---|---|---|
| Basic prenatal education, health services, and parenting education | 104 | 82.5 |
| Prevention of poor birth outcomes | 80 | 63.5 |
| Micronutrient provision | 31 | 24.6 |

[20] "Not reported" refers to programs that did not specify the type of service they provided.

In Annex 20, the leading service for the prenatal period was “Provision of prenatal education, newborn care and initial parenting education for mothers and fathers” (83, 66%). Programs providing prenatal education and care offered a diverse array of services, with an average 4.3 services per program.

**Prenatal education and care programs should give greater attention to preventing poor birth outcomes and ensuring the provision of essential micronutrients.**

### 4.5.3 Delivery and neonatal services

In contrast to prenatal education and care services, slightly fewer programs (86, 20%) included delivery and/or neonatal services, suggesting relatively few health services in the study sample provided fully continuous IECD and ECI programs. In Annex 20, the many types of delivery and neonatal services are presented. It was found that education on basic infant care, hygiene, and breastfeeding guidance was the main service provided (n = 54, 63%).

In Table 24, delivery and neonatal services are clustered by type.

*Table 24: Types of Delivery and Neonatal Services*

| Type of services | N | % |
|---|---|---|
| Support for basic neonatal child care and breastfeeding | 54 | 62.8 |
| Collaboration with NICUs and referrals to ECI services | 43 | 50.0 |
| Neonatal Screening | 42 | 48.8 |

Referrals and neonatal screening were listed for about half of the programs providing delivery and neonatal services. However, the numbers and types of screenings were reported to be very few. Of the 42 programs providing delivery and neonatal screening services, over one-quarter (29%) provided only one of the eight screening services listed in Annex 21. Additionally, only six programs (14%) offered all eight screening services. On average, programs reported providing fewer than four of the eight screening services (Mean = 3.5). Only 25 programs provided neonatal developmental screenings during children’s first 30 days.

IECD and ECI programs in LMIC should promote the provision of more neonatal micronutrient, developmental and other screenings, as well as the development of linkages and referrals of ECI programs with all NICU programs.

### 4.5.4 Inclusive ECD services for children (0 to 36 months)

Given rapid early brain growth and the development of foundational abilities in all domains of child development, the period from birth to 36 months is exceedingly important. For children with at-risk status, at a minimum, the provision of IECD services is essential. As reported in Annex 22, 301 (71%) of the programs included in the survey reported they provided Inclusive ECD services. Programs provided an average of 4.5 of the 11 services listed in Annex 21.

Table 25 presents clusters of various types of IECD services that are arrayed in Annex 22. For each category, a program is included if the respondent reported providing IECD services for at least one of the items in the cluster.

*Table 25: Types of IECD Services for Children (0 to 36 months)*

| Type of services | N | % |
|---|---|---|
| Parent education and family support | 247 | 82.1 |
| Center-based services | 198 | 65.8 |
| Home visiting | 177 | 58.8 |
| Teacher training on inclusive education | 165 | 54.8 |
| Child protection | 98 | 32.6 |
| Health and nutrition services | 96 | 31.9 |

Parent education and family support were found in 82% of the IECD programs. The frequency of center-based services (66%) slightly exceeded home visiting services (59%). In-service teacher training on inclusive education skills for teachers, principals and parents was found in 55% of the programs serving children from birth to 36 months. However, respondents reported their programs gave relatively less attention to child protection services (33%) and child health and nutrition services (32%), which are critically needed during this formative developmental period.

It is important to note that in Annex 22, it was found that although parents of children with at-risk status and other needs often require time to relax from providing child care and development activities, only 9% of programs provided respite care services.

**Given positive results from the provision of home visiting services, home visiting should be given greater attention in IECD and ECI services (Duffee et al, 2017). Support for in-service teacher training for inclusive education is an important finding. However, depending upon the relative strength and functionality of linkages with other health and human services, IECD programs might need to focus more on the provision of services for child protection, health and nutrition and respite care.**

### 4.5.5 Inclusive ECD services (3 to 8 years)

The highest number of respondents (n = 339, 80%) reported providing IECD services for children from 3 to 8 years of age. In total, 260 of the 339 programs (77%) reported continuous service provision across the birth to 3 and 3 to 8 age ranges. The remaining 79 programs (23%) reported offering IECD services only to children 3 to 8 years.

In Annex 23, the full array of responses regarding IECD services for children from 3 to 8 years of age is presented. These programs reported providing an average of 4.3 of the services listed in the survey.

In Table 26, the clustered responses are presented:

*Table 26: Types of IECD Services for Children 3 to 8 Years of Age*

| Type of services | N | % |
|---|---|---|
| Center-based services | 269 | 79.4 |
| Parent education and support | 236 | 69.6 |
| Teacher training on inclusive education | 192 | 56.6 |
| Home visiting services for children and their parents | 171 | 50.4 |
| Child protection services | 121 | 35.7 |
| Child health and feeding services | 85 | 25.1 |

As expected, almost 80% of the IECD programs for children from 3 to 8 years of age are center-based. However, notably a considerable number of parenting programs continue to be provided for this older age group (n = 236, 70%). In addition, half of the programs delivered home visits for children and parents. As reported in Annex 23, services for inclusive pre-primary education or the kindergarten transition year ranked second in frequency of provision (n = 196, 58%). Respondents reported teacher training on inclusive education as a service provided by 57% (n = 192) of the IECD programs for children from 3 to 8 years of age. Once again, the provision of child protection services (n = 121, 36%) and child health and feeding services (n = 85, 25%) were low. Only 19% (n = 64) of programs provided special education center-based services for children with severe or complex situations (see Annex 23). Respite services, which are essential for overly stressed parents, continued to be very low (n = 23, 7%).

For programs serving children from 3 to 8 years, greater attention might be given to services for inclusive pre-primary education and the kindergarten transition year. Inclusive education has proven challenging to implement in all world regions, and the preschool years are often the last ones to feature full inclusion. Once again, greater attention to child protection and child health and nutrition services may be needed, especially to ensure full inclusion of children with at-risk situations.

### 4.5.6 ECI programs

Respondents that stated their programs provided ECI services and also listed one or more of the usual methodological approaches usually found in ECI programs were included in the final list of ECI programs.

In total, 241 programs (57%) met the criteria for ECI service provision. The 241 programs were provided in 98 countries. In Table 27, a regional breakdown is presented of ECI programs. Arrayed by percent of countries per region, the leading region was East Asia and the Pacific, followed by Sub-Saharan Africa and Europe and Central Asia. All world regions have some ECI programs; however, several countries in each region still lack ECI programs.

*Table 27: Regional breakdown of ECI programs*

| Region | No. of ECI Services | % of countries in region | % of ECI services (241) |
|---|---|---|---|
| East Asia & Pacific | 45 | 65.2 | 18.7 |
| Sub-Saharan Africa | 70 | 60.9 | 29.0 |

| Region | No. of ECI Services | % of countries in region | % of ECI services (241) |
|---|---|---|---|
| Europe & Central Asia | 65 | 60.2 | 27.0 |
| Latin America & Caribbean | 30 | 47.6 | 12.4 |
| North America | 10 | 47.6 | 4.1 |
| Middle East & North Africa | 6 | 42.9 | 2.5 |
| South Asia | 15 | 41.7 | 6.2 |
| | 241 | 56.6 | 100.0 |

Table 28 provides a breakdown by country income levels. It reveals that ECI programs have been developed in low-income and lower middle-income countries as well as in upper middle-income and upper-income countries.21

*Table 28: ECI programs per country income level*

| Country income level | No. of ECI Services | % within income group of countries | % of ECI services (241) |
|---|---|---|---|
| Low-income | 36 | 50.0 | 14.9 |
| Lower middle-income | 92 | 59.7 | 38.2 |
| Upper middle-income | 50 | 48.5 | 20.7 |
| High-income | 60 | 65.2 | 14.1 |
| Missing categorization | 3 | 60.0 | 1.2 |
| | 241 | 56.6 | 100.0 |

**This finding reveals that countries at all income levels are providing more intensive and individualized ECI services for children with at-risk conditions, developmental delays, disabilities or behavioral or mental health needs. ECI services are no longer available only in high-income countries.**

Table 29 presents the types of ECI services provided by the 241 programs. ECI programs provided an average of 8.6 of the 22 listed services, thereby demonstrating they contained many of the usual attributes of ECI services.

*Table 29: Types of ECI Services (n = 241)*

| Type of services | N | % |
|---|---|---|
| Provision of parent education and support | 160 | 66.4 |
| Community outreach services | 135 | 56.0 |
| Child developmental screening | 135 | 56.0 |
| Comprehensive assessments of child development with parent participation | 130 | 53.9 |
| Provision of case coordination and referrals, as needed | 111 | 46.1 |
| Parents participate as members of interdisciplinary or transdisciplinary teams | 108 | 44.8 |
| Child developmental surveillance/monitoring | 107 | 44.4 |

[21] A complete list of the number of ECI programs per country is available upon request from RISE Institute.

| Type of services | N | % |
|---|---|---|
| Provision of physical therapy services | 98 | 40.7 |
| Provision of speech/language and hearing therapy or pathology services | 97 | 40.2 |
| Provision of home visits as the primary service for most program children | 95 | 39.4 |
| Provision of parent, sibling or peer support groups | 94 | 39.0 |
| Preparation of program exit and transition plans with parents, child and next service provider | 89 | 36.9 |
| Provision of or help to obtain assistive technologies | 86 | 35.7 |
| Preparation of Individualized Family Service Plans (IFSP) with parents | 85 | 35.3 |
| Psychological and/or psychiatric support and treatment for child and family | 83 | 34.4 |
| Provision of occupational therapy services | 77 | 32.0 |
| Child and family intake | 73 | 30.3 |
| Establishment of ECI eligibility | 73 | 30.3 |
| Provision of leisure or cultural activities | 69 | 28.6 |
| Provision of visits to child care centers are the primary service for over 30% of program children | 60 | 24.9 |
| Designation of one program specialist as main visitor to the child and family, with team's professional support | 54 | 22.4 |
| Provision of vision therapy services | 48 | 19.9 |
| Other | 3 | 1.2 |
| Not reported | 3 | 1.2 |

Table 29 reveals that many ECI programs reported they met several of the basic requirements of ECI services and had adopted foundational elements of ECI service delivery. Some 66% of ECI programs provided parent education and support; 56% conducted community outreach services; 56% conducted developmental screenings; 54% provided developmental assessments with parental participation; 46% provided case coordination and referrals; and 44% included parents as members of transdisciplinary or interdisciplinary teams. However, some ECI programs needed to add more core ECI services. For example, only 95 (39%) provided home visits as the primary service for most program children, and only 85 (35%) of the ECI programs prepared Individualized Family Service Plans (IFSPs). Only 98 (41%) provided therapeutic services, and 86 (36%) provided assistive technologies for children with disabilities. Surprisingly, merely 37% prepared program completion and transition plans for entry into inclusive pre-primary schools, kindergarten or primary schools, and 30% had eligibility guidelines.

**Many ECI programs still have a long way to go to attain the basic core elements found in high-quality programs of well-designed ECI systems. For example, special attention should be given to the provision of developmental assessments, eligibility guidelines, IFSPs, visits in the natural environment of the child, therapeutic services, and the provision of program completion and transition plans. Several of these areas could be improved rapidly through the development of national ECI Strategic Plans, Program Guidelines and Procedures, service and personnel standards, supervisory systems, pre- and in-service training systems, and program monitoring and evaluation processes.**

### 4.5.7 Developmental screening services

A key part of IECD and ECI programs should be the provision of universal developmental screening services. When asked if their programs provided developmental screenings, only 161 (38%) of the 426 programs reported conducting screening activities. Developmental screening services are typically a component of ECI services, but they are also conducted by some IECD services. The majority of programs providing developmental screening services also reported ECI service provision (81%; $\chi 2 = 61.56$, $p < .001$). Overall, programs reporting ECI service provision were 5.8 times more likely (CI = 3.67 – 9.23) to provide developmental screening than programs not providing ECI services, and yet developmental screening may be conducted by parents and a wide variety of IECD and other types of services.

In Table 30, program responses are presented regarding the ages when children are screened:

*Table 30: Ages When Children Are Screened (n = 161)*

| When children are screened | N | % |
|---|---|---|
| 30 days after birth | 46 | 28.6 |
| 3 months to 6 months | 75 | 46.6 |
| 12 months to 24 months | 84 | 52.2 |
| Annually after 24 months | 73 | 45.3 |
| Other[22] | 44 | 27.3 |

The most frequent age range for screening was from 12 to 24 months (n = 84, 52%). Screening for the 3 to 6 months period was similar (n = 75, 47%). On average, programs reported screening provision across two of the four periods reported in Table 30. Just over half reported screening during only one period (53%) and only 17% reported screening across all four periods.

**A major international campaign for universal developmental screening is urgently needed to identify all children requiring developmental assessment and to ensure they receive ECI services they may need to achieve their full potential.**

### 4.5.8 Inclusive health and nutrition services

Almost half of the IECD and ECI programs and initiatives reported they provided inclusive health or nutrition services (47%), thereby demonstrating the substantial inclusion of these services in IECD and ECI programs.

Annex 24 summarizes the full array of inclusive health and nutrition services provided in IECD and ECI programs. On average, programs reported providing four of the ten services listed in Annex 23 (Mean = 4.0). The predominant types of health and nutrition services were: basic health and nutrition education and the promotion of healthy behaviors (n = 145, 73%); referrals for immunizations, well-child check-ups and other maternal and child

[22] Other = 0 to 42/60 months or 7 years; 24 to 60 months; 36 or 48 months plus, and parental or other demand for screening.

health care services (n = 88, 44%); promotion of exclusive breastfeeding (n = 85, 43%); and education on complementary feeding (n = 84, 42%). Far fewer programs offered nutrition interventions combined with early stimulation activities (n = 66, 33%).

In Table 31, the health and nutrition services listed in Annex 24 were combined into clusters:

*Table 31: Types of Inclusive Health or Nutrition Services*

| Type of services | N | % |
|---|---|---|
| Health and nutrition promotion, education, and counseling | 168 | 84.8 |
| Special health services for children with disabilities | 101 | 51.0 |
| Referrals for health services | 88 | 44.4 |
| Nutritional assessments and rehabilitation | 75 | 37.9 |
| Maternal and child health services | 59 | 29.8 |

Health and nutrition promotion, education and counseling were the most frequent type of service (n = 168, 85%) as well as attention to special health services for children with disabilities (n = 101, 51%). However, referrals to health services (n = 88, 44%) and nutritional assessments and rehabilitation (n = 75, 38%) were relatively low.

**Of special concern was the low rate of nutritional interventions combined with early stimulation activities. Since 1976, research has shown that to achieve sustainable nutritional rehabilitation, it is essential to combine nutrition and health interventions with infant and young child stimulation, and yet many programs continue to focus solely on nutritional interventions. Renewed efforts are needed to ensure all nutrition interventions include early stimulation activities, with the full involvement of parents and other caregivers.**

**In addition, referrals to health services, and nutritional assessments and rehabilitation services were lower than expected. The importance of building stronger collaborations between IECD and ECI programs and health and nutrition services cannot be overstated.**

### 4.5.9 Rehabilitation or habilitation services

In most world regions, the “medical model” of rehabilitation and/or habilitation services predated the provision of ECI services for young children that emerged in the 1970s and 1980s. Some regions, such as North America, Australia, and parts of Western and Eastern Europe, have increasingly adopted the ECI “social model” of support with parents and children, fully including parents and other caregivers in all aspects of ECI services. Prior rehabilitation programs in these regions have evolved into ECI services through modifying their core concepts, guidelines and procedures, structures, contents, methods, and training and supervisory systems.

**In some regions, such as Latin America, center-based rehabilitation or habilitation services remain the principal or only form of therapeutic services offered for young**

**children. Consideration should be given to developing and implementing family-centered ECI services, as has been the case in most other regions.**

Some 47% (n = 199) of programs reported providing rehabilitation or habilitation services. They provided an average of three (Mean = 2.8) of the five services listed in Annex 25. Of the 199 programs providing rehabilitation services, 31% were located in Sub-Saharan Africa, 26% were in Europe and Central Asia, 18% were in East Asia and the Pacific, and 13% were located in Latin America and the Caribbean. Although the percentage of programs located in South Asia (9%), North America (3%), and the Middle East and North Africa (2%) were comparatively lower, the differences among regions were not statistically significant ($\chi 2 = 10.60$, $p = .102$).

*Table 32: Types of Rehabilitation or Habilitation Services*

| Type of services | N | % |
|---|---|---|
| Assessments of child development | 153 | 76.9 |
| Community-based rehabilitation | 126 | 63.3 |
| Provision of therapies | 125 | 62.8 |

As reported in Table 32, a large percentage of rehabilitation and habilitation service providers conducted assessments of child development (n = 153, 77%). Of special note is the frequency of community-based rehabilitation services (63%), demonstrating their continued utility in many countries. These programs usually included various therapies (n = 199, 63%).

**The field of "community-based rehabilitation" often provides services resembling home-based ECI services; however, CBR still mainly uses a medical-therapeutic model. Increasingly, ECI and CBR services collaborate closely in order to serve as many eligible children as possible.**

### 4.5.10 Inclusive water, sanitation and hygiene (WASH) services

Non-potable water, absence of or poorly maintained toilets and latrines, and inadequate personal, home, and center hygiene can lead to chronic illnesses and malnutrition in children, both of which can cause high levels of developmental delays. For these reasons, sanitation and water services should be included in IECD and ECI programs, in countries of all income levels, and most especially in the tropics given water-borne infectious diseases found in these regions.

WASH services were found in almost one third (n = 124, 29%) of the IECD and ECI programs. On average, respondents reported providing two of the four inclusive WASH services listed in Table 33 (Mean = 2.0). In all, 52 programs (42%) reported providing at least one WASH service, and 15 programs (12%) reported the provision of all four services.

*Table 33: Types of Inclusive WASH Services*

| Types of inclusive WASH services | N | % |
|---|---|---|
| Hygiene education for the home environment | 85 | 68.5 |
| WASH services (waste disposal, sewage systems, latrines, etc.) | 54 | 43.5 |
| Provision of clean water services to address diseases causing delays and disabilities | 54 | 43.5 |
| Adapted bathrooms, facilities and/or equipment for children with disabilities | 48 | 38.7 |
| Other | 1 | 0.8 |
| Not reported | 3 | 2.4 |

Predominant WASH areas included: hygiene education for the home environment (n = 85, 69%); WASH services (n = 54, 44%); and the provision of clean water services to address diseases causing delays and disabilities (n = 54, 44%). Fewer programs focused on adapting bathrooms, facilities and/or equipment for children with disabilities (n = 48, 39%).

**IECD and ECI services should give greater attention to providing or collaborating with accessible and inclusive WASH services, especially in countries and communities with notable needs for improved sanitation and hygiene.**

### 4.5.11 Inclusive child and social protection services

In addition to education and health, child and social protection services played an essential role in IECD and ECI programs. A total of 229 IECD and ECI programs (54%) provided child and social protection services. They provided an average of 4.8 of the 15 services listed in Annex 26.

The top five child and social protection services listed in Annex 25 were found in all world regions:

- Training to strengthen child protection and family support systems (n = 145, 63%);
- Services to prevent child abuse, neglect and exploitation (n = 122, 53%);
- Social inclusion services to strengthen families in their care giving roles (n = 115, 50%);
- Design of legislation and policies to promote child and disability rights, including social inclusion (n = 97, 42%); and
- Provision of safe spaces for young children with disabilities (n = 85, 37%).

In Table 34, we clustered the findings in Annex 26 to examine trends in child and social protection services.

*Table 34: Types of Child and Social Protection Services*

| Type of child and social protection services | N | % |
|---|---|---|
| Policy, training and support for child and social protection services | 179 | 78.2 |
| Child and social protection services | 178 | 77.7 |

| Type of child and social protection services | N | % |
|---|---|---|
| Provision of culturally appropriate child and social protection services | 127 | 55.1 |
| Provision of monitoring, evaluation and research on protection issues | 62 | 27.1 |
| Support for prevention of institutionalization and promotion of deinstitutionalization | 59 | 25.8 |
| Cash transfers and conditional cash transfers | 31 | 13.5 |

Many efforts have been conducted in all world regions to foster policies, training, and support for child and social protection services (n = 179, 78%) as well as to provide these services (n = 178, 78%). Relatively fewer initiatives have focused on ensuring IECD and ECI programs were equitable and fully accessible to minority cultural or ethnic groups (n = 127, 55%). Expanded efforts for monitoring, evaluation and research on child and social protection issues were noted (n = 62, 27%). Despite major international efforts to prevent institutionalization and promote deinstitutionalization, only a few programs were found to support these initiatives (n = 59, 26%). Conditional cash transfers (n = 31, 11%) and cash transfers (n = 12, 5%) were not included in most IECD and ECI programs.

**Quality IECD and ECI programs become more effective when child protection policies are implemented. Therefore, there is a need to work hand in hand to ensure policies are in place. As noted before, more programs to prevent institutionalization and support deinstitutionalization services are urgently needed, and ECD and disability stakeholders should include them in their advocacy efforts. More conditional cash transfers might be considered to support child rights, child development, and protection services for children with developmental delays and disabilities.**

## 4.6 Parental Participation and Program Accountability

Prior research on successful nationwide programs for ECD in Latin America revealed that parents and families were always actively engaged in program planning and oversight (Vargas-Barón, 2009b). Therefore, this global survey also sought to assess parental participation in IECD and ECI programs.

### 4.6.1 Roles and activities of parents, grandparents and legal guardians

The vast majority (93%) of IECD and ECI programs reported enabling at least one program role for parents, grandparents and legal guardians. Based on the list presented in Table 35, programs provided an average of almost four roles or activities (Mean = 3.9) to parents, grandparents, and legal guardians.

*Table 35: Roles of Parents, Grandparents and Legal Guardians in IECD and ECD Programs*

| Type of roles in programs | N | % |
|---|---|---|
| Participation in identifying child needs | 240 | 56.3 |
| Participation in child development assessments | 170 | 39.9 |

| Type of roles in programs | N | % |
|---|---|---|
| Provision of volunteer support for program | 172 | 40.4 |
| Community outreach | 156 | 36.6 |
| Participation in child development screening | 145 | 34.0 |
| Participation in program design or evaluation | 135 | 31.7 |
| Participation in child development surveillance or monitoring | 128 | 30.0 |
| Participation in individualized family service plans (IFSP) | 123 | 28.9 |
| Evaluation of your IECD or ECI program | 119 | 27.9 |
| Provision of material support for program | 106 | 24.9 |
| General program oversight | 77 | 18.1 |
| Provision of fundraising support for program | 62 | 14.6 |
| Program does not have parents, grandparents, or legal guardians in any role | 30 | 7.0 |
| Other | 12 | 2.8 |
| Not reported | 45 | 10.6 |

The most frequently reported role was “participation in identifying child needs” (n = 240, 56%). This is an essential role for parents and others with responsibility for child rearing and development, along with participation in child developmental screening, assessments, individualized family service plans (IFSPs), and in medical surveillance and monitoring. To a lesser extent, parents were also involved in program evaluation (n = 119, 28%) and program oversight (n = 77, 18%).

Table 36 clusters these roles into four categories:

***Table 36: Roles of Parents, Grandparents and Legal Guardians in IECD and ECD Programs***

| Type of participation in services | N | % |
|---|---|---|
| Participation in program services | 284 | 66.7 |
| Support for program services | 239 | 56.1 |
| Program design, evaluation and oversight | 206 | 48.4 |
| No participation at all in program | 30 | 7.0 |

This analysis reveals a relatively high level of parental participation in program services (n = 284, 67%), and support for program services (n = 239, 56%). The level of parental involvement in program design, evaluation and oversight is noteworthy as well (n = 206, 48%).

To further assess parental involvement, Annex 27 uses program categories that are not mutually exclusive. They provide a greater understanding of the types of IECD and ECI programs that involve parents in specific activities. Although major differences across types of services were anticipated, the rates of parent involvement generally did not vary greatly. However, programs that designated themselves as “mostly ECI programs,” “rehabilitation/habilitation” or “social protection services” especially promoted parental involvement in program services.

**Based on these results, parent and family participation and involvement has become very important to the design, implementation, and accountability of IECD and ECI programs.**

### 4.6.2 Internal monitoring and evaluation and instruments[23]

A high level of internal monitoring and evaluation was found in IECD and ECI programs. A total of 332 programs (78%) reported using internal monitoring and evaluation procedures and instruments.

*Table 37: Internal Monitoring and Evaluation Procedures and Instruments by Service Type*

| | Percent with internal monitoring and Evaluation procedures |
|---|---|
| IECD services (0 – 36 months) | 81.1% |
| IECD services (3 to 8 years) | 80.2% |
| ECI services | 83.8% |
| Rehabilitation or habilitation services | 83.4% |
| Social Protection services | 88.2% |

**Table 37 reveals that over 80% of all major types of IECD and ECI programs conducted internal monitoring and evaluation activities. This finding confirms that these programs greatly value quality and accountability.**

### 4.6.3 External evaluations

Almost half (48%) of the IECD and ECI programs reported that an external evaluator had assessed their program. In Table 38, the level of use of external evaluators was at or above 50% in each major type of IECD and ECI programs.

*Table 38: External Evaluation by Service Type*

| | Percent reporting evaluation by an external evaluator |
|---|---|

[23] Internal monitoring and evaluation refers to the design and implementation of a monitoring and evaluation system, including input, output and outcome indicators, approved instruments, targets, and the development of a data collection system, database, data analysis and interpretation, and provision for regular reporting. Program personnel conduct an internal monitoring and evaluation system. External and independent specialists design and conduct external evaluations. IECD and ECI programs need both internal and external monitoring and evaluation systems.

| | Percent reporting evaluation by an external evaluator |
|---|---|
| IECD services (0 – 36 months) | 52.2% |
| IECD services (3 to 8 years) | 49.9% |
| ECI services | 52.3% |
| Rehabilitation or habilitation services | 56.8% |
| Social Protection services | 56.8% |

**This relatively high level of external monitoring and evaluation was found in all types of IECD and ECI programs. These results, combined with the high level of internal monitoring and evaluation, reveal that IECD and ECI programs generally seek to be accountable and of acceptable quality. It could be hypothesized that because IECD and ECI programs require well-trained professionals in leading managerial, programmatic, supervisory and technical roles, their understanding of the importance of accountability may be higher than that of general ECD services. Some international and national foundations and other donors are beginning to invest in the development of external evaluation research projects especially in ECI programs, with the participation of national and international evaluators.**

## 4.7 Barriers and Challenges Faced by IECD and ECI Programs

The Global Survey sought to identify major barriers and challenges regarding program development, growth, demand and quality that are faced by IECD and ECI programs in all world regions. From lists in each category, respondents were asked to select their top four barriers and challenges.

The following sections present the top four most highly ranked responses in each of the four areas. Complete responses are provided in Annexes 28 to 31.

### 4.7.1 Systemic barriers and challenges hindering program development

A wide array of responses to this issue may be reviewed in Annex 28. The most highly ranked barriers or challenges to program development were:

- Inadequate funding (50%);
- Lack of national administratively collected data on childhood developmental delays and disabilities (32%);
- Lack of policies, plans, legislation or regulation supporting the program (28%); and
- Issues of stigma and lack of inclusion (23%).

Inadequate funding was to be expected but the perception that the lack of adequate national data on childhood developmental delays and disabilities was notable. A lack of various types of policy instruments is still considered to be a major barrier to the further

development of national IECD and ECI systems. The need for initiatives to overcome stigma and the lack of inclusion is also a widely shared need.

### 4.7.2 Program barriers and challenges hindering program growth

In Annex 29, barriers and challenges to program growth identified by program respondents are listed. The top four barriers or challenges to program growth were:

- Lack of enough services for children with at-risk, developmental delays, disabilities or behavioral or mental health needs (61%)
- Lack of community outreach to identify children with at-risk situations, delays, disabilities or behavioral or mental health needs (41%)
- Lack of universal developmental screening for children (38%)
- Lack of developmental surveillance and monitoring conducted by physicians (35%)

In addition, many respondents stated they were concerned their programs lack up-to-date information technologies. They were also concerned about the relative lack of services for young children with delays or disabilities separate from adult services.

As noted, inadequate program coverage was endemic to IECD and ECI programs, along with inadequate community outreach. Needs for both universal developmental screening as well as for medical developmental surveillance and monitoring by medical providers were quite similar, and indeed, both are required to ensure early identification of developmental delays and disabilities.

### 4.7.3 Barriers and challenges hindering program demand

Barriers and challenges hindering program demand are presented in Annex 30. In all world regions, the top four leading constraints to program demand were:

- Lack of capacity to meet demand and program has waiting lists (47%)
- Lack of advocacy for your program services and the children and families you serve (43%)
- Caregivers are not empowered (41%)
- High program fees or other costs to families keep them from applying (20%)

Some respondents reported that great variation exists among programs with regard to demand, thereby suggesting that demand for IECD and ECI programs and program costs and revenue streams should become domains for future study in most countries.

### 4.7.4 Barriers and challenges hindering program quality

In Annex 31, barriers and challenges to achieving program quality were prioritized. The top four barriers and challenges related to program quality were:

- Lack of properly trained and qualified personnel (46%)
- Lack of research opportunities (32%)
- Lack of supervisory services, including mentoring, coaching and reflective supervision (31%)

- Lack of education, training and program materials (30%)

When the items in Annex 31 were clustered by topic, training and personnel qualifications were most often mentioned, followed by program accountability and supervision. All three are critically important to achieving high program quality, but clearly major emphasis was placed on training.

- ***Training and personnel qualifications: 541 mentions***
- ***Program accountability: 241 mentions***
- ***Supervision: 130 mentions***

## 4.8 Achieving Program Success

### 4.8.1 Factors enhancing program success

In Annex 32, survey respondents identified many factors they believe enhance program success. Several important clusters of key factors regarding program success were identified, and they are arrayed below by frequency of mention:

*Table 39: Factors Enhancing Program Success*

| Types of Factors | No. of mentions |
|---|---|
| **Leading factors** | |
| Program and external expertise | 383 |
| Pre- and in-service training | 183 |
| Parent and caregiver empowerment | 143 |
| Enabling policy environment and policy and political support | 127 |
| Networking and collaboration | 115 |
| **Other factors** | |
| Supervision | 95 |
| Use of screening instruments, other tools and technologies | 95 |
| Accountability and data availability through monitoring, evaluation and research | 83 |
| Adequate governmental and other diversified support | 34 |
| Use of classification systems | 13 |
| General shared understanding of disability | 12 |
| | |

Respondents identified program and external expertise as major factors leading to program success, followed by the provision of pre- and in-service training enabling improved levels of expertise. The area of parent and caregiver empowerment, usually found in high-quality IECD and ECI programs, was identified as important to achieving program success.

An enabling policy environment and policy and political support also ranked highly. Thus, the preparation and adoption of policies, strategic plans, and laws was considered essential to attaining strong national systems of IECD and ECI program services.

Important mentions also included: supervision; provision of tools and accountability; use of screening instruments and other tools and technologies; and accountability and data through monitoring, evaluation and research. These results reveal that more attention should be given to these areas to ensure they contribute to achieving IECD and ECI program success. After this point, a sharp drop-off in mentions occurred, reflecting not only factors less important to attaining program success but also areas where far more attention will be needed. The paucity of mentions regarding adequate governmental and other diversified support reflected the lack of funding. Only 34 IECD and ECI programs felt their success was due to adequate funding. The use of classification systems also ranked very low, as was a general shared understanding of disability.

### 4.8.2 Recommendations for creating, improving and expanding IECD and ECI programs

Respondents were asked to make recommendations for creating, improving, and expanding IECD and ECI program services. Detailed results are presented in Annex 33. The leading recommendations were:

*Table 40: Recommendations for Creating, Improving and Expanding Program Services*

| Types of recommendations | No. of mentions |
|---|---|
| **Leading recommendations** | |
| Expand investment in IECD and ECI programs | 201 |
| Increase advocacy and social communications | 177 |
| Improve service coordination | 147 |
| Improve and expand parent education and support | 143 |
| Develop policies, plans or laws for IECD and ECI programs | 137 |
| Improve pre- and In-service training and workforce certification systems | 130 |
| Establish universal developmental screening and referrals for assessments | 118 |
| **Less mentioned recommendations** | |
| Improve program contents | 89 |
| Develop national monitoring and evaluation systems | 59 |
| Achieve greater program equity through service access and quality assurance | 55 |
| Improve supervisory systems | 52 |
| Expand use of ICF-CY | 12 |
| | |

Expanding investment in IECD and ECI programs received the greatest number of mentions. Once again, policy advocacy and social communications were found to be high in the list, followed by improved inter-agency service coordination and parent education and support.

Respondents also recommended the development of more enabling policies and plans for IECD and ECI programs. The expansion of pre- and in-service training was supported as well as improvement of the workforce, along with the establishment of certification systems.

The provision of universal developmental screening and referrals was the next most important area. Indeed, nations are increasingly establishing policies to provide universal developmental screening but there is a long way to go before all children requiring IECD and ECI program services will be identified at birth and during the neonatal period and early months of life, and then quickly referred to appropriate services.

Recommendations less often selected by respondents were also important. They clustered around topics central to internal program improvement and growth, and included: the paucity of program contents that are evidence-based, high in quality, and culturally and linguistically appropriate; monitoring and evaluation systems designed into each IECD and ECI program; greater program equity; expanded service access; overall quality assurance; and the establishment of modern and effective supervisory systems. The use of the ICF-CY was less frequently recommended to ensure program success.

As seen below, to make major progress in expanding and improving national IECD and ECI systems of services, a high priority must be placed on increasing national and international investments in those systems.

## 4.9 Investing in IECD and ECI programs

### 4.9.1 Types of funding sources supporting IECD and ECI programs

Annex 34 presents the types of funding sources that survey respondents reported for their IECD and ECI programs, including both major and minor sources of funding support.

***Table 41: Types of Funding Sources Supporting IECD and ECI Programs***

| Types of sources | No. of mentions |
|---|---|
| International organizations | 279 |
| National, regional and local governments | 209 |
| Private organizations | 107 |
| Local fundraising | 107 |
| National non-governmental organizations | 84 |
| **Less mentioned sources** | |
| Insurance reimbursement systems | 4 |
| Taxes of various types | 3 |
| Research budget | 1 |
| | |

The largest number of mentions was of international organizations followed by government at national, regional and local levels. However, taken together, national non-governmental and governmental sources of funding (515 mentions) outweigh international support (279 mentions).

National non-governmental support is inherently unstable but it helps to complement governmental support. International governmental funding continues to be very important to IECD and ECI program provision in most countries.

Ultimately, IECD and ECI programs are eminently local and national. To become financially sustainable, they must attract stable, long-term national governmental funding from all levels possible as well as non-governmental support to cover annual recurrent costs. International support should mainly be used for program development costs, such as design, planning, initial training, and technical innovation. Over dependency upon international funding for meeting recurrent costs often leads to a lack of sustainability and to the decline -- and even the demise -- of essential programs.

***Current minor sources of support***

Relatively few mentions were made of insurance reimbursement systems, taxes, and research budgets. In the future, it is likely that insurance reimbursement will grow because in some countries, such as the United States, insurances have helped to fund ECI programs. A variety of taxes have been helpful in several countries. Fundraising, although not captured here, is also essential to building long-term, sustainable financial support for IECD and ECI programs.

### 4.9.2 Proportion of governmental support

Only 130 (31%) of the 426 respondents answered the question regarding the proportion of funding from national governmental sources. Of these 130 programs, 86 reported they received all of their funding from a combination of government sources (e.g., the total summed to 100%). For the remaining 44 programs, the amount of government funding ranged from very little to 96%. The general rule of diversifying funding sources appears to be important for IECD and ECI programs.

### 4.9.3 Percent of annual funding from relevant sectors of government

Only 121 of the 426 programs (28%) provided data regarding governmental sectors funding their services. Of the 121 programs, most of them (n = 89, 74%) reported that their funding came from a variety of governmental sectors. For the remaining 32 programs (except for four that reported that sectors did not fund them), the percent of funding ranged from 1% to 99%. Annex 35 provides the descriptive statistics for the percent of governmental funding by sector.

Education was the leading sector supporting IECD and ECI programs. The health sector was ranked second. The child and social protection sector provided the least governmental funding, although in several countries, it plays a leading role in IECD, and most especially in ECI, due to the placement of disability programs in the protection/social welfare sector.

These findings demonstrate considerable sectoral diversity as well as the wide range of multisectoral support of IECD and ECI programs. Based on these partial data, no one sector appears to usually fund these programs. Detailed finance and cost studies of IECD and ECI programs should be conducted.

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# 5 Survey Recommendations

The following recommendations are based on the findings and conclusions of the Global Survey of Inclusive Early Childhood Development and Early Childhood Intervention.

The survey's large sample of respondents for 426 IECD and ECI programs located in 121 countries of all world regions could not be fully representative of all such programs in the world. However, many findings were quite robust, and the authors found most results to be quite consistent with their observations of these programs in many countries.

## 5.1 Develop, improve and scale up IECD and ECI Services

- IECD and ECI services should be greatly expanded to ensure all children with at-risk situations, developmental delays, disabilities or behavioral or mental health needs are able to access to services. Priority should especially be given to developing and expanding IECD and ECI programs in countries with humanitarian situations, including conflicts and natural disasters. More specifically, consideration should be given to the following:
    - Services for child protection and child health and feeding should be greatly expanded to ensure good child nutrition and growth as well as safe child development;
    - Although home visiting services appear to be increasing, only 59% of IECD programs provided home visiting services. Many more IECD and ECI home visiting programs are needed in all countries;
    - Services for inclusive initial education and care for infants and toddlers, pre-primary education and the kindergarten transition should be greatly expanded;
    - Given that high rates of chronic illness and developmental delays are related to non-potable water, poor sanitation and inadequate hygiene, more attention should be paid to the provision of accessible and inclusive WASH services in IECD and ECI programs;
    - Respite services should be greatly expanded to ensure parents and caregivers of children receiving IECD and especially ECI services have a break from child care and development activities;
    - Many more rural IECD and ECI services are needed, with a priority placed on ensuring rural and ethnic groups are served in culturally and linguistically appropriate ways;
    - ECI programs especially should include and expand available services for children with autism spectrum disorder (ASD), attention deficit and hyperactivity disorders (ADHD) as well as children with mental health needs, such as depression and stress due to traumatic experiences;
    - In all world regions, nations should expand the development of specialized programs focused on improving child access to services and the quality of life of children with disabilities through the provision of accessible infrastructure and assistive products. Special attention should be given to WASH infrastructure in both development and humanitarian contexts (UNICEF, 2017). IECD and ECI programs should promote the affordability and availability of assistive devices for children with disabilities.

- IECD programs should endeavor to develop continuous multisectoral systems of services, from preconception education and health and nutrition care to inclusive pre-primary and primary education.

- To meet the strong demand for services for children with at-risk situations, developmental delays and disabilities, nations should expand the development of integrated national ECI systems with the full participation of all major sectors: education; health; nutrition; sanitation/WASH; and child protection.

- Horizontal coordination and interagency agreements should be established and/or strengthened between less individualized and intensive IECD programs and more individualized and intensive ECI programs. IECD and ECI services should always work to complement each other and fully coordinate their services.

- Countries should also develop major IECD and ECI initiatives in a complementary manner, including the following activities:

    - Nationwide policy advocacy and social communications campaigns;
    - Universal developmental screening and surveillance activities;
    - Continuous pre- and in-service training systems;
    - Supervisory systems at all levels;
    - Monitoring and evaluation systems;
    - Population surveys on child development levels; and
    - Focused research projects.

## 5.2 Greatly increase investments in IECD and ECI programs to expand services rapidly

**Investing in IECD and ECI programs now constitutes a growing leadership field for international development partners as well as for national governments.**

- During the next 5 to 10 years, international organizations will continue to be critically important in providing technical and financial support for the design, development, and improvement of national IECD and ECI systems and programs.

- Given the importance of national multisectoral coordination for these systems, international donors should support all participating sectors and encourage strong intersectoral coordination.

- To achieve lower costs, ECI programs should continue to be integrated under one lead governmental sector and administrative system, with the technical and financial participation of other relevant sectors.

- To achieve extensive program growth and long-term sustainability, national, provincial and municipal governmental investment in IECD and ECI programs must be expanded rapidly, with the goal of supporting core recurrent expenses.

- In countries with decentralized fiscal systems, training should be provided to IECD and ECI programs to ensure their full participation in annual budget cycles conducted at provincial and municipal levels as well as central levels.

- To fund IECD and ECI services, governments usually contract with an array of registered, accredited, and competent non-governmental organizations that adhere to program guidelines and procedures as well as service and personnel standards.

- To achieve sustainability and be continuously innovative, non-governmental organizations should develop diversified funding systems, including a wide array of activities, such as: fundraising; vouchers; insurance reimbursements; and grants from foundations, the private sector and others.

- Additional research is urgently required on the financing of IECD and ECI programs, along with cost studies and budgetary analyses to enable the preparation of projections and simulations needed for annual program planning and budgeting.

## 5.3 Invest in communication for development (C4D).

Individuals and communities should be engaged to create positive behavioral and social change to address stigma and discrimination and shift social norms towards girls and boys with disabilities. Families of children with disabilities, Parent Associations, and Organizations of Persons with Disabilities (OPDs) should be consulted at every stage of the communication process, from design of the strategy to evaluation.

## 5.4 Expand advocacy efforts

- Advocacy campaigns for IECD and ECI programs and the children and families they serve should be expanded in order to build, strengthen, and increase support for these vital services.

- Expanded social communications campaigns are needed to address stigma, lack of inclusion, and inadequate awareness among governmental leaders, communities and families.

- In all world regions, international advocacy campaigns should be mounted to:

    - Spur national and international investment in IECD and ECI systems of services;
    - Develop national policies, strategic plans, legislation and regulations for IECD and ECI services;
    - Expand and improve IECD and ECI services;
    - Promote universal developmental screening, surveillance, and monitoring in all countries;
    - Increase dedication to preventing institutionalization and achieving deinstitutionalization; and

- Encourage the establishment of essential respite care services for parents of children receiving ECI services.

## 5.5 Promote the regional development of IECD and ECI services

- All regions require more, larger and better IECD and ECI programs. Special attention should be given to the following regions:
    - Countries of Latin America and the Caribbean, and Europe and Central Asia should give greater emphasis to developing, expanding and/or improving ECI programs;
    - Nations of the Middle East and North Africa, Sub-Saharan Africa, South Asia, and Southeast Asia and the Pacific should place strong emphasis on expanding and improving both IECD and ECI programs; and
    - The ECD Task Force for Children with Disabilities (ECDtf), in collaboration with the ECD Action Network (ECDAN), UNICEF, UNESCO, WHO and other agencies, should help to develop low cost but effective regional, national and network initiatives to promote, design, and implement IECD and ECI services as well as to ensure “lessons learned” are shared widely.

## 5.6 Prioritize expanding IECD and ECI services in low- and middle-income countries

- Although many LMIC have already developed considerable numbers of IECD and ECI programs and some have established national ECI systems, many more large-scale IECD and ECI programs are urgently required to meet the developmental and support needs of children and families living in poverty and other difficult situations.

## 5.7 Ensure all countries affected by humanitarian crises receive IECD and ECI services

- To support families whose children have developmental delays and disabilities due to (or exacerbated by) trauma and deprivations caused by humanitarian crises, greater priority should be given to developing and expanding IECD and ECI programs in all such countries.

## 5.8 Promote multisectoral, transdisciplinary and interdisciplinary service coordination

- Nations designate their lead sectors for IECD and ECI programs. Education was found to have been designated as the main lead sector in all regions, in countries of all income levels, and in crisis countries, Therefore, in those countries where education is the lead sector, it will be important to support the education sector in its leadership role. It will be important to ensure the full participation of the child protection, health, nutrition and WASH sectors in all IECD and ECI programs. For those countries where child protection or health/ nutrition has been designated as

the lead sector, the education sector should be encouraged to participate fully in IECD and ECI programs.

- IECD programs should usually be multisectoral. For technical reasons a few IECD programs sometimes are mainly sectoral, i.e. child immunizations, nutritional rehabilitation, and WASH services. However, those programs should be closely linked through systems of referrals and data sharing agreements to other sectoral and multisectoral programs.

- All ECI programs should be multisectoral, transdisciplinary or interdisciplinary, and integrated to ensure their services will be high in quality and cost-effective.

## 5.9 Integration in existing administrative systems

- To provide affordable, flexible and responsive services, ECI programs should use **one integrated administrative system** that plans and integrates the contributions of all participating sectors at municipal, regional and central levels.

- It is increasingly important to national ECI programs to work with Ministries of Finance and Planning as well as Ministries of Education, Health and Protection to develop strong support for, and assist with the scale-up of IECD and ECI systems and requisite accountability systems (e.g., monitoring, evaluation, and reporting).

- Given the high prevalence of stunting and developmental delays in most LMIC, the role of the ECI and IECD programs should greatly strengthen their services for nutritional assessment, education and care as well as collaborate closely with nutritional services of the health sector.

## 5.10 Increase geographical program coverage

- Most IECD and ECI programs that responded to the survey (55%) were found to be large in scale (international, regional or national in coverage) rather than medium-sized or small pilot initiatives. Some smaller small programs fully in line with national guidelines, procedures and service and personnel standards will always be needed to develop innovations and meet growing needs and demands for services in underserved areas.

- If external evaluations reveal good program outcomes, special attention should be given to stimulating the improvement and expansion of smaller- and medium-scale IECD and ECI initiatives to complement larger-scale programs and increase geographical coverage.

- At the same time, many more large-scale IECD and ECI programs are urgently needed in all LMIC.

- Valuable programs with complete program development processes of all sizes should be given technical and financial support to go to scale as important parts of national IECD and ECI systems.

- Although a surprising number of IECD and ECI programs reported they serve rural areas, semi-rural areas and towns, many more services are needed in those areas.

- Priority should be placed on serving ethnic groups in culturally and linguistically appropriate ways. In this regard, external evaluations should be conducted on successful IECD and ECI programs serving ethnic groups to identify, assess and disseminate effective program methodologies and lessons learned.

## 5.11 Give priority to IECD and ECI policy planning

- To establish a permanent legal basis for IECD and ECI programs, countries generally prefer to use national policies or strategic plans with action plans rather than legislation. Some countries use laws to support specific aspects of IECD and ECI programs, such as service regulations, coordination, interagency agreements or financing mechanisms.

- Although almost three-quarters of the IECD and ECI programs in the sample had developed some form of national policy instrument providing a legal basis for these programs, most nations still require additional, stronger and more effective policy and normative instruments.

- To ensure the long-term sustainability of IECD and ECI programs, more technical support is needed for national policy and strategic planning, and most especially for countries still lacking a strong legal basis for their national ECI systems.

- The education, protection, health, nutrition and WASH sectors should always be fully included in all stages of policy and program design and development.

- Because most ECI programs lacked officially adopted national program guidelines and procedures, technical protocols, and other regulations, bylaws, and/or service and personnel standards, additional technical support should be provided, with attention given to the consideration of culturally appropriate options.

- Policy planners and program developers should ensure that strong multisectoral and participatory planning processes are used, giving special attention to providing:

    - Multisectoral approaches for achieving effective coordination;
    - Transdisciplinary or interdisciplinary and culturally-derived program standards, contents, methods and procedures;
    - Full accessibility to all program services;
    - Cross-sectoral and interdisciplinary pre- and in-service training;
    - Joint transdisciplinary and interdisciplinary supervision; and
    - Multisectoral systems of accountability with comprehensive program monitoring, evaluation, and reporting activities.

## 5.12 Promote key objectives for IECD and ECI programs

- Nations and international donors should place greater priority on developing national systems of ECI services that coordinate well with general IECD services.

- Objectives for IECD and ECI programs should include the following, at a minimum:

    - Improve birth outcomes through preconception and prenatal education and care, the provision of deliveries conducted by skilled medical personnel, and neonatal screening and services that are linked with referrals to postnatal and other ECI programs, as appropriate;
    - Conduct community outreach and universal developmental screening as well as medical surveillance and monitoring;
    - Provide ECI programs with all of their evidence-based key attributes, such as formation of transdisciplinary or interdisciplinary teams, developmental and family assessments, eligibility determination, individualized family service plans, visits in the natural environment of the child, case coordination, and program completion and transition services that are fully linked with appropriate IECD and inclusive education services;
    - Offer parenting services and case coordination support, combined with ensuring child and parental rights;
    - Ensure multisectoral coordination, continuous programming, and interagency agreements among education, health, nutrition, WASH, and child protection services;
    - Develop an effective professional and paraprofessional workforce, including continuous pre- and in-service training systems, certification and recertification, career ladders and salary scales, etc.;
    - Establish regulations and guidelines for the registration and accreditation of services that are well aligned with and meet service and personnel standards;
    - Prevent institutionalization and support the deinstitutionalization of young children; and
    - Implement national systems for program monitoring, evaluation and reporting, including the provision of external evaluations.

## 5.13 Expand service coverage for preconception, pregnancy, and early years

- Although 30% of IECD and ECI programs reported providing prenatal education and care, more programs should be encouraged to focus on improving birth outcomes through the provision of preconception and prenatal education and care, essential micronutrients, neonatal health services, and continuous parenting education and support.

- Many IECD and ECI programs mainly focus on serving families with children from birth to 36 months of age. In line with neuroscience research on the developing brain and the *Nurturing Care Framework*, this age group especially needs these programs.

- IECD and ECI programs should be greatly expanded for all types of children living in at-risk situations including “children on the move” and in refugee or internally displaced persons camps (IDP) as well as children with developmental delays,

disabilities or behavioral or mental health needs because they are seriously underserved. Without intervention many of these children will develop permanent lifelong delays and disabilities.

- IECD and ECI programs and activities should continue to be family-centered and place emphasis on serving parents, caregivers, and program personnel to help ensure virtuous cycles of program improvement.

- Three-quarters of the IECD and ECI programs surveyed provided in-service training for education personnel. In the future, comparable attention should also be paid to training health, nutrition, WASH, and child protection personnel who play key roles in these integrated and/or multisectoral services.

## 5.14 Promote and expand universal developmental screening services in all nations

- A well designed and implemented system of community outreach, developmental screening and referrals with follow up should be developed in all countries to ensure children identified with a possible delay or disability are referred rapidly for developmental evaluation, and if needed, receive ECI services.

- Both IECD and ECI programs as well as other health, nutrition and child protection services should collaborate in conducting universal neonatal screenings and developmental screening services for all infants and toddlers at a minimum of 9, 18, (24) and 30 months of age or whenever parents or others have a concern (American Academy of Pediatrics, 2018). Some nations conduct screenings at 3, 6, 9, 12, 18 months, and each 6 months thereafter until 36 months in order to identify children at the earliest possible times.

- Based on expressed concern, autism screenings should be conducted at 18 and 24 months (Ibid.). Depending upon instrument availability, screening before 18 months would be advisable.

- All developmental screening instruments must be well adapted, culturally appropriate, and show sufficient evidence of validity to ensure results are reliable.

- Developmental surveillance and monitoring activities, conducted by physicians and skilled nurses, should complement developmental screenings, wherever possible.

## 5.15 Provide comprehensive and continuous IECD programs

- Greater attention should be given to the provision of preconception and prenatal education and care, delivery services given by skilled and accredited health professionals, and a wide array of neonatal screenings to improve birth outcomes and ensure a good beginning for newborns.

- In line with the *Nurturing Care Framework*, greater attention should be given to improving parenting skills, child development, and home environments, and

prevent the onset of developmental delays. In addition, screenings and assessments are increasingly being used in IECD, and especially in ECI programs, to identify parental depression, assess child diets, and evaluate home environments with respect to risks related to parent-child interaction, hygiene and safety.

- To increase their effectiveness, IECD services should increasingly provide home visits and give relatively less attention to holding group sessions for parents and caregivers of infants and toddlers.

- Center-based IECD services for infants and young children should give special attention to the provision of greatly expanded opportunities for in-service teacher training on inclusive education skills for teachers, principals and parents, including Universal Design for Learning (UDL). These inclusive services should be registered and carefully regulated at national, regional and municipal levels.

- Both IECD and ECI programs should devote greater attention to providing or creating stronger referrals and coordination systems among services for child protection, health, nutrition, WASH, and inclusive education, with a special emphasis on nutritional rehabilitation services combined with stimulation for malnourished children with developmental delays.

- To support the parents of children with developmental delays and disabilities, to the extent possible, IECD and especially ECI services should provide, sponsor or arrange for respite care services for parents and other caregivers.

## 5.16 Encourage parent and caregiver involvement.

- Parent participation and empowerment was found to be present in 93% of IECD and ECI programs, and therefore, it is essential for all effective IECD and ECI programs.

- Every effort should continue to be made to include parents, grandparents, legal guardians and caregivers in a wide variety of roles in these programs.

- In addition, efforts should be made to empower parents to seek, join, and participate in developing the IECD and ECI programs they and their children require. Of special importance is the role of parents in program planning and oversight.

## 5.17 Establish sustainable national IECD and ECI systems with training and supervision

- Improvement of the IECD and ECI workforce through the development and expansion of continuous pre- and in-service training services and workforce certification systems constitutes the number one priority for achieving program quality.

- National ECI plans focused on workforce development, pre- and in-service training and supervision are urgently needed in many nations to enable improved ECI program development, equity, innovation, training, quality assurance, accountability, and expansion in phases.

- Major international efforts are required to provide technical support for developing sustainable national ECI systems with high-quality and effective ECI programs.

- Although many ECI programs provide parent education and support, community outreach, developmental screenings, transdisciplinary or interdisciplinary teams, comprehensive functional developmental assessments of children and family assessments with full parental participation, and case coordination services and referrals, they need considerably more technical support for their programs.

- ECI programs especially require stronger legal and financial bases to ensure sustainability, as well as regulations, such as ECI program guidelines and procedures, to ensure all key ECI elements are in place, such as:

    - Culturally appropriate, reliable, validated and universal developmental screenings;
    - Parental participation in transdisciplinary or interdisciplinary teams;
    - Comprehensive developmental and family assessments;
    - Eligibility guidelines;
    - Individualized Family Service Plans with full parental participation;
    - Visits with parents and caregivers in homes and other natural environments of the child that focus on the use of daily child care routines;
    - Assistance to ensure accessibility, secure assistive technologies, and obtain case coordination services and referrals, as needed;
    - Preparation of program completion and transition plans in collaboration with IECD programs and inclusive education services; and
    - Other core elements of high-quality ECI programs.

- Supervisory systems featuring mentoring, coaching and reflective supervision should be developed at central, regional and program levels.

- Continuous internal and external monitoring, evaluation, and reporting systems that function effectively at municipal, regional and central levels, are required especially to support program planning and improvement, and to ensure full program accountability.

## 5.18 Develop effective inclusive child and social protection services

- To ensure full social equity, nations should greatly expand the provision of inclusive child and social protection services. Child and social protection services should be formally linked to IECD and ECI services.

- Through coordinating child protection policies and programs with IECD, ECI and other relevant services, all nations could prevent the institutionalization of children from birth to three years, rapidly deinstitutionalize young children, and arrange for family placements.

- Countries should also study options for using conditional cash transfers to fund ECI programs that are linked with child and social protection, health and nutrition services.

## 5.19 Achieve full program accountability through monitoring, evaluation and research

- Parents and legal guardians should become increasingly involved in program oversight and evaluation in order to help improve program quality, growth and sustainability.

- In line with Sustainable Development Goal indicator 4.2.1,[24] each nation should conduct periodic national population surveys to monitor child developmental levels in each region.

- IECD and ECI programs should continue to conduct internal monitoring and evaluation activities, with a focus on quality improvement and program planning and expansion.

- Using culturally appropriate and validated instruments, national systems of universal developmental screening and program monitoring and evaluation should be developed and implemented.

- Future global, regional and national surveys of IECD and ECI programs should focus on:

    - Management, structure, and supervisory systems;
    - Program registration, accreditation or licensing;
    - Service and personnel standards:
    - Program and evaluation instruments and guides;
    - Workforce development systems, including pre- and in-service training, certification/recertification, career ladders and salary systems;
    - Monitoring, evaluation and reporting systems; and
    - Use of findings in annual program and financial planning.

- External program evaluations should continue to be conducted on leading IECD and ECI programs to identify good practices and lessons learned, and findings should be distributed rapidly and widely through global, regional and national networks.

## 5.20 Provide more technical support

- Targeted and individualized technical support is needed across all world regions. In South Asia, and the Middle East and North Africa additional technical support to develop, improve and expand both IECD and ECI services. For Latin America and

[24] Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex.

the Caribbean, substantial technical support to develop national ECI systems that will complement general ECD services is required.

- This survey demonstrated that countries at all income levels are providing more intensive and individualized services for children with at-risk conditions, developmental delays, disabilities, and behavioral or mental health needs. However, a major international effort is required to provide technical support to these programs as well as guidance for developing comprehensive, good quality, and sustainable national ECI systems.

- Additional technical support is required for national policy development, strategic planning, and to help countries consider their options regarding the contents of IECD and ECI normative instruments including program guidelines and procedures as well as service and personnel standards.

- Currently many ECI programs provide parent education and support; community outreach services; developmental screenings; comprehensive developmental assessments with parental participation; case management and referrals; and parental participation in interdisciplinary or transdisciplinary teams; however, these programs need additional technical support to expand other dimensions of their programs, such as individualized family service plans, transdisciplinary or interdisciplinary teams, comprehensive internal monitoring and evaluation systems, and completion and transition plans for children and families as they enter inclusive education and other social services.

- Finally, it is important that international agencies expand and improve the competence of their personnel in IECD and ECI planning and programming in order to help nations meet their technical as well as funding needs for program development.

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# 6 Call for a Global Agenda for Inclusive ECD and ECI Programs

Based on recommendations gleaned from the survey, we are issuing Call for a Global Agenda for the Improvement and Expansion of IECD and ECI programs.

The Call presents the following strategies and initiatives to be implemented by international agencies, national governments and civil society organizations, and communities:

## Global Agenda for Inclusive ECD and ECI Programs

1. **Expand and improve national leadership for IECD and ECI programs.**

Within the international frameworks of the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and Convention on the Elimination of All Forms of Discrimination against Women, ensure each nation designates its lead ministry for national IECD and ECI programs. In every nation, develop a high-level, effective and sustainable National Multisectoral Steering Committee and Technical Task Force for IECD and ECI policy planning and program development, including ministries of finance and planning as well as ministries of education, health and child protection, parents and children, civil society organizations, disabled peoples organizations, parent associations, universities, institutes, and the private sector.

2. **Conduct expanded advocacy and communications for development campaigns.**

Advocacy is urgently needed to overcome stigma, enable educational and social inclusion, and build greater awareness of the needs of families with children with developmental delays and disabilities. To reach governmental leaders, communities and families, greatly expanded campaigns should be conducted for policy advocacy and social communications in close collaboration with parent associations and disabled people's organizations. All types of media and community activities should be used to develop and deliver key messages supporting IECD and ECI services. In all world regions, international advocacy campaigns should be mounted to (a) spur international and national investment in IECD and ECI programs; (b) promote universal developmental screening, surveillance, and monitoring in all countries; (c) increase dedication to preventing institutionalization and achieving deinstitutionalization; and (d) encourage the establishment of essential case coordination and respite care services for parents of children receiving ECI services.

3. **Assess the development of IECD and ECI programs in each nation.**

## Global Agenda for Inclusive ECD and ECI Programs

In each country, a major study should identify and map IECD and ECI programs and supporting resources in terms of institutions, pre- and in-service training, human resources and workforce development, and investments. Attention should be given to identifying program strengths, needs and plans for development and growth. A national population study on child development levels should be conducted at the household level to measure child development for Indicator 4.2.1 of the Strategic Development Goals as well as to use results for national and regional planning, and for use as a baseline for future national assessments of child development outcomes over time.

A detailed ECI Situation Analysis should be prepared including results from the mapping survey, salient studies and statistics on children with developmental delays and disabilities, and reviews of the national and regional policy context. Consultation workshops should be carried out with all stakeholders, such as ministries and other governmental agencies, IECD and ECI programs and coalitions, municipal and regional leaders, parents, professionals and paraprofessionals, associations, universities, and training institutes. High-level interviews should be conducted with leaders at central, regional and municipal levels who are strategically important but unable to attend consultation workshops in order to secure their recommendations and future support for IECD and ECI programs.

4. **Strengthen multisectoral involvement.**

Given the multidisciplinary nature of IECD and ECI services especially in LMICs, multisectoral coordination among education, health, nutrition, WASH and child protection services sectors is paramount. Strong leadership and participation of the education sector is of central importance; however, greater attention to inclusion of child protection and child health and nutrition sectors, in particular, will help ensure all children in IECD programs can access child and family protection, health, and nutrition services. International donors, rather than designating a single sector for IECD and ECI services, should encourage countries to designate the lead sector for IECD and ECI services in accordance with their institutional strengths and policy contexts.

5. **Place top priority on developing policies, strategic plans, and laws for IECD and ECI systems.**

On the basis of the preparatory activities presented above, the legal basis for IECD and ECI programs should be established through preparing or updating Strategic Plans, Action plans, Laws, and Regulations, including ECI Program Guidelines and Procedures, and Service and Personnel Standards. Greater attention should be given to developing policies for the provision of continuous services from preconception and prenatal care to improve birth outcomes, services for children from birth to 36 months, and up to inclusive pre-primary and primary schooling. The transition from policy planning to policy implementation should be well structured to build effectively on the broad base

## Global Agenda for Inclusive ECD and ECI Programs

of commitment that is developed during the participatory policy planning process.

6. **Establish universal developmental screening and referrals.**

Top priority should be placed in each country on conducting activities for expanding community outreach and establishing a universal system of developmental screening, with referrals to ECI programs where key activities would be performed, including:

- Forming transdisciplinary or interdisciplinary teams;
- Conducting developmental and family assessments;
- Making eligibility determinations;
- Preparing individualized family service plans;
- Providing visits in the natural environment of the child using daily child care routines;
- Conducting case coordination services; and
- Preparing program completion and transition services that are fully linked with IECD and inclusive education services.

7. **Improve the quality of IECD and ECI programs and encourage parent involvement.**

Through the provision of technical support and funding, improve the quality of IECD and ECI program. Full program equity should be ensured, as well as open access and physical accessibility to IECD and ECI services, in line with child and family needs and eligibility guidelines. Activities should be conducted, such as:

- Developing and implementing of ECI Program Guidelines and Procedures;
- Adapting, field testing and providing educational, training and program materials;
- Providing pre- and in-service training for professionals and paid paraprofessionals;
- Continuing to promote full parental participation in program activities and in all decisions regarding their children;
- Developing supervisory systems with mentoring, coaching, and reflective supervision, combined with in-service training at all levels;
- Promoting appropriate uses of information technologies to support program services; and
- Attaining full program accountability through conducting continuous supervision, parental oversight, monitoring, evaluation, and reporting.

8. **Increase investment in IECD and ECI programs.**

## Global Agenda for Inclusive ECD and ECI Programs

International investments in IECD and ECI programs should be greatly expanded, with a special emphasis on LMIC and countries with humanitarian crises. Concurrently, national governmental investments should be rapidly increased to provide core support to IECD and ECI programs, while ensuring that all programs build a diversified funding base with core support from government at all levels. Nations with decentralized systems of budget preparation and funding allocation must ensure that timely budgeting exercises are conducted annually with IECD and ECI programs at municipal and regional levels as well as at national levels. Training materials for government specialists and IECD and ECI program directors and managers should be developed, clearly specifying their roles, responsibilities and guidelines for program management, budgeting and financial reporting.

Governmental entities at all levels should work together to ensure core funding is provided to meet the annual recurrent costs of IECD and ECI programs. Programs should also seek additional sources of funding to complement governmental contracts in order to support further program development and innovative activities, in-service training, and technical excellence.

Additional research is urgently required regarding the financing of IECD and ECI programs, along with studies on: program demand; program costs and expenditures, including fees if any; and budgetary analyses. These studies are required in order to prepare projections and simulations to maximize the use of resources for annual program planning and budgeting.

**9. Provide high quality and fully accountable IECD and ECI services in each nation.**

IECD and ECI services should be expanded in phases, initially giving attention to quality assurance through developing experimental service sites (pilot sites) and conducting internal and external evaluations. Each nation should develop a country strategy for program expansion while maintaining and enhancing quality, equity and accountability. Program accountability should be improved through helping programs establish strong internal monitoring and evaluation systems, using monitoring and evaluation manuals with reliable and validated instruments and guides. External evaluations on program inputs, outputs and outcomes should be conducted in each nation for all major types of IECD and ECI programs.

**10. Expand networking and coordination for IECD and ECI services.**

The development of national IECD and ECI networks, coalitions and/or associations should be promoted to ensure a high level of interagency networking, collaboration and sharing of innovations. Through formal interagency agreements, strong horizontal coordination should be established as well as bottom-to-top and top-to-bottom vertical coordination at municipal, regional and central levels.

## Global Agenda for Inclusive ECD and ECI Programs

Through implementing this Global Agenda for the Improvement and Expansion of IECD and ECI Programs in all nations, we shall greatly improve the developmental status of children everywhere. By supporting parents and helping all young children achieve their full potential, we shall create – at long last – a virtuous cycle of improved human development and wellbeing.

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## Annex 1. Glossary of Terms

| Glossary of Terms | |
|---|---|
| **Terms** | **Definitions*** |
| **Access** | **Access** is providing a wide range of activities and environments for every child by removing physical, attitudinal, legal or organizational barriers and offering multiple ways to promote learning and development. In many cases, simple modifications can facilitate access for individual children. Universal Design for Learning (UDL) approaches are another way to use principles and practices to ensure that every young child has access to learning environments, to typical home or educational routines and activities to the general education curriculum, and to necessary prosthetic and assistive technologies for children to develop optimally. |
| **Assistive Technologies** | **Assistive technologies** comprise products and related services that improve the functioning of people with disabilities and allow them to participate in various facets of life (communication, mobility, self-care, household tasks, family relationships, education, engagement in play and recreation). They refer to any product, especially produced or generally available, that is used by or for persons with disability: for participation; to protect, support, train, measure or substitute for body functions/structures and activities; or to prevent impairments, activity limitations or participation restrictions. They include devices, equipment, instruments and software. (e.g. wheelchair, shower seat, eyeglasses, Braille systems for reading and writing, headphone, timer, adapted games). They are also known as "assistive devices." |
| **Children with behavioral or mental health needs** | **Children with behavioral or mental health needs** include those with biological, brain and psychological changes that result in conditions such as autism spectrum disorders, attention deficit and hyperactivity disorders, interpersonal interaction difficulties, hearing and vision limitations, poor self-regulation, etc. Mental health needs include trauma from stressful situations, depression and other conditions. |
| **Children with disabilities** | **Children with disabilities** refers to those who have long-term physical, mental, intellectual or sensory conditions that may require environmental modifications and access to habilitation and/or devices to facilitate their activities of daily living and full and effective participation in society on an equal basis with others. A child may have single or multiple conditions affecting mobility, communication, receptive and expressive speech and language, swallowing and access to nutrition or psychosocial conditions that affect relations with others. |

| | |
|---|---|
| **Classification of Disability** | **The International Classification of Functioning, Disability and Health: Children and Youth Version (ICF-CY)** regards disability as neither purely biological nor social but instead the interaction between health conditions and environmental and personal factors. The UN Convention on the Rights of Persons with Disabilities (CRPD) is based on the WHO social model of disability. It integrates environmental modification and inclusive early childhood development with healthcare, habilitation, and educational access. Disability may occur at three levels:<br>• An impairment in body function or structure resulting in a limitation in physical activity<br>• Limitations in cognitive functioning; or<br>• A restriction in participation in schools and/or other services |
| **Community-based rehabilitation** | **Community-based rehabilitation** is a general strategy at the community level for the provision of services for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities. |
| **Developmental Delay** | Developmental delay refers to children who experience significant variation in the achievement of expected developmental norms for their actual or adjusted age. A norm is a range of typical development from one age to another, e.g. child walks alone briefly from 9 to 15 months. |
| **Developmental Screening** | Developmental screening is the process by which a developmental screening tool (with evidence of reliability, validity and psychometrically-sound cutoffs based on data from a normative sample) is administered, scored, and used to facilitate a discussion with the parent to determine follow-up action. Developmental screening assesses child development across multiple domains (e.g., gross motor, fine motor, communication, problem-solving, personal social) and is typically parent-completed, either independently or with support from trained personnel. Although developmental screening can occur within the context of developmental surveillance in a healthcare setting, it can also occur in other contexts such as in early childhood intervention services, early years centers, community programs, libraries, or the home setting. |

| | |
|---|---|
| **Disability** | Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. (*Convention on the Rights of Persons with Disabilities*) |
| **Developmental Surveillance/ Monitoring** | Developmental surveillance (often labeled "monitoring" by non-medical professionals) is an information gathering process that is flexible, longitudinal, continuous and cumulative. Developmental surveillance/monitoring is completed by a health care professional and includes at least five components: (a) eliciting and attending to parent concerns about their child's development; (b) documenting and maintaining a developmental history; (c) making accurate observations of the child; (d) identifying the presence of risk and protective factors; and (e) maintaining an accurate record of the process and findings (AAP, 2006; Marks, Glascoe, & Macias, 2011). Developmental surveillance/monitoring can be unstructured or structured. If structured, the health care provider incorporates the use of a developmental screening tool (that has strong evidence of reliability and validity) into the developmental surveillance/monitoring process. Conversely, unstructured surveillance/monitoring would be guided by clinical impression or use of a tool that does not have evidence of validity or reliability (e.g., use of a checklist or developmental milestones). |
| **Early childhood** | **Early childhood** spans the period from preconception and pregnancy to eight years of age. It is the most intensive and rapid period of brain development throughout the lifespan, and the brain has great plasticity during this period. Therefore, early childhood is considered to be the most critical and foundational stage of human development. |
| **Early Childhood Development** | **Early childhood development** refers to the holistic development of a child in the following areas: perceptual (e.g., vision, hearing, touching); fine and gross motor (physical); cognitive; language and communication; and social, emotional and adaptive behaviors. It also includes family development and participation; child health, nutrition, and hygiene; home and center sanitation and safety; early education; and child rights and protection. |

| | |
|---|---|
| **Early Childhood Intervention Services** | **Early childhood intervention services** are multisectoral, integrated and transdisciplinary or interdisciplinary, and they are designed to support families with young children from birth to three/five years who are at risk of or have developmental delays, disabilities or behavioral or mental health needs. ECI programs include a range of individualized services to improve child development and resilience, and strengthen family competencies and parenting skills to facilitate children's development. They often also involve advocacy for the educational and social inclusion of these children and their families. |
| **Early Childhood Intervention Systems** | **Early Childhood Intervention systems** include coordinated national inter-sectoral and transdisciplinary or interdisciplinary services that promote the child's age appropriate growth and development and support families during the critical early years from birth to three/five years of age. ECI systems usually are supported by national policy and include guidelines and procedures, regulations, and service and personnel standards. The mission of an Early Childhood Intervention System is to ensure that all families who have at-risk children in this age range receive resources and support that assist them to maximize their child's physical, language, cognitive, and social/emotional development while respecting the diversity of families and communities. |
| **Inclusion** | **Inclusion** is a term that reflects reducing inequality and fostering the transformation of systems to be inclusive of everyone. Inclusive communities design universally and put into place measures to support all children's participation at home, at school and in their communities. Where barriers exist, inclusive communities transform the way they are organized to meet the needs of all children. Inclusion involves changes and modifications in content, approaches, structures and strategies with a common vision that covers all children of the appropriate age range and a conviction that it is the responsibility of the regular system to educate all children. |

| | |
|---|---|
| **Inclusive early childhood development services** | **Inclusive early childhood development services** include children from birth to eight years with delays and disabilities in early childhood programs, together with their peers without delays and disabilities. These services hold high expectations and intentionally promote participation in all learning and social activities, facilitated by individualized accommodations; and use evidence-based services and supports to foster their development (cognitive, language, communication, physical, behavioral, and social-emotional), friendships with peers, and sense of belonging. This applies to all young children with disabilities, from those with the mildest delays and disabilities to those with the most significant disabilities. Early childhood systems that are inclusive consider the principles of access, equity, participation and support. |
| **Integration in early childhood** | **Integration in early childhood** traditionally refers to early childhood development services for children at risk of or with developmental delays, disabilities or behavioral or mental health needs in mainstream settings. It does not always consider the principles of access, equity participation and support. |
| **Universal Design for Learning (UDL)** | **Universal Design for Learning** is an approach designed to provide all students of all abilities an equal opportunity to learn in inclusive environments through flexible curricular approaches. |

*These definitions were adapted from American Academy of Pediatrics, DEC/NAEYC, Illinois Department of Human Services, the United Nations, US Department of Education, US Department of Health and Human Services, UNESCO, UNICEF and WHO.

## Annex 2. Country Reported On by Region

| Region<br>Country | N | % within region |
|---|---|---|
| **Sub-Saharan Africa (n = 115)** | | |
| Nigeria | 15 | 13.0 |
| Zimbabwe | 13 | 11.3 |
| South Africa | 10 | 8.7 |
| Kenya | 8 | 7.0 |
| Malawi | 8 | 7.0 |
| Tanzania | 7 | 6.1 |
| Burkina Faso | 4 | 3.5 |
| Liberia | 4 | 3.5 |
| Mozambique | 4 | 3.5 |
| Rwanda | 4 | 3.5 |
| Swaziland | 4 | 3.5 |

| Region<br>Country | N | % within region |
|---|---|---|
| Uganda | 4 | 3.5 |
| Zambia | 4 | 3.5 |
| Cameroon | 3 | 2.6 |
| Lesotho | 3 | 2.6 |
| Angola | 2 | 1.7 |
| Ethiopia | 2 | 1.7 |
| Ghana | 2 | 1.7 |
| Mauritania | 2 | 1.7 |
| Central African Republic | 1 | 0.9 |
| Congo | 1 | 0.9 |
| Democratic Republic of the Congo | 1 | 0.9 |
| Gabon | 1 | 0.9 |
| Madagascar | 1 | 0.9 |
| Mali | 1 | 0.9 |
| Namibia | 1 | 0.9 |
| Sao Tome and Principe | 1 | 0.9 |
| Senegal | 1 | 0.9 |
| Sierra Leone | 1 | 0.9 |
| South Sudan | 1 | 0.9 |
| Togo | 1 | 0.9 |
| **Europe and Central Asia (n = 108)** | | |
| Croatia | 13 | 12.0 |
| Portugal | 9 | 8.3 |
| Georgia | 7 | 6.5 |
| Ukraine | 6 | 5.6 |
| Bulgaria | 5 | 4.6 |
| Macedonia, the former Yugoslav Republic of | 5 | 4.6 |
| Russian Federation | 5 | 4.6 |
| United Kingdom | 5 | 4.6 |
| Belarus | 4 | 3.7 |
| Kosovo | 4 | 3.7 |
| Republic of Moldova | 4 | 3.7 |
| Serbia | 4 | 3.7 |
| Turkey | 4 | 3.7 |
| Armenia | 3 | 2.8 |
| Azerbaijan | 3 | 2.8 |
| Albania | 2 | 1.9 |
| Austria | 2 | 1.9 |
| Bosnia and Herzegovina | 2 | 1.9 |
| Germany | 2 | 1.9 |
| Ireland | 2 | 1.9 |
| Italy | 2 | 1.9 |
| Montenegro | 2 | 1.9 |
| Romania | 2 | 1.9 |
| Tajikistan | 2 | 1.9 |
| Greece | 1 | 0.9 |
| Hungary | 1 | 0.9 |
| Kyrgyzstan | 1 | 0.9 |

| Region<br>Country | N | % within region |
|---|---|---|
| Netherlands | 1 | 0.9 |
| Slovak Republic | 1 | 0.9 |
| Spain | 1 | 0.9 |
| Sweden | 1 | 0.9 |
| Switzerland | 1 | 0.9 |
| Uzbekistan | 1 | 0.9 |
| **East Asia and the Pacific (n = 69)** | | |
| Philippines | 14 | 20.3 |
| Myanmar | 10 | 14.5 |
| Australia | 8 | 11.6 |
| Singapore | 6 | 8.7 |
| Vietnam | 6 | 8.7 |
| Cambodia | 5 | 7.2 |
| New Zealand | 2 | 2.9 |
| Thailand | 2 | 2.9 |
| Cook Islands | 2 | 2.9 |
| Indonesia | 2 | 2.9 |
| Solomon Islands | 2 | 2.9 |
| Tonga | 2 | 2.9 |
| American Samoa | 1 | 1.4 |
| Kiribati | 1 | 1.4 |
| Marshall Islands | 1 | 1.4 |
| Mongolia | 1 | 1.4 |
| Niue | 1 | 1.4 |
| Papua New Guinea | 1 | 1.4 |
| Tuvalu | 1 | 1.4 |
| Vanuatu | 1 | 1.4 |
| **Latin America and Caribbean (n = 63)** | | |
| Colombia | 18 | 28.6 |
| Nicaragua | 6 | 9.5 |
| Argentina | 5 | 7.9 |
| El Salvador | 5 | 7.9 |
| Peru | 4 | 6.3 |
| Brazil | 3 | 4.8 |
| Jamaica | 3 | 4.8 |
| Trinidad and Tobago | 3 | 4.8 |
| Bolivia | 2 | 3.2 |
| Chile | 2 | 3.2 |
| Guatemala | 2 | 3.2 |
| Uruguay | 2 | 3.2 |
| Costa Rica | 1 | 1.6 |
| Guyana | 1 | 1.6 |
| Haiti | 1 | 1.6 |
| Honduras | 1 | 1.6 |
| Mexico | 1 | 1.6 |
| Sint Maarten (Dutch) | 1 | 1.6 |
| St. Vincent and the Grenadines | 1 | 1.6 |

| Region<br>Country | N | % within region |
|---|---|---|
| Venezuela | 1 | 1.6 |
| **South Asia (n = 36)** | | |
| India | 9 | 25.0 |
| Afghanistan | 7 | 19.4 |
| Bangladesh | 7 | 19.4 |
| Nepal | 6 | 16.7 |
| Pakistan | 3 | 8.3 |
| Bhutan | 2 | 5.6 |
| Sri Lanka | 2 | 5.6 |
| **North America (n = 21)** | | |
| United States | 16 | 76.2 |
| Canada | 4 | 19.0 |
| Bermuda | 1 | 4.8 |
| **Middle East and North Africa (n = 14)** | | |
| Tunisia | 4 | 28.6 |
| Egypt | 2 | 14.3 |
| Israel | 2 | 14.3 |
| Oman | 2 | 14.3 |
| State of Palestine | 2 | 14.3 |
| Iraq | 1 | 7.1 |
| Malta | 1 | 7.1 |

## Annex 3. World Region by Income Level

| Region | N | % within region |
|---|---|---|
| **Sub-Saharan Africa (n = 115)** | | |
| Low-income | 58 | 50.4 |
| Lower middle-income | 43 | 37.4 |
| Uper middle-income | 14 | 12.2 |
| **Europe and Central Asia (n = 108)** | | |
| Lower middle-income | 21 | 19.4 |
| Upper middle-income | 45 | 41.7 |
| High-income | 42 | 38.9 |
| **East Asia and the Pacific (n = 69)** | | |
| Lower middle-income | 45 | 65.2 |
| Upper middle-income | 5 | 7.2 |
| High-income | 16 | 23.2 |
| Missing | 3 | 4.3 |

| Region | N | % within region |
|---|---|---|
| **Latin America and the Caribbean (n = 63)** | | |
| Low-income | 1 | 1.6 |
| Lower middle-income | 16 | 25.4 |
| Upper middle-income | 38 | 60.3 |
| High-income | 8 | 12.7 |
| **South Asia (n = 36)** | | |
| Low-income | 13 | 36.1 |
| Lower middle-income | 23 | 63.9 |
| **North America (n = 21)** | | |
| High-income | 21 | 100.0 |
| **Middle East and North Africa (n = 14)** | | |
| Lower middle-income | 6 | 42.9 |
| Upper middle-income | 1 | 7.1 |
| High-income | 5 | 35.7 |
| Missing | 2 | 14.3 |

## Annex 4. Regional Breakdown of Countries Affected by Humanitarian Crises

| Humanitarian crisis country | N | % |
|---|---|---|
| **Sub-Saharan Africa** | **48** | **40.3** |
| Nigeria | 15 | 12.6 |
| Kenya | 8 | 6.7 |
| Malawi | 8 | 6.7 |
| Liberia | 4 | 3.4 |
| Uganda | 4 | 3.4 |
| Cameroon | 3 | 2.5 |
| Ethiopia | 2 | 1.7 |
| Central African Republic | 1 | 0.8 |
| Democratic Republic of the Congo | 1 | 0.8 |
| Mali | 1 | 0.8 |
| Sierra Leone | 1 | 0.8 |
| **East Asia and the Pacific** | **24** | **20.2** |
| Philippines | 14 | 11.8 |
| Myanmar | 10 | 8.4 |
| **Latin America and the Caribbean** | **19** | **16.0** |
| Colombia | 18 | 15.1 |
| Haiti | 1 | 0.8 |
| **South Asia** | **13** | **10.9** |
| Afghanistan | 7 | 5.9 |

| Humanitarian crisis country | N | % |
|---|---|---|
| Nepal | 6 | 5.0 |
| | | |
| **Europe and Central Asia** | **10** | **8.4** |
| Ukraine | 6 | 5.0 |
| Turkey | 4 | 3.4 |
| | | |
| **Middle East and North Africa** | **5** | **4.2** |
| Egypt | 2 | 1.7 |
| Palestine | 2 | 1.7 |
| Iraq | 1 | 0.8 |
| **Total** | **119** | **100.0** |

## Annex 5. Type of Organization for Which Respondents Reported Working

| Organization Type | N | %* |
|---|---|---|
| **National Organizations** | **167** | **39.2** |
| National non-governmental organization (NGO) | 117 | 27.5 |
| Community-based organization (CBO) | 22 | 5.2 |
| Disabled people organization (DPO) | 14 | 3.3 |
| Faith-based organization (FBO) | 7 | 1.6 |
| Parent organization, association or federation | 7 | 1.6 |
| | | |
| **International Organizations** | **114** | **26.8** |
| International NGO (INGO) | 64 | 15.0 |
| UN Agency | 43 | 10.1 |
| International foundation or corporate foundation | 5 | 1.2 |
| World Bank | 2 | 0.5 |
| | | |
| **Government** | **50** | **11.7** |
| National or federal government | 29 | 6.8 |
| Regional, provincial, or state government | 14 | 3.3 |
| Local, municipal, or county government | 7 | 1.6 |
| | | |
| **Academic or Research Institution** | **48** | **11.3** |
| | | |
| **Private Organizations** | **26** | **6.1** |
| Private organization (business, corporation, or other private for-profit enterprise) | 6 | 1.4 |
| Private voluntary organization | 6 | 1.4 |
| Social enterprise | 5 | 1.2 |
| Private or corporate foundation | 5 | 1.2 |
| Public-private partnership | 4 | 0.9 |
| | | |
| **Other national institution** | **21** | **4.9** |
| Health organization or hospital | 10 | 2.3 |
| National foundation or charity | 5 | 1.2 |
| National or regional network | 3 | 0.7 |
| Private consultancy | 2 | 0.5 |

| Organization Type | N | %* |
|---|---|---|
| Educational organization | 1 | 0.2 |

## Annex 6. Professional Field in Which Respondent Reported Working

| Professional field | N | % |
|---|---|---|
| **Health, nutrition, and therapies** | **95** | **22.3** |
| Pediatrics or pediatric neurology | 17 | 4.0 |
| Public or Community health | 17 | 4.0 |
| Rehabilitation or habilitation | 11 | 2.6 |
| Occupational therapy | 8 | 1.9 |
| Nursing | 7 | 1.6 |
| Child screening, surveillance, and monitoring | 5 | 1.2 |
| Medicine | 5 | 1.2 |
| Speech and language therapy or pathology | 5 | 1.2 |
| Audiology, Otology, or Ear, Nose and Throat | 4 | 0.9 |
| Nutrition | 3 | 0.7 |
| Physical Therapy | 6 | 1.4 |
| Psychiatry | 3 | 0.7 |
| Autism and related behavioral disorders | 1 | 0.2 |
| Genetic counseling | 1 | 0.2 |
| Neurology | 1 | 0.2 |
| Optometry | 1 | 0.2 |
| **Inclusive, pre-primary and special education** | **86** | **20.2** |
| Inclusive education | 30 | 7.0 |
| Pre-primary education | 22 | 5.2 |
| Special education | 21 | 4.9 |
| Education | 13 | 3.1 |
| **Early Childhood Development (ECD)** | **79** | **18.5** |
| **Social science field and humanities** | **62** | **14.6** |
| Child development | 23 | 5.4 |
| Psychology or Child psychology | 22 | 5.2 |
| Anthropology | 8 | 1.9 |
| Science or Research | 3 | 0.7 |
| Sociology | 3 | 0.7 |
| Economics | 1 | 0.2 |
| History | 1 | 0.2 |
| Philosophy | 1 | 0.2 |
| **Early Childhood Intervention (ECI)** | **47** | **11.0** |
| **Policy, management, administration, and advocacy** | **35** | **8.2** |
| Management and administration | 23 | 5.4 |
| Policy | 2 | 0.5 |
| Advocacy | 10 | 2.3 |

| Professional field | N | % |
|---|---|---|
| **Child Protection or Social Services** | **22** | **5.2** |
| Law, disability, and human rights | 14 | 3.3 |
| Social work or case coordination | 8 | 1.9 |

## Annex 7. Respondents Primary Role in Organization

| Primary Role | N | % |
|---|---|---|
| Executive director, program director, administrator, or manager | 146 | 34.3 |
| ECD specialist | 70 | 16.4 |
| Academic or education specialist | 49 | 11.5 |
| Child protection, human rights, disability, or family support specialist | 45 | 10.6 |
| Medical health specialist, therapist, or defectologist | 31 | 7.3 |
| Researcher or evaluator | 16 | 3.8 |
| Advocacy, public relations, community relations, or outreach | 14 | 3.3 |
| ECI specialist | 13 | 3.1 |
| Supervisor or coach | 13 | 3.1 |
| Trainer | 13 | 3.1 |
| Policy planner | 8 | 1.9 |
| Non-professional (e.g., paraprofessional, parent) | 5 | 1.2 |
| Advisor or consultant | 3 | 0.7 |

## Annex 8: Type of Program

| Program type | N | % |
|---|---|---|
| Both ECD and ECI | 169 | 39.7 |
| ECD only or mainly | 109 | 25.6 |
| No ECD or ECI services | 100 | 23.5 |
| ECI only or mainly | 48 | 11.3 |
| Total | 426 | 100.1 |

## Annex 9: Programs Reporting More than One National Legal Framework

| Official national legal or normative framework | a | b | c | d | e |
|---|---|---|---|---|---|
| a. A national policy or section of a policy (n = 99) | -- | 71 (71.7) | 46 (46.5) | 37 (37.4) | 12 (12.1) |
| b. A national strategic plan and/or an action plan (n = 93) | 71 (76.3) | -- | 42 (45.2) | 38 (40.9) | 8 (8.6) |
| c. A national law/act or section of a law/act (n = 65) | 46 (70.8) | 42 (64.6) | -- | 29 (44.6) | 12 (18.5) |
| d. Program protocol, regulations, bylaws and/or standards (n = 57) | 37 (64.9) | 38 (66.7) | 29 (50.9) | -- | 10 (17.5) |

| Official national legal or normative framework | a | b | c | d | e |
|---|---|---|---|---|---|
| e. Other legal or normative framework (n = 25) | 12 (48.0) | 8 (32.0) | 12 (48.0) | 10 (40.0) | -- |

## Annex 10: Founding Year of Program by Income Group[25]

| Income group | 1950s N | 1960s N | 1970s N | 1980s N | 1990s N | 2000s N | 2010-present N |
|---|---|---|---|---|---|---|---|
| High-income | 0 | 2 | 6 | 7 | 12 | 29 | 35 |
| Upper middle-income | 1 | 0 | 3 | 3 | 8 | 25 | 63 |
| Lower middle-income | 1 | 2 | 2 | 8 | 21 | 49 | 69 |
| Low-income | 0 | 0 | 1 | 2 | 6 | 23 | 38 |

## Annex 11: Founding Year of Program by Countries Affected and Not Affected by Humanitarian Crises

| Humanitarian crisis status | 1950s N | 1960s N | 1970s N | 1980s N | 1990s N | 2000s N | 2010-present N | Total N |
|---|---|---|---|---|---|---|---|---|
| Affected by humanitarian crises (n = 119) | 2 | 1 | 2 | 6 | 18 | 33 | 54 | 116 |
| Not affected by humanitarian crises (n = 307) | 0 | 3 | 10 | 14 | 29 | 95 | 154 | 305 |
| Total | 2 | 4 | 12 | 20 | 47 | 128 | 208 | 421 |

## Annex 12: Programs Reporting Engagement of Only One Sector

| Region | Education (%) | Health (%) | Social Protection (%) | Nutrition (%) |
|---|---|---|---|---|
| Europe and Central Asia (n = 30) | 22 (73.3) | 4 (13.3) | 4 (13.3) | 0 (0.0) |

[25] The number of programs reporting in Tables X and Y is 421. Five programs are from countries lacking an income group designated by the World Bank, and therefore, are not included in the breakdown by income group.

| Region | Education (%) | Health (%) | Social Protection (%) | Nutrition (%) |
|---|---|---|---|---|
| Sub-Saharan Africa (n = 23) | 13 (56.5) | 7 (30.4) | 2 (8.7) | 1 (4.3) |
| East Asia and the Pacific (n = 13) | 11 (84.6) | 2 (15.4) | 0 (0.0) | 0 (0.0) |
| Latin America and the Caribbean (n = 12) | 10 (83.3) | 2 (16.7) | 0 (0.0) | 0 (0.0) |
| South Asia (n = 6) | 4 (66.7) | 1 (16.7) | 1 (16.7) | 0 (0.0) |
| North America (n = 9) | 7 (77.8) | 2 (22.2) | 0 (0.0) | 0 (0.0) |
| Middle East and North Africa (n = 2) | 2 (100.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) |

## Annex 13: Combination of Sectoral Involvement for Programs Reporting Multisectoral Engagement

| Sector | a | b | C | d | e |
|---|---|---|---|---|---|
| a. Education (n = 307) | -- | 266 (86.6) | 252 (82.1) | 142 (46.3) | 104 (33.9) |
| b. Health (n = 286) | 266 (93.0) | -- | 232 (81.1) | 142 (49.7) | 102 (35.7) |
| c. Social protection (n = 269) | 252 (93.7) | 232 (86.2) | -- | 127 (47.2) | 94 (34.9) |
| d. Nutrition (n = 148) | 142 (95.9) | 142 (95.9) | 127 (85.8) | -- | 89 (60.1) |
| e. WASH (n = 106) | 104 (98.1) | 102 (96.2) | 94 (88.7) | 89 (84.0) | -- |

## Annex 14: Sectoral Engagement by Region

| Region | Education (%) | Health (%) | Social Protection* (%) | Nutrition (%) | WASH (%) | Other (%) |
|---|---|---|---|---|---|---|
| Europe and Central Asia | 89 (82.4) | 66 (61.1) | 72 (66.7) | 12 (11.1) | 2 (1.9) | 1 (0.9) |
| Sub-Saharan Africa | 96 (83.5) | 89 (77.4) | 79 (68.7) | 53 (46.1) | 39 (33.9) | 1 (1.0) |
| East Asia and the Pacific | 62 (89.9) | 53 (76.8) | 46 (66.7) | 29 (42.0) | 25 (36.2) | 0 (0.0) |
| Latin America and the Caribbean | 48 (76.2) | 47 (74.6) | 41 (65.1) | 30 (47.6) | 18 (28.6) | 0 (0.0) |
| South Asia | 29 (80.6) | 27 (75.0) | 23 (63.9) | 14 (38.9) | 16 (44.4) | 2 (5.6) |
| North America | 17 (81.0) | 13 (61.9) | 6 (28.6) | 2 (9.5) | 1 (4.8) | 0 (0.0) |
| Middle East and North Africa | 13 (92.9) | 9 (64.3) | 9 (64.3) | 9 (64.3) | 5 (35.7) | 0 (0.0) |

## Annex 15: Sectoral Engagement by Income Level

| Region | Education (%) | Health (%) | Social Protection* (%) | Nutrition (%) | WASH (%) | Other (%) |
|---|---|---|---|---|---|---|
| Low-income | 64 (88.9) | 58 (80.6) | 48 (66.7) | 34 (47.2) | 33 (45.8) | 2 (2.8) |
| Lower middle-income | 137 (89.0) | 110 (71.4) | 110 (71.4) | 67 (43.5) | 48 (31.2) | 1 (0.6) |
| Upper middle-income | 88 (85.4) | 69 (67.0) | 62 (60.2) | 32 (31.1) | 18 (17.5) | 0 (0.0) |
| High-income | 82 (89.1) | 63 (68.5) | 52 (56.5) | 13 (14.1) | 5 (5.4) | 1 (1.1) |

## Annex 16: Sectoral Engagement by Countries Affected and Not Affected by Humanitarian Crises

| Region | Education (%) | Health (%) | Social Protection* (%) | Nutrition (%) | WASH (%) | Other (%) |
|---|---|---|---|---|---|---|
| Affected by humanitarian crises | 108 (90.8) | 80 (67.2) | 79 (66.4) | 49 (41.2) | 41 (34.5) | 2 (1.7) |
| Not affected by humanitarian crises | 268 (87.3) | 224 (73.0) | 197 (64.2) | 100 (32.6) | 65 (21.2) | 2 (0.7) |

## Annex 17: Types of Children Targeted

| Targeted children | N | % |
|---|---|---|
| **Group 1 – Children with disabilities or behavioral or mental health needs** (All children [including those with disabilities], children with disabilities, children with behavioral or mental health needs) | 398 | 93.4 |
| **Group 2 – Children with developmental delays or at risk status** (Children with developmental delays, children at risk of developmental delays or disabilities, children living in severe poverty, children in other difficult situations, children of minority ethnic or language groups, & children in emergency situations) | 266 | 62.4 |

## Annex 18: Combinations of Approaches for Programs Reporting 3 or More Approaches

| Approach | a (%) | b (%) | c (%) | d (%) | e (%) | f (%) |
|---|---|---|---|---|---|---|
| a. ECI (n = 150) | -- | 125 (83.3) | 116 (77.3) | 78 (52.0) | 45 (30.0) | 55 (36.7) |
| b. Integrated ECD (n = 149) | 125 (83.9) | -- | 118 (79.2) | 72 (48.3) | 53 (35.6) | 48 (32.2) |
| c. Inclusive education (n = 146) | 116 (79.5) | 118 (80.8) | -- | 72 (49.3) | 45 (30.8) | 64 (43.8) |
| d. Community-based Rehabilitation (CBR) (n = 94) | 78 (83.0) | 72 (76.6) | 72 (76.6) | -- | 25 (26.6) | 34 (36.2) |
| e. WHO/UNICEF Care for Development (n = 63) | 45 (71.4) | 53 (84.1) | 45 (71.4) | 25 (39.7) | -- | 17 (27.0) |
| f. Universal Design for Learning (UDL) (n = 70) | 55 (78.6) | 48 (68.6) | 64 (91.4) | 34 (48.6) | 17 (24.3) | -- |

## Annex 19: Types of Preconception Services Included in Programs

| Type of services | N | % |
|---|---|---|
| Health and nutrition referrals | 50 | 61.0 |
| Nutrition services | 49 | 59.8 |
| Health services and counseling | 48 | 58.5 |

## Annex 20: Types of Prenatal Education and Care Services

| Type of services | N | % |
|---|---|---|
| Provision of prenatal education services, newborn care and initial parenting education for mothers and fathers | 83 | 65.9 |
| Provision of or referrals to prenatal health care visits | 61 | 48.4 |
| Education for the prevention of low birth weight | 55 | 43.7 |
| Preparation for a positive delivery and good infant-parent bonding | 54 | 42.9 |
| Education for the prevention of prematurity | 45 | 35.7 |
| Prevention of and referrals for mother-to-child HIV/AIDS | 39 | 31.0 |
| Identification of high-risk pregnancies | 37 | 29.4 |
| Screening, referrals and/or provision of services for parental mental health, substance abuse or domestic violence | 35 | 27.8 |
| Provision of or referrals for prenatal screening and/or ultrasound services | 31 | 24.6 |
| Provision of or referrals for securing folic acid | 31 | 24.6 |
| Provision of or referrals for securing iron supplements | 29 | 23.0 |
| Prevention of and referrals for perinatal complications (asphyxia, infections) | 27 | 21.4 |

| Type of services | N | % |
|---|---|---|
| Genetic counseling | 14 | 11.1 |
| Other | 14 | 11.1 |
| Not reported | 9 | 7.1 |

## Annex 21: Types of Delivery and Neonatal Services

| Type of services | N | % |
|---|---|---|
| Education on basic infant care, hygiene and breastfeeding guidance | 54 | 62.8 |
| Referrals to ECI programs for parents of infants at risk of delays or with disabilities | 38 | 44.2 |
| Neonatal developmental screenings during child's first 30 days | 25 | 29.1 |
| Ensuring neonatal screening for jaundice | 24 | 27.9 |
| Neonatal screening for hearing impairments | 20 | 23.3 |
| Collaboration with neo-natal intensive care units (NICU) to transition child and parents from NICU to home | 20 | 23.3 |
| Neonatal screening for visual impairments | 18 | 20.9 |
| Ensuring neonatal screening for iron deficiency | 17 | 19.8 |
| Ensuring neonatal screening for heart defects | 15 | 17.4 |
| Ensuring neonatal screening for hypothyroidism | 15 | 17.4 |
| Ensuring neonatal screening for phenylketonuria | 12 | 14.0 |
| Other | 14 | 16.3 |
| Not reported | 1 | 1.2 |

## Annex 22: Types of IECD Services for Children (0 to 36 months)

| Type of services | N | % |
|---|---|---|
| Parent education and support services | 226 | 75.1 |
| Home visiting services for children and parents on parenting education and support and child development activities | 177 | 58.8 |
| Center-based ECD services | 167 | 55.5 |
| In-service teacher training on inclusive education skills for teachers, principals and parents | 144 | 47.8 |
| Case coordination and referrals to health, nutrition, education services | 139 | 46.2 |
| Pre-service teacher training on inclusive education skills for teachers, principals and parents | 108 | 35.9 |
| Child protection and case coordination services | 98 | 32.6 |
| Child health and nutrition services | 96 | 31.9 |
| Center-based child care and development services only for children with at-risk situations, developmental delays, disabilities or atypical behaviors | 89 | 29.6 |
| Inclusive nursery, crèche or child care and development services | 75 | 24.9 |
| Respite services for parents (to help them rest from care giving) | 27 | 9.0 |
| Other | 5 | 1.7 |
| Not reported | 7 | 2.3 |

| Type of services | N | % |
|---|---|---|

## Annex 23: Types of IECD Services for Children (3 to 8 Years of Age)

| Type of services | N | % |
|---|---|---|
| Parent education and support services | 233 | 68.7 |
| Inclusive pre-primary education or kindergarten transition year | 196 | 57.8 |
| In-service teacher training on inclusive education skills for teachers, principals and parents | 170 | 50.1 |
| Home visiting services for children and their parents | 171 | 50.4 |
| Center-based child care and development services for children with at-risk situations, developmental delays, disabilities or atypical behaviors | 162 | 47.8 |
| Child protection services | 121 | 35.7 |
| Pre-service teacher training on inclusive education skills for teachers, principals and parents | 118 | 34.8 |
| Special center-based child care and development only for children with developmental delays, disabilities or atypical behaviors | 98 | 28.9 |
| Child health and feeding services | 85 | 25.1 |
| Provision of special education center-based services **only** for children with severe or complex situations | 64 | 18.9 |
| Respite services for parents (to help them rest from care giving) | 23 | 6.8 |
| Other | 2 | 0.6 |
| Not reported | 10 | 2.9 |

## Annex 24: Types of Inclusive Health or Nutrition Services

| Type of services | N | % |
|---|---|---|
| Health and nutrition education and promotion of healthy behaviors | 145 | 73.2 |
| Referrals for immunizations, well-child check-ups and other maternal and child health care services | 88 | 44.4 |
| Promotion of exclusive breastfeeding for first six months | 85 | 42.9 |
| Education on complementary feeding | 84 | 42.4 |
| Nutritional counseling | 76 | 38.4 |
| Special health care services for children with disabilities | 67 | 33.8 |
| Nutritional assessments | 67 | 33.8 |
| Nutrition interventions combined with early stimulation activities | 66 | 33.3 |
| Maternal and child health care services | 59 | 29.8 |
| Nutritional rehabilitation | 44 | 22.2 |
| Other | 8 | 4.0 |
| Not reported | 2 | 1.0 |

## Annex 25: Types of Rehabilitation or Habilitation Services

| Type of services | N | % |
|---|---|---|
| Assessments of child development | 153 | 76.9 |
| Community-based rehabilitation | 126 | 63.3 |
| Center-based physical therapy services | 98 | 49.2 |
| Center-based speech therapy services | 91 | 45.7 |
| Center-based occupational therapy services | 86 | 43.2 |
| Provision of assistive devices | 1 | 0.5 |
| Other | 5 | 2.5 |
| Not reported | 3 | 1.5 |

## Annex 26: Types of Child and Social Protection Services

| Type of child and social protection services | N | % |
|---|---|---|
| Provision of training to strengthen child protection and family support systems | 145 | 63.3 |
| Provision of services to prevent child abuse, neglect and exploitation | 122 | 53.3 |
| Provision of social inclusion services to strengthen families in their care giving roles | 115 | 50.2 |
| Support for the design of legislation and policies to promote child and disabilities rights including social inclusion | 97 | 42.4 |
| Provision of safe spaces for young children with disabilities | 85 | 37.1 |
| Culturally appropriate child rearing practices are used and promoted | 79 | 34.5 |
| Ensuring all ethnic and linguistic groups are welcome to use program services | 79 | 34.5 |
| Program services are culturally appropriate and provided in the home language | 73 | 31.9 |
| Provision of protection services for children affected by conflicts or natural disasters | 53 | 23.1 |
| Provision of studies to identify reasons for the social exclusion of children with disabilities | 52 | 22.7 |
| Children have easy physical access to homes, agencies and other buildings | 48 | 21.0 |
| Provision of services to prevent institutionalization of children through family therapy, counseling or preservation services, financial assistance and respite care | 46 | 20.1 |
| Provision of services to deinstitutionalize children through family support, emergency and other transition services to families (biological, foster or adoptive) | 35 | 15.3 |
| Development of budgeting and investment monitoring systems for programs serving children with at-risk situations, developmental delays, disabilities and atypical behaviors | 26 | 11.4 |
| Provision of conditional cash transfers to parents or legal guardians of children with at-risk situations, developmental delays, disabilities and atypical behaviors | 26 | 11.4 |
| Provision of cash transfers (without conditions) to parents or legal guardians of children with at-risk situations, developmental delays, disabilities and atypical behaviors | 12 | 5.2 |

| Type of child and social protection services | N | % |
|---|---|---|
| Other | 7 | 3.1 |
| Not reported | 11 | 4.8 |

## Annex 27: Parent or Official Caregiver Role by Program Type

| Region | Type of Parent or Official Caregiver Role (%) | | | |
|---|---|---|---|---|
| | Participation in program services | Support for program services | Program design, evaluation, and oversight | No participation at all in program |
| IECD services (0 – 36 months) | 71.4% | 57.5% | 52.2% | 5.0% |
| IECD services (3 to 8 years) | 68.4% | 61.9% | 50.4% | 5.6% |
| ECI services | 83.4% | 59.8% | 57.7% | 2.1% |
| Rehabilitation or habilitation services | 81.9% | 64.8% | 58.3% | 1.0% |
| Social protection services | 80.8% | 65.1% | 59.8% | 2.6% |

## Annex 28: Systemic Barriers and Challenges to Program Development

| Type of systemic barrier or challenge | N | % |
|---|---|---|
| Inadequate funding | 212 | 49.8 |
| Lack of national administratively collected data on childhood developmental delays and disabilities | 135 | 31.7 |
| Lack of policies, plans, legislation or regulation supporting your program | 117 | 27.5 |
| Issues of stigma and lack of inclusion | 98 | 23.0 |
| Lack of awareness or understanding of national government leaders | 92 | 21.6 |
| Lack of nationally representative surveys that collect data on childhood developmental delays and disabilities | 91 | 21.4 |
| Lack of awareness or understanding of families or local communities | 91 | 21.4 |
| Administrative burdens and excessive bureaucratic processes | 68 | 16.0 |
| Difficulty of access to certain geographical locations or remote areas | 60 | 14.1 |
| Transportation infrastructure, access and costs | 57 | 13.4 |
| Lack of a shared definition of inclusion | 55 | 12.9 |
| Lack of awareness or understanding of local leaders | 52 | 12.2 |
| Lack of implementation of the ICF-CY | 31 | 7.3 |
| Lack of awareness or understanding of regional government leaders | 33 | 7.7 |

| Type of systemic barrier or challenge | N | % |
|---|---|---|
| Unclear or old classifications, or coexistence of old and new classifications of developmental delays and disabilities | 21 | 4.9 |
| Lack of awareness or understanding of colleagues | 19 | 4.5 |
| Lack of trained professionals, specialists, and training services | 9 | 2.1 |
| Other | 15 | 3.5 |
| No reported barriers | 65 | 15.3 |

Additional systemic barriers and challenges, identified through write-in comments, included:

***Research-related barriers and challenges***

- Lack of studies on the cost-effectiveness of IECD and ECI programs
- Need for the implementation of evidence-based programs, which require investment in research and prevention

***Barriers and challenges related to coordination and multisectorality***

- Difficulties experienced in securing national ownership of a multisectoral initiative
- Lack of effective coordination of ECD processes across respective governmental ministries
- Limited bandwidth and technologies to communicate and coordinate with programs in remote and rural areas.

## Annex 29: Barriers and Challenges Hindering Program Growth

| Type of program barriers or challenges | N | % |
|---|---|---|
| Lack of enough services for children with at-risk, developmental delays, disabilities or atypical behaviors | 260 | 61.0 |
| Lack of community outreach to identify children with at-risk situations, delays, disabilities or atypical behaviors | 174 | 40.8 |
| Lack of universal developmental screening for children | 162 | 38.0 |
| Lack of developmental surveillance and monitoring conducted by physicians | 149 | 35.0 |
| Lack of up-to-date information technologies for the program (computers, software, telephone applications, other devices) | 120 | 28.2 |
| There are no dedicated child services (identification, ECI, inclusive pre-primary schools) separate from adult services | 99 | 23.2 |
| Lack of financial resources | 14 | 3.3 |
| Lack of trained specialists or support staff | 13 | 3.1 |
| Lack of awareness, information, perception, or prioritization | 9 | 2.1 |
| Lack of decentralized and local level services | 4 | 0.9 |
| Lack of collaboration or coordination | 3 | 0.7 |
| Lack of inclusive education and special education services | 2 | 0.5 |
| Lack of policies | 2 | 0.5 |
| Other | 3 | 0.7 |
| No reported barriers | 76 | 17.8 |

| Type of program barriers or challenges | N | % |
|---|---|---|

## Annex 30: Barriers and Challenges Hindering Program Demand

| Type of program barriers or challenges hindering demand | N | % |
|---|---|---|
| Lack of capacity to meet demand, and program has waiting lists | 201 | 47.2 |
| Lack of advocacy for your program services and the children and families you serve | 182 | 42.7 |
| Caregivers are not empowered | 175 | 41.1 |
| High program fees or other costs to families keep them from applying | 86 | 20.2 |
| Lack of demand for your program services | 64 | 15.0 |
| Lack of sufficient resources | 23 | 5.4 |
| Lack of staff, specialists, and training | 5 | 1.2 |
| Lack of access or limited reach | 5 | 1.2 |
| Other | 32 | 7.5 |
| No reported barriers | 75 | 17.6 |

In response to “Other,” some programs mentioned a lack of:

- Coordination, in terms of planning, service coordination and fragmentation of services;
- Screening and referral capacity due to a lack of available services;
- Support from the government, parents or the community;
- Awareness, knowledge and information on the part of parents and physicians; and
- Lack of policies, donors and community support for programs.

## Annex 31: Barriers and Challenges Hindering Program Quality

| Barriers and challenges | N | % |
|---|---|---|
| Lack of properly trained and qualified personnel | 194 | 45.5 |
| Lack of research opportunities | 135 | 31.7 |
| Lack of supervisory services, including mentoring, coaching and reflective supervision | 130 | 30.5 |
| Lack of educational, training and program materials | 127 | 29.8 |
| Lack of or insufficiency of in-service training | 115 | 27.0 |
| Lack of a program monitoring and evaluation system | 107 | 25.1 |
| Lack of or insufficiency of pre-service training | 105 | 24.6 |
| Lack of a monitoring and evaluation manual with instruments and guides | 99 | 23.2 |
| No reported barriers | 69 | 16.2 |

## Annex 32: Factors Enhancing IECD and ECI Program Success

| Factors enhancing success | N | % |
|---|---|---|

| Factors enhancing success | N | % |
|---|---|---|
| Expertise available in your organization | 209 | 49.1 |
| Expertise, good practices and lessons learned from other organizations or countries | 174 | 40.8 |
| Continuous in-service training for personnel | 99 | 23.2 |
| Empowered caregivers | 95 | 22.3 |
| Effective and frequent supervision | 73 | 17.1 |
| Facilitative or enabling policy environment | 64 | 15.0 |
| Strong network for inter-program exchange and support | 62 | 14.6 |
| Interagency or cross-sectoral collaboration | 53 | 12.4 |
| Availability of tools (standardized validated instruments) for developmental screening to detect developmental delays and other needs in young children | 50 | 11.7 |
| Strong pre-service training resources for personnel | 49 | 11.5 |
| Family leadership and/or empowered parents or caregivers | 48 | 11.3 |
| Well-developed monitoring and evaluation system and instruments | 41 | 9.6 |
| Adaptation of training course or curricula | 35 | 8.2 |
| Strong political support | 32 | 7.5 |
| Availability of data on childhood developmental delays and disabilities | 32 | 7.5 |
| Good policy support | 31 | 7.3 |
| Tools and culture for reflective practice | 22 | 5.2 |
| Use of digital technology | 22 | 5.2 |
| Adequate government financing | 18 | 4.2 |
| Adequate core financing from governmental sources, complemented by other diversified funding sources | 16 | 3.8 |
| Use of methodological guidelines or classification systems, including the WHO International Classification of Functioning, Disability and Health | 13 | 3.1 |
| Shared understandings of disability and inclusion in the general population | 12 | 2.8 |
| Use of assistive technologies, technological devices | 11 | 2.6 |
| Association with an external evaluation research project | 10 | 2.3 |
| Use of video technology | 10 | 2.3 |
| Use of audition technology | 2 | 0.5 |
| Other | 25 | 5.9 |
| No factors reported | 60 | 14.1 |

## Annex 33: Recommendations for Creating, Improving and Expanding Program Services

| Recommendation | N | % |
|---|---|---|
| Expand advocacy and communications to reduce stigma, discrimination and increase demand for services | 177 | 41.5 |
| Improve the coordination of IECD and ECI programs | 147 | 34.5 |
| Expand government funding for IECD and ECI programs | 144 | 33.8 |
| Improve and expand parent education and support | 143 | 33.6 |
| Develop policies, plans or laws for IECD and ECI programs | 137 | 32.2 |

| Recommendation | N | % |
|---|---|---|
| Establish a universal system for developmental screening linked to referrals, intake and child and family assessments | 118 | 27.7 |
| Improve and expand pre- and in-service training/capacity development | 96 | 22.5 |
| Improve program contents (curricula, educational materials and methods) | 89 | 20.9 |
| Develop a national monitoring and evaluation system for IECD and ECI programs | 59 | 13.8 |
| Achieve greater equity through improving access to services and quality assurance | 55 | 12.9 |
| Improve and expand systems for supervision, coaching and mentoring | 52 | 12.2 |
| Expand the use of the WHO International Classification of Functioning, Disability and Health – Children and Youth Version (ICF-CY) | 51 | 12.0 |
| Provide free IECD and ECI programs through using grants, vouchers to parents or program subsidies | 35 | 8.2 |
| Develop certification and recertification systems linked to professional career ladders and salary scales | 34 | 8.0 |
| Lower program costs for families through using grants, vouchers to parents or program subsidies | 22 | 5.2 |
| Other | 17 | 4.0 |

## Annex 34: Types of Funding Sources Supporting IECD and ECI Programs

| Funding sources for IECD and ECI programs | N | % |
|---|---|---|
| International non-governmental organizations (INGOs) | 116 | 27.2 |
| National government, through grants, contracts or vouchers | 112 | 26.3 |
| Fundraising by your organization (lotteries, dinners, auctions, etc.) | 107 | 25.1 |
| No funding support reported | 72 | 16.9 |
| Foundations or corporate foundations | 72 | 16.9 |
| UN agencies | 68 | 16.0 |
| Municipal, local government support | 58 | 13.6 |
| Regional government support | 39 | 9.2 |
| National non-governmental organizations (NGOs) | 36 | 8.5 |
| Corporations and other private business groups | 35 | 8.2 |
| Bilateral government agency grants or contracts | 34 | 8.0 |
| Service organizations (Lions, Rotary, etc.) | 20 | 4.7 |
| World Bank | 20 | 4.7 |
| Embassy grants | 18 | 4.2 |
| National community-based organization (CBOs) | 13 | 3.1 |
| Regional agencies or banks | 11 | 2.6 |
| National faith-based organization (FBOs) | 9 | 2.1 |
| International disabled people organizations (IDPOs) | 6 | 1.4 |
| International faith-based organization (IFBOs) | 6 | 1.4 |
| National disabled people organizations (DPOs) | 6 | 1.4 |
| Insurance reimbursement system | 4 | 0.9 |

| Funding sources for IECD and ECI programs | N | % |
|---|---|---|
| Payroll tax, excise tax, natural resources tax, import/export tax, alcohol and cigarette taxes, etc. | 3 | 0.7 |
| Research budget | 1 | 0.2 |
| Other | 5 | 1.2 |
| Not applicable | 4 | 0.9 |

## Annex 35: Percent of Governmental Funding by Sector

| | Percent of Governmental Funding by Sector | | | | |
|---|---|---|---|---|---|
| Governmental Sector | Mean | Std. Deviation | Median | Min | Max |
| Education | 56.9 | 39.7 | 50.0 | 0 | 100 |
| Health/Nutrition | 49.0 | 38.4 | 40.0 | 0 | 100 |
| Protection | 32.1 | 36.6 | 20.0 | 0 | 100 |
| Other[26] | 48.3 | 41.3 | 27.5 | 0 | 100 |

[26] No information was provided for "other."

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