Asia-US Partnership 2004
Early Child Development in Primary Care
November 5-6, 2004
Ko `Olina, Hawai`i
Preface

The Department of Pediatrics, John A. Burns School of Medicine, University of Hawai`i at Manoa has collaborated with Johnson & Johnson Pediatric Institute, L.L.C., to bring together pediatric leaders from Asia, including China, Hong Kong, India, Philippines, Singapore, and Thailand, and from the United States. Additional support was provided by the U.S. Maternal and Child Health Bureau, Consuelo Foundation of Hawai`i and Philippines, World Bank, and the American Academy of Pediatrics.

The Department of Pediatrics, John A. Burns School of Medicine, University of Hawai`i at Manoa gives priority to implementing integrated services in early childhood—health, education, family support, community—to increase effective services that serve all children. The Johnson & Johnson Pediatric Institute, L.L.C., is committed to initiatives that enhance clinical practice, thus improving health care for children and families. We gratefully acknowledge contributions of Asia-US Partnership participants for sharing their insight to improve outcomes in health and early child development for children and families worldwide.
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Department of Pediatrics, John A. Burns School of Medicine, University of Hawai`i at Manoa

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Asia-US Partnership 2004: Early Child Development in Primary Care
November 5-6, 2004, Ko`Olina, O`ahu, Hawai`i

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Philippines (left)- KinderPlus, Cabiao and Cuyapo rural ECCD programs
Hawaii (above)- Na Kamalei, O‘ahu rural ECD program
Final Report

About the Asia-US Partnership

The delivery of primary child health care encompasses the promotion of health (i.e., “well care”), acute care, and chronic care of children. This three-pronged approach to supporting a system of pediatric services applies to all communities and all societies. The methods, means, and effectiveness in providing these services can vary dramatically from country to country due to a society’s institutions and governance, histories, cultural complexities, economies, geography, and regional ties.

Countries engaged in the Asia-US Partnership (AUSP) reflect a wide diversity of experiences and priorities in creating systems of health care for all children. While some still face stark realities of widespread malnutrition, lack of immunizations, infectious diseases (conditions tied to the “old morbidity”), all countries within AUSP recognize the importance of new challenges and new research centered on optimal child development (the “new morbidity”). This understanding demands a shift in vision-- away from an exclusively medical model focused on clinical “problems” or “crisis care,” and towards a model that gives particular attention to current scientific research on early brain development, applying “what we know” about early child development to create integrated, community-based systems of health, education, and family support services to meet the needs of all children and their families.

Over the past two years, pediatric leadership from the United States and selected Asian nations have met and corresponded to share and analyze their experiences in applying the science of early child development in the delivery of health care to young children. In February 2003, the first “think tank” convened in Hawai`i to initiate a forum for high-level scientific exchange on the science of early child development and its application to primary care. Subsequently, many of these pediatric leaders met at the Asian Pediatric Congress in Bangkok, Thailand (November 2003) and determined a follow-up meeting in Hawai`i would play a key role in moving the group’s identified goals forward.
In November 2004, recognized US and Asian pediatric leaders in early child development, educators and related health professionals traveled from China (Beijing, Shanghai, Hong Kong SAR), India, Singapore, Philippines, Thailand, and the US met for a two day meeting held at Ko`Olina on the island of O`ahu in Hawai`i.

Asia-US Partnership Goals

The ultimate goals of this Asia-US Partnership are to initiate change within Asia and the US by:

- Identifying and prioritizing scientific knowledge applicable to cross-cultural exchange
- Recognizing the influence of culture on the principles of child development and delivery of care
- Deepening interactions within a network of country specific leaders for ongoing exchange and outreach
- Promoting awareness of the importance of early child development
Translating Science to Practice: Updates on the Science of Early Childhood Development

Jack P. Shonkoff, MD, co-edited From Neurons to Neighborhoods: The Science of Early Childhood Development (National Research Council and Institute of Medicine of the National Academy of Sciences, 2000) and chairs the recently established National Scientific Council on the Developing Child (www.developingchild.net). Dr. Shonkoff’s current work centers on emergent scientific research of brain development and on a commitment to translate this science for opinion leaders and policy makers. The implications of this new science for early childhood development and the science of early childhood intervention point to the need for countries and communities to apply more focus and resources to developing integrated systems of care that combine health, education, and family support, particularly during the first five years of children’s lives.

Core Concepts of Early Childhood Development

Each of us is the product of an ongoing interaction between the influence of our personal life experiences (“nurture, culture, environment”) and our unique genetic endowment (“nature”). Recent neuroscience research indicates it is crucial to move beyond perpetuating a false dichotomy between the two, recognizing that environment and genetics combine dynamically throughout early childhood in their ongoing influence on a child’s health and development:

- Human relationships are the “active ingredients” of environmental influence on child development.
- Nurturing, responsive, and individualized interactions build healthy brain architecture that provides a strong foundation for all future growth and development.
The way to promote healthy development in young children is to think about how we can promote the well-being of healthy families who live in healthy communities.

- Excessive and repeated stress causes the release of chemicals that disrupt the development of the brain by impairing its growth and hindering the formation of healthy neural circuits.
- Beyond the adverse effects of “toxic” stress, substantial scientific evidence indicates that poor nutrition, specific infections, and a range of neurotoxins also can harm the development of the immature brain.
- Significant parental mental health problems, especially maternal depression, substance abuse, and family violence impose heavy developmental burdens on young children.

The characteristics of relationships are key to child development and will vary within and across cultures. For children in every culture, experiencing positive nurturing relationships with important people in their lives contributes to healthy brain development. And, clearly, excessive, chronic, continuous, “toxic” levels of stress impact negatively by interfering with the emerging architecture and function of the developing brain.

Neuroscience research has demonstrated that early brain architecture develops within the time constraints of sensitive periods. The development of neural circuits—very well developed connections among clusters of brain cells that become parts of systems that mediate all human behavior—is highly programmed genetically to occur during specific time periods. And, the way in which those circuits get developed is highly influenced by human experience.
**Key Issue:** The timing of developing neuro-circuitry is genetic, but its evolving architecture is influenced by experience. The way the brain develops is hierarchical, so the most basic circuits that mediate the most basic behaviors and functions are established first, and then they are superceded by higher level circuits that mediate higher level functions. A child’s experiences during a sensitive or critical period influence whether the brain develops a healthy circuit or a disrupted or abnormal one. And once that period ends and the next level of circuits start to come on line, the essential development of those earlier circuits is completed.

**Sobering Message:** Children’s brains develop according to an ongoing interaction between a genetically-based timetable and the significant influence of environmental factors, mediated most importantly through human relationships. Children whose adverse early experiences lead to the development of poor circuits will have to adapt to those faulty circuits for the rest of their lives.

**Reassuring Message:** The brain holds the capacity to change and adapt and to respond with plasticity. The window of opportunity for healthy development remains open for many years. Thus, children can adapt to the challenges of faulty neuro-circuits that developed early if they have the right kind of environment and, the right kind of relationships, but it is more difficult and more expensive—from a biological perspective, and from a societal perspective—to try to remediate the burden of impaired brain architecture than it is getting it right the first time.

**Essential Features of Effective Interventions**
- Provider knowledge, skills, and relationship with family
- Individualization of services
- Quality of program implementation
- Family-centered, community-based orientation
- Timing, intensity, and duration of intervention
Critical Perspectives on the Science of Early Childhood Intervention

Our aim is to articulate the science of early brain development and apply it to creating early childhood services that can make a difference, change developmental trajectories, and shift the odds for more favorable outcomes for children. The goal is to introduce appropriate interventions as early as possible while brain plasticity is at its most flexible. Doing this is not necessarily easy but the question we must ask ourselves is, “why are we not doing more with what we already know?” Most important, how can we close this gap between what we know and what we do to promote the healthy development of young children?

- If we really want to maximize the return on investments in public education during middle childhood and adolescence, we must assure access to high quality early care and education provided by well-trained staff during the preschool years.

- If we want positive developmental outcomes for young children, we must adopt a broad-based approach to pediatric care focused on the interrelated goals of healthy children in healthy families within healthy communities.

Challenges for Implementing Effective Interventions

- Increasing access and participation
- Ensuring greater quality control
- Defining and achieving cultural competence
- Reducing fragmentation and strengthening infrastructure
- Assessing costs and making choices
Translating Theory to Practice: Notions of Culture

Jackie Goodnow, PhD, grounded in the discipline of psychology, focuses her work on the nature of human development, particularly culturally-informed perspectives on parenting that can be translated into research questions and practice. Moving beyond a conventional approach where “cross-cultural” assumes largely discreet, monolithic “cultures,” Dr. Goodnow encourages using more complex notions of culture, cultural groups, and of translating cultures while creating and implementing systems of care related to early child development.

Concepts of Culture in Advocating for Early Childhood Development

Very often we use the word “culture” or the adjective “cultural” with the idea of national differences in mind, yet culture does not mean just national groupings. This understanding is key in advocating effectively for early childhood development. For example, Jack Shonkoff talks about three cultures in search of a shared mission—the culture of science, the culture of politics, and the culture of service delivery. Rather than conceptualizing culture as something “out there” like the air we breathe, we are actually referring to groups of people who share certain features. Four suggestions in rethinking the relationship between how we think about culture and advocating for early child development:

*Stop using the word “culture” and use “cultural groups” instead.*

Once people start doing this, they begin to think differently about membership, participation, access, similarities. The use of the term “cultural groups” intersects nicely with current anthropological research that promotes “all societies are multiple and contested.” This is useful in understanding that all cultural groups are made up of subgroups, for example, alternative medicine and formal medicine, alternative schools and formal schools. Homogeneous cultural groups do not exist.
People within cultural groups often use “shortcuts.”
Using heuristics to think about the worlds we encounter, we tend to say, “All I need to know is that you are from China or the United States—that’s all I need to know, and I’ll know exactly what you’ll be like.” Another shortcut: “Everybody in this social box is like everybody else.” Although we clearly understand that there are differences within our own social and cultural groups, we consistently identify those within other groups as homogeneous. This commonly leads to misperceptions that everybody within these social groups will like each other, get along, understand each other.

People within cultural groups tend to adopt an “evaluative” stance.
This points to a recognition of the difficulty in breaking habits of thinking that your own way is the best way of doing things, the only way, or the natural way. Of course, it would simplify our lives considerably not to have all these alternatives to think about and to critically evaluate our own assumptions and judgments. Part of the challenge is getting beyond that very human tendency towards taking an evaluative stance, especially when talking about cultural competence and the basic difficulty is in establishing trust on the other person’s part. Constant encounters with a variety of other cultural groups can play a key part in identifying our own evaluative stances and recognizing when they become barriers to our ultimate goals.

Translation at this point in time is no longer an issue of simply translating languages.
“Translating” science into policy and practice requires the work of persuading, advocating, negotiating, and forming alliances. Advocacy efforts may become more effective if we move beyond simply identifying the problems, in this case in early child development, and providing “success stories” when they do occur. What I am missing is the “reality of translation.” How can we talk more about strategies in telling the untold stories, focusing on the process of moving from problem to success story and on what we have to do to get from one to the other?
Based on these notions of “culture” and “translation,” my caution surrounding discussions of early child development is that we need to proceed by emphasizing “life is not a rocket launch.” Whether referring to individual children or to programs that serve children and families, the idea that the first years are very important cannot be denied. Some policymakers may jump to the idea that prevention is all they need to support. Prevention is a huge step in serving the needs of all children, but there will always be a need for recovery routes. In translating what we know about early child development to policymakers, we need to promote the idea of maintaining a good start is just as important as creating a good start in the first place.

Country Priorities: Applying Science to Practice

In preparation for translating early child development in primary care, each country delegation was asked to submit three country priorities for this meeting. Calvin C. J. Sia, MD, AUSP Chair, compiled these priorities for children’s health in Asia and the United States using six main areas and relating them to wide differences between the countries including: national resources; health and education structures; cultural groups; population numbers; rural/urban; and, orientation of health priorities related to “old” and “new” morbidities.

Top Priorities for Children’s Health in Asia and the United States

Reduce maternal, infant and child mortality and morbidity
  • Mother and unborn child – family planning, proper maternal nutrition, provision of prenatal, antenatal and postnatal care
  • Newborns and infants – parental education and care, accessible health systems
  • Early intervention services; early stimulation programs
  • Application of research knowledge on reducing birth defects

Improve children’s nutrition condition
  • Breast feeding, healthy eating and physical activity
  • Nutritional education for parents
  • Malnutrition – protein energy malnutrition, iron deficiency
  • Vitamin and mineral supplementation to children
  • Obesity and diseases relating to unhealthy lifestyles leading to adult diseases
Three Main Priorities

Three main issues cut across diverse national and cultural realities to surface for all participating countries: child nutrition-breastfeeding; child nutrition-obesity; and, child social and emotional well-being. Emphasizing the needs of the whole child, each of these issues moves the focus of early child health beyond simply clinical encounters for disease-oriented treatment to addressing critical psycho-social needs through integrated systems implemented by a wide range of inter-professional early child development specialists.

CHILD NUTRITION- BREASTFEEDING

Patricia IP, MD, Hong Kong—we set up a baby friendly hospital initiative… through intensive training of nurses and doctors by the Department of Health… so progressively, we have increased our rates of breastfeeding on discharge from hospital from something like 19% about 10 years ago to now it’s around 60%… this is only on discharge from hospital, and we are looking for exclusive breastfeeding, so we have a long way to go…

Tom TONNIGES, MD, USA—we have had the same set of issues but we’ve had a lot of pressure from corporate America that make it difficult to promote breastfeeding… the AAP has just completed a two year process of developing a policy statement on breastfeeding that is peer reviewed and evidence based… breastfeeding is one of the most important things we can do around early child development… I can’t think of any other low cost, high impact strategy than breastfeeding… we have had a lot of problems implementing baby friendly hospital initiatives because of possible litigation and corporate pressure…

Promote optimal children’s psychological and behavioral development

- Social and emotional well-being in growing up
- Lighten up academic pressure for the young child; stress from school
- Emotional and behavioral problems
- Mental health issues

Prevent and control communicable and non-communicable diseases

- Urgent problems such as respiratory and GI infections, SARS
- Accidents and injuries – violent and non violent injuries
- Vitamins, iodine, etc.

Safeguard and advocate for children’s rights to survival, protection, development and participation across the life cycle

- Provision and rehabilitative and supportive services to address psychological trauma and other needs
- Promotion of family and community empowerment
- Provision of better parent training/caregiver programs

Promote wellness, early intervention and followup services as a continuum of an integrated system of care

- Prevention of birth defects
- Early stimulation programs, early intervention for developmental problems
- Accessibility to health services by all children, especially disadvantaged families – new immigrants, children living in poverty, single parent
- Multidisciplinary support services/collaborative practices/linkages
- Community-based services
- Governance: national/regionalization/community program and policy development
- Financial sources
Swati BHAVE, MD, India—in 1994, the Academy of Pediatrics decided to stop taking sponsorship from all the infant food supplements… it was a great blow to them and a very courageous decision on our part as we received a lot of funding from them in the past… in India, it is now the law of the land… if any medical or paramedical professional receives sponsorship from these infant food supplement companies, they can go to jail….

Lina LAIGO, Philippines—we also have baby friendly hospital initiative since the early 90s… but our problem with breastfeeding is the low rate of practice… breastfeeding exclusively up to six months was around 33%… with the mothers start substituting powdered milk and other foods at around two or three months… we are now trying to convince mothers to continue breastfeeding… all hospitals in the Philippines are baby friendly but I think we still have a long way to go in teaching mothers to have health-seeking behavior… so they can go for pre- and post-natal check up and have more proper care…

Nittaya KOTCHABHAKDI, MD, Thailand—for Thailand, the baby friendly initiative have been extended throughout all the hospitals… so we have 70% breastfeeding on discharge… but our main problem is how to sustain exclusive breastfeeding… we had the figure of only 3% ten years ago and now it’s 19% after a serious campaign… so we still have a lot to do on exclusive breastfeeding, even for four months…

SHEN Xiaoming, MD, China—we have great success in larger cities where parent education has been effective… there, breastfeeding is about 80%… but we still have problems in smaller cities… again, because parental knowledge is not enough… and a major problem is that mothers have to go back to work after six months maternity leave… some workers have tried to set up centers in the workplace for nursing that is positive in increasing the rate of breastfeeding…

CHILD NUTRITION- OBESITY

Chet JOHNSON, MD, USA—I think almost all physicians and public health workers recognize that children being overweight is a serious health concern… it always involves the family and community and school… we tend to think of it as a problem of the US and Europe, but there’s more and more evidence that this is becoming a worldwide problem….

SHEN Xiaoming, MD, China—Traditionally, we did not see obesity as a problem in China… until now, pediatricians in China considered obesity a problem for western kids, not Chinese kids… in recent years, we’ve found we have this problem in our kids… some reasons responsible for that—now a family has one child, two parents, and four grandparents, so those children are overfed… and also now fast food is doing better and better business in cities like Shanghai… and I don’t know why, but Chinese kids seem to love it…

Jack SHONKOFF, MD, USA—Most people think of malnutrition as a problem of underweight, largely found among poor people and consider obesity to be a problem primarily among those who are economically more secure. In fact, obesity has become a major problem among the poor related in part to limited education about nutrition and easy access to unhealthy, high caloric foods…

Lina LAIGO, Philippines—nearly half of women giving birth are malnourished… in the latest study done on nutrition, an increasing number of obese children was observed… but the problem for most families in the Philippines is putting food on the table, the right kind of food… and we’re still working on the reduction of malnutrition among children….
CHILD SOCIAL & EMOTIONAL WELL-BEING

CHOW Chun-bong, MD, Hong Kong SAR— Initially we were thinking that ADHD or possibly autistic features were less common in Hong Kong than in other countries… but we found we are quite similar in this instance… what we found were significantly different was the score on fear, it’s much higher in Chinese students…. Recently, there’s a lot of concern, especially on the psychological and behavioral aspect… the major concern is coming from child abuse, another homicide/suicide… another aspect of concern is the economic downturn, where both parents work and leave their children with a domestic worker until 8 or 9 at night leaving very little time to spend with their children… school reforms are focused on not putting too much academic pressure on our children… this is creating stress for teachers… and many families are choosing to send their children abroad to school… we are convening groups of pediatric psychiatrists and developmental pediatricians to look into how we can tackle these problems… most of our services are fragmented, and there are only 10 or 20 pediatric psychiatries in Hong Kong… pediatricians are mainly still focused on everyday illnesses… so there is a great need for training… we hope that the system will become more integrated and look upon the children as one system, more integrated, the physical, psychological, and social as one system…

HO Lai Yun, MD, Singapore— In Singapore, we thought we had provided a lot for our children. Recently, we conducted research of children to look at what we have been doing for our children, determining the needs of our children… surprisingly, in all age groups, the youngest to the 18 year olds the top of the list was they are lonely… we discovered they need someone to talk to at home… with both parents working outside the home because they need a double income, it’s given rise to juvenile delinquency… not serious crime, but they become naughty and do mischievous things, mainly to attract attention… so this is the area that we think we need to go in to make sure they are growing up healthy…. When we come to the pressure issue, the pressure is not coming from the Department of Education… the big pressure is coming from the parents, not the school system… the parents have high expectations of their young children… to do well, to succeed…

Jack SHONKOFF, MD, USA-- This is a more complicated issue than it appears to be… because pressure to succeed academically certainly can be a major burden for children from higher educated and wealthier families… on the other hand, for children growing up in families with limited education and significant economic insecurity pressure to perform well academically is often associated with better school performance… I don’t know much about the relevant science here, but it seems that excessive pressure on children in higher income families with higher achieving parents can be terribly threatening, whereas the same message in a low income family from a parent with limited education can represent a message of high aspiration and confidence in a better future… this is another example of the importance of cultural context within a society… so we have to be careful about jumping to conclusions about parenting beliefs or practices that play out very differently in different settings…
CASE STUDIES

Each AUSP participating country identified three basic areas as key to achieving optimal early child development. These were: 1) ensuring quality pediatric health care delivery that is accessible and integrated with other early child development services; 2) training parents, child care and health professionals; and, 3) working to shift the political will in each country to provide resources for developing and implementing integrated early childhood programs. Core discussions centered on applying the emergent science of early child development to these priorities in the specific areas of research, training, service, and advocacy with the aim of creating integrated systems that support the physical, mental, and social health of all children. Case studies offered a way to focus on nation- and culture-specific approaches to stimulate discussion on how to implement integrated systems of health, education, and family support related to early child development and primary care. Case studies included here exemplify the projects discussed.

Case Study: Philippines
Kinder Plus- A School for Life (Early Childhood Care in the Countryside)
Presented by Alexis L. REYES, MD, prepared in conjunction with Perla D. SANTOS OCAMPO, MD

Program Introduction: Kinder Plus is an early childhood care and development program—a product of a long study by child rights advocates that integrates early education, health, and nutrition. It is the demonstration pilot project of a national initiative that promotes policy on Early Child Development.

Addressing the Needs: As national support for providing early childhood education devolved, local governments took over child development and other social services with very little experience on how to manage them. Launched in March 2000 in Cabanatuan City, Nueva Ecija, through partnerships of national government agencies, local government units, and a non governmental organization, the Kinder Plus program aimed to provide basic holistic needs of young children (birth to 6 years) by assisting local governments and public...
schools serving disadvantaged families and generating increased public awareness, participation and support for various early child development programs. Communities selected were considered disadvantaged, high risk due to impact of natural disasters, with a prevalence of illegal gambling and drug abuse.

**Program Activities:** Phase I focused on training in the communities by developing and implementing educational materials for all early childhood development shareholders, including community development workers/service providers, municipal and provincial government representatives. Phase II focused on implementation of the home-based and community-based programs. The home-based Parent-Child program consisted of playgroups for 0-3 year olds where trained parent volunteers engaged the older children and parents in play and song, teaching them the basics in math, conducting storytelling sessions and developing the children’s psychomotor coordination through games. The Parent Education Program sponsored workshops where parent groups discussed family life issues, early childhood development, livelihood, and literacy. Kinder Plus Resource Center Kits furnished reference materials to service providers, including brochures and posters on the basic principles of early child development, a Kinder Plus developmental checklist, rap song and videos on parenting from the Philippine Children’s Television Foundation (PCTVF).

**Results:** Three years after this program was launched, local officials reported a significant decrease in gambling and other vices. Parent and child surveys conducted in November 2001 reported increased parental awareness on issues like child rearing, proper ways of dealing with children, discipline and other concerns like personality development. The Kinder Plus program has restored the dignity of parents who now see themselves as assets to their communities as they lead productive lives as parent volunteers. For the first time in their lives, parents are acknowledging that their children are bright and that they [parents] can be good teachers.
Case Study: China
He Is as Happy Now as Other Children
Presented by LI Yan, PhD, for JIN Jiang, PhD

Program Introduction: I have a success story to tell from a family’s point of view. Zhao Long is a 10 year old boy in Heping District of Tianjin City. He always stayed at home and never went out before community Early Childhood Development workers visited his family for baseline survey in 2001 because his parents didn’t want people to know they have a disabled son.

Addressing the Needs: Many children ages 3-5 years of poor families and most children below 3 years of age, including some disabled children, did not go to kindergartens before the local government decided to provide community-based Early Childhood Development services.

Program Activities: The new Early Child Development policies adopted at the national and local levels focused on developing a community-based Early Child Development network of service providers to implement integrated services to every family with children below 6 years of age. Local education authorities implemented a baseline survey and developed individual plans for every community to deliver flexible services to meet family needs in each community, such as play groups, home visits, and weekend classes.

Results: 100% of children below 6 years of age and their parents, including immigrant children, receive Early Childhood Development services in all districts of Tianjin. Zhao Long’s parents sent him to get special training over a long period of time. Now, he can talk and play with other children happily.
Case Study: Hong Kong SAR
Promotion of Breastfeeding
Presented by Patricia IP, MD

Program Introduction: The benefits of breastfeeding to the health and development of children, for mothers and the community, are well known. The breastfeeding rate in Hong Kong reached a nadir of only 5% in 1978. Efforts to revive the practice of breastfeeding were scattered until the implementation of policies and systematic services launched through the global Baby Friendly Hospital Initiative (BFHI). The Hong Kong Committee for UNICEF helped establish the Baby Friendly Hospital Initiative Hong Kong Association in 1992 with the aim to promote, support and protect breastfeeding.

Addressing the Needs:
- Perception that formula feeding is the modern way of infant feeding; that nutrition-wise, formula is similar to breastfeeding; that formula feeding is safe and convenient; that breastfeeding is not important in a ‘developed region’ with low infant mortality and readily accessible healthcare at ‘low’ cost
- Healthcare workers who lack the knowledge and skills in breastfeeding practices and counseling
- Hospital practices that impede the establishment of breastfeeding
- Aggressive marketing of breastmilk substitutes
- Increase in women in the labor force; that formula feeding liberates women from childcare

Program Activities: A baseline survey was done in 1992 on the breastfeeding rate at discharge from maternity units, the compliance of the Ten Steps to Successful Breastfeeding and the observation of violations of the International Code of Marketing of Breastmilk Substitutes in hospitals. Subsequent progress was monitored with annual surveys followed by annual press conferences where government agencies providing the leadership in breastfeeding programs report on their achievements regarding the promotion of breastfeeding. Training initiatives have included: train-the-trainer and breastfeeding counselor courses conducted by the Department of Health, Hospital Authority and HK Midwifery Association; developing and implementing local adaptations of WHO Breastfeeding Counseling Course; collaborating with hospitals to conduct peer counseling courses. Activities also include providing direct support to mothers via “Baby Friendly Hotline” staffed by volunteer lactation consultants, developing public education campaign, monitoring and reporting code violations; and, achieving cooperation with support groups such as La Leche League, Hong Kong Breastfeeding Mothers Association.

Results: The breastfeeding rate on discharge from maternity units rose from 19% in 1992 to 61.1% in 2003.
Integrated Services: A US Perspective on Early Child Development in Primary Care

Merle McPherson, MD, the Director of the Children with Special Health Needs Division, Maternal and Child Health Bureau, U.S. Department of Health Resources and Services Administration, introduced federally sponsored initiatives in the United States implemented over the past 30 years aimed at developing an appropriate model of care for children with special health needs as an example to learn from—both successes and challenges. Dr. McPherson’s efforts provided leadership for national discussion and consensus-building, guiding the U.S. away from a model that talked about “diagnosing and treating crippling conditions” and instead engaging voluntary agencies, professional organizations, and families to move toward a systems model of family-centered, community-based, comprehensive care delivered by a new generation of inter-professional leaders.

The question we are left to wrestle with is “what is the responsibility of the federal government?” in implementing the model of integrated services, ensuring universal sustainability of those services, promoting family-professional partnerships, and cultivating and supporting a new generation of inter-professional leaders.

We all know that creating change is not easy and it takes a long time. Here are some areas we in the US have invested in at the federal level:

- National consensus building—shifting the focus away from diagnosis and medical condition and moving toward a model of family-centered, comprehensive care;
- Developing law—emphasizing facilitation of the development of community-based systems of care at the federal level rather than implementation which takes place at the local level;
- Redefining the children we serve—expanding the targeted population from those we used to refer to as “disabled” and “crippled” to include “children who need services and supports over and above what children generally need” (e.g., chronically ill children; children with behavioral, developmental, and emotional conditions and those at risk for these conditions); also recognizing that effective systems of care will meet the needs of all children;
- Identifying goals for 2010—ensuring systems are in place that represent family-centered, culturally-competent, coordinated and comprehensive care with a commitment to community inclusion.
How do we evaluate our efforts? For determining if we are reaching our goals, rather than evaluating the management and administration of services within this integrated system of care, we shifted evaluation to families and providers in communities to ask them how they would know there was a system of care in place that provide services and supports you need for your children and families. Following this, we developed six core components as performance measures:

- Families work in partnership
- Every child has access to quality healthcare through a Medical Home
- Adequate insurance financing
- Ongoing assessment and surveillance to facilitate early intervention
- Families have access to community level services that are easy to use (integrated services, community development)
- Youth are healthy and independent, ready to work, adult health care and employment

Based on these six performance measures, we conducted a national baseline survey through telephone interviews with families to evaluate systems in place. Results indicated there are high numbers of children who receive regular health care (95% of families reported their children had a regular, ongoing source of health care), yet families’ responses also reported that there is less success in care coordination from physicians to other services those children needed and the actual family-centered care.

We have not yet achieved the quality we want and need. So, there is plenty of work ahead to reach our 2010 goals to effectively serve children and families with integrated systems of care. As I have heard from many countries here today, the challenges remain: universality, equity, and sustainability.
Next Steps: Charges and Challenges

The major question each country currently faces is, “How can we apply emerging scientific knowledge surrounding early child development to primary care and create integrated systems of care that meet the needs of all children?” Answers to this question among AUSP participating countries will vary widely, yet all answers and subsequent activities will converge on four main areas: service, training, research, and advocacy. Each AUSP participant has identified opportunities intended to shift local and national systems toward meeting the needs of early child development in their respective countries. Specific commitments for “next steps” arose during the final session of the meeting:

**Service**

*Create a comprehensive, country-wide report examining community-level interventions.*

*Revise health curriculum for students, grades 7-12, to address nutrition and exercise issues.*

*Develop a Listserv, especially related to low-cost, high-impact interventions, for AUSP participants through the American Academy of Pediatrics.*

*Develop a program on positive parenting for IEP affiliates. Provide incentives for affiliates to conduct the one-day training.*

**Training**

*Develop and implement training for: pediatric sub-specialists related to early child development; general pediatricians in developmental pediatrics; professional care-takers in nurseries, child care centers, educational community; and, grandparents on child development through use of mass media.*

*Develop training for pediatricians where they follow a child/family with special needs over 4-5 years of their training and prepare a report on the impact of the experience on their learning.*

*Implement existing training on infant management for parents while also developing parallel program for nurses (early intervention, screening, positive parenting, touch, etc.).*
Incorporate concept of Medical Home into residency program, develop manuals for parents and caregivers, promote community involvement.

Develop training program for parent involvement in early childhood development.

Develop training workshops for pediatricians, pediatric nurses and midwives on the practical implication of ECCD, namely neonatal behavioral assessment, the Touch Point concept, child developmental assessment and early intervention.

Initiating the official Developmental and Behavioral Pediatric Fellowship Training Program.

Develop training workshops with existing curriculum for pediatricians in developmental-behavioral pediatrics and for nurses and midwives in topics such as newborn behavior screening, positive parenting.

Ensure participation of people with expertise in early childhood development in American Academy of Pediatrics meetings.

**Research**

Develop appropriate language development scale incorporating what we have learned from previously translated developmental scales in U.S. and U.K.

Explore and propose feasibility of population-based longitudinal study from antenatal through adolescence into adulthood to investigate determinants of health.

Develop a survey instrument for baseline measurement of implementation and effectiveness of the Medical Home.

Develop and implement indigenous tribal people survey tool, based on previous international examples and leading toward the development of international assessment tool.

Determine unmet social-emotional needs of children-- what do the children themselves think they need? What do professionals think children need?
Advocacy

Implement a systematic child death review; current registry on abused children does not include children who died from abuse.

Invite international speakers as resources to assist with advocacy efforts in our countries.

Initiate a two-year national program to create early child development systems based on the Medical Home concept that engages national and local stakeholders in research, training, and service.

Work with National ECD Steering Committee (Health, Education, Social Development, Local Administrative Organization, and community) for social mobilization and integrated ECCD particularly for the disadvantaged population.

Work with various ministries to address issues of child abuse and neglect and develop indicators for child wellness, social and emotional well-being.

Develop working paper series related to research on early child brain development for policymaking leaders in the US and Asian countries.

Rewrite existing national child health standards in ways that incorporate a new evidence-based approach.

The main goal of the Asia-US Partnership is to cultivate ongoing, active international networks of inter-professional early childhood leaders to promote awareness of early child development and reshape early childhood systems in each of their countries. To do this, “action steps” for the coming year address expanding networks of AUSP participants while building networks of early child development professionals within their own countries—including senior pediatric health professionals, recruiting and mentoring junior colleagues, reaching out to pediatric health leaders working with early education and family support professionals. The initiative means promoting concepts of early child development through the lens of recent scientific neuroscience research within the pediatric and policymaking communities in each country. This also means creating programs related to research, training, service, and advocacy aimed at implementing, evaluating, and strengthening early child development outcomes for children and families in all participating countries.