



The Republic of the Union of Myanmar

National Strategic Plan *for* Early Childhood Intervention

*A National Service Programme for All Children with Special Needs
and their Families*



2017 - 2021



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Ministry of Social Welfare, Relief and Resettlement

in close collaboration with:

Ministry of Health and Sports
Ministry of Education
Ministry of Home Affairs
Ministry of Planning and Finance
Ministry of Border Affairs
Ministry of Labour, Immigration and Population
Ministry of Information

2017 – 2021

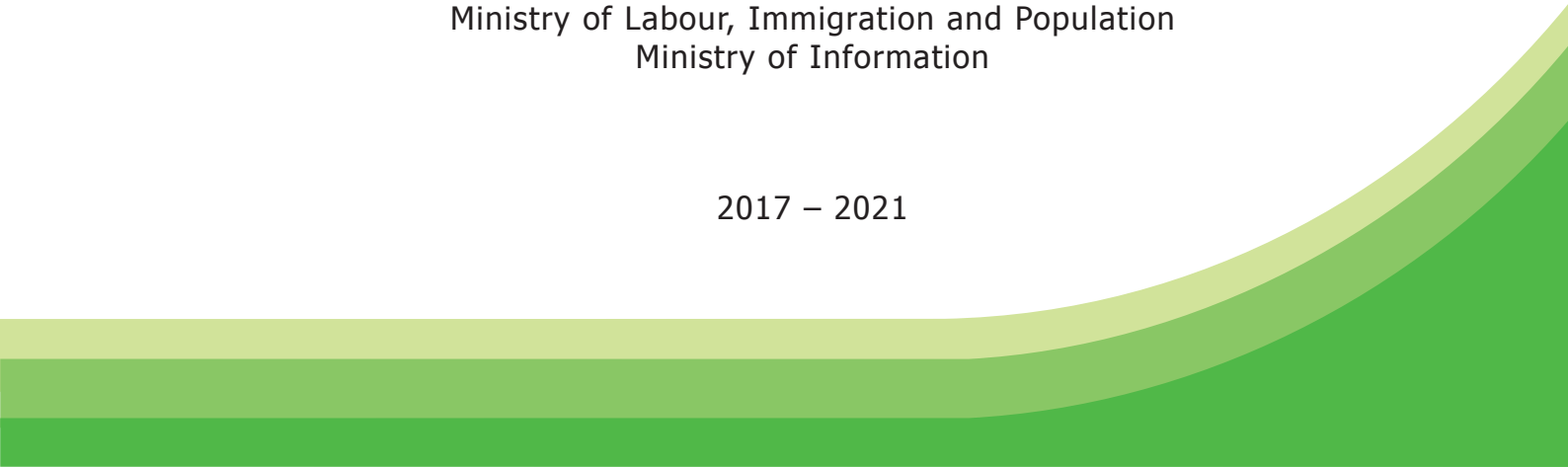


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Preface



Dr. Win Myat Aye

Union Minister

Ministry of Social Welfare, Relief and Resettlement

In 2017, it is estimated that at least 42% to 45% of young Myanmar children and their families require ECI services. The low-cost and cost-effective ECI services presented in the ECI Strategic Plan, its Action Plan and its Programme Guidelines and Procedures, will rapidly reduce the high rates of children with developmental delays, malnutrition, chronic diseases, disabilities and behavioural disorders.

The Goal of the ECI Strategic Plan is that by 2021, initial ECI services will be developed in all 21 States, Regions and Self-Administered Areas, and by 2025, vulnerable children in all communities of all Townships will be served.

For the status of Myanmar's young children to be improved, a unified nationwide commitment is required. Under the leadership of the Ministry of Social Welfare, Relief and Resettlement, participating ministries include: Ministry of Health and Sports, Ministry of Education, Ministry of Home Affairs, Ministry of Planning and Finance, Ministry of Border Affairs, Ministry of Labour, Immigration and Population, and Ministry of Information. These ministries are committed to prepare, pilot test, and expand ECI services as rapidly as possible.

The preparation of the National Strategic Plan for ECI is the result of a highly participatory and multisectoral policy-planning process. The Plan was developed through the close collaboration of all participating ministries along with many non-governmental, faith-based, community-based and private sector organisations that represent the following sectors: social welfare and protection, education, health, nutrition, and environmental sanitation. This planning process was supported through the full collaboration of UNICEF and The Leprosy Mission of Myanmar.

To lead the planning process, the Ministry of Social Welfare, Relief and Resettlement established an ECI Steering Committee and an ECI Task Force of technical specialists. Many planning meetings were held in addition to extensive consultations in various regions. Drafts of the Strategic Plan were widely reviewed both in regions and centrally before they were finalised and adopted. An Action Plan for the implementation of the Strategic Plan has also been developed, along with ECI Programme Guidelines and Procedures.

We wish to thank the members of the ECI Steering Committee and the ECI Task Force for their dedicated work.



Dr. Win Myat Aye
Union Minister

Ministry of Social Welfare, Relief and Resettlement

Foreword



Bertrand Bainvel

Country Representative, UNICEF (Myanmar)

In the earliest years of life, especially in the first 1,000 days, babies and young children need nutrition, stimulation, protection and love for optimal brain development and the best start in life. The first three years are particularly critical, as it is a period of rapid brain development and learning. During this time young children's healthy development depends on nurturing care - defined as care which ensures health, nutrition, responsive caregiving, safety and security, and early learning. It is also the time when children respond most readily to interventions.

Deprivation of nutrition, protection and stimulation can lead to cognitive, emotional and behavioural disadvantages. The burden and cost of inaction is high. Around 42-45 percent of all children under the age of five in Myanmar are at higher risk of not reaching their developmental potential due to stunting, poverty, and disadvantage, which threaten their nurturing care.

For most children attentive care and love will help them develop, while for others due to disabilities, behavioural disorders, or significant delays in their development, additional, sometimes individualized support is needed to help them grow and develop to their full potential. This is the purpose of the National Strategic Plan for Early Childhood Intervention (ECI), an essential component of the Myanmar Policy for Early Childhood Care and Development (ECCD) which was adopted in 2014. With this strategy, Myanmar now has an important tool to coordinate actors and services, and mobilise domestic and international resources, to improve the development of Myanmar's most vulnerable infants and young children.

Once implemented, this National Strategic Plan for ECI will enable Myanmar to address several Sustainable Development Goals, as well as its commitments under the Convention on the Rights of Children, and the Convention on the Rights of Persons with Disabilities. Above all, it will greatly improve the development of the nation's children.

The time to act is now. Through the SDGs, we now must ensure that children not only survive, but thrive. This strategic plan will facilitate the scale-up in implementation of early childhood development policy and its multi-sectoral services, to reach the most disadvantaged children in Myanmar: leaving no one behind.

A handwritten signature in blue ink, appearing to read 'B. Bainvel', is centered on the page.

Bertrand Bainvel
UNICEF Representative to Myanmar

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INTRODUCTION



1. Introduction

The Need and the Hope

Early [Introduction to ECI including definition and needs for ECI services, age range of children included and types of eligibility for ECI services and relationship to regular ECCD services for infants and young children.]

Early childhood intervention (ECI) services are intensive and serve children principally from birth to age three and up to five years of age. They are tailored to meet the needs of individual children with fragile birth status, developmental delays, disabilities, malnutrition, chronic health issues that affect their development, and atypical behaviours, such as autism spectrum, attention deficit and hyperactivity disorders. ECI services complement general ECCD services as presented in the National ECCD Policy. ECI services are more intensive and individualised than ECCD services in order to improve the development of children with greater developmental needs.

Research in many countries has demonstrated that ECI services greatly improve child development and also lower the need for and costs of services for child health and nutrition care, special education, and related child and social protection programmes.





In Myanmar, we estimate that at least 40% of children require ECI services for short to longer periods of time. At present, 35.1% of Myanmar children are moderately to severely stunted; all of these children are likely to have one or more developmental delays. In addition, at least 5% to 12% of the nation's children will be identified to have disabilities, chronic diseases or atypical behaviours.

Over time, approximately 70% of the children who will be served will improve in their development, attain expected levels of development for their age, and will consolidate their gains within one to two years. Other children, approximately 30%, will have lifelong disabilities or other conditions, and ECI services usually greatly improve their development and help them to achieve their full potential.

For these reasons, ECI services are essential and very beneficial for all nations. They also ensure strong parental participation in the ECI programme and they

train parents in methods for maximising the development of their children. They provide needed support for families trying to deal with situations they never expected to occur in their lives.

In addition, ECI services reduce child abandonment and the institutionalisation of children in orphanages and other institutions. For children formerly living in institutions, they provide needed services for overcoming developmental delays and for improving the development of children with disabilities, malnutrition, chronic illnesses and atypical behaviours.

ECI services have also played a critically important role in enabling the deinstitutionalisation of children because many of these children had delays or disabilities, and they require ECI services as they move to family homes. The support of ECI services also makes it possible for these children to return to their families or to live with other nurturing and caring substitute families. ECI services support these children and their parents, guardians and caregivers.

Support for ECI in the National ECCD Policy

Strategy 3 of the National Policy for Early Childhood Care and Development of 2014 establishes the policy mandate for developing the National Strategic Plan for ECI:

ECCD Policy Strategy 3: Early Childhood Intervention Services, 0 to 5 years
<i>Develop, improve and expand early childhood intervention and rehabilitation services to help each child achieve his or her full potential, and to prevent the discrimination and stigmatisation of children with special needs.</i>

This Strategic Plan is also linked to the global Sustainable Development Goals (SDG) that will be formally established in September 2015. Specifically, Target 4.2 is devoted to improving child development.

SDG Target 4.2
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.

The National ECI Strategic Plan of Myanmar is fully consistent with and supports the implementation of provisions under Articles 23.3 and 25.b of the Convention on the Rights of Persons with Disabilities (CRPD):

Convention on the Rights of Persons with Disabilities
<i>States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realising these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.</i>
<i>States Parties shall... provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons.</i>

ECI services include a process for conducting the following activities:

- Community outreach to identify children with special needs
- Universal screening of child development
- Referrals to ECI services
- Initial ECI intake
- Comprehensive child and family assessments
- Establishment of eligibility for ECI services
- Preparation of an Individualised Service Plan
- Regular home visits or visits to a daily childcare centre (usually once or twice a week), including the parents and the child caregiver
- Regular re-assessment and plan revision
- Transition services to inclusive preschools or primary schools or, if needed, special services for children with complex disabilities
- Follow-up services, as needed

All visits are conducted in the natural environment of the child and family. They are not conducted in separate and costly centres unless the child is enrolled daily in a child care centre or preschool.

Each ECI service site will establish a Transdisciplinary Team composed of key specialists, a few of which will be new (*) to Myanmar:

- Early Intervention Specialists*
- Home visitors who will be trained paraprofessionals
- Physical Therapists
- Speech Therapists*
- Occupational Therapists*
- Social Workers
- Physicians (as needed)
- Rehabilitation specialists
- Nurses
- Midwives
- Psychologists
- Others, as per need

Initial pre-service training in Myanmar, other countries or through distance learning will be required to prepare a strong cohort of early intervention specialists, speech therapists and possibly some occupational therapists.

The National Strategic Plan for ECI has been developed using a highly participatory approach. Initially the lead ministry, the Ministry of Social Welfare, Relief and Resettlement (MoSWRR) and all collaborating ministries were confirmed. Then the ECI Steering Committee was formed to guide strategic planning and the ECI Task Force was named. The terms of reference of both the Committee and the



Task Force were established. Preparatory meetings of the ECI Steering Committee and Task Force were held during June-July 2015 and many activities were undertaken, including field visits to Patheingyi and Mawlamyine. Subsequently the first draft of Strategic Plan was prepared and reviewed by the Task Force, and the second draft was prepared. Consultation workshops using the second draft were held in four regions: Central Myanmar (Yangon), Upper Myanmar (Mandalay), Mon State (Mawlamyine) and Sagaing State (Monywa). In addition, meetings were held with key ministerial leaders to review second draft of the Strategic Plan. Using the result of all of the regional and central reviews, the third draft of the Strategic Plan and the Action Plan were prepared. They were reviewed by the Task Force and Steering Committee and revised again to prepare the fourth draft of the Strategic Plan and the second draft of the Action Plan. In addition ECI Programme Guidelines and Procedures were prepared and reviewed by the Task Force.

After reviewing and updating the Strategic Plan and Action Plan, the final forms of both documents were prepared and they were submitted to the Cabinet of Ministers for adoption. The National Strategic Plan is to be presented in a launch ceremony in Nay Pyi Taw, and full implementation of the Strategic Plan and pre-service training for the Pilot Year will commence.

ECI SITUATION ANALYSIS



2. Situation Analysis

2.1 Introduction

In 2014, The Government of the Republic of the Union of Myanmar adopted the Myanmar Policy for Early Childhood Care and Development (ECCD). Strategy three of the Policy called for the establishment of early childhood intervention (ECI) services from birth to five years of age.

<p style="text-align: center;">ECCD Policy Strategy 3: Early childhood intervention services, 0 to 5 years</p>
<p>Develop, improve and expand early childhood intervention and rehabilitation services to help each child achieve his or her full potential, and to prevent the discrimination and stigmatisation of children with special needs.</p>

The *Situation Analysis of Early Childhood Care and Development in Myanmar* conducted to assist with planning the ECCD Policy discovered that high levels of infant and young child developmental delays, malnutrition, chronic illnesses, disabilities and behavioural disorders (UNICEF, 2012). It was noted that these fundamental needs regarding child and human rights and development had received inadequate attention. Concern was also expressed about the numbers of street children and social orphans, some of whom had been institutionalised.

This Situation Analysis will provide data regarding: 1) the status of infants and young children in Myanmar; 2) resources that exist or are needed to improve their development and support parents and larger families; and 3) the policy environment regarding ECI.

Strengths of the Myanmar social welfare, health and education systems will be noted as well as gap areas requiring increased investment to develop a sustainable national ECI system of community-based services strongly supported at both regional and national levels.

2.2. Definition of ECI services at the systems Level

ECI is an interdisciplinary, integrated and coordinated system of individualised and intensive services provided in the natural environment of the family with a child from birth to three (3) years of age and up to five (5) years of age. Because of rapid brain growth during the first 36 months of life, it is essential to enrol infants and young children in ECI services as early as possible. To become sustainable, the ECI system must have a legal basis, appropriate ECI programme guidelines and procedures, standards, and other regulations as well as adequate financial, training and material support from Government at all levels as well as from civil society and the private sector

2.3 Types of children requiring ECI services

ECI programmes provide comprehensive services requiring the effective functioning of various systems. They provide developmental activities and family support for the parents and legal guardians of infants and young children with the following conditions:

- Children with developmental delays in any major developmental domain as assessed by an ECI professional using an approved assessment instrument. Developmental delay can occur in: perceptual (hearing, seeing, touch, etc.), fine motor, gross motor, language/communication, cognitive, social, emotional, development, as well as in adaptive skills, including self-regulation and self-help skills;
- Children diagnosed to have a mental or physical disability in any area. A disability may be identified through securing a medical diagnosis from a trained physician or the application of a developmental assessment scale. Problems of functioning are usually classified using the International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) of the World Health Organisation or an assessment conducted by an ECI professional using a nationally-approved assessment instrument;
- Children with genetic or biological condition, such as Down syndrome, Rett syndrome, Angelman syndrome, cerebral palsy and other conditions;
- Prenatal exposure to toxins through extensive maternal use of street drugs, utilisation of certain prescription drugs, environmental toxins or substance abuse resulting in foetal alcohol syndrome or other substance-related developmental delays and disabilities;
- Malnourished children who are stunted (shorter than normal); underweight; or wasted (low weight for height). Malnutrition is usually but not solely assessed by height and weight measurements conducted by a physician, trained nurse or an ECI professional. Research has shown that all children with malnutrition develop from one to several developmental delays in other areas, such as language and cognitive development;
- Children with micronutrient deficiencies or impacts, such as iron deficiency anaemia or insufficient vitamin A, zinc or iodine, as well as lead poisoning, all of which can lead to life-long developmental delays and various health disorders;
- Children at high-risk of developing delays or disabilities due to challenging circumstances in their family or community environments.
- Low in birth weight infants, depending upon a medical doctor's assess-



ment of fragile status and risk but usually around 1,800 grams but no greater than 2,300 grams;

- Preterm babies - delivered at less than 37 weeks of gestation;
- Infants affected at birth by respiratory distress, lack of oxygen, infection, a brain haemorrhage or another neonatal health condition;
- Children with a chronic illness or disease that causes developmental delays or disabilities, such as HIV and AIDS, Zika, malaria or tuberculosis;
- Trauma that causes a brain injury, physical or mental delay or a disability; or
- Children with behavioural disorders and poor self-regulation, such as autism, attention deficit hyperactivity disorder (ADHD), or learning difficulties such as visual, reading, auditory, geographic and various forms of sensory-motor dyslexia.

2.4. Status of children and families to be served by the ECI System

Demographics and annual birth rate

Based on the 2014 Census, the total population of Myanmar in 2012 was 52,797,300, and the population under 5 years of age was 4,434,400. The total number of annual live births is over 921,900. The annual growth rate is approximately 1%, and it expected to decline in coming years. Myanmar is an agricultural country; only 33.2% of the population live in urban areas.



Causes and rates of developmental delays, disabilities and behavioural disorders

There are many causes of developmental delays and disabilities in infants and young children. No comprehensive national survey has yet been conducted to measure the incidence of developmental delays and disabilities. In addition, critically important data are lacking in some areas; many existing studies are out-of-date. Nonetheless, they provide some understanding of the dimension of the need. Fortunately, the 2012 national census, Multiple Indicator Cluster Survey (MICS) conducted by UNICEF, and several specialised studies do give us a general understanding of some aspects of child development and information about some causes of developmental delays and disabilities. Following is a discussion of some of these dimensions.

Preconception

Preconception education and health care are essential to help women prepare to have successful pregnancies and deliveries and well-developed infants. However, these services are only beginning to be provided in Myanmar. We lack statistics regarding the coverage of initial preconception services. Of particular concern are the health and nutritional status of parents prior to conception as well as during pregnancy.

Micronutrient deficiencies in adolescents, pregnant and lactating women

Basic food consumption for the poorest population groups is a major problem, and there are widening gaps between states/regions and rural and urban areas (IHLCA, 2010). According to the *Global Hunger Index*, 18.8% of the population is in hunger (National Nutrition Centre, 2013). In some States, such as Chin, the food poverty incidence is as high as 25%. These families are unable to meet their minimum daily caloric intake, and their children tend to be malnourished and delayed. However, in some urban areas, with the growth of sedentary lives and an abundance of foods of poor nutritional value, obesity, diabetes and high blood pressure are increasing. These conditions are perilous for women, causing infertility, miscarriages and pre-eclampsia.

Data on the micronutrient status of fathers are lacking but for adolescent and pregnant women, the following is found. Vitamin A and iodine deficiencies have been significantly reduced (but not eliminated) through supplementation; however, iron deficiency anaemia, folic acid deficiency, and vitamin B-1 deficiency (beriberi) remain of great concern as causes of developmental delays and disabilities in both mothers and children. Iron deficiency anaemia is exceedingly high; 45% of non-pregnant women of reproductive age and 26% of adolescent schoolgirls are anaemic (NNC 2013). The best available local estimates are from a 1994 study conducted by the Department of Medical Research (Lower Myanmar), which showed that 58% of the pregnant women were anaemic. A study on anaemia and worm infestation among under 5 children and pregnant women carried out by the Nutrition Section of the Department of Health in 2004 found 71% of pregnant mothers were anaemic (MoH and UNICEF, 2013). These women usually have developmental delays and most of their children will have permanent and severe developmental delays unless their mothers receive treatment before, during and after pregnancy.

With regard to folic acid, no current data on deficiencies could be found although it is well known that many Myanmar women of childbearing age have high-levels of folic acid deficiencies. Adequate levels of folic acid are essential to prevent most neural tube defects in infants (hydrocephaly, spina bifida, microcephaly, poor brain growth, etc.). The most critical period when a developing foetus requires folic acid is between 22 and 28 days after conception; well before many women even know they are pregnant. Especially in unplanned pregnancies, a decision to take folic acid supplements may come too late to provide maximum benefits. Thus the administration of folic acid supplementation must begin during the preconception period. It is estimated that about 70% of pregnant women in all townships receive folic acid supplementation and expanded coverage is urgently needed (UNICEF, 2010a). Among pregnant women B1 deficiency was 6.4%, and among lactating mothers, it was 4.4% (MOH, 2013). Vitamin B12 deficiencies,



which also cause anaemia in pregnant women and mothers, are also found in Myanmar but the current rate of deficiency was unavailable.

Antenatal care and deliveries

High rates of maternal mortality and infant, neonatal and child mortality are linked to many socio-economic factors such as moderate to severe poverty, domestic and community violence, maternal malnutrition as well as preventive and antenatal health care. In 2016, UNICEF reported that at least 83.1% of pregnant women had at least one antenatal visit, but only 73.4% had at least four visits. Most of the pregnant women who received four or more antenatal visits had a secondary or higher level of education. At delivery, 70.6% of women had a skilled birth attendant but only 36.2% gave birth in an institution. Although antenatal care has improved to some degree, most visits occur close to delivery when it is too late to treat women for malnutrition, micronutrient deficiencies and disease. Antenatal services must be expanded and improved.

Maternal mortality rate

Given the low coverage of antenatal services and high numbers of deliveries without a skilled birth attendant, it is not surprising that the maternal mortality rate in 2012 was 320 per 100,000 births (UNICEF website, 2017), with an adjusted rate of 200 per 100,000 births. A 2005 study, the *Nationwide Cause Specific Maternal Mortality Survey*, found maternal mortality occurred in 140 births per 100,000 births in urban areas and 363 in rural zones, demonstrating the need for greatly expanded medically managed delivery services in rural areas.

Infant and child mortality and the occurrence of fragile infants

In 2012, the infant mortality rate was 41 infants per 1,000 live births, neonatal mortality rate was 26 per 1,000 live births, and the overall under-five mortality rate was 52 per 1,000 live births, showing that delivery and neonatal periods are especially challenging for the survival of infants. ¹Prematurity, low birth weight, respiratory illnesses, diarrhoea and neonatal jaundice are linked to infant and neonatal mortality (*Under Five Mortality in Myanmar, 2015*).

Birth registration

Myanmar has made major efforts to register all births. The total birth registration from 2005-2012 was 72.4% (UNICEF website, 2017). Registrations in rural areas (63.0%) were much lower than in urban areas (89.6%) (UNICEF website, 2017). This achievement could be linked with a child tracking system that would enable the follow up of fragile infants from birth onward.

Low birth weight

Infants born with low birth weight (below 2,500 grams) are usually fragile and require special attention and nurturing care. Some are severely developmentally delayed at birth and already have disabilities. Many infants are not weighed at birth, and for this reason it is difficult to assess the national rate of low birth weight. The MICS for 2009-2010 found that 8.6% of the children born during the preceding year were low in birth weight. When asked if the children had been weighed at birth, parents reported that only 56.3% of them had been weighed.



¹ All mortality rates are dependent upon health facility reports. Families living in remote or conflict areas lacking health facilities rarely officially report mortalities. Because of this, reported rates are lower than actual rates. These reported statistics appear to be inaccurate; however, many Myanmar sources state that most infant deaths occur within 2 months of birth.

The low birth weight rate may be above 15%. Regional studies found low birth weights ranging from 7.1% to 36.2%. Clearly more attention should be given to accurately weighing and measuring infants at birth and to identifying those with low birth weight and fragile conditions for early childhood intervention. Low birth weight could be reduced through giving more attention to expanding preconception and antenatal services, especially for high-risk pregnancies. All infants born under 2,500 grams should be screened not only at birth but also frequently thereafter. If developmental delays are suspected, they should be referred to ECI services. Infants who are low in birth weight are most likely to be stunted in their later growth. In on study on Myanmar, low birth weight explained 13% of all stunting (Save the Children et al., 2014).

Breastfeeding immediately after birth (timely initiation of breastfeeding)

The MICS 2009-2010 survey found that 75.8% of infants were breastfed within 1 hour of birth. However, the rate of exclusive breastfeeding from birth to six months was only 23.6% (MICS, 2009-2010). Continued breastfeeding to 20 to 23 months was relatively high at 65.4%. However, due to high levels maternal malnutrition, the quality of breast milk may not be optimal. A measure of this is the prevalence of adequately fed infants from birth to 11 months at only 41.0% (Ibid).

Stunting

Stunting (low height for age) serves as a major international proxy variable for the incidence of developmental delays. It is correlated with poor school performance and low future productivity.

The Myanmar MICS 2009-2010 survey found a very high rate of stunting: 35.1%. Virtually all of these children will be developmentally delayed in one or more areas of development: perceptual, fine motor, gross motor, language, cognitive, social and emotional development including self-regulation. Stunting is highest amongst children from 24 to 35 months of age; however, 15% of infants under 6 months of age are already stunted due to poor growth from pregnancy onward. An anthropometric study conducted by the National Nutrition Centre on the nutritional status of adolescent students in 2002 reported that stunted growth was observed among 37.6% of boys and 30.4% of girls. Stunting disproportionately affects children living in poor households. According to MICS 2009-2010 data, children under-five years of age living in the poorest households are more than twice as likely to be stunted (46.6%) than those living in the wealthiest households (20.7%). However, it is significant that 20% of children in the wealthiest households are stunted. Though mothers with no education are significantly more likely to have children who are stunted, more than a quarter



of children whose mothers have a secondary education or higher are stunted (MNPED & MOH, 2011). These findings suggest that some key determinants of stunting, such as poor child feeding practices, exist in households at all levels of socioeconomic status. Furthermore, raising incomes without changing nutrition-related behaviours will not overcome stunting in Myanmar (Cashin, 2016).

Micronutrient deficiencies in infants and young children

In addition to stunting, Myanmar children have many micronutrient deficiencies. The prevalence of anaemia among infants 6 to 20 months of age was found to be over 80%. This alarming rate reveals that virtually all infants and toddlers are at a very high risk of becoming developmentally delayed (MNPED & UNICEF, 2013). For children under five years of age, the rate was a bit lower: 64.6% (Ibid.). Anaemia must be rapidly reduced and combined with infant stimulation activities.

Infantile Vitamin B1 deficiency (Beriberi) is the fifth leading cause of deaths among children during the first year of life in Myanmar (NNC, 2007). The majority of deaths due to infantile beriberi occur among infants from 2 to 3 months of age. Hospital-based Infantile Beriberi Surveillance from May 2005 to November 2007 by the National Nutrition Centre in 35 hospitals of 21 townships, showed in a total of 725 reported cases, of which 44 cases died (6.2%), most of them in the 2 to 3 months age group. About half of the reported cases were identified with a definitive diagnosis of infantile beriberi (54% of reported cases and 47% of death cases), establishing a mortality rate at 5.3% (National Nutrition Centre, 2013).

Surprisingly, Vitamin A deficiency is quite high among children from 6 to 59 months: 30.1% (MoH, 2013). Vitamin A supplementation currently reaches 86.0% of the nation's children (UNICEF, 2017). Iodine deficiency is also noted, with only 68.8% of households consuming iodised salt (MICS 2009-2010). On its website, UNICEF reports that this rate had risen significantly to 92.9% by 2012. However the rate of iodine deficiency in young children is currently unavailable. Iodine deficiency causes mental disabilities and developmental delays.

In addition, many children suffer from intestinal parasites, worms and bouts of malaria that further rob their bodies of essential nutrients. Parasites are especially prevalent in coastal areas (MNPED & UNICEF, 2013). The combination of parasites, worms and diseases suppress the development of young children, and most especially in those who already lack adequate levels of micronutrients.

Congenital anomalies and other disabilities

The 2014 National Census reported only 1.35% of children had disabilities. This result is questionable in light of international disability statistics. WHO states, *"More than a billion people are estimated to live with some form of disability, or about 15% of the world's population (based on 2010 global population estimates). This is higher than previous World Health Organization estimates, which date from the 1970s and suggested around 10%."* It also states, *"Only the Global Burden of Disease measures childhood disabilities (0–14 years), which is estimated to be 95 million (5.1%) children, of whom 13 million (0.7%) have "severe disability" (WHO, 2011).*

Given high levels of congenital anomalies, micronutrient deficiencies and early injuries, disabilities in infants and young children in Myanmar may be between 5% and 10%, with an estimate of at least 7%.

The *Situation Analysis of Children with Disabilities* (UNICEF, 2016) found that the rates of main causes of disability occurred as follows:

- Existed at birth (65%)
- Diseases or illness (20%)
- Accident or injury (5%)
- Mis-injection (5%)
- Undetermined causes (5%)

Because of the high rate of deaths and disabilities related to birth outcomes, we sought information regarding the occurrence of the following conditions at birth. The recent *Study on the Causes of under-five mortality in Myanmar* reported that major causes of newborn mortality (within 1 month of birth) are prematurity/low birth weight (36%) and birth asphyxia (26%) (MOH, 2015). The study also revealed that neonatal jaundice accounted for 15% of infant deaths. Children who survive neonatal jaundice but are not treated often have major developmental

delays (Ibid). In all, neonatal sepsis accounts for 12% of infant deaths, and approximately 3% of all reported births are affected by prolonged labour that often causes asphyxia, often resulting in death or disabilities (UNICEF 2016).

Congenital anomalies cause 5% of infant mortality. These usually include: neural tube defects such as hydrocephalus, microcephaly, spina bifida, Down syndrome, fragile X, cerebral palsy and mental retardation.

The World Health Organization (WHO) has identified 6 major birth defects in Myanmar, stating per 1,000 births: birth defects of the cardiovascular system (7.9%), Haemoglobin syndromes (4%), G6PD deficiency (3.1%), Down syndrome (1.7%), and neural tube defects (0.7%) (WHO, 2013). Overall, WHO estimated that 59 out of 1,000 infants have birth defects, translating to a prevalence rate of 5.8% (Ibid.). This is a much larger and more accurate number than most current available data sets, including the latest census, and it helps to predict the number of children with disabilities at birth. In all, WHO estimates that annually 59,435 children are born in Myanmar with birth defects (Ibid.).

Behavioural disorders

Many behavioural disorders are very difficult to identify before 18 months of age. However, currently neuro-paediatricians and neuroscientists are beginning to identify unusual brain configurations that appear to presage the onset of unusual behaviours, such as Autism Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD). The actual incidence of ASD and ADHD in Myanmar is not known.

Disabilities caused by childhood injuries

Due to unsafe household practices, children walking and playing in roads, and a lack of safe playgrounds for young children, many are injured each year, and some of these injuries led to lifelong disabilities. Some 2% of under-five deaths were caused by injuries (WHO, 2008).



Childhood delays and disabilities caused by chronic illnesses or diseases

Additional causes of under-five deaths included: neonatal death (45%); diarrhoea (20%); pneumonia (16%); malaria (3%); measles (3%); HIV/AIDS (1%); and others (10%) (WHO, 2008). These statistics demonstrate the fragile nature of children during the neonatal period and their high levels of chronic illnesses and diseases that often cause developmental delays and disabilities. At present, statistics are unavailable regarding the numbers of children who develop delays or disabilities due to chronic illnesses or diseases.

HIV prevalence in pregnant women 15-19 years is 0.3%, and for those 20-24 years the rate was slightly higher at 0.8%. Among high-risk youth it was significantly higher: 3.4% in 15-19 years old female sex workers, 7.4% in 20-24 years old female sex works, 7.4% in 15-19 years old drug users, and 14.8% in 20-24 years old drug users (UNFPA 2007). Regarding mother to child transmission prevention, only 72% of pregnant women with HIV were taking anti-retroviral to prevent mother to child transmission. The remaining 28% were at high risk of transmitting HIV to their infants. In addition only 35% of people identified to be living with HIV were taking anti-retroviral drugs. Infants and young children infected or affected by HIV/AIDS in one or both parents tend to be severely developmentally delayed. They all require early intervention services.

High levels of morbidity (upper respiratory, intestinal infections, dental caries)

Many children are deeply affected by high levels of morbidity, including upper respiratory and intestinal infections, tuberculosis, dental caries, and malaria. From 2008-2012, 69.3% of children sought care for suspected pneumonia, and 60.6% sought treatment by oral rehydration salts for diarrhoea. Approximately



76% of the population lives in malarial regions, and it is a major cause of death and illness in children. Morbidity from malaria from 1988–2011 ranged from 4.2 to 8.6 million annually. A significant number of children are severely impacted in their development due to contracting highly infectious diseases.

The impacts of chronic diseases and illnesses

Myanmar was anticipated to lose at least US \$430 million from 2006 to 2015 due to high rates of chronic diseases (Lancet, 2007). Without early childhood intervention services and related health and nutrition services, the national burden and costs of chronic diseases that cause developmental delays and disabilities, will continue to be exceedingly high.

Children affected by parents with leprosy

Although leprosy has been overcome in Myanmar, thousands of parents who suffered from leprosy have children for whom they cannot provide full care and nurturing. Because of this, The Leprosy Mission of Myanmar manages housing, education and health care for their young children, and more support is needed for these services. Children unable to receive these services due to limited funding for TLMM, often suffer from malnutrition and delays.

Young children placed in institutions

Untold numbers of children born into homes with severe poverty are placed in monasteries, orphanages and other types of residential institutions even though their parents are alive. Approximately 1,400 children are housed in six residential care facilities managed by the Department of Social Welfare (DSW). Some children are placed in institutions due to having developmental delays, malnutrition, chronic illnesses, disabilities or behavioural disorders. These children are often called “social orphans” because their parents placed them there or they abandoned them. Some well-meaning but impoverished parents hope that their children will have a better life because of these services.

However, research has demonstrated that children placed in institutions without special needs upon entry became developmentally delayed or disabled due to a lack of nurturing, loving and stimulating care that only families and consistent caregivers can provide (Garner, 2011). As a result, all of young children placed in institutions require special attention and support and they should be deinstitutionalised and placed in family homes as soon as possible (Ibid.).

Although the actual number of institutionalised children from birth to five years of age is not known, the MICS 2009-2010 found that 5.4% of all children aged 0-17 years were not living with a biological parent (6.6% urban, 5.0% rural). About 2% of 0-4 year-olds were already placed in institutions. The prevalence of orphans aged 0-17 years overall was reported as 6.6%. According to the study

The Situation of Children in Residential Care Facilities in Myanmar, in 2011 a total of 12,493 children lived in 147 facilities, and there were considerably more boys (9,447) than girls (3,046). Some 36.7% of the facilities accepted children with disabilities, the majority of which were reported to have disabilities (82.4%). However, the study stated that only 600 children under five years of age lived in care facilities, and also that most of the children were not orphans. Some of these children may also still have contact with their relatives, guardians or community. Some 75% of the children know the location of their parents, relatives or guardians; however, only 20% visit their parents, and 12% are visited by their parents. Most children are left at facilities by parents and relatives usually at the start of the school year, suggesting that education and poverty are key reasons why children end up in residential care facilities (UNICEF, 2011).

In spite of the high incidence of social orphans, reunification and reintegration into families is not perceived as a normal practice among both parents and resident staff. Fewer than 1 in 5 facilities were reported to be looking for the parents of young children at their facilities, and fewer than 1 in 10 had a budget for children to maintain contact with their families. Less than half of caregivers had received training regarding young child care and development. Caregivers worked an average of 60 hours per week, and were responsible for an average of 48 children each. Admission and recordkeeping were particularly weak, with only half of the facilities maintaining a case record for each child.

Children at high risk of becoming developmentally delayed and disabled

Cumulative mental health, physical and socio-economic risks have highly negative impacts on child development. Many young children affected by detrimental conditions become developmentally delayed or disabled. These risks often coincide with one or more of the situations presented above. It is impossible to assess the number of children negatively affected by these situations, but it is a very high percentage of Myanmar's young children.

- ***Children living in severe poverty***

According to the Asian Development Bank, in 2016, 25.6% of the population lives below the poverty line. In rural areas, poverty is reported to be twice as high. All of the children living in poverty are either developmentally delayed or are at high risk of delay. Many of these children will be stunted; therefore, most of them would be included in the 35.1% national rate of stunting; however, we know that children from middle and upper income groups are also sometimes stunted. With improving standards of living it is expected that stunting will slowly decline; however, without stimulating intervention, child development levels are unlikely to improve.

- **Children lacking access to primary health care**

Children who are at high risk of chronic illnesses, malnutrition and developmental delays and who live in poverty and lack access to primary health care will require early childhood intervention services. At present, Myanmar is making a major effort to expand health care coverage; however, no statistics are available for the coverage of infants and young children. Various services range from 60.6% (for diarrhoea treatment) to 85% (diphtheria, pertussis and tetanus (DPT3)) (MICS 2010-2012). Because rural health coverage is considerably inferior to urban health services, rural children in certain States and Regions are at high risk of becoming delayed and disabled.

- **Children unregistered at birth**

As noted, the total birth registration from 2005-2012 was only 72.4% (UNICEF website, 2017). Subsequently, unregistered children are often unable to access social, health and educational services. The *Situation Analysis of Children with Disabilities in Myanmar* states that 27% of children with disabilities lack a birth certificate, with strong regional differences in this rate (UNICEF, 2016). Children unable to access basic social services are at a higher risk of becoming developmentally delayed or disabled.

- **Children affected by natural disasters**

Millions of Myanmar families are regularly affected by natural disasters. Monsoons, floods, earthquakes and landslides cause many families to lose their homes and possessions. In recent flooding, over 1.5 million people were directly affected. The children of families affected by cyclical natural disasters are often developmentally delayed and some become disabled. They seldom receive the health, nutrition, early childhood development services and the security they require to develop well and most need early intervention services.



- ***Children living in conflict and related areas***

Families with young children who live in conflict areas, communities with high levels of stress including violence and crime, refugee camps, internally displaced or living in camps or homes in isolation, usually have infants and children who are subjected to severe stresses that result in a wide range of developmental delays. Several thousands of young children are at high risk of becoming developmentally delayed. Recent research revealed that these children now carry genetic markers that will result in a propensity to intergenerational delays. Thus, every effort should be made to serve these highly vulnerable families and single mothers with young children.

- ***Domestic violence, child abuse and excessive punishment***

Although data are not available, some domestic violence is found in Myanmar. It often occurs among families who are stressed by poverty, conflict and community violence. Where domestic violence is found, infants and children become developmentally delayed, especially in social and emotional areas. Some children also become physically abused as well, and physical, sexual and emotional abuse cause children to become developmentally delayed in social and emotional areas. They may also become cognitively and language delayed due to their suffering. High levels of child abuse have been noted in some regions of Myanmar.

- ***Child neglect and low levels of parental/caregiver stimulation and care***

Neglect has been found to be even more injurious to children's development than abuse. It results in low levels of parental and caregiver stimulation and care. Children who are neglected become more developmentally delayed than those who are given negative attention. Abused children are also often loved and are given some positive as well as negative attention. Both child abuse and neglect can be overcome through parent education and support services. Throughout the world, it has been found that children with developmental delays and disabilities are more abused and neglected than children with typical development.

- ***Children of parents with mental health and related problems***

At present no statistical measures of parental mental health problems are available. They include maternal and paternal depression, maternal social isolation, a wide variety of mental health issues, and substance abuse, including prescription and street drugs, excessive alcohol consumption, tobacco and betel use, and compulsive gambling. All of these conditions can lead to infant and child developmental delays and disabilities. Studies are needed to identify families and populations with special mental health needs.

- ***Children living in inadequate housing, water, hygiene and sanitation***

Although major progress has been made to improve housing, water quality, household, ECCD and preschool hygiene and sanitation, much remains to be done. The MICS for 2009-2010 reports that improved drinking water sources serve 84.1% of the population and improved sanitation facilities are found in 77.3% of households. Rates are considerably lower in rural areas. Specialists working in Water, Sanitation and Hygiene find that more needs to be done to improve these services. Unclean water and poor sanitation cause high levels of infant and child morbidity, and when these conditions become chronic, children develop delays in many areas.

Estimate of early childhood developmental delays and disabilities

Myanmar lacks a national assessment of prevailing rates of developmental delays, disabilities and atypical behaviours in young children, and survey is urgently needed for purposes of appropriately planning and targeting ECI and related health, nutrition, sanitation, education and protection services.

However, by joining together rates of moderate to severe stunting (35.1%), childhood anaemia (64.6%), and the approximate rate of disabilities in children under five years of age (7%), it may be estimated that at least 42% to 45% of young Myanmar children and their families require ECI services.

The status of young children in Myanmar constitutes a national emergency. It is essential to develop a national ECI service system to improve child development, achieve human and disability rights, increase national workforce productivity, and reduce future costs for health, nutrition and remedial education.

2.5. Institutional resources and services

An array of institutions and services are available for some children with developmental delays, disabilities and behavioural disorders, mainly in urban areas. Efforts are underway to expand them as well as to fill major service gaps in both rural and urban areas.

Maternal and child health

Maternal and Child Health (MCH) is a priority of the Government of Myanmar. The Ministry of Health (MoH) provides essential MCH services through its many hospitals and health centres located throughout the nation. They provide the

following services: some preconception education and care; extensive antenatal care; the management of complications during pregnancy; deliveries conducted by trained physicians and midwives; HIV testing and antiretroviral treatment for mothers and children; services for Hepatitis B and Syphilis; extensive immunisation; childhood disease management for 0-5 year children, including hospitalisation, child oncology, and other services. Urban areas generally have greater health care coverage than rural areas. MoH is making a major effort to expand and improve MCH care very rapidly.

Neonatal period

Neonatal screenings

A few neonatal screens are applied in some hospitals that are mainly located in cities. It has been recommended that all hospitals and birthing centres conduct most, and eventually all, of the recommended screenings, including: jaundice; congenital hypothyroidism; anaemia; glucose-6-phosphate dehydrogenase deficiency (G6PD); visual and auditory capacity; galactosemia; phenylketonuria (PKU); and neonatal meningitis. Some of these screenings would be phased in before others.

Postnatal check ups, Newborn and child health care, well-baby check-ups

The MoH is increasingly providing guidance for newborn health checkups as well as home visits offered by health volunteers. General paediatricians, family doctors, general physicians, midwives, and nurses provide paediatric care services at the primary care level for children 0-5 years of age. Developmental paediatricians are rarely found in Myanmar. Immunization is the most widely used child health service, and greatly increased immunisation coverage has been achieved. Regular well-baby check-ups should be required during the first year of life during services administered by primary health care providers, and they could be combined with immunisations.

Universal child developmental monitoring, surveillance and screening

No national programme currently exists for universal developmental screening, monitoring and surveillance from birth to three or five years of age. Monitoring and screening should be included in all paediatric service packages provided by public and private sector clinics. Some Myanmar physicians already conduct monitoring and surveillance activities. In addition, other persons can be trained to conduct developmental screenings, such as community volunteers, nurses, midwives and preschool teachers. Screening services using the Ages and Stages Questionnaire III (ASQ III) and ASQ-Social Emotional II (ASW-SE II) are currently being established in Myanmar. Several trainers of trainers in screening have



been prepared. A universal system of surveillance and screening for children 0 to 3 years of age and up to 5 years of age is being designed, along with incentives, monitoring and annual reporting and planning mechanisms.

Rehabilitation resources

Various specialised Government services are available for children with special health conditions, including physical rehabilitation, assistive technologies, and some mental health services. Centre-based rehabilitation services and some community-based rehabilitation work are provided through rehabilitation hospitals, clinics and NGOs such as The Leprosy Mission of Myanmar (TLMM), New World Therapeutic Centre, EDEN Centre for Disabled Children, Myanmar Maternal and Child Welfare Association plus a variety private providers. More rehabilitation hospital services are needed as well as home-based early childhood intervention services.

Special schools for children with disabilities

To date, the nation has focused mainly on the provision of centre-based rehabilitation, with both government schools and NGOs establishing “special schools” for children with disabilities. They rarely include children with developmental delays, and yet they to need attention. Most of these schools mainly serve children over five years of age and they almost never serve children under three years of age. In addition they lack a standardised curriculum, in part because no national standards for special education currently exist. They rarely use comprehensive developmental curriculums based on Universal Design for Learning (UDL), and they lack transition programmes from special preschools into inclusive primary education programmes.

ECCD and ECI Resources

Hundreds of ECCD programmes have been developed in Myanmar (UNICEF, 2012). However, these programmes rarely serve children with disabilities. This situation is beginning to change.

Currently, MoSWRR is planning ECI services, with strong support from other ministries and UNICEF. As yet, no ECI services are provided in Myanmar. With over 40% of the nation's children requiring services, the provision of a national ECI programme is urgently needed.

Deinstitutionalisation and the emergence of new needs for ECI services

Many nations have discovered that in order to deinstitutionalise young children, it is essential to provide ECI services to families receiving these children. They have found that it is essential to support parents who receive children with special needs, including their developmental, health, nutrition and educational needs. ECI services are essential for the wellbeing and good development of children with delays and disabilities and their families.

2.6 ECI human resources

One of the major challenges will be the development of an adequate supply of trained human resources for ECI services, including both professional and para-professional personnel. Myanmar is fortunate to have many universities, physicians, nurses, midwives, psychologists, and social workers. Skilled neuro-paediatricians and physiotherapists are available; however, the latter are rarely trained to serve young children and they require additional training.

The following types of specialists are needed: early intervention specialists (a new field for Myanmar); paraprofessional home visitors; speech/language therapists; occupational therapists; additional social workers; developmental paediatricians; nutritionists; special educators to serve children with severe mental retardation and other disabilities; trainers of trainers; and ECI service managers, supervisors, planners, evaluators and researchers.

2.7 Education and training resources for ECI services

Currently limited resources are available for training ECI professionals in various new specialties in Myanmar. As yet, no university-level education programme has been developed to provide degree-level programmes to prepare early intervention specialists, although some are in the planning stages. No official certification and recertification system for early intervention specialists has been designed as yet. In addition, pre- and in-service training will be required for paraprofessional home visitors who would work under the supervision of early intervention specialists and other ECI professionals.

Interim pre-service training arrangements are needed until ECI training programmes can be established at the university level. The most efficient resource for training early intervention specialists may be faculties of psychology at several universities in various regions. In addition a strong in-service training programme will be needed for ECI services throughout Myanmar.

National and international support for ECI services in Myanmar

The following ministries have expressed support for ECI services: MoSWRR; MoH; MoE; Ministry of Finance; Ministry of Home Affairs; Ministry of Planning and Economic Affairs; Ministry of Border Affairs; Ministry of Information; and others. In addition, regional leaders and ministries have stated their strong support for ECI services. However, as yet MoSWRR has not developed a solid budgetary framework for piloting and then expanding ECI services throughout the nation.

International support will be critically important for the planning, preparation, and piloting of ECI services. At present, UNICEF has helped with initial planning stages and is poised to continue providing support as funds become available. International NGOs are providing important support, and it is hoped that other international donors will step forward.

2.8 Policy Analysis

International conventions and other normative legal instruments

Convention on the Rights of the Child and related documents

On 15 July 1991, Myanmar ratified the *Convention on the Rights of the Child* (CRC). The United Nation's *General Comment 7, Implementing Child Rights in Early Childhood*, further strengthens national requirements for ensuring young children receive their full rights (United Nations, 2006; Bernard van Leer, 2006). These instruments established the right of children to receive comprehensive early childhood care and development services, including ECI services. This National Strategic Plan is primarily based on these international normative documents as well as Strategic Priority 3 for ECI of the National ECCD Policy of Myanmar.

Myanmar has also signed *the Optional Protocol to the Convention of the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* in 2012; the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *Convention Against Transnational Organised Crime*; and the *Protocol Against the Smuggling of Migrants by Land, Sea and Air*, also supplementing the same Convention. Because ECI services will support many types of vulnerable children these documents will be relevant to future ECI plans. Myanmar adheres to the declaration of *A World Fit for Children* that was adopted in 2002 during a Special Session of the UN General Assembly.



This declaration set priorities including the promotion of healthy lifestyles and the provision of high-quality education for every child, beginning in early childhood.

Millennium Development Goals and the Sustainable Development Goals

The *UN Millennium Development Goals*, adopted in 2000 by 189 nations including Myanmar, provided a set of measurable, time-limited global goals for overcoming poverty, famine, diseases and illiteracy by 2015. Early childhood will be included in Target 4.2 of The Sustainable Development Goals that are being established in 2015, and they will replace the UN Millennium Development goals. Target 4.2 will be related to early childhood development (United Nations, 2015).

Education declarations at the international level

In 2000, Myanmar was a signatory to the *Dakar Framework for Action for Attaining Education for All* (EFA) that included Goal 1 that called for "expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children." In 2015, the *Framework for Action Education: Towards inclusive and equitable quality education and lifelong learning for all* was issued in Incheon, Republic of Korea as the successor to the Dakar Framework.

Target 4.2, of both the Incheon Framework and the Sustainable Development Goals, replaces EFA Goal 1. It states: "By 2030, ensure that all girls and boys will have access to quality early childhood development, care and pre-primary (pre-school) education so that they are ready for primary education."

The ECI Strategic Plan will enable Myanmar to achieve Target 4.2 given its emphasis on maximising the development of all children, including those who are at risk or have a disability, developmental delay or other eligible condition.

International disability documents

The Salamanca Statement (UNESCO, 1994) called for formal education institutions to find ways to educate all children from preschool onward, including those with developmental delays and disabilities. On 7 December 2011, Myanmar ratified the *Convention on the Rights of Persons with Disabilities* but it has not yet ratified its *Optional Protocol*. Myanmar is dedicated to disability rights, and most especially, to serving children with developmental delays and disabilities and to identifying them as soon as possible from birth onward to ensure they will receive essential services for child development and health care. Myanmar is also committed to providing early childhood intervention services as well as inclusive preschool, kindergarten, primary and secondary education for children with special needs.

Discrimination Against Women

The status of women is closely linked to the status of children. Myanmar ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) on 22 July 1997, with the exception of Article 29 dealing with arbitration. CEDAW contains provisions that refer to protecting pregnant women and mothers and to the importance of developing policies related to the rights of children and their parents. The ECI Strategic Plan will be important for ensuring the rights of pregnant women, mothers, and young girl children.



Additional relevant normative documents

In addition, with respect to human rights treaties, Myanmar signed the *Charter of the Association of the Southeast Asian Nations (ASEAN)* in 2008. Myanmar also signed the *Vienna Declaration and Programme of Action*, at the World Conference on Human Rights in 1993; the *Durban Declaration and Programme of Action*, from the World Conference Against Racism in 2001; the *Universal Declaration on the Eradication of Hunger and Malnutrition*, from the World Food Conference 1974; and the *Declaration of the Commitment on HIV/AIDS*, from the United Nations General Assembly Special Session on HIV/AIDS in 2001.

Selected national policies and procedures related to ECI services

The National Constitution of Myanmar states that “*The Union shall care for mothers and children, (...) and the disabled*” and that every citizen has a right to education, protection, and health care.” These statements are strengthened by the corresponding statements within The Public Health Law (1972) and the Social Security Law (2012) provide a legislative basis for expanding access to health care, social protection and related benefit packages.

Strategy Three of the *National Policy for Early Childhood Care and Development* (2014) establishes the policy mandate for developing the National ECI Strategic Plan. The Ministry of Social Welfare, Relief and Resettlement (MoSWRR), the Ministry of Health (MoH), and the Ministry of Education (MoE) agreed to collaborate to develop the National ECI System.

The Law on the Rights of Persons with Disabilities (2015) stated, “*Every disabled child – must have the opportunities to get education including the early childhood nurturing and life skills*” and the MoSWRR was asked to ensure these services would be provided.

The Myanmar Situation Analysis of Children with Disabilities, 2016, calls for the:

- Establishment of early identification services;
- Individualised and intensive early childhood intervention services;
- Development of an early childhood intervention system by the Department of Social Welfare; and
- Inclusion of children with disabilities in all educational institutions, including preschools.

Furthermore, it states, “*The MoSWRR (DSW), in close partnership with the Ministry of Education and the Ministry of Health, should develop national guidelines and systems for the early identification and registration of persons with disabilities that are in accordance with the UNCRPD and use protocols compliant with the International Classification of Functioning (ICF). The system should be compatible with e-platform technologies and gather data in real-time to inform*

evidence-based planning and resource allocation as well as the monitoring of expenditures."

Upcoming legislation is expected to reinforce the importance of inclusive preschool, kindergarten and primary school, thereby ensuring that children with developmental delays, disabilities and behavioural disorders will be able to join typically developing children in all schools. Depending upon the decision of parents, a limited number of children with severe disabilities or perceptual limitations (visual or auditory) may continue to be placed in separate and specialised schools.

2.9 Recommendations

The following recommendations are based on the findings of this situation analysis.

- Ensure the highest level of Government commitment for the development, funding and full implementation of ECI services on a phased basis throughout Myanmar for children requiring intensive and individualised attention for developmental delays, malnutrition, chronic illnesses, disabilities, behavioural disorders, rehabilitation and other interventions;
- Develop and adopt a National ECI strategy and the Action Plan;
- Develop an ECI organisational structure with processes for planning, implementation, coordination, supervisory and accountability to ensure programme sustainability;
- Develop and officially approve a national regulatory framework for ECI services in Myanmar, including ECI Programme Guidelines and Procedures and ECI service and personnel standards that are tied to a com-



prehensive monitoring and evaluation system;

- Ensure strong ECI advocacy at policy, regional and community levels, as well as effective communications activities;
- Develop a nationwide universal developmental screening, monitoring and surveillance system, involving parents and paraprofessionals as well as professionals;
- Conduct, monitor and evaluate initial ECI service activities in selected Pilot Sites;
- Develop subsequently at least one ECI service provider site in each region, with phased expansion to all municipalities;
- Promote support for ECI services the regional/state and municipal levels;
- Develop short-term and long-term training programmes for the preparation of essential professionals and paraprofessionals for the National ECI System;
- Prepare a training programme for Early Intervention Specialists (EIS) as a specialisation requiring Bachelor's degree and for some, a Master's level education;
- Establish university-level education programmes for speech/language therapists, occupational therapists and physical therapists who will serve children from birth to five years of age, and other specialties as required;
- Provide high-quality in-service training programmes and distance learning programmes for professionals and paraprofessionals;
- Develop a strategy for recruiting and training volunteers at the community level during the expansion of services to new regions and districts of the country;
- Design a national ECI supervisory, monitoring and evaluation system that is targeted at ensuring continuous quality assurance and improvement;
- Develop a costing and budgeting system for ECI services at all levels, from central to regional and municipal levels;
- Establish an ECI research capacity, including conducting population-based surveys on developmental delays, disabilities and other needs;
- Build a multi-year, cost-effective plan for the national financing of ECI services; and
- Strengthen collaboration with international development partners to ensure the continued provision of technical and financial support for ECI programme development in Myanmar.

ECI VISION AND MISSION STATEMENT

3



3. ECI Vision and Mission Statement

The National ECI System of Myanmar is designed to achieve the following Vision

ECI Vision Statement

All of Myanmar's vulnerable children from birth to five years of age with developmental delays, malnutrition, disabilities and other special needs are able to access high-quality ECI services in order to enjoy their rights and achieve their full developmental potential.

To achieve this Vision, the Mission of ECI services in Myanmar uses a coordinated, comprehensive and intersectoral approach, including especially the child welfare, health, nutrition, and education sectors.

Mission Statement of the National ECI System

The Mission of the National ECI System is to:

- Conduct advocacy, communications for development and awareness activities for all families, communities, stakeholders and decision makers.
- Ensure strong coordination among all relevant ministries, State and Regional Governments, and townships and their partner agencies for implementing ECI services including: governmental, non-governmental, faith-based and community-based organisations, private sector agencies, higher education institutions, and professional associations.
- Develop strong linkages and inter-agency agreements with services in the ECCD Policy and other policies and plans related to child health, mental health, nutrition, sanitation, education and protection.
- Screen all children from birth to 5 years of age and identify all high-risk children who may be eligible for ECI services.
- With their parents' full agreement and participation, refer them to ECI services where transdisciplinary teams, including the parents, will conduct standardised assessments, establish programme eligibility and develop individualised service plans.
- Provide ECI services in the natural environment of the child that build on the strengths and meet the needs of each child and family.
- Plan and progressively provide high-quality and individualised ECI services for eligible children in all regions of Myanmar.
- Facilitate children's learning and development within their families and communities.

- Build on the strengths of families of children with special needs and assist them to provide enabling, stimulating and safe environments that meet their needs and those of their children.
- Ensure that children enrolled in ECI services will transition from those services to inclusive preschools, kindergartens, primary schools, and will be fully included within society.

ECI CORE CONCEPTS AND PRINCIPLES

4



4. ECI Core Concepts and Principles

The following core concepts and principles will guide ECI services in all 21 States, Regions and Self-Administered Areas of Myanmar:

Equity and parental and child rights

- Children and families of all income levels whose children are eligible for ECI services are welcome to receive them.
- Child and parental rights to give consent for the provision of services and to protect the privacy and confidentiality of family records and files are fully respected.
- Families are encouraged to help identify children with special needs, volunteer for local ECI services, and conduct fundraising activities to provide additional support to meet special ECI service needs.
- After screening, all children identified to be potentially eligible for ECI services are referred for assessment, and decisions are made regarding programme eligibility
- For children who are screened and found to be ineligible for ECI services, referrals are made to other collaborating services for early childhood and family development, and some children are re-screened after a designated number of months.
- All ECI services are free-of-charge to all eligible children and their mothers and fathers or legal guardians.
- Children and families of all ethnicities of Myanmar are welcome to access and fully benefit from culturally appropriate ECI services.
- Children affected and traumatised by natural disasters and other emergency circumstances receive immediate ECI services as well as other social welfare support.
- All ECI personnel are thoroughly trained in and follow all guidelines for child and parental privacy rights, confidentiality and informed parental consent.
- Through ECI services and collaborating ECCD services, a “continuity of care” is provided for children from birth to five years of age.
- ECI services provide counselling for family preservation and work to end the institutionalisation of young children from birth to five years of age in order to prevent children from becoming developmentally delayed in institutional settings.

- Special attention is given to children who have been placed in institutions, with the goal of arranging for a family placement.
- Similarly, ECI services support fathers, mothers and substitute parents who receive children from orphanages in order that the children may overcome their delays and disabilities, and benefit from loving, nurturing and stimulating care provided in a family setting.
- ECI services are based on building trust with each family through respecting the family's culture, language, values, attitudes and ways of coping with adversity.
- ECI services actively assist parents and children to understand and achieve their rights, and they ensure child, parental and human rights are fully attained.
- The roles of both participating parents and ECI service providers are always fully transparent.

Child-centred, family-focused and community-based

- All ECI services are consistently child-centred and based on each child's strengths and abilities as well as his or her next areas for growth and development.
- Every effort is made to identify children requiring ECI services either at birth or as soon after birth as possible, and definitely before 36 months of age.
- All ECI services are developmentally appropriate through being in line with each child's assessed needs, age and stage of development.
- All children are unique and develop in different ways; therefore, all ECI services are individualised and are at the level of intensity and duration that each child and family require.
- Child-centred and family-focused ECI services are structured around the daily routines of the child.
- All ECI services are family-focussed, defining "family" to include a wide variety of diverse family structures, including extended families, legal guardians, grandparents and others who live in the family home.
- Parents may request that regular child caregivers or teachers in inclusive preschools or other child care settings be included in service visits.
- ECI service offices are community-based; they are located in community settings where parents and other families can easily access them and service personnel can make regular home visits to programme families.

Intersectoral and interdisciplinary pre- and in-service training

- Because ECI services are intersectoral and interdisciplinary, all ECI personnel are trained in child protection, education, health and nutrition as well as in a variety of specialised fields.
- Pre- and in-service training is provided to prepare several categories of specialists, including early intervention specialists (a new interdisciplinary field in Myanmar) and speech/language therapists (new), occupational therapists (new) and physiotherapists who learn about activities to do with children and parents from birth to 60 months of age, and up to 72 months of age to cover the transition period.
- In addition, training includes other professionals, who add ECI services to their existing professional development, including: psychologists, social workers, physicians, nurses, midwives, and others.
- For the ECI system, planners, supervisors, managers, trainers of trainers, and other support staff receive special pre- and in-service training at the MA level.
- All ECI professionals are thoroughly trained in ECI concepts and principles, the development and functioning of transdisciplinary teams, programme guidelines and procedures, screening methods, conducting assessments, developing individualised service plans, conducting monitoring and evaluation, and other topics.
- Paraprofessionals are carefully selected, given pre- and continuous in-service training and well supervised and mentored to ensure they make high-quality home visits and support families well.
- All home visitors are trained to provide culturally appropriate home visits in the home languages of the families.
- To ensure ECI services are high in quality, equitable and accountable, ECI supervisors are trained to provide reflective supervision, coaching and mentoring, conduct in-service training, and carry out essential monitoring and evaluation activities during each visit to the field.
- All ECI personnel are trained to work in teams and to respect and earn the trust of families.

Comprehensive, balanced and transdisciplinary services

- Through community, health and home outreach activities, all children in Myanmar receive developmental surveillance and screening; referrals, as needed, to ECI services for assessment to establish programme eligibility; an Individualised Service Plan; regular ECI services; and a comprehensive transition plan.

- ECI services are comprehensive, coordinated, integrated, transdisciplinary and intersectoral, including the full participation of the social welfare, health and education sectors.
- ECI services are balanced, addressing the area of the child's developmental delay, malnutrition, chronic illness or disease, disability or atypical behaviour and also all other areas of child development in order to ensure well-rounded child development.
- Every child enrolled in ECI services has a local health care service and receives all expected nutrition and preventive and primary health care services.
- Attention is also given to helping parents assess and improve the environmental stimulation, safety and hygiene of their home and its community setting.
- ECI services feature the use of transdisciplinary teams, including professionals specialised in each child's strengths and special needs.
- All ECI services are culturally appropriate through ensuring the use of the home language as well as respecting each family's cultural ideals for good child care and development.
- An ECI Code of Conduct guides the behaviour of ECI personnel, and ECI programme managers and supervisors use this Code of Conduct as an important element in the review of personnel performance.

Focus on the natural environments of the child and full parental participation

- ECI services are conducted with the child and his or her parents and caregivers in the natural environment of the home in order to maximise child development through the provision of consistent nurturing care and activities.
- ECI services use the natural daily routines of mothers, fathers and caregivers with children, such as bathing, dressing feeding, changing, shopping, playing and going to bed in order to maximise the provision of learning opportunities for the good development of young children with special needs.
- When preferred by the family, visits are conducted with parents and caregivers in community centres for child care and development and in preschools.
- Parents are empowered to advocate for their child, and as full partners, to establish and officially approve the goals for their child's development.

- Parents guide the development of their children and are free to select the ECI services that they and their child will receive.
- ECI services create partnerships between parents, professionals and home visitors for purposes of conducting comprehensive and timely assessments and for preparing, implementing and reviewing Individualised Service Plans that are responsive to parents' priorities for their children and families.
- Individualised Service Plans are based on the child's strengths and next developmental steps in all areas of child development, including the senses, physical, hand-eye coordination, mental (cognitive), language, social and emotional development, including self care.
- With the agreement of the parents, Individualised Service Plans also include special areas of family development, such as parenting skills, home safety and hygiene, health and nutrition care and child or family protection issues.
- Parents are always involved in all activities with their children; professionals never work directly with children without the full participation of the parents and/or a designated child caregiver.

Support for transition of child and family to future inclusive services

- ECI services prepare parents and children for completing the ECI programme when they have achieved age-appropriate level of development and they have fully consolidated their gains.
- ECI services prepare parents and children for programme transition from three (3) to five (5) years of age to inclusive preschool, kindergarten or primary school services, with an emphasis upon developing barrier-free and supportive environments for children with disabilities.
- Children will be transitioned to special schools only upon the request of parents and after they have assessed the capacity of their children to interact with other children.
- Research has shown that virtually all children learn best through learning and playing with children of all abilities around them.
- ECI services strongly promote the inclusion of children participating in ECI services in all educational, health and social environments.

Intersectoral coordination and collaboration

- As they are established in each Township, ECI services promote the development of Township ECI Committees and informal parent support groups.



- Township ECI Committees are progressively linked with Township Committees on the Convention on the Rights of the Child (CRC) and other Township Committees present in each Township.

- All ECI services establish formal systems of coordination and good collaboration with educational, health, nutritional, social welfare and protective services, at all levels of Government, and with national and international non-governmental, faith-based and community-based organisations, private sector services, institutions of higher education and professional associations.

- Effective intersectoral coordination and collaboration benefit each child and family and help to ensure that comprehensive child-centred and family-focused services become fully sustainable.

- To develop good intersectoral and interagency coordination, a robust and well-organised system of referrals to and from other social services is developed and carefully monitored to ensure children and families receive the complementary services they require, as those services become progressively available over time.

- ECI services develop a continuous system of supervision, in-service training, and data collection for monitoring, evaluation and child tracking in order to ensure the provision of well-planned, high-quality, equitable, and fully accountable and transparent services.
- Each year, parents and other programme participants evaluate the quality and effectiveness of local ECI services, and they provide their evaluation reports to regional and national ECI managers who use them to strengthen and recognise the achievements of local services, as appropriate.
- A limited number of research projects essential to planning and evaluating ECI services are conducted.
- To ensure the long-term sustainability of ECI services, attention is given to policy and programme advocacy, annual financial planning and budgeting at all levels, continuous pre- and in-service training, the provision of service and personnel standards, and effective supervision, monitoring and evaluation.

ECI PRIMARY GOALS AND OBJECTIVES

5



5. ECI Primary Goals and Objectives

Primary Goals of the National ECI System

ECI services will identify, screen and assess vulnerable children, with parents and professionals working together to achieve balanced child development through implementing individualised service plans to create stimulating, safe, protected and hygienic home environments.

- ECI services will be designed and prepared from 2015 to 2017.
- Pilot projects will be implemented in three Regions or States during 2017-2018.
- Through continuously expanding ECI services, by 2021 all 21 States, Regions and Self-Administered Areas will have begun some ECI services.
- By 2025, all vulnerable children in communities of all Townships will be served.

To achieve these Primary Goals, the following National ECI Objectives will be attained:

National ECI Objectives

Objective 1: Gain the support of national, regional and local decision makers, stakeholders, parents and community members for the development and provision of ECI services in all 21 States, Regions and Self-Administered Areas of Myanmar.

Objective 2: Ensure that all infants and children are screened, and those who are believed to be eligible for ECI services are identified and referred to ECI services for assessment, establishing eligibility and service provision.

Objective 3: Improve the developmental status and well being of vulnerable infants and children from birth to five years of age who are eligible for ECI services through designing and implementing high-quality ECI services, and ensure a good transition to inclusive preschool, kindergarten or primary school.

Objective 4: Ensure all ECI personnel are well trained, skilled and competent, ECI professionals are fully certified, and all ECI programmes are well supervised.

Objective 5: Ensure 21 States, Regions and Self-Administered Areas of Myanmar establish some ECI services by 2021, and prepare a plan to provide ECI services in all Townships by 2025.

Objective 6: Ensure all ECI services are fully accountable through implementing a comprehensive ECI Management Information System and related evaluation and research activities.

Objective 7: Establish a “continuum of care” for vulnerable children through the development of effective intersectoral and interagency collaboration and coordination.

Objective 8: Develop a well-organised, sustainable, high-quality and well-funded national ECI system of services.

ECI STRATEGIC PRIORITIES



6. ECI Strategic Priorities

In order to achieve the Goals and Objectives of the ECI Strategic Plan, the following Strategic Priorities will be pursued. The eight Strategic Priorities are listed by theme.

<i>ECI Strategic Priorities</i>
<p>Strategic Priority 1 on Advocacy, Communications and Awareness</p> <p>Conduct Coordinated ECI Advocacy and Communications Campaigns, with communications messages and awareness activities at the highest levels and at all State, Regional and grassroots levels to build support for the nationwide development of ECI services.</p>
<p>Strategic Priority 2 on Community Outreach, Developmental Screening and Referrals</p> <p>Ensure the provision of ECI services for special needs children and children at high risk of developmental delays through conducting community outreach and universal screening services combined with referrals for assessments and ECI services, as needed.</p>
<p>Strategic Priority 3 on ECI Service Development</p> <p>Design and implement ECI programme services that are home-based and comprehensive by means of establishing: ECI Programme Guidelines and Procedures; child and family assessments; transdisciplinary teams including parents and other caregivers; Individualised Service Plans; culturally appropriate curricula and home visiting methods; individualised services for children, families and caregivers; plans for programme completion or transition; and ECI service standards.</p>
<p>Strategic Priority 4 on Pre- and In-Service Personnel Training and Development</p> <p>Provide pre-service training and continuous in-service training and mentoring to ensure the preparation of competent ECI administrators, supervisors, professionals, paraprofessionals and volunteers, including the establishment of selection criteria, roles and responsibilities, personnel standards, certification, recertification, career ladders and salary scales.</p>



Strategic Priority 5 on Establishment and Phased Expansion of ECI Services

Develop a phased plan for service implementation, with the goal of establishing ECI services in all 21 States, Regions and Self-Administered Areas by 2021 and in communities of all Townships by 2025.

Strategic Priority 6 on ECI Programme Accountability

Develop an ECI Management Information System, which includes child tracking, child and family files, monitoring, evaluation, reporting and research linked to continuous programme planning.

Strategic Priority 7 on Intersectoral Collaboration and Coordination

Provide an effective “continuum of care” for all children enrolled in ECI services, through conducting intersectoral collaboration and coordination, referrals to health, nutritional and protection services, and transitions to inclusive preschools, kindergartens and primary schools.

Strategic Priority 8 on the ECI Organisational Structure

Develop a robust ECI organisational structure, with effective and timely processes for planning and coordination that include the Community, Township, District, State, Regional and Union levels.

7 ECI ACTIVITIES AND SERVICES



7. ECI Activities and Services

In order to achieve the goals and objectives of the National ECI System, a series of activities and services will be conducted under each strategic priority. The contents of each strategic priority are presented below.

Strategic Priority 1 on Advocacy, Communications and Awareness

Conduct Coordinated ECI Advocacy and Communications Campaigns, with communications messages and awareness activities at the highest levels and at all State, Regional and grassroots levels to build support for the nationwide development of ECI services.

1.1 Technical Group for ECI Advocacy, Communications and Awareness

MoSWRR will collaborate with MoHS, MoE, MoHA, MoPF, MoL, MoBA, and MoI as well as with leading ECI specialists from national and international NGOs, FBOs and CBOs and private sector institutions to establish a strong and dynamic Technical Group for ECI Advocacy, Communications and Awareness. As possible, media and IT specialists and volunteer students in communications will support the Technical Group.

Members of the Technical Group will draft their terms of reference (TOR). The TOR will be based on the ECI Strategic Plan and Action Plan. A final version of the TOR will be prepared and approved by MoSWRR.

Initially, the Technical Group for ECI Advocacy, Communications and Awareness will meet bi-weekly in order to develop its first National ECI Advocacy and Communications Plan. Subsequently, depending upon needs, biweekly or monthly meetings will be held to implement their plans.

1.2 Annual Plans for National ECI Advocacy and Communications to conduct Coordinated ECI Advocacy, Communications and Awareness Campaigns

Annual National ECI Advocacy and Communications Plans will be prepared to conduct Coordinated ECI Advocacy, Communications and Awareness Campaigns, select communications messages, and implement nationwide, regional, township and community advocacy as well as communications for development and awareness activities.

The first National ECI Advocacy and Communications Plan will be developed and implemented for the period from June to December 2017.

Initially, special attention will be given to policy advocacy at national and regional levels in order to inform and engage leaders at the highest levels. Advocacy, communications for development and awareness activities at grassroots levels will also be essential to build support for the nationwide development of ECI services and to inform communities, parents and service providers about the importance and benefits of ECI. On a phased basis, advocacy, communications for development, and awareness activities will be implemented throughout the country.

All types of media will be used in Coordinated ECI Advocacy and Communications Campaigns including phone-based social media, Internet, television, radio, cultural events and print media (banners, handouts, pamphlets, and posters). Media campaigns will select famous musicians, actors and others as “champions for ECI.”

1.3 Development of Policy Briefs for leaders at national regional, district, township and community levels, the ECI website, and ECI telephone applications

In order to reach successive groups of decision makers and other leaders at national, regional, township and community levels, ECI Policy Briefs will be drafted from different perspectives for decision makers and circulated widely. Each year at least four Policy Briefs will be prepared on priority topics, preferably on a quarterly basis.

A national ECI website will be designed, developed and maintained for parents, professionals, paraprofessionals, and ECI sites. The Policy Briefs will be placed on the website, along with ECI Programme Guidelines and Procedures, information and an ECI booklet for parents and families, service and personnel standards, screening information, announcements, a calendar of events, training opportunities, job openings and other matters. The National ECI Office will keep the website up-to-date on a monthly basis at a minimum.



A telephone application for ECI professionals and paraprofessionals will be developed, updated and maintained monthly to maintain close communications with them, and provide in-service training and support their fieldwork.

1.4 Training for librarians on ECI services and development of collaborations between

libraries and ECI Service Sites

A training module will be developed for librarians at the Township level. It will include information about ECI services and will encourage collaboration between libraries and ECI services in each Township as they are progressively established through the nation.

Training will be given in all nine Pilot Sites with a special focus on supporting libraries' plans to become community centres for children and parents. This important collaboration will support good child development, parenting education and the lifelong learning of parents.

1.5 Provision of stakeholder awareness training sessions at the regional, township and community levels

Upon the invitation of local authorities of Communities, Townships and nearby Townships where ECI services will be developed, brief and high-impact stakeholder awareness training sessions about ECI services will be designed and held. They will also promote positive community attitudes and behaviours regarding children with developmental delays and disabilities.

Stakeholder awareness training sessions will be provided in all 21 States, Regions and Self-Administered Areas by 2018 in preparation for the introduction of ECI services in all States, Regions and Self-Administered Areas by 2019-2021. These awareness training sessions will seek to develop new and positive behaviours and attitudes on the part of local ECI stakeholders, including: parents, teachers and other service providers, local community and Township leaders, higher authorities as present, religious leaders, journalists and others.

1.6 Preparation and application of information and awareness module on ECI services for child development and disability NGOs, FBOs, CBOs and professional associations

Because ECI is a new social development service in Myanmar, an information and awareness module will be prepared specifically for professional associations, child development and disability agencies, associations, and groups, with the twin goals of building strong support for ECI services and forging sustainable linkages between ECI services and those entities.

The information and awareness module will be offered to all of these entities

during 2017-2018, with the goal of conducting related training activities in all 21 States, Regions and Self-Administered Areas by December 2018. Training will also be offered annually because personnel turnover is significant in Myanmar. The module may include posters, pamphlets and booklets.

1.7 Development of a communications strategy to support the expansion of ECI services at all levels, including vertical and horizontal communications for sharing innovations and lessons learned

A communications strategy will be developed during 2017 for use during the training period for Pilot Sites from October to December 2017. Subsequently it will be applied during the 2018 Pilot Site Year.

In 2018, as ECI services expand from the initial Township Pilot Sites in three States and Regions to additional service sites in those same States and Regions, the communications strategy will be needed.

In addition, using this communications strategy, ECI services will progressively be introduced in other States, Regions and Self-Administered Areas. The strategy will promote vertical and horizontal communications among ECI Service Sites for sharing local innovations and lessons learned.

1.8 Assessment of effectiveness of ECI advocacy, communications and awareness activities

In order to assess the effectiveness of selected ECI advocacy, communications and awareness activities, rapid monitoring and evaluation processes will be developed. These assessments will address topics such: communications processes; outreach effectiveness; retention of messages; balanced attention to gender roles to encourage good fathering and mothering; and impacts of main messages as measured by attitudinal and possibly behavioural changes.

Each year, for a discrete list of advocacy, communications and awareness activities, rapid monitoring and evaluation activities will be developed. This will include the development, testing, revision and application of easy-to-use instruments and guides as well as the development of a central database. In addition, focus groups and interviews will be designed and held.

Strategic Priority 2 on Community Outreach, Developmental Screening and Referrals

Ensure the provision of ECI services for special needs children and children at high risk of developmental delays through conducting community outreach and universal screening services combined with referrals for assessments and ECI services, as needed.

2.1 Preparation of Technical Group for Community Outreach, Developmental Screening and Referrals

A Technical Group for Community Outreach, Developmental Screening and Referrals will be established to develop and oversee community outreach and developmental screening, and the ECI referral system linked to health, nutrition, sanitation, education, protection and other social welfare services.

The TOR and Work Plan will be prepared and followed in order to meet all of the Technical Group's objectives.

2.2 Plan for Developmental Screening Programme

In order to ensure the provision of ECI services for special needs children and children at high risk of developmental delays, it is essential to conduct universal screening services to identify children with developmental delays, disabilities, malnutrition, chronic illnesses, fragile birth status, atypical behaviours and other high-risk situations. Screening services will include a system for making referrals to ECI services for child development assessments and other services, as needed. This system will be harmonised with the social work referral system that MoSWRR specialists are currently developing.

To be effective, developmental screening tools must be translated and adapted to local cultures. After initial piloting in Pilot Sites, they should be validated to ensure they are fully capable of identifying children with conditions that would make them eligible for receiving ECI services.

The overall Plan for the ECI Developmental Screening Programme will be prepared by April 2017, well before the establishment of ECI Pilot Sites in late 2017.

The Plan will include the following sections, at a minimum:

- Outreach and awareness activities for developmental screening in each participating Township (See 1.11)
- Selection, translation, adaptation, trial training, application and evaluation of screening instrument(s) in all Pilot Sites;
- Evaluation results reviewed, and screening instruments and training modules revised as needed;
- Finalisation of the training module for training screeners;
- Development of the referral system, a referral pathway, and forms for referring children and families to ECI services for assessment, eligibility decision, and regular ECI services;
- Development of a list of screening times for each child considered to be possibly at risk for developmental delays but who does not appear to have them as yet; and

- Creation of a list of other services for young children and parents who would benefit from receiving general ECCD services.

After the Pilot Year, the revised screening instruments will be validated for Myanmar using a larger sample of children.

2.3 Selection, translation and adaptation of easy-to-use instruments for developmental screening

A Technical Group for ECI Screening and Assessment will be established, and an international consultant with extensive experience in developmental screening will assist the Technical Group.

One of the first and most important activities of the Technical Group for ECI Screening and Assessment will be the phased development of a national system for universal developmental screening, including the identification of easy-to-use developmental screening instruments. It will be essential to translate and adapt the screening instruments and guides to the Myanmar language, and then field test and revise the materials. As additional languages are selected for use during the Pilot period, the screening instruments will be translated and adapted to those languages and cultures.

Progressively, additional versions of the screening tools will be developed to ensure the inclusion of all ethnic and linguistic groups of Myanmar. After the Pilot Site year, it is anticipated that many more ethnic and linguistic groups will be served and the screening tools, forms and guides will be translated and adapted rapidly for use in additional Townships, States, Regions and Self-Administered Areas after 2017 until national level coverage is attained.

2.4 Development of a referral system, guidelines for parental rights including privacy and informed consent, and initial intake forms and procedures

Once children have been screened and are judged to be potentially eligible for ECI services, they will be referred to ECI services. The system for referral and the guidelines for parental rights will be prepared, including privacy and informed parental consent for referral. Referral forms and rules for prompt response will be designed and put into place. These rules will be stated in specific sections of the ECI Programme Guidelines and Procedures, along with forms for referral and initial programme intake activities, as provided in the ECI Monitoring and Referral Manual.

Records will be kept of all children who have been screened as well as those who will be referred for assessment and initial ECI programme intake. Many children will be found not to be at risk or not to have a developmental delay, disability or

atypical behaviour, and they will be referred to general ECCD services and other available programmes for children and families in each locale.

As ECI services are established in each region, a handbook will be developed listing all available local and regional service programmes and resources for children and families. The handbook will be updated annually and it will also be placed on the ECI website.

Children, who have been screened and are not found to be potentially eligible for ECI services and yet are at some level of environmental or biological risk for developing delays, will be followed-up on a regular basis (at least each six months, and in some cases each three months) until the each child attains 36 months of age. After that, to ensure the child continues to develop well, follow-up screenings will be conducted annually until the child reaches 60 months of age. All children with a potentially eligible condition will be referred to ECI services for assessment as they become available in each Township.



2.5 Selection and training of professionals, personnel of governmental, non-governmental, faith-based and community-based organisations, paraprofessionals and community volunteers in developmental surveillance and screening

A training module on developmental screening will be prepared, including the instruments, forms and guides, to train the persons who will conduct screening at the community level.

Initially, one-day training will be conducted in the Pilot Sites using introductory presentations, and demonstration, practice and role-playing sessions. Subsequently, training will be provided for entire States and Regions. The Technical Group for ECI Screening and Assessment will identify the types of professionals and paraprofessionals who will be invited to conduct developmental screenings.

It will be important to train physicians, with a special focus on paediatricians, family doctors, gynaecologists and obstetricians who often conduct general developmental surveillance. They will be encouraged to add developmental screenings to their regular child check ups.

Other hospital and clinic staff, such as nutritionists, nurses, nurse aides, midwives, auxiliary midwives, traditional birth assistants, and community health workers will also be trained in the application of easy-to-use screening instruments. Based on

their skill levels, several of these persons will become certified in training others in their own professions.

In addition to medical and health personnel, the following types of persons will also be trained to conduct developmental screenings: ECI staff members; child caregivers; preschool, kindergarten and primary school teachers; and volunteers in community services, such as volunteer personnel in disaster management brigades who are trained by local government entities.

2.6 Provision of continuous information and awareness campaigns on screening, referral and assessment processes

As ECI services expand to additional Townships and Communities, local information campaigns will be needed to inform all local families about identifying children from birth to 36 months of age and up to 60 months of age who may be eligible for ECI services. These campaigns will be provided continuously and will include information on developmental screening; where to go to ask questions about child development; a system for making referrals (a "referral pathway") to ECI services and from ECI to other complementary services, as available; the child and family assessment process; the establishment of programme eligibility; and basic information about ECI services themselves.

2.7 Application and evaluation of developmental screening tools in all Pilot Sites

Once the ECI Pilot Sites have been selected and training has been given to all relevant persons who could conduct screening activities, the screening tools will be applied to all children from birth to 36 months of age and up to 60 months of age. Priority will be given to children from birth to 36 months of age because early identification is critically important for preventing developmental delays and improving the development of children with special needs. The parents of all children considered to be potentially eligible for ECI services must be referred to them.

The application of screening tools will be rapidly evaluated in each Pilot Site, with the objective of identifying how the screening tools and application process might be improved in the future.

2.8 Validation of screening tools

Once screening tools and training module for on how to screen children have been evaluated, they will be field tested, revised and improved during the Pilot Year. Subsequently, the improved screening instruments will be validated by means of screening a large sample of children using the screening tools selected by the ECI programme in comparison to an internationally recognised child assessment instrument, such as the Battelle Developmental Inventory - II.

If the results from the instruments are similar, then the screening tools will be considered to be appropriate for application in Myanmar.

Strategic Priority 3 on ECI Service Development

Design and implement ECI programme services that are home-based and comprehensive, by means of establishing: ECI Programme Guidelines and Procedures; child and family assessments; transdisciplinary teams including parents and other caregivers; Individualised Service Plans; culturally appropriate curricula and home visiting methods; individualised services for children, families and caregivers; plans for programme completion or transition; and ECI service standards.

3.1 Establishment of Technical Group for Service Development

To prepare the contents, methods, materials, training manuals and modules for ECI services, a Technical Group for Service Development will be established. The Terms of Reference and Work Plan for the Technical Group will be developed.

3.2 Preparation of ECI Programme Guidelines and Procedures

To become successful and sustainable, ECI systems must be developed using complete programme development processes. This section presents several of the key materials, methods, methods and training modules and manuals required to develop ECI services well.

Furthermore, ECI services have a usual sequence of activities. The **Flow Chart of ECI Activities** on the next page presents the sequence of main activities provided in ECI services.

In order to ensure ECI programme services are uniformly of high quality throughout Myanmar, it is essential to develop and establish universal ECI Programme Guidelines and Procedures. Although the contents (curricula, methods, personnel and languages used) of ECI services must be provided in a way that is consistent with cultural ideals of parenting and the languages of each national ethnic group, basic procedures of ECI services will be used in all ECI service sites.

The ECI Programme Guidelines and Procedures will cover topics such as: personnel code of conduct; outreach activities; developmental surveillance and screening; roles and composition of transdisciplinary teams; child and parental rights, informed consent and confidentiality; intake and referrals; assessments; and eligibility.

ECI Programme Guidelines and Procedures will help ensure the same quality of services will be provided in all regions and cultures of Myanmar.



The first version of this document will be prepared and approved upon the initiation of programme development activities in early 2017. To meet evolving needs and in order to learn from programme experiences, the ECI Programme Guidelines and Procedures will be reviewed and revised after the Pilot Site year (2017-2018) in January to March 2019, and thereafter each two years, with the second comprehensive review to be conducted in January 2021.

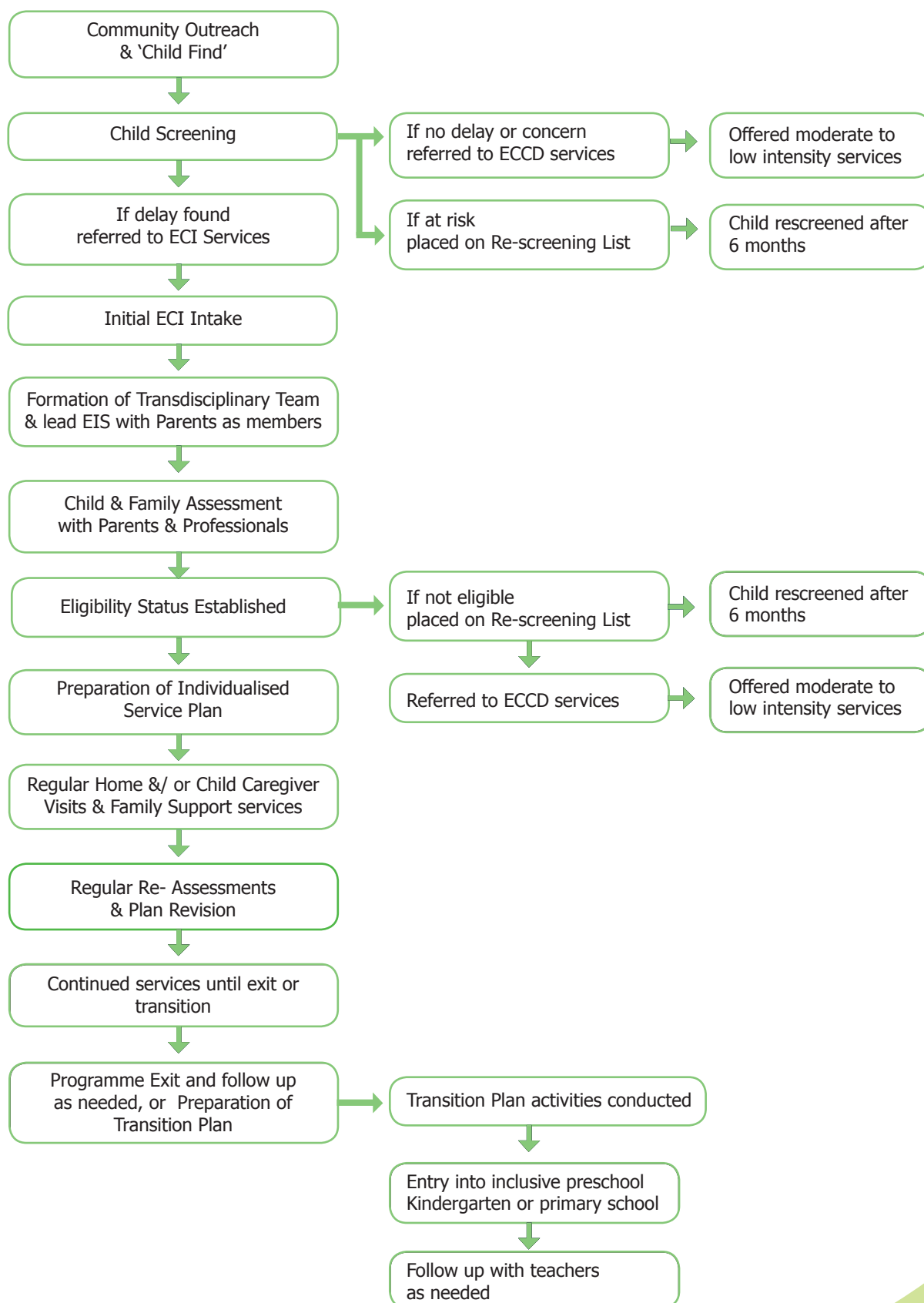
3.3 Preparation of assessments of child, family and home

Before opening the ECI Pilot Sites, the Technical Group for ECI Screening and Assessment in collaboration with the Technical Group for Supervision, Monitoring, Evaluation and Supervision, will develop plans for the selection, adaptation, field testing, review and production of child and family assessments.

With regard to infants and children, it is expected that, with informed parental consent, one comprehensive and balanced instrument will be selected to assess child development, the Assessment, Evaluation and Programming System (AEPS). This instrument will be used throughout Myanmar. This instrument is criterion-referenced to a comprehensive and rich child development curriculum.

In addition to the comprehensive assessment instrument, the Technical Group may want to include a language development assessment and an autism spectrum disorder assessment. The rights to use these instruments, their manuals and forms will be secured, and then translation and adaptation will be required, along with field testing, instrument revision and production.

Flow Chart of ECI Services



In addition, assessments will be selected and/or developed to assess the child nutritional status, family environment, parent-child interaction, and home hygiene and safety. Parental satisfaction with ECI services will also be measured (See Strategic Priority 6 on ECI Programme Accountability).

If not already provided, training and field manuals will be developed or translated and adapted, field tested, revised and copied to train professionals in how to conduct selected assessments in a reliable manner. The system for training ECI professionals to conduct assessments is included under Strategic Priority 5 on Pre- and In-Service Personnel Training.

3.4 Development of Guidelines and a Training Module for Transdisciplinary Teams

General guidelines for the formation of Transdisciplinary Teams will be provided in the ECI Programme Guidelines and Procedures.

To ensure that all ECI service sites are well prepared in the techniques of Transdisciplinary Teams, a training module will be prepared, included in the ECI Pilot training programme, and also presented once again in each ECI service site, once they are formed. This training module will feature demonstration and practice sessions, coaching and mentoring.

Annual training in team formation and activities by means of observations and coaching will be provided. In addition, supervisors will pay special attention to this critically important dimension of interdisciplinary activities for the provision of individualised and intensive services for children and families.

This training module will also be used in future pre-service training programme for professional ECI personnel.

3.5 Development of Individualised Service Plans

The objectives, form, methods and guide of the nation's Individualised Service Plan (ISP) for children and families will be developed in collaboration with national ECI professionals. The form will be translated, adapted as needed, field tested, revised and copied for use in Pilot Sites. In addition, a training module will be prepared to help ECI professionals and paraprofessionals collaborate sensitively and appropriately with parents in developing their ISPs.

Once tested in the Pilot Sites, it is anticipated that the ISP form, methods and guide will be further adjusted to meet prevailing child development, familial and cultural needs in each cultural setting. The revised ISP form, guide and training module will be widely distributed for use as ECI services expand throughout Myanmar. It is expected that this instrument will be modified from time to time to meet the needs of different cultural settings.

3.6 Development of culturally appropriate ECI home visiting curricula, materials and methods

The development of culturally appropriate home visiting curricula, materials and methods will be essential to ensuring high-quality ECI services are provided and maintained over time. Flexibility will be required of all ECI services to ensure they meet the needs of children and families in each State or Region, Township and ethnic or linguistic group. For example, services with families in rice paddies will differ to some degree in form and content from those in Shan highland villages. Pilot Site services will make it possible to assess the effectiveness of initial programme service approaches.

Excellent ECI child development curricula, materials and home visiting methods exist but they must be thoroughly translated and adapted to meet the realities of Myanmar families from many cultures. Should these materials not be adapted, families might reject programme contents and methods as irrelevant to their lives and their children's development.

Culturally appropriate curricula in the following areas will need to be selected or developed for the use of home visitors:

- Expected child development sequences, from birth to 60 months, with activities in all areas of development according to age and developmental levels;
- Child and family health and nutrition;
- Home and community water, sanitation and hygiene;
- Learning through play, using Myanmar traditional child development activities;
- How to conduct effective home visits;
- How to educate adults effectively; and
- Other areas, as needed.

3.7 Development of guidelines for individualised services through visits in the natural environments of the child (home or daily child care centre)

Individualised services will be offered to all children and families eligible for and enrolled in ECI services. These services will be offered at Community and Township levels, and some may be located at the District level until enough trained ECI service providers are available at the Township level.

Guidelines and forms for planning, making and reporting on home visits will be prepared for the use of home visitors/case managers and ECI professionals.

References to these guidelines will be placed in the ECI Programme Guidelines and Procedures. The full list of core and optional/auxiliary ECI services will also be presented in the ECI Programme Guidelines and Procedures.

A training module on the provision of individualised ECI services for children, parents, extended family members, child caregivers and preschool teachers will be prepared, field tested, revised and used for the establishment of each ECI Pilot Site. Once programme services have been piloted, further revisions will be made in this module.

To the extent possible, the following individualised services for children, families and child caregivers will be provided in the natural environment of the child:

- Child development, parent education and ECI personnel supervisory services offered by early intervention specialists, physiotherapists, occupational therapists and speech therapists, special educators, nutritionists, nurses and other professionals;
- Home visits offered by trained and supervised paraprofessionals, some of whom may have been initially trained as midwives, auxiliary midwives, nurses aides, community health workers, social work assistants, assistant teachers, ECCD or preschool teachers, and others;
- Family support services offered by social workers, psychologists and others;
- For mental health and behavioural disorders, psychologists and other specialists will be engaged as they become trained and available in each State, Region and Self-Administered Area;
- Nutrition services offered by nutritionists and others trained in nutritional interventions;
- For health care services, children and families will be referred to District or Township physicians and paediatricians, as available. The Ministry of Health is progressively placing paediatricians with a Diploma of Child Health (DCH) in each Township;
- Each child will be required to be up-to-date in immunisations, receive regular health check ups and assessments of nutritional status (height and weight measurements);
- For home nursing care, referrals will be made to Township health care services;
- For health diagnostics and specific rehabilitation services for children with complex physical disabilities, referrals will be made to major rehabilitation hospitals and centres;

- Given the high level of demand for help with prosthetics and physiotherapy on the part of children with physical disabilities and children who become disabled due to injuries or accidents, special attention will be given to expanding and improving rehabilitation services; and
- Vision and hearing specialists including audiologists, who are usually located in large cities or in nearby States, Regions and Self-Administered Areas will also help to provide services to children with auditory or visual impairments.

3.8 Design of plans for programme completion or transition

A form and a training module to prepare plans for the completion or transition of children and families from ECI services to an inclusive preschool, kindergarten or primary school will be drafted, field tested, revised and duplicated for use in ECI Pilot Sites. Subsequently, the form and training module will be revised, as needed, for general use during the expansion of ECI services in Myanmar.

ECI children who achieve typical levels of development and consolidate their gains will complete ECI programme services. Some of them may enter other general ECCD services for children with low to no risk of developmental delays or other ECI-eligible conditions.

For children with continuing delays or disabilities, at least one year before children and parents leave ECI services, Transition Plans will be developed with parents, other caregivers and inclusive preschool, kindergarten or primary school directors and teachers. ECI personnel will make visits to inclusive preschools, kindergartens and primary schools to present each child and family to their future teachers and headmasters. They will note each child's strengths, abilities and next areas of expected development. They also help teachers learn how to guide and develop the child well within the classroom environment. They will continue to visit the school from once a week to once a month depending upon need, until the child makes a good transition. This usually occurs within three months' time, although a few children and/or teachers may require follow-up visits for up to six months' time.

It is anticipated that over 95% of the children leaving ECI services will transition to inclusive preschool or primary school services. The parents of about 5% of the children with many and/or complex disabilities may prefer to send their children to a special school, such as a school for visually or auditorily impaired children. Many research studies have demonstrated that children with Down syndrome, Cerebral Palsy, Autism Spectrum Disorders and other physical and/or mental conditions benefit most from attending inclusive preschools, kindergartens and primary schools. In addition, research has also revealed that children with typical

levels of development benefit greatly from learning new communications skills and making friends with children of varying abilities.

3.9 Development of ECI Service Standards and ECI Programme Registration

Based on the foregoing essential elements of high-quality and effective ECI services and ECI Programme Guidelines and Procedures, ECI Service Standards and ECI Guidelines for Programme Registration will be drafted. Draft Service Standards and the Guidelines will be widely shared in order to gain comments from ECI ministries, ECI programme directors, all types of ECI specialists and other personnel who will be affected by them.

Once all comments have been gathered, the first versions of ECI Service Standards and ECI Guidelines for Programme Registration will be distributed in late 2017. Initially, each three years, the Service Standards and ECI Guidelines for Programme Registration will be reviewed and modified, as needed. All programme materials that are linked to these documents will also be reviewed for possible changes.



3.10 Development of training module for parent empowerment focusing on child and parental rights

A training module will be developed for the use of ECI professionals, paraprofessionals and volunteers regarding: parent empowerment; child and parental rights; informed written consent; parental roles in the screening and assessment of their children; the preparation of Individualised Service Plans; and the full participation of parents in ECI services.

This module will be used to prepare parents and other family members for positive participation in ECI services. It will also be used to prepare Township and community leaders and members in child and parental rights, especially with respect to ECI services. The module will be rapidly field tested, revised and cop-

ied for use in training for Pilot Sites. It will be applied in all nine Pilot Sites and reviewed and revised at the end of the year for use in all future ECI Service Sites.

3.11 Preparation of educational materials and training modules on good parenting skills for home visitors and other ECI personnel

Because of the strengths of most Myanmar families in the area of nurturing child care and development, it would appear that little work is required to improve parenting skills; however, due to high levels of malnutrition, severe poverty, trauma caused by stressful family situations, natural disasters, and community conflicts, many parents need support to maintain good parenting skills and adopt new ones to improve the development of their young children, especially during the critical period from birth to 36 months -- and up to 60 months of age.

Special attention will be given to ensuring balanced parenting education is provided for both fathers and mothers. Paternal roles will be highlighted as well as maternal roles.

Two books and two training modules will be translated and thoroughly adapted for the use of home visitors and parent educators during home visits and group sessions. These training modules will cover each month of child development from birth to 60 months of age. For each month, the materials will provide the following elements: expected child development; activities for good physical development, language, cognitive, social and emotional development; key health, nutrition, safety and hygiene messages; and a no-cost toy making activity.

3.12 Prevention of institutionalisation of children birth to five years of age plus deinstitutionalisation and family placement of children already in institutions

Special attention will be given to preventing the institutionalisation of infants and children from birth to five years of age in orphanages. A high-impact training module on this topic will be prepared. Research has demonstrated that all young children placed in institutions usually become developmentally delayed in one or more areas due to inadequate care and stimulation. Infants and children from birth to five years of age need to live in a loving family home. The ECI programme will also help with the deinstitutionalisation of young children. For young children who already have been placed in an orphanage, ECI services will be provided in the institution until a good home can be found for them.

Once deinstitutionalised, birth families or other substitute families will be given home visits and support to develop these children well and to attempt to overcome developmental delays due to having been placed in orphanages. Families will receive family counselling, family therapy, and family preservation services,

as they become available as core ECI services. As possible, cash transfers will be given to families living in poverty who are unable to provide enough food and care for their child or a child they receive as a substitute family.

Some children have complex disabilities. In these instances, parents may decide to enrol their children in daytime special education centres, in accordance with their needs. It is understood that most children with cerebral palsy, Down syndrome, visual or auditory impairments, and other disabilities usually attend inclusive preschool and inclusive primary schools. Only children with the most complex situations or difficult behaviours should attend special schools.

3.13 Refugee, internally displaced or disaster-affected children and parents/caregivers

A “packet” including a training manual with training modules and ECI materials will be developed in 2018 to provide special and intensive services to children and families who are refugees, internally displaced or affected by natural disasters and community conflict.

The parent education and child development training manual, training modules and ECI materials will be provided for the use of ECI personnel working with these high-risk groups. Emphasis will also be placed on providing strong mother and family support services as well as case management.

3.14 Preparation of guidelines and a training module for community meetings to establish ECI services

To ensure communities and parents know the ECI Strategic Plan has been adopted and is being implemented, brief guidelines and a training module will be prepared on ECI services for use in Townships.

With the support of local authorities, community advocacy for ECI services will be conducted at schools, health centres and other Township and community centres. In addition, in places where families live in scattered hamlets, volunteers will conduct home visits to inform parents about ECI services.

3.15 Development of a training module on ECI services and inclusive education

A training module will be developed on the importance of the early identification and provision of ECI services for children with special needs, the core concepts and methods of inclusive education, its benefits for children of all ability levels, and the roles of parents and teachers in inclusive education.

ECI service providers and others will also use this module to inform parents and other professionals and community volunteers about ECI services and their linkage with inclusive preschool, kindergarten and primary education.

3.16 Design of a training module on preparation for having healthy babies and positive parenting for adolescents in secondary schools, youth groups and universities

Once ECI services are well established in the three States and Regions, a special module on preparing for having children and developing good parenting knowledge and skills will be prepared for presentation to adolescents in secondary school health classes, youth groups and universities.

For adolescents who have already become parents of a child with special needs, a programme will be designed especially for them. Usually such parents are eager to learn how to take good care of their young children and develop them well. Every effort will be made to help adolescent mothers and fathers stay in school or return to school as they undertake complex parenting roles.

Strategic Priority 4 on Pre- and In-Service Personnel Training and Development

Provide pre-service training and continuous in-service training and mentoring to ensure the preparation of competent ECI administrators, supervisors, professionals, paraprofessionals and volunteers, including the establishment of selection criteria, roles and responsibilities, personnel standards, certification, recertification, career ladders and salary scales.

This Strategic Priority includes: 1) activities to develop an effective pre and in-service training system for ECI personnel; and 2) organisational guidelines for personnel quality, certification and recertification, remuneration, career ladders, supervision and development.

4.1 Establishment of the Technical Group for ECI Training

To guide all pre and in-service training of professionals, paraprofessionals and volunteers, the Technical Group for ECI Training will be established with its terms of reference and Work Plan. It will hold regular bi-weekly or monthly meetings.

4.2 Development of the Plan for the Pre-Service ECI Training of Professionals

A Technical Group for ECI Training will develop a detailed Plan for Pre-Service ECI Training and will manage transparently the identification of selection criteria, advertisement of training opportunities, and selection of high-quality candidates. Every effort will be made to ensure that candidates will be selected in a timely and effective manner for each type of training opportunity.

By March 2017, the Plan for Pre-Service ECI Training will be prepared for the training of ECI administrators, supervisors, professionals, paraprofessionals and volunteers. In order to be fully responsive to both the developmental period and the phased expansion of ECI services, it will cover the period from 2017 to 2021.

The Plan for Pre-Service ECI Training will be developed with representatives of the academic community as well as with training specialists from other national training institutions. International ECI training specialists might also support in country and distance training in specific fields, such as training for early intervention specialists, speech/language therapists, occupational therapists, physiotherapists specialised to work with infants and young children, nutrition specialists, educational, clinical and community psychologists, autism spectrum disorder specialists, and others.

The Plan will also include the provision of regional and international training for specific types of ECI professionals rarely found in Myanmar, such as the ones listed above.

Special attention will be given to enrolling Myanmar specialists in graduate level distance training programmes for ECI at the Certificate and Master's Degree levels, especially for the preparation of early intervention specialists and special educators for both ECI and inclusive education services in Myanmar.

4.3 Preparation of a plan for rapid regional and international training for trainers of trainers in specific fields

Pre-service training of one or more of the following types will be required and provided for the preparation of all ECI administrators, supervisors, and other professionals usually included in national ECI systems.

By March 2017, rapid regional and international training will be identified, developed and offered to prepare trainers of trainers in the following high-priority areas:

- Early intervention specialists;
- Speech/language therapists;
- Occupational therapists;
- Physiotherapists to serve infants and young children;
- Nutritionists;
- Autism spectrum disorder specialists, and
- Psychologists in ECI service areas.

4.4 Development of specialised national Bachelor's and/or Master's degree programmes

In addition, national universities will develop several Bachelor's and Master's degree programmes to train, or in some cases to enrich, the training of:

- Early intervention specialists;
- Speech/language therapists;
- Occupational therapists;
- Physiotherapists to serve children, 0 to 5 years of age;
- Nutritionists, focusing on nutritional rehabilitation, stimulation and parent education;
- Nurses in ECI screening and other methods;
- Psychologists to serve with children with atypical behaviours and families with complex and high-risk situations;
- Social workers in ECI support methods; and
- Teachers trained in ECI to work in inclusive preschools, kindergartens and primary schools.

These special university Bachelor's and Master's degree programmes will be developed in various academic centres, possibly including: universities of public health and medicine; universities of nursing; universities of medical technology for physiotherapists, speech/language therapists and occupational therapists; Universities of Yangon and Mandalay for psychology and social work; School of Social Welfare and Disability in Yangon; Universities of Education in Sagaing and Yangon for special education; University for the Development of the National Races of the Union (UDNR) for early intervention specialists; and other universities and institutes yet to be identified, especially at regional levels, focusing initially on the Pilot States and Region.

Affiliate or joint international university partnerships for conducting ECI professional training will also be developed to establish strong and up-to-date higher education programmes.

4.5 Development of ECI Master's degree leadership programme for ECI administrators, planners, supervisors, evaluators and advanced trainers of early intervention specialists

One Master's degree leadership programme in ECI services will feature special courses for ECI planners, administrators, supervisors, evaluators and advanced trainers of early intervention specialists. Training topics will include programme planning, management, leadership and communication skills, supervision, on-the-job training techniques, preparing trainers of trainers, and essential skills for monitoring, evaluation, research and child tracking services. This Master's degree programme will also include courses for early intervention specialists that are centrally important for the development of the National ECI System of Services

as trainers of trainers. The university home for this programme will be selected in early 2017, with the hope of enrolling students in November 2017.

4.6 Identification of international distance education courses for enrolment of Myanmar specialists

Graduate-level distance training programmes at the Certificate and Master's Degree levels will be identified and offered to selected students. At least one distance certificate-level course will be provided for persons wishing to become early intervention specialists.

Every effort will be made to offer a distance Master's Degree programme to train early intervention specialists and inclusive educators for ECI and inclusive education services in Myanmar.

4.7 Development of national distance ECI education programmes

It is anticipated that by 2018, national distance education programmes will be designed and developed for training early intervention specialists. These courses will provide professional certification and will also offer workshops and mentoring services for recertification. At least 50% of the programmes will include coaching, mentoring and reflective supervision through the exchange of videos and the provision of guided short-term field experiences. Reflective supervision will include regular discussion on the part of both the supervisor and the supervised staff member regarding skills, behaviours, emotional states and knowledge used in the provision of ECI services. The supervisor will collaborate with and support the person supervised, and both will gain a better understanding of programme activities as a result of their exchanges in a setting of mutual trust and honesty.

4.8 Pre-service training for Pilot Sites

Initially, time-limited and carefully developed regional pre-service training will be required for training the personnel of nine Pilot Sites in three States and Regions from 1 October to 31 December 2017. The ECI personnel of each region will receive training for one month. Each Pilot Site will officially begin its work in January 2018. The goal will be to ensure all personnel for each site will have been selected, trained and prepared for field work by 12/2017.

This first pre-service training programme will be flexibly conducted in one training site in each State or Region as well as in each of the field sites. It will feature introductory classes (30% to 40% of the time) in the State or Regional capital, and field site training through demonstration, practices, mentoring and coaching (60% to 70% of the time) in both the central training site and field sites.

A pre-service training syllabus will be developed and all materials prepared for training ECI personnel will be presented and utilised. Trainees will receive a full

set of all manuals, curricula, materials, instruments and guides for use in their field sites.

This initial general ECI pre-service training programme will be evaluated using a pre post design, with the goal of using lessons learned for the formulation of the permanent and sustainable national training programmes presented above.

4.9 Establishment of pre-service training requirements and training services for paraprofessional home visitors from all ethnic and language groups

In order to achieve a high level of programme coverage, it will be necessary to train many paraprofessionals to become home visitors. All paraprofessional home visitors will work under the direct supervision, coaching and mentoring of professionals. They will be trained to conduct screenings, referrals, case management and home visits. They will not be permitted to conduct child development assessments, individualised service plans or plans for programme completion or transition to other services. Only professionals will be permitted to conduct these activities.

Criteria for selecting paraprofessionals will be established as well as job descriptions and terms of reference. Depending upon availability, preference will be given to training persons with Bachelor's degrees or some university training in health and social development fields as well as some other fields. As possible, some midwives, auxiliary midwives, nurses, nurse aids, public health supervisors, experienced community health volunteers, preschool educators and early childhood care and development workers will be considered as candidates to become full- or part-time home visitors. Personal factors, skills and characteristics are often as very important in selecting paraprofessionals.

Paraprofessional home visitors will receive training that is very similar professional early intervention training; however, it will be of a shorter duration. Paraprofessionals will be trained within a one to three-month period, followed by intensive and continuous in-service training, coaching and mentoring. They will receive training in topics, such as: screening; assisting with assessments; child development curricula, methods and essential elements of all basic therapies; home visiting techniques; filling out the programme's home visiting forms; basic child development sequences; child protection laws and regulations; child and parental rights; parenting education and support; Braille, large print and sign language, as needed; the selection and preparation of ECI volunteers; communications skills; adult learning approaches; teamwork skills; and how to work effectively under supervision in an organisation.

Paraprofessional home visitors will be trained in their regions and will be given guided in-service training with field experiences, coaching, mentoring and reflec-

tive supervision. It is hoped that by 2018, some elements of training for paraprofessional home visitors will be provided by means of distance learning modules.

It is expected that after considerable service in ECI programmes, some valuable and expert paraprofessional home visitors will want to study to become professionals. Opportunities for professional training will be offered to those interested in becoming professionals.

4.10 Preparation of pre-service training for volunteers

Several types of volunteers will be used in ECI sites, and terms of reference will be prepared for them. Volunteers often help with community and family outreach, receiving parents and other visitors at the ECI Service Site, taking phone calls, organising food and clothes closets for emergency family support, managing toy libraries, preparing papers for and arranging meetings, etc.

Volunteers may be trained to support ECI personnel with most types of activities that do not involve viewing programme and family files and other kinds of information that are under privacy guidelines.

The pre-service training of volunteers will be very brief, usually comprising one-half to one day. Modules for training volunteers will be prepared. Volunteers will be given name tags identifying them as Volunteers, as well as bags or other items they may need to assist them with their work.

Community gatherings should be held each year to officially recognise and celebrate the accomplishments and contributions of ECI volunteers. A Lead Volunteer award might be given, along with certificates for each volunteer.

4.11 Preparation and use of job descriptions and personnel standards

Job descriptions and personnel competencies, including TOR with their roles and responsibilities, will be prepared for all types of ECI personnel, including professionals and paraprofessionals as well as selected types of volunteers.

Based on these documents, ECI Personnel Standards will be drafted. Draft standards will be reviewed, revised and approved by the ECI Task Force and later by the National ECI Office (See **Strategic Priority 8 on Organisational Structure, Annual Planning and Budgeting**).

At least once a year, personnel standards will be discussed with ECI personnel in each ECI service site in order to help ensure they follow them. The content of national personnel standards will be reviewed each three years and revised as needed.



4.12 Establishment of certification and recertification requirements

In collaboration with participating universities and institutes, rules and procedures for the certification and recertification of early intervention specialists and other ECI professional specialists will be developed.

Universities providing ECI Certificate Programmes and training at the Bachelor's degree and Master's degree levels in ECI fields of expertise, will officially certify that each specialist is fully competent to provide ECI services of his or her area of expertise.

Every two years, each certified ECI specialist will be required to take a total of at least 80 hours of officially approved courses or workshops on ECI topics in order to maintain his or her certification to provide ECI services. At least 60% of training for recertification must be provided through field demonstrations, practice sessions, coaching, mentoring, and reflective supervision. Training will either be free of charge or very low in cost.

Recertification will also be dependent upon receiving positive references from programme supervisors and managers.

An easy to use personnel performance form will be designed and implemented to ensure 360 reviews are conducted each six months for each staff member.

Information about the certification and recertification of ECI professional personnel and available courses and workshops will be shared with all ECI service programmes and personnel through the national ECI website.

4.13 Establishment of career ladders and requirements for access to professional positions

Subsequent to the development of ECI rules for certification and recertification, career ladders will be established for professional and paraprofessional positions. Information on ECI career ladders will be placed on the ECI website.

It is anticipated that each ECI position will be placed at one of the following levels on a career ladder:

- Senior level
- Intermediate level
- Beginning level

For example, newly trained specialists lacking field experience would be placed at the beginning level. Previously trained persons (such as physiotherapists) with some field experience would be placed at the intermediate level. Previously trained persons with extensive field and supervisory experience (such as experienced professional nurses with long-term supervisory experience) might rise to the senior level more quickly than others.

Attention will also be given to providing training opportunities for paraprofessional early intervention specialists (home visitors) who aspire to become professional early intervention specialists or other types of professionals. A career path will be opened to permit paraprofessionals to become fully trained professionals.

4.14 Establishment of annual salary scales and support for field personnel

Annual salary scales for all ECI positions will be established at the national level and posted on the ECI website.

For remote Townships with high costs of living, the State, Regional and Self Administered Area Governments will consider providing additional incentive payments and other forms of support to help provide services in remote rural areas that will require the use mobile teams and other flexible service approaches.

4.15 Development of a Plan for Continuous ECI In-Service Training

Annual Plans for Continuous ECI In-Service Training will be prepared with the first one prepare by October 2017. In-service training will be provided for administrators, supervisors, professionals, paraprofessional home visitors, and volunteers.

To ensure ECI specialists will be able meet national requirements for recertification, each year an annual list of approved workshops and field experiences will be prepared and provided throughout Myanmar and on the ECI website, with the goal of locating training as close as possible to ECI service sites.

The content of these training sessions will include practical field work, as well as workshops on special topics and emerging research in early childhood intervention, early childhood development, parenting, neuroscience, learning psychology, social work, policy planning, and other fields. National universities and institutes as well as visiting scholars, trainers of trainers, and experienced practitioners from other countries will offer these workshops and training experiences.

As noted above, brief training modules will be prepared for the in-service training of volunteers. Local professionals and paraprofessionals will teach these modules on-site to volunteers. This training is often considered to be a bonus for volunteers since they learn skills that will be valuable for other types of future paid work. Some ECI volunteers may wish to take additional training to become paraprofessional home visitors or to study to become professional ECI staff members.

A continuous and multi-layered system of in-service training will be provided. The most effective forms of in-service training provide few classes and mainly use field training activities, including demonstration and practice, coaching, mentoring and reflective supervision.

However, central and regional workshops will be held, along with annual ECI conferences featuring special workshops for credit toward certification and recertification. In the future, distance learning opportunities will also be developed for the use of those who can access a computer, a tablet or pad or a smart phone.

Most in-service training activities will be based in field sites, with opportunities for coaching and mentoring activities provided by supervisors and team leaders.

In addition, inter-site exchanges will be fostered as an effective way to share innovations, good practices and lessons learned.

Finally, regional and international study and/or training tours will be arranged and offered, especially for those individuals who have excelled in their work. Some specialists will be invited to attend regional and international conferences devoted to ECI and related fields of work.

4.16 Development of the ECI Supervisory System

The job description and terms of reference for ECI supervisors will be prepared. As stated above, ECI supervisors will be trained at the Master's degree level. Those who initially lack a Master's degree will be required to earn it within a three-year period from programme entry.

Supervisors will conduct four main types of activities that will be presented in a Manual for Supervisors, along with checklists, guidance and recommended in-service training approaches and methods for conducting reflective supervision. They will:

- Supervise ECI service sites and their personnel, in accordance with ECI service and personnel standards;
- Assist with guiding ECI personnel regarding complex and challenging child and family development situations, including assisting with and/or observing assessments and ISPs, going on home visits, and helping with transition plans;
- Provide biweekly or monthly in-service training modules, mainly through demonstration and practice sessions, for all staff members and especially for paraprofessionals, focusing on areas of special interest and need for each ECI service site; and
- Conduct basic monitoring, evaluation and follow up activities in order to ensure a high level of internal programme accountability.

Supervisors will report to and will be supervised by the National ECI Office, and regional offices as they are established.

Strategic Priority 5 on Establishment and Phased Expansion of ECI Services

Develop a phased plan for service implementation, with the goal of establishing ECI services in all 21 States, Regions and Self-Administered Areas by 2021 and in communities of all Townships by 2025.

In order to establish ECI services in all 21 States, Regions and Self-Administered Areas of Myanmar by 2021, and in communities of all of the nation's Townships by 2025, six phases will be conducted for: 1) programme planning and contents development; 2) pre-service training for personnel of ECI Pilot Sites; 3) a year of programme implementation in nine Pilot Sites; 4) programme revision in light of experiences, monitoring and evaluation results; 5) programme expansion to all States, Regions and Self-Administered Areas by 2021; and 6) expansion to all Townships by 2025.

To help achieve ECI programme objectives and expand the programme to nationwide coverage, virtually all programme contents will be designed before personnel are trained and Pilot Sites are opened.

5.1 Phase I: Planning National ECI System and preparing programme contents for establishing Pilot Sites (June 2015-October 2017)

During Phase I, the National ECI System will be designed through the preparation and adoption of this ECI Strategic Plan and the development and adoption of ECI Programme Guidelines and Procedures, included in Strategic Priority 3 on ECI Service Development.

The ECI Task Force will establish a Technical Group for ECI Service Development to address all developmental work during 2017. During 2017 all programme contents, methods and core elements described in the Strategic Plan will be developed, field tested and prepared for use in pre- and in-service training and for the preparation and selection of Pilot Sites.

The ECI Task Force will approve a Work Plan and Gantt Chart to help ensure all elements for the Pilot Sites will be ready for use by the end of the third quarter of 2017.

The basic pre- and in-service training system, supervisory system and monitoring and evaluation system will be designed during Phase I.

5.2 Phase II: Pilot Site Training (01/10-31/12/2017)

Pre-service training for professional and paraprofessional personnel of Pilot Sites will be conducted in each of the three regions.

Initial sessions will present core concepts, contents, methods, instruments, and other forms and their guides. About half of the training will feature field training, demonstrations, practices sessions. Trainees will be coached and mentored in order to help learn rapidly how to work effectively with parents and children.

At the same time, initial work to set up the Pilot Sites will be conducted in order to be able to initiate work in early January in each Site.

5.3 Phase III: Establishing and implementing Pilot Sites, with the support and collaboration of regional stakeholders (October 2017-December 2018)

All preparatory work for the ECI Pilot Sites will be conducted from 1 October to 31 December 2017. Initial ECI service implementation will focus on the establishment of nine ECI Pilot Sites in three States or Regions of Myanmar. At least one urban Township site and two rural Township sites will be included in each State or Region. Special attention will be given to working with Regional offices of MoSWRR, MoHS, MoE, MoHA, MoPF, MoL, MoBA, and MoI, as appropriate, as well as with Regional Prime Ministers and Parliaments.

The Pilot Sites will officially begin in January 2018 and will extend to December 2018. These Pilot Sites are expected to become permanent ECI service sites. Therefore, many activities will be pursued during the Pilot Year to ensure their long-term sustainability.

The system for monitoring and evaluation and for the development of the database of the ECI Management Information System will be established during 2017 (See **Strategic Priority 6 on ECI Programme Accountability**). The internal evaluation will officially begin in December 2017 to January 2018 in order to

secure baseline data and thereby measure programme inputs, outputs and outcomes (results). This internal evaluation will be completed by the end of March 2019. The results will be used to improve and expand local services and to revise some elements of the ECI system of services.

In addition to the internal evaluation of the Pilot Sites, it is hoped that an external evaluation will be conducted with support from an international donor. For the external evaluation, at least one comparison site will be selected in each State or Region. Because of its depth and complexity, the external evaluation is expected to require more time for data analysis, and will be completed by the end of April 2019.

5.4 Phase IV: Revision of ECI programme in light of monitoring and evaluation results and training of more professionals, paraprofessionals and volunteers (December 2018-March 2019)

Based on results of the internal and external evaluations, during the period from November 2018 to March 2019, the ECI system of services will be revised and adapted.

By November 2018, the ECI Task Force, Technical Group for Planning and Developing ECI Pilot Sites, and consultants as needed, will have prepared a Work Plan for the review and revision of programme contents, methods, instruments, manuals and guides. The reviews and revisions will take place during the period from November 2018 to March 2019, and longer if necessary. The preparation of programme documents in additional languages will begin during this period and continue during Phase V.

A cost study, based on actual Pilot Site costs, will be conducted in order to prepare projections and simulations to anticipate project budgetary needs for programme expansion from 2019-2021.

The Work Plan will also include activities for the pre-service training of additional Early Intervention Specialists and other professionals, paraprofessionals and volunteers.

Continuous in-service training of professionals, paraprofessionals and volunteers in Pilot Sites will also be conducted in order to help with the expansion of existing Pilot Sites and the future development of other service sites in each of the three initial States and Regions.

5.5 Phase V: Expansion of ECI services to other sites in each initial State and Region, and to the rest of the 21 States, Regions and Self-Administered Areas of Myanmar (April 2018-December 2021)

From April 2018 to December 2021, the ECI programme will be rapidly expanded.

Criteria for programme expansion to additional Townships will be established. They will be based on experiences and lessons learned in the Pilot Sites.

The ECI Task Force and the Technical Groups will prepare a Work Plan for programme expansion based on these criteria and also on the demand for services and the targeting of regions with higher levels of high-risk infants and young children. Decisions regarding this expansion will be conducted by means of collaboration among all participating leaders and parents in Communities and Townships, and State, Regional and Self-Administered Area ministries as well as academic training institutions and others who will assist with the preparation of human resources.

At least one cluster of ECI Township services will be developed in each of the 21 States, Regions and Self-Administered Areas of Myanmar by the end of 2021.

Once Pilot Site activities are underway and monitoring and evaluation reports are circulated to decision makers in each State, Region and Self-Administered Area. It is anticipated that there will be a high level of demand for ECI services in each entity. Regional parliaments, MoHA and other ministries and others will then consider providing financial support for basic ECI services. Other sources of funding support will also be identified. (See **Chapter 9: Financial Support for the National ECI System and Services**).

In each of the three States and Regions with Pilot Sites, it is expected that ECI services will expand rapidly and provide ECI services in all of their Townships. Every effort will be made to achieve a high level of programme coverage in those areas by the end of 2021 but attention must also be given to ensuring all 21 States, Regions and Self-Administered Areas develop ECI services in some of their Townships.

5.6 Phase VI: Expansion of ECI services to communities in all Townships in Myanmar (January 2021-December 2025)

Phase VI will be implemented under the next five-year ECI Strategic Plan and Action Plan, which will be developed during 2021. On the basis of the experiences, challenges and achievements of the first five-year Strategic Plan, ECI services will be expanded rapidly to provide universal services throughout Myanmar by 2025.

At least one ECI service will be located in or will serve the communities of each Township. In some rural areas, it is likely that some ECI services will serve two or more Townships, perhaps through locating their offices at the District level.

Decisions regarding programme expansion will be conducted with all participating leaders and parents of Communities, Townships, Districts, and State and Regional parliaments and ministries.

Strategic Priority 6 on ECI Programme Accountability

Develop an ECI Management Information System, which includes child tracking, child and family files, monitoring, evaluation, reporting and research linked to continuous programme planning.

6.1 Design of ECI Management Information System

The ECI Task Force will establish a Technical Group for ECI Supervision, Monitoring, Evaluation and Planning to guide work that links programme supervision and accountability with programme planning and development over time.

The Technical Group will help to design and implement an ECI Management Information System (ECI-MIS) that will be carefully designed during 2016-2017. The ECI-MIS will include the National Child Tracking System, child and family data from ECI field sites (maintained in an anonymous form), key monitoring and evaluation data, and some research projects, as appropriate and beneficial to system accountability.

While the instruments, guides, and Manual are being prepared (See 6.2), the database system for the ECI-MIS will be designed. Once the database system has been developed, field trials will be conducted using data from the nine Pilot Sites.

Linkages with Central Statistics Organisation (CSO), Health Management Information Systems, the future Education Management Information System and Social Welfare Management Information System, and any other relevant databases will be pursued and considered.

The ECI-MIS will use data provided through the provision of regular reports from ECI service sites. Data will be arrayed by State, Region and Self-Administered Area, type of population (urban/town/rural), ethnic group and population income levels as well as by the ages and gender of children, type of family, and education level of parents.

Every six months, the ECI-MIS will issue a report with analyses by State, Region and Self-Administered Area as well as at the national level. These reports will be linked to continuous programme planning.

The ECI-MIS database system will be continuously assessed, revised and implemented during the expansion of ECI services. In 2018, a comprehensive review of the system will be conducted, and it will be modified and improved according to need.

6.2 Selection or development of instruments and guides for programme monitoring, evaluation and child tracking

ECI monitoring and evaluation instruments, guides and programme forms that have proven to be useful in many countries, plus others developed to meet the unique needs of Myanmar will be selected or other ones will be developed. During the first three quarters of 2017, all instruments will be translated into at least three national languages, adapted to local cultures and ecologies, and field tested. Subsequently, they will be revised and prepared for implementation in the Pilot Sites. To the greatest extent possible, they will be constructed in such a way that data entry for instruments will be the same in each language. Each year these items will be translated and adapted to four additional languages.

6.3 Development of ECI Manual for Monitoring, Evaluation and Child Tracking

Parallel to the preparation of monitoring and evaluation instruments and their guides, a comprehensive ECI Monitoring and Evaluation Manual will be developed. The Manual will include the objectives of the system, a listing of all expected indicators for inputs, outputs and outcomes, charts on the timing of instrument application, reporting requirements at Community, Township, District, State, Region, Self-Administered Area and national levels, and other items. The approved instruments and their guides will be included in the Manual.

6.4 Preparation of a training module for ECI personnel on child and parental rights, informed consent and confidentiality of individual records

A training module will be prepared on child and parental rights in programme monitoring and evaluation for all ECI personnel regarding especially the importance of informed consent and the confidentiality of individual child and family records. Rules will be explained for ensuring informed consent before referrals and conducting key ECI activities, such as assessments and Individualised Service Plans. The confidentiality of individual records will include procedures for ensuring only persons with the “right to see” family files and other data will be permitted to do so. They will also explain the need to use unique identifying numbers rather than personal names in data sets. The system for using such numbers will be explained in the ECI Manual for Monitoring, Evaluation and Child Tracking.

6.5 The design and implementation of ECI research projects

Research projects will be conducted to help target ECI services to places where they are most needed and to conduct external evaluations on the development of the ECI System.

Initially, a comprehensive study will be conducted on the developmental status of children in all 21 States, Regions and Self-Administered Areas of Myanmar. The incidence of developmental delays, fragile birth status, malnutrition, chronic illnesses, disabilities and atypical behaviours will be identified. Funding for this study will be sought from both national and international sources. This study will also provide a baseline for the measurement of the impact of the ECI programme over time.

As previously noted, an external evaluation of key ECI programme development processes and outcomes should be conducted in the Pilot Sites. Comparison communities will be selected in each State, Region and Self-Administered Area participating in the Pilot effort.

Additional action research projects will be identified conducted once these activities have been completed. It is anticipated that at least two action research projects will be undertaken each year. Support from international sources will be sought for these projects.

Strategic Priority 7 on Intersectoral Collaboration and Coordination

Provide an effective “continuum of care” for all children enrolled in ECI services, through conducting intersectoral collaboration and coordination, referrals to health, nutritional and protection services, and transitions to inclusive preschools, kindergartens and primary schools.

7.1 Development of Plan for Intersectoral Collaboration and Coordination to ensure a “continuum of care” for children with special needs and their families

The ECI Task Force will establish a Technical Group for ECI Intersectoral Collaboration and Coordination. The Technical Group will establish a Plan for Intersectoral Collaboration and Coordination to ensure the provision of an effective “continuum of care” that includes referrals to health, nutritional, protection and other available services, provision of complementary services, follow up on referrals as well as support for transitions to inclusive preschools and primary schools.

7.2 Identification of all intersectoral and interagency partners for collaboration and coordination in all States, Regions and Self-Administered Areas

A survey (mapping study) instrument will be designed and will be used to identify all agencies and groups that should be involved in creating the “continuum of care” in each State, Region and Self-Administered Area with participants from

primary, secondary, tertiary levels. Initially, this survey will focus on the 3 initial States and Region and also focus on the 9 Townships selected to become Pilot Sites. The survey instrument will be revised based on experiences in the Pilot Sites and later applied in all new ECI programme sites.

7.3 Development of interagency protocols and agreements, as needed

The Technical Group for ECI Intersectoral Collaboration and Coordination will explore alternative approaches to establishing sustainable interagency relationships, protocols and agreements. Consideration will be given to preparing a format for possibly establishing interagency agreements and protocols in each participating Pilot Township, District, State and Region. ECI personnel will be trained in ways to cultivate good inter-institutional relations and establish interagency protocols and agreements when they are needed to ensure the sustainability of systems for collaboration and coordination.

Based on experience during the Pilot period, approaches to establishing interagency protocols and agreements will be reviewed. Lessons learned in each State, Region and Self-Administered Areas would be applied as the ECI programme expands.

7.4 Designation of Task Force Technical Groups for collaboration and coordination, by type of function and Strategic Priority

Eight Technical Groups will be designated by functions and by Strategic Priority to ensure the full development of effective intersectoral and interagency collaboration and coordination:

1. Technical Group for ECI Advocacy and Communications
2. Technical Group for ECI Screening and Assessment
3. Technical Group for ECI Training
4. Technical Group for ECI Service Development
5. Technical Group for Planning and Developing ECI Pilot Sites
6. Technical Group for ECI Supervision, Monitoring, Evaluation and Planning
7. Technical Group for ECI Intersectoral Collaboration and Coordination
8. Technical Group for ECI Organisational Structure, Annual Planning and Budgeting

Terms of reference will be developed for each Technical Group and then reviewed and approved by the ECI Task Force, with special attention to advice from the following ministries: MoHS, MoE, MoHA, MoPF, MoL, MoBA, and MoI and others, as needed.

7.5 Preparation of training manual on intersectoral and interagency collaboration and coordination, with attention to each Technical Group

To ensure the seven Technical Groups function well, a Training Manual on Intersectoral and Interagency Collaboration and Coordination will be developed, field tested, revised and duplicated for use in each Pilot Site. After the Pilot period, this training module will be reviewed and revised for use as ECI programme sites are established.

7.6 Development of ECI Committees for each Township or District

In each participating Township and District (as needed), beginning with the Pilot Sites, intersectoral and interagency ECI Township Committees will be developed. Representatives of all participating ministries, civil society organisations and private sector groups will be invited to join and participate actively in these Committees. Guidelines for the TOR of Township ECI Committees will be prepared, including criteria for membership, positions and major Committee functions for collaboration and coordination at Township or District levels.

7.7 Preparation of national and regional one-year and five-year development plans and budgets

Upon the request of MoSWRR and the National ECI Intersectoral Committee, the ECI Task Force and its Technical Groups will assist with the preparation of annual ECI submissions for one-year and five-year national development plans and budgets regarding the ECI system, with a focus on ECI needs, benefits, goals and outcomes. The ECI submission should be prepared in June of each year in order to be ready when it will be due in August.

ECI Service Sites and other ECI Offices will promote and ensure continuous advocacy is conducted at the Village/Ward, Township and District levels for inclusion of the ECI programme and its budget in submissions to the Regional Development Plan and Budget.

Guidelines will be provided to ensure each ECI Service Site maintains complete and transparent programme files and financial systems to meet national standards and to be able to meet six-monthly performance and financial audit requirements. ECI programme coordinators and selected professionals in each Pilot Site will be trained in how use the guidelines, formats for programme performance and expenditure reports.

During 2017-2018, each Pilot Site will prepare six-month programme performance and expenditure reports (financial reports) submit them to MoSWRR and the National ECI Intersectoral Committee. The first performance report, including inputs and outputs, should be submitted in September for the period from April

to September (or January to September). The second/annual performance report will include inputs, outputs and outcomes and the annual financial report. It will be submitted in March 2018, and will cover the entire fiscal year.

In addition, formats and guidelines for monthly reports on expenditures and programme performance, including inputs and outputs, will be prepared for the use of all ECI Service Sites. Relevant personnel will be trained in how to use these monthly formats.

Finally, within the ECI system, Quality Assurance Committees will be established, including technical ECI leaders who will report to the Minister of MoSWRR and National ECI Intersectoral Committee.

Strategic Priority 8 on Organisational Structure, Annual Planning and Budgeting

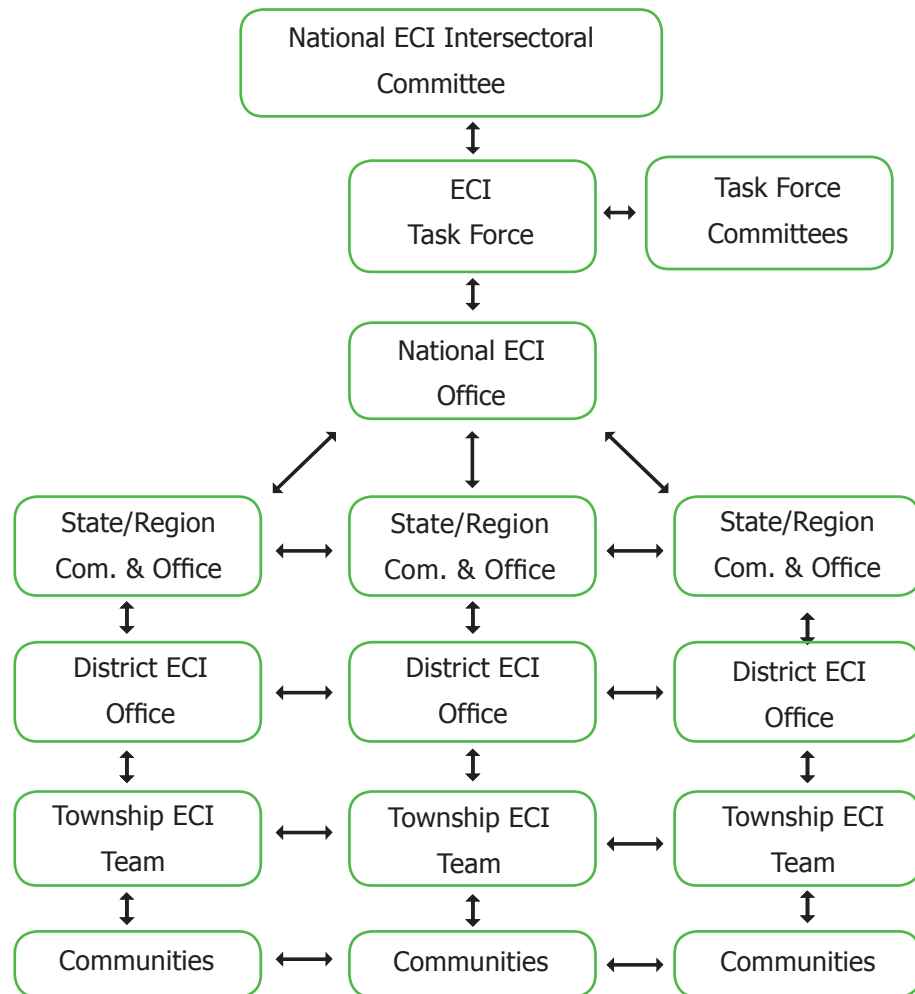
Develop a robust ECI organisational structure, with effective and timely processes for planning and coordination that include the Community, Township, District, State, Regional, Self-Administered Area and Union levels.

In order to conduct ECI services in all 21 States, Regions and Self-Administered Areas of Myanmar by 2021, and in all 325 Townships of Myanmar by 2025, it is essential to develop a Comprehensive ECI Organisational Framework for planning, implementing, coordinating, supervising, training, monitoring and evaluating all ECI services.

The following chart presents the future ECI organisational framework. It must be emphasised that this full organisation structure will not be achieved for several years.



Organisational Framework of ECI Services



8.1 Development of the ECI Organisational Structure, in phases

As presented in **Strategic Priority 5 on the Establishment and Phased Expansion of ECI Services**, the ECI organisational structure will be developed in an evolutionary manner in order to learn step-by-step about how to overcome challenges and to identify effective regional approaches.

During 2017, the ECI Task Force will develop a detailed plan for ECI organisational development. At this time, the following steps in organisational development are foreseen for Phases I to V:

Phase I and II: Planning National ECI System and preparing programme contents for

establishing Pilot Sites and training personnel (January 2017-December 2017)

- The current ECI Task Force will guide the development of the national ECI programme and plan for implementation during 2015 and the first quarter of 2017.

- The National ECI Office will be created during the first quarter of 2017. It will have a small team that will work with the ECI Task Force to develop the ECI programme and design, prepare and establish the Pilot Sites by the end of 2017.

Phase III: Establishing and implementing Pilot Sites, with the support and collaboration of regional stakeholders (October 2017-December 2018)

- During 2016-2017, the Technical Group for ECI Intersectoral Collaboration and Coordination will be established.
- In 2017-2018, the National ECI Office will guide the development, implementation, coordination, supervision, monitoring and evaluation of the nine Pilot Sites in three States and Regions
- In addition, the current ECI Task Force will be continued during 2017, and it will become a permanent body with additional specialists added, as needed and appropriate.
- Small State and Regional ECI Offices will be initiated by January 2018 in each of the three States and Regions selected to be ECI Pilot Sites, and they will help to develop and support the Pilot Sites.
- ECI Transdisciplinary Teams will be established in each Pilot Site to implement ECI services in the nine participating Townships.

Phase IV: Revision of ECI programme in light of monitoring and evaluation results and training of more professionals, paraprofessionals and volunteers (December 2018-March 2019)

- Based on programme experiences and the results of monitoring and evaluation, the ECI programme will be revised and improved.
- All Pilot Sites will be engaged in evaluating their services and in helping to revise the ECI system of services based on lessons learned and identified good practices.

Phase V: Expansion ECI services to other sites in each initial State and Region, and to the rest of the States, Regions and Self-Administered Areas of Myanmar (April 2019-December 2021)

- As the original ECI Pilot Sites in three States and Regions expand their ECI services to additional Townships and Communities, District ECI Offices will be created to help with coordination, supervision, in-service training, monitoring and evaluation as well as the transmission of reports from Townships to State and Regional ECI Offices and the National ECI Office for database management.

- Additional States, Regional and Self-Administered Regions will open ECI services: 5 in 2018; 5 in 2019; and 7 in 2021. As ECI service sites are established in new Townships, ECI Regional offices will be established in each of these States. .
- As the need arises, ECI District Offices will be established.
- By 2021, all 21 States, Regions and Self-Administered Areas will have some level of Township services, and some District offices may have been created for clusters of Townships that require additional support.

Phase VI: Expansion of ECI services to communities in all Townships in Myanmar (January 2021-December 2025)

- During Phase V, the full array of ECI services will be made available in communities of all Townships and by 2025.
- It is also expected that during this Phase, some Districts will develop ECI offices to support the Townships and coordinate with State, Regional and Self-Administered Area Offices and the National Office.

8.2 Description of organisational entities of the National ECI System

During 2017, TOR will be developed for each of the entities of the National ECI System, including their membership, roles and responsibilities. The ECI National Office, with the support of the National ECI Intersectoral Committee and the ECI Task Force, will develop the National ECI System from 2017 forward. Following are brief descriptions of each of the entities.

National ECI Intersectoral Committee

The National ECI Intersectoral Committee will replace the ECI Steering Committee. It will be composed of national decision makers, including the Ministers or Deputy Ministers of MoSWRR, MoHS, MoE, MoHA, MoPF, MoL, MoBA, and MoI. Other members will include directors of selected national and international non-governmental organisations (NGOs); faith-based organisations (FBOs); higher education institutions; professional associations; and private sector organisations.

The National Committee will be chaired by the Minister of MoSWRR, with the Deputy Minister of Education as Secretary and Deputy Minister of MoHS as Treasurer. The National Committee will collaborate closely with the Myanmar Council of Persons with Disabilities; review and adopt TOR of all ECI entities; approve protocols, service and personnel standards and other major ECI documents; lead intersectoral and interagency collaboration and coordination; guide the work of the Task Force; and review and approve reports and plans provided to them by the ECI Task Force and the National ECI Office.

ECI Task Force

The ECI Task Force will continue to include technical leaders from the ministries and agencies represented on the National ECI Intersectoral Committee plus other specialists, as appropriate. The Task Force will provide technical oversight of the National ECI Office, will support it in its technical work, and will report to the National ECI Intersectoral Committee. The Task Force will establish its Technical Groups, as outlined in Section 7.4.

National ECI Office

The National ECI Office will be established in 2017. It will conduct annual planning and budgeting activities; lead national service collaboration and coordination; ensure all planned pre- and in-service training is undertaken; supervise ECI services at all levels; lead monitoring and evaluation activities; and ensure reports are prepared and circulated according to schedule.

Located in the MoSWRR, with modest core support from the annual budget of MoSWRR, initially the National ECI Office will have the following ECI staff members: a director who is an early intervention specialist; at least one health/nutrition specialist that has been recommended by and approved by MoHS; an inclusive education specialist recommended and approved by MoE; a finance and budgeting officer; a monitoring, evaluation and reporting specialist; and a database specialist for the ECI-MIS. Support for special projects will also help to expand this small Office, in accordance with its needs.

State, Regional and Self-Administered Area ECI entities

- *State, Regional and Self-Administered Area ECI Committees*

As additional ECI services are developed in each State, Region and Self-Administered Area, a State, Regional or Self-Administered Area ECI Committee will be established, with representatives from all participating regional ministries plus other relevant agencies identified in each geographic area.

- *State, Regional and Self-Administered Area ECI Offices*

A State, Regional Self-Administered ECI Office will be opened in each State, Region or Self-Administered Area, with one administrator who is an early intervention specialist, initially at least one half-time ECI supervisor and a half-time monitoring, finance and budgeting officer. These offices are expected to grow over time. They will ensure the development of effective regional planning, collaboration and coordination, training, supervision, monitoring, evaluation and reporting.

District ECI Offices

As needed, District ECI Offices will be added, with one administrator and at least one District-level ECI supervisor. For highly populous Districts, additional personnel will be required.

8.3 Overview of the organisational framework at the Township level

Although the National, State, Regional and Self-Administered Areas and sometimes District levels will lead and coordinate ECI activities, the most important level is the Township level where services are provided to children, families and caregivers in wards and villages.

A detailed plan for service collaboration and coordination at the Township level will be developed during 2017.

The following chart presents general organisational relationships between Township ECI Transdisciplinary Teams and sectoral services currently provided or soon to be offered by the MoSWRR, MoHS and MoE. Some of these roles do not exist in some Townships; therefore, flexibility will be needed. The interconnectedness of these services must be strong in order to ensure that children achieve their full potential.

Sector/Services	MoSWRR	MoHS	MoE	Intersectoral ECI Services
Township Offices	Township MoSWRR Office	Township Health Centre/Sub-Centre	- Township Education Office	Transdisciplinary ECI Team
Township Committees	Township Child Rights Committee	Township Health Committee	Focal ECI Team of Education Office	Township ECI Committee
Professionals	Social work case manager	- Medical Officer - Nurses	- Township Education Officer - Headmasters - Teachers	ECI team leader & professionals
Paraprofessionals	Social work paraprofessionals	- Midwives - Health aides	Assistant teachers	ECI home visitors
Volunteers	Social work volunteers	- Auxiliary midwives - Health workers	Preschool & school volunteers	ECI volunteers

Township Offices

- Township MoSWRR Offices are being progressively established, and they will help to support local ECI services.
- Township Health Centres and/or Health Sub-Centres will collaborate fully with local ECI services with respect to the provision of preventive and primary health care services; diagnostics for children enrolled in ECI services; and referrals to hospitals and other forms of health care, as needed.

- Township Education Offices will ensure that good transition activities from ECI services to inclusive preschool, kindergarten and primary school services are developed; special education services are fully supported. Township Education Offices will also assist with the planning of ECI services, as needed.
- Transdisciplinary ECI Teams will be formed progressively in each participating Township. They will coordinate fully with the Township MoSWRR Offices, the Township Health Centres, and the Township Education Offices; develop the full range of local ECI services; and coordinate with District and State, Regional or Self-Administered Area ECI Offices.

Township Committees

Four types of Township Committees exist or soon will be established at the Township level:

- Township Child Rights Committees (TCRC) currently are present in all Townships.
- Township Health Committees (THC) are present in all Townships.
- Township Education Offices will create Focal ECI Teams in each Township as ECI services are established in them.
- Township ECI Committees (TECIC) will be established as ECI service sites are founded and they will collaborate with all other Township committees; conduct community outreach; help with screening to find eligible children; support ECI services; and conduct community oversight of local ECI services.

Professional Personnel

- Social work case managers, a role that MoSWRR is currently establishing, will assist with community outreach; help to identify children for screening; conduct screening activities as needed; participate in Transdisciplinary ECI Teams upon request; send and receive referrals from ECI services; and help, as needed, with case management activities for ECI children and their families.
- The Medical officer and nurses will conduct preventive, primary care and diagnostic services for children enrolled in ECI services; make referrals to hospitals and other levels for children with complex or emergency situations; and participate in Transdisciplinary ECI Teams, upon request.
- Township Education Officers, preschool, kindergarten and primary school headmasters, teachers will support transition activities from ECI services to inclusive preschools, kindergartens and schools; receive professional ECI team members in the preschools, kindergartens and schools to help

teachers learn about the abilities, challenges and needs of children transitioning from ECI services to school-based services; and special educators, as available, will participate in Transdisciplinary ECI Teams, upon request.

- The ECI team leader and all other ECI professionals will coordinate their services closely with the social work case manager, the medical officer and nurses, and school headmasters and teachers; give and receive referrals from all participating professionals; and support comprehensive case management for all children and parents enrolled in ECI services.

Paraprofessional Personnel

- During coming years, social work paraprofessionals will assist social work case managers as they are posted to Townships, and under their guidance, they will also collaborate closely with Township Transdisciplinary ECI Teams by conducting screening activities, if they meet basic criteria for doing so and successfully receive brief training in screening.
- Midwives and health aides will be invited to become trained in child screening and will be asked to support ECI home visitors in their visits to children and their families.
- As appropriate, assistant teachers will be prepared to work with children with disabilities and developmental delays as they transition to inclusive preschools and primary schools.
- ECI home visitors will receive extensive pre-service training in order to provide visits to homes and child care giving facilities; collaborate closely with other sectoral professionals and paraprofessionals; and help with referrals to and from ECI services.

Volunteers

- Social work volunteers will support social work case managers; refer children to ECI services for screening; and conduct other activities as specified in their TOR.
- Auxiliary midwives and community health workers will help to find children who need to be screened; conduct screening activities, as appropriate; and make referrals to ECI services, as needed.
- Preschool and school volunteers will support teachers and others with children who have special needs and will refer children to ECI services, as appropriate.
- ECI volunteers will support ECI personnel with their caseloads and with other activities that will be specified in their TOR.

FINANCIAL SUPPORT FOR THE NATIONAL ECI SYSTEM AND SERVICES



8. Financial support for the National ECI System and Services

Budget projections 2017-2021

The overall cost of the ECI programme for the years of 2017 to 2021 is presented in the following chart, which is based on the budget amounts calculated in the ECI Action Plan.

General ECI Projected Budget, 2017-2021

Strategy	2017	2018	2019	2020	2021	Sub-Totals per Strategy
Strategy 1	46,000	31,500	41,000	41,000	41,000	200,500
Strategy 2	39,500	30,000	62,000	47,000	47,000	225,500
Strategy 3	145,800	52,500	119,000	99,000	94,000	510,300
Strategy 4	354,950	167,500	379,250	274,250	270,250	1,446,200
Strategy 5	21,000	763,500	2,768,937	4,008,408	5,953,876	13,515,721
Strategy 6	72,000	149,000	62,000	44,000	44,000	371,000
Strategy 7	41,500	10,000	25,000	26,000	29,000	131,500
Strategy 8	45,500	143,250	262,368	409,875	589,952	1,450,945
Total	766,250	1,347,250	3,719,555	4,949,533	7,069,078	17,851,666

Investing in Myanmar's Children: Financial Sources

All national ECI systems receive mainly receive their support from government sources in order to ensure that each nation's most vulnerable children will be served. Families living in poverty are unable to pay for ECI services. However, they often volunteer their support for the programme in practical and tangible ways.

Because most of the families who will be served will be low in income, ECI services will be provided free-of-charge. However, for middle- and upper-income

families, they will be encouraged to donate from 20% to 50% of the costs of their services to the ECI programme, based on a sliding fee scale related to their annual or monthly income.

Government support is essential to cover all recurrent (regularly occurring) expenses, such as salaries and benefits, supervisory services, offices and utilities, transportation, supplies and pre- and in-service training and monitoring and evaluation expenses. Usually, salaries compose from 70% to 75% of each the costs of each ECI service site, and the remainder must cover other programme needs.

Usually, some level of international and non-governmental support is essential for programme start-up and to meet developmental costs, such as the preparation of educational materials, media, developmental screening and assessment instruments, training programmes and workshops, and other items including translation to all national languages. External support often covers part of the cost of pilot programme sites, initial monitoring and evaluation activities, the development of the supervisory system, standards setting, etc.

Central Governmental investment in ECI

With the support of the National Parliament's Budget Committee, the budget for ECI services will be established in all participating ministries.

As noted previously, the lead ministry for ECI services is MoSWRR. A target of at least 8% of the MoSWRR budget should be devoted to ECI services.

This target will be achieved in a phased manner, beginning in 2017 with the goal of 4% of the Ministry's annual budget devoted to developing ECI services. By 2021, at least 8% of the MoSWRR will be dedicated to serving the nation's most vulnerable children and their families.

In addition, the Ministry of Health and the Ministry of Education will devote at least 1% of their budgets to ECI services in 2017, and progressively increase their support to 3% of their budgets by 2021. This investment in ECI services will greatly lower future costs for health and nutrition services.

The Ministry of Home Affairs, the Ministry of Finance and the Ministry of National Planning and Economic Development have expressed their strong support for ECI services. The Ministry of Home Affairs will be particularly helpful in ensuring strong regional support for ECI.

The Ministry of Labour, Employment and Social Security, the Ministry of Border Affairs, the Ministry of Immigration and Population, and the Ministry of Information will make contributions to specific ECI activities by means of budgets for specific initiatives and of in-kind support, such as for media campaigns, the use of their facilities for training and service provision, and other activities such as meetings, transportation and other forms of collaboration.

Regional and Municipal Governments

Regional Parliaments, Ministries and their agencies will also be important partners in funding ECI services.

As ECI services enter each State, Region and Self-Administered Area, these entities will be asked to devote at least 2% of their budgets to ECI services, and subsequently this amount should rise to the level needed to ensure all children eligible for ECI services are enrolled and receive the attention they require. It is anticipated that in the initial regions served, the support for ECI services will be expanded to at least 4% of total regional budgets by 2021.

The strong demand for services and the improved outcomes for children and families will help regional leaders to justify these expenditures.

Each year, all participating regions will be requested to begin budget planning very early in order to ensure they include ECI in their list of services to be funded.

Every effort should be made to assist regional leaders and their agencies to focus strongly on supporting ECI services. Initial discussions regarding the high levels of child development needs in each region provide reason for hope that regional officials will give a very high priority to funding ECI services for their cities, towns, villages and rural areas.

Leaders for ECI services in each region will play critically important roles. They will be able to ensure that children in their areas will be able to develop far better than has been the case in the past. They will be honoured nationally for their dedication and for their achievements.

National Fund for ECI

With the adoption of the National Strategic Plan for ECI, a **National Fund for ECI** will be established.

In collaboration with the Ministry of Health and Sports and the Ministry of Education, and with the full participation of the Ministry of Planning and Finance, Ministry of Home Affairs, and the Ministry of Social Welfare, Relief and Resettlement will establish and administer this sole-use Fund. It will have an independent Board of Directors, terms of reference, a sole-use bank account, and very tight fiscal controls.

The National Fund will be able to receive donations from well-wishers and other benefactors, corporations, businesses, banks, foreign governments and international agencies, and other sources of support.

The Board of Directors will produce an annual report listing all donors, the amounts received in donations, and the ECI services and activities that were sponsored in locations throughout Myanmar.

Medical Insurance Schemes

Not all children will have a medical diagnosis. Some will have developmental delays in speech or other areas of development, autism spectrum disorders and other situations that do not require a medical diagnosis.

For children with a medical diagnosis that is covered by insurance, with parents' collaboration, insurance agencies will be charged for allowable costs under their list of services provided. Protocols will be prepared to ensure the reimbursement of services rendered will be managed transparently and correctly.

National and International Non-Governmental, Faith-Based and Community-Based Organisations

Many national and international NGOs, FBOs and CBOs already donate considerable funds and services to Myanmar children's services and services for children, youth and adults with disabilities. They will be strongly encouraged to expand their services to include ECI services. The Government will contract with those that are officially registered and are assessed to meet national ECI programme guidelines, procedures and standards.

Disabled Persons Organisations (DPOs)

Similarly, DPOs devoted to supporting persons with disabilities are found throughout Myanmar; however, due to the lack of an ECI Strategic Plan, most of them have not previously focused on the development of young children. With the advent of this ECI Strategic Plan, DPOs will be encouraged to develop and/or advocate for ECI services.

International Development Partners

Increasingly, international development partners are supporting the funding of developmental and pilot costs of ECI services in all world regions. Some of these international donors include:

- Development banks, such as the Asian Development Bank and the World Bank
- Multilateral agencies, such as UNICEF, UNDP, UNESCO, WHO, FAO and others
- Regional agencies: European Union, ASEAN, and others
- Bilateral agencies, such as Ministry of Foreign Affairs of Japan and JICA, Singapore Cooperation Programme, Korean International Cooperation Agency, Irish Aid, Ministry of Foreign Affairs of Israel (MASHAV), US Agency for International Development (USAID), Finland's FINNIDA, Swedish International Development Cooperation Agency (SIDA), Canadian International Development Agency (CIDA), Department of Foreign

Affairs and Trade of Australia, Department for International Development (DfID), Norway's NORAD, Danish International Development Agency (Danida), Federal Ministry for Economic Cooperation and Development of Germany (GIZ) and others

- International foundations, such as the Open Society Foundation, the Bernard van Leer Foundation, the Children's Investment Fund Foundation, the Buffet Foundation, the Asia Foundation, and others
- International corporations are beginning to fund ECI services in some nations

Public/Private Partnerships

ECI services will be provided mainly through public/private partnerships. A successful example of this approach is the collaboration between MoSWRR and various DPOs.

These partnerships should be further strengthened and expanded to ensure their capability to provide enough ECI services as they expand quickly throughout Myanmar to meet the demand for child and family services.

Higher Education Partnerships

In order to ensure the strong pre- and in-service training is provided for all ECI personnel on a continuous basis, higher education partnerships will be forged in Myanmar and with ECI service systems and universities in other countries, such as Australia, the United States of America, Canada, Finland, Sweden and Norway.

These higher education partnerships will focus mainly on training but they might also embrace monitoring and evaluation, external evaluation, and research projects.

Additional Possible Sources of Support for ECI

Depending upon the level of political will, various nations have provided support for ECCD and/or ECI. The following types of innovative funding have been used in various countries:

- Payroll taxes
- Sales taxes
- Import/export taxes
- Liquor and tobacco taxes
- Airplane ticket taxes
- Entry and/or exit taxes at airports
- Luxury taxes (jewelry, cars, watches, etc.)

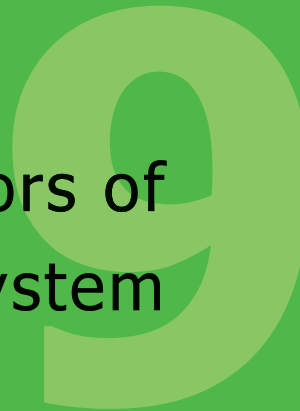
- Natural resource taxes (gems, forestry, metals, etc.)
- Lotteries (a percentage of an existing lottery is easiest)
- “Adoption” of ECI service sites by corporations, businesses or banks
- Benefactors
- Fundraising events, including auctions of motorcycles, bicycles, household goods, cell phones; music and art events; community dinners and festivals; sports events, etc.

Annual ECI Planning and Budgeting Cycle

Special attention will be paid to ensuring careful planning occurs during Myanmar’s annual planning and budgeting cycle. This planning must be conducted not only at the Central Governmental level but also at State, Regional and Self-Administered State levels, and wherever possible, at Municipal levels.

The National ECI Office should place top priority on ensuring that the budget cycle includes well-developed budgets for ECI services in all participating States, Regions and Self-Administered Areas.

Main Indicators of the National ECI System



9. Main Indicators of the National ECI System

Of necessity, the ECI Action Plan includes a host of operational indicators, most of which are indicators for inputs or outputs related to the tasks or steps of specific ECI activities or services.

Some of the indicators are outcome (results) indicators. The following list of outcome indicators is keyed to a generic system for monitoring and evaluating ECI services at programme, regional and national levels. This list is necessarily short because it becomes very costly to measure even indicators in a valid and consistent manner. The use of this list of indicators will help greatly to make the Myanmar National ECI System highly accountable and transparent.

Outcomes of Early Childhood Intervention Services			
Outcome Objectives	Indicators	Measures	Targets
Child and Parent Development			
Work with parents to achieve IFSP goals with the child	Number and percent of children whose IFSP goals are achieved	*IFSP Form *IFSP Form Review	70% of the child's IFSP goals are achieved
Work with parents to achieve IFSP goals of the parents	Number and percent of parents who achieve their IFSP goals	*IFSP Form *IFSP Form Review	80% of the parents' IFSP goals are achieved
Improve child development, as possible	Number and percent of children whose development has improved according to the a comparison of first and subsequent assessments	*Selected child assessment	70% of the children are assessed to have improved in their development relative to their ages
Ensure that parents feel well-supported by ECI Services	Number and percent of parents who state that they feel well-supported by ECI Services	*Annual Parent Survey	90% of parents state that they feel well-supported by ECI Services

Parenting Knowledge and Skills			
Maintain or improve home safety (pre/post)	Number and percent of parents enrolled in parenting services maintain or improve the safety of their homes	* Home Safety Assessment	90% of parents enrolled in parenting services maintain or improve their home safety scores
Maintain or improve parenting skills regarding child development and care (pre/post)	Number and percent of parents enrolled in parenting services who maintain a good level of parenting skills or improve them	* Parenting Skills Interview	90% of parents enrolled in parenting services maintain a good level of parenting knowledge about child development and care or improve their knowledge
Child Nutrition			
Improve the rate of exclusive breastfeeding until infant is 6 months of age	Number and percent of infants who are exclusively breastfed until 6 months of age	* Diet Analysis Charts	80% of mothers breast-feed exclusively to 6 months of age
Ensure infants and children receive appropriate amounts of breast milk or formula and amounts and types of complementary foods after 6 months of age	Number and percent of infants and children over 6 months of age who receive appropriate amounts and types of complementary foods	* Diet Analysis Charts	90% of infants and children receive appropriate amounts breast milk or formula and amounts and types of complementary foods after 6 months of age
Weigh and measure children each 3 months	Number and percent of children enrolled in services who are weighed and measured	* Growth Chart	100% of children are weighed and measured each 3 months
Ensure that children have appropriate height and weight for age	Number and percent of children enrolled in services who have appropriate height and weight for age	* Growth Chart	70% of children who are enrolled in services have or attain appropriate height and weight for age, (to the extent possible)
Ensure children found to be malnourished (stunted, wasted, underweight or obese) receive special nutrition and ECI Services	Number and percent of children found to be malnourished who are referred to special nutrition and ECI Services	* Growth Chart * Referral Form from ECI Services to Other Agencies	100% of children found to be malnourished are referred to special nutrition services, as available

Child Health			
Ensure all children have a medical care home (consistent health care centre services)	Number and percent of children who have a medical care home	* Intake Form for Parent-Child and ECI Services * Immunisation and Well-Child Check-Up Form * Referral Form from ECI Services to Other Agencies	100% of children have a medical care home or gain one due to ECI support and referrals
Ensure children have regular infant or well-child medical checkups	Number and percent of children who receive regular well-child medical check-ups	* Immunisation Form and/or * Well-Child Check- Up Form	95% of children have regular infant or well-child medical checkups
Ensure all expected immunisations for age of child are completed (unless child has been ill)	Number and percent of children who receive all expected immunisations for age	* Immunisation and Well-Child Check- Up Form	95% of children have all expected immunisations for their age

The foregoing list of outcome objectives, indicators, measures and targets is robust and comprehensive. More ECI outcome indicators may be added later.

In order to measure these outcome indicators, the Monitoring and Evaluation Manual mentioned in the Strategic Plan (Section 6.3) must be developed and implemented, along with a database system.



10 Annexes



I. Acronyms

CBO	Community-Based Organisation
CRC	Convention on the Rights of Children
CRPD	Convention on the Rights of Persons with Disabilities
ECCD	Early Childhood Care and Development
ECI	Early Childhood Intervention
EIS	Early Intervention Specialists
FBO	Faith-Based Organisation
MoBA	Ministry of Border Affairs
MoE	Ministry of Education
MoPF	Ministry of Planning and Finance
MoHS	Ministry of Health and Sports
MoHA	Ministry of Home Affairs
MoL	Ministry of Labour, Immigration and Population
MoI	Ministry of Information
MoSWRR	Ministry of Social Welfare, Relief and Resettlement
NGO	Non-Governmental Organisation
OT	Occupational Therapists
PT	Physiotherapists
PTA	Parent-Teacher Associations
S/LT	Speech/Language Therapists
SDG	Sustainable Development Goals
TCRC	Township Child Rights Committees
TECIC	Township ECI Committees
THC	Township Health Committees
TOR	Terms of Reference

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3. ECI Steering Committee and Task Force Member List



ECI Steering Committee Member List

No.	Name	Designation	Responsibility	Department/Ministry /Organization
1	U Soe Kyi	Director General	Chair	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
2	Dr. San San Aye	Deputy Director General	Deputy Chair	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
3	U Aung Kyaw Moe	Director	Member	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
4	U Win Htain Kyaw	Director	Member	Department of Relief and Resettlement, Ministry of Social Welfare Relief and Resettlement
5	Dr. Myint Myint Than	Director	Member	Child Health Development, Department of Public Health Ministry of Health and Sports
6	Dr. Hla Myat Thway Eaindra	Director	Member	Maternal and Reproductive Health, Department of Public Health, Ministry of Health and Sports
7	Dr. May Khin Than	Director	Member	Nutrition, Department of Public Health, Ministry of Health and Sports
8	Dr. Kyaw Khine Oo	Director	Member	Department of Health Professional Resource Development and Management, Ministry of Health and Sports
9	Dr. Thida Hla	Director	Member	Department of Medical Service, Ministry of Health and Sports
10	Dr. Khin Myo Hla	Professor/Head	Member	Physical Medicine & Rehabilitation Department, Yangon General Hospital, Ministry of Health and Sports
11	U Ko Lay Win	Deputy Director General	Member	Department of Educational Research Planning and Training, Ministry of Education
12	U Myint Aung	Director	Member	Department of Higher Education, Ministry of Education
13	Dr. Nilar Kyu	Professor/Head	Member	Psychology Department, Yangon University, Ministry of Education
14	U Htay Win	Assistant Director	Member	Education & Training Department, Ministry of Border Affairs
15	U Myat Tun Oo	Director General	Member	General Administration Department, Ministry of Home Affairs
16	Daw Nu Nu Htwe	Assistant Director	Member	Department of Planning, Ministry of Finance and Planning
17	Daw Tin Tin Aye	Assistant Director	Member	Department of Budgeting, Ministry of Finance and Planning

ECI Steering Committee Member List

No.	Name	Designation	Responsibility	Department/Ministry /Organization
18	U Aung Zaw Lin	Manager	Member	News and Periodical Enterprise, Ministry of Information
19	Daw Soe Soe San	Deputy Director	Member	Department of Population, Ministry of Labor, Immigration and Population
20	Dr. Latt Latt Wai	Deputy Director	Member	Social Security Board, Ministry of Labor, Immigration and Population
21	U Bu Lane	Assistant Director	Member	Education & Training Department, Ministry of Border Affairs
22	Daw Thazin Nwe	Chair	Member	Myanmar Maternal & Child Welfare Association
23	Dr. Zaw Moe Aung	Country Director	Member	The Leprosy Mission (Myanmar)
24	Dr. Aye Aye Yee	Education Specialist(ECD)	Member	UNICEF (Myanmar)
25	Daw Yu Yu Swe	Director	Secretary	Department of Social Welfare

Early Childhood Intervention Task Force Member List

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2	Dr. Myint Thein Tun	Professor	Member	Physical Medicine & Rehabilitation Department, (1000) bedded hospital(NPT), Ministry of Health and Sports
3	Daw Khin Thein	Professor/Advisor	Member	Department of Maternal & Child Health Nursing, University of Nursing -Yangon
4	Dr. Khin Thida Aung	Medical Superintendent	Member	National Rehabilitation Hospital
5	Dr. Lwin Lwin Oo Hlaing	Deputy Director	Member	Department of Medical Service, Ministry of Health and Sports
6	Dr. Nilar Aye	Team Leader	Member	Child health, Department of Public Health, Ministry of Health and Sports
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10	Dr. Hnin Hnin Lwin	Deputy Director	Member	Maternal and Reproductive Health, Department of Public Health, Ministry of Health and Sports
11	Dr. Aye Myat Min Aye	Consultant Pediatric Neurologist	Member	Yangon Children Hospital, Ministry of Health and Sports
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13	Daw Thiri	Lecturer	Member	University of Community Health (Magway), Ministry of Health and Sports
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15	Dr. Latt Latt Wai	Deputy Director	Member	Social Security Board, Ministry of Labor, Immigration and Population
16	Dr. Tin Mar Cho	Professor	Member	Psychology Department, Yangon, Ministry of Education
17	Dr. Myo Thuzar Khin	Associate Professor/ Head	Member	Department of Physiotherapy University of Medical Technology, Yangon

Early Childhood Intervention Task Force Member List

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19	Daw Thuzar Win Tun	Assistant Director	Member	Department of Basic Education, Ministry of Education
20	Daw Win Ohmar	Deputy Director	Member	Department of Relief & Resettlement, Ministry of Social Welfare Relief and Resettlement
21	Daw Yu Yu Swe	Director	Secretary	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
22	U Swan Yi Ya	Deputy Director	Member	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
23	Daw Ohmar Swe	Staff Officer	Member	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
24	Daw Ohmar Khine	Staff Officer	Member	Department of Social Welfare, Ministry of Social Welfare Relief and Resettlement
25	U Nay Lin	Staff Officer	Member	MRTV Ministry of Information
26	Daw Thin Thin Khine	Staff Officer	Member	MRTV Ministry of Information
27	Daw Ei Ei Kyaw	Deputy Staff Officer	Member	General Administration Department, Ministry of Home Affairs
28	U Nay Htun	EC	Member	Myanmar Federation of Person with Disability
29	Daw Saw Ohmar	Project Officer	Member	Myanmar Nurse and Midwife Association
30	U Htha Uke	Managing Director	Member	Eden Center for Disabled Children
31	Dr. Ko Ko Oo	Auditor	Member	Myanmar Physically Handicapped Association
32	U Moe Ko Ko Kyaw	Member	Member	Myanmar Physiotherapy Association
33	Daw Yin Yin Mya	Advisor	Member	Myanmar Red Cross Society
34	U San Hla	Member	Member	Myanmar Professional Social Workers Association
35	Dr. Sunshine Aung	Assistant Project Manager	Member	Marie Stope International
36	Daw Jue Kyaw Thet Wai	Physiotherapist	Member	Retired Service Personalle's Hospital

Early Childhood Intervention Task Force Member List

No.	Name	Designation	Responsibility	Department/Ministry /Organization
37	Dr. Kyi Kyi Ohn		Member	Save the Children
38	Ms. Margaret Jackson or Scott Braunschweig	Country Manager	Member	Catholic Relief Services
39	Sister Elizabeth Chit Pone	Education Sector Head	Member	Catholic Relief Services Karuna Myanmar Social Services
40	Daw Moe Yee Oo	Program assistant	Member	International Committee of the Red Cross
41	U Zaw Oo	Protection Specialist	Member	World Vision
42	Ms. Caroline Mary Guein	Inclusion Project Coordinator	Member	Handicap International
43	Daw Ann Julie	Department of Head	Member	Christian Education Department, Myanmar Baptist Convention
44	Dr. Kyaw Win Sein	Nutrition Specialist	Member	Nutrition Section, UNICEF (Myanmar)
45	Dr. Chit Ko Ko	Child Protection Specialist	Member	Child Protection Section UNICEF (Myanmar)
46	Dr. Sarabibi Thuzar Win	Maternal and Child Health Specialist	Member	Maternal and Child Health Section UNICEF(Myanmar)
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48	Dr. Roe Nwe Wai	Project Manager	Member	The Leprosy Mission (Myanmar)

