RCPCH Global Update 2025-26

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Contents

Introduction

In the last 10 years, 'RCPCH Global' has developed a portfolio of programmes, working in partnership with local paediatric professional bodies in low- and lower-middle-income countries in Africa, Asia and the Middle East. Our strategy has been to focus on supporting improvement in the quality of frontline clinical care for mothers, newborns and children in hospitals and health centres in Kenya, Uganda and Rwanda, Sierra Leone and Nigeria, Myanmar, Nepal, India and Pakistan, Palestine (West Bank and Gaza) and Lebanon, generating over USD$15m worth of grant-funded programme activity.

Over this time, we have developed a core set of strategic and operational approaches – supporting local paediatric partners to lead on child health initiatives from policy level to clinical practice; ensuring that clinical skills training is embedded in improvements in the operating environment, from infrastructure and equipment to workforce planning and continuous professional development. We have also extended and widened our working remit – from a hospital-centred approach to a 'district' focus, incorporating outreach to the primary level to better support the care continuum from antenatal and intrapartum through perinatal and neonatal to infant and paediatric health and care.

Through long-term programme partnerships, we have seen significant changes in standards of care, care capacity and clinical outcomes in some of the poorest and most challenging humanitarian environments in the world – with paediatric mortality in our Sierra Leone ETAT+ programme falling from 13.6% to under 9% between 2017 and 2021; and with neonatal mortality in our bespoke Rwandan neonatal, obstetric and perinatal programmes falling by almost 50% between 2017 and 2024.

With these changes, though, come new challenges – and the need for our operating model to adapt and evolve. One notable area of change – with rising rates of neonatal survival – is the escalation of interest, among global health agencies, national Ministries, and local paediatric partners, in 'early childhood development'; more specifically interest in measures to understand and mitigate the challenges of developmental delay among newborns consequent on difficulties in antenatal and intrapartum care, which are often highly amenable to intervention but which, unaddressed, can lead to life-long disability.

In the main body of this RCPCH Global Update, we present examples of new programme developments – in Nigeria, Lebanon and Rwanda – focusing on our traditional operating model, improving perinatal and neonatal care in health centres and hospitals, but extending beyond discharge, to support government and local partners to develop cost-efficient developmental monitoring capabilities in the primary care level, to identify and work with community, civil society and facility-based clinical partners providing support to parents to understand, manage and access specialised therapeutic care for children from the early signs of developmental delay through to a more socially inclusive model of child and adolescent disability welfare.

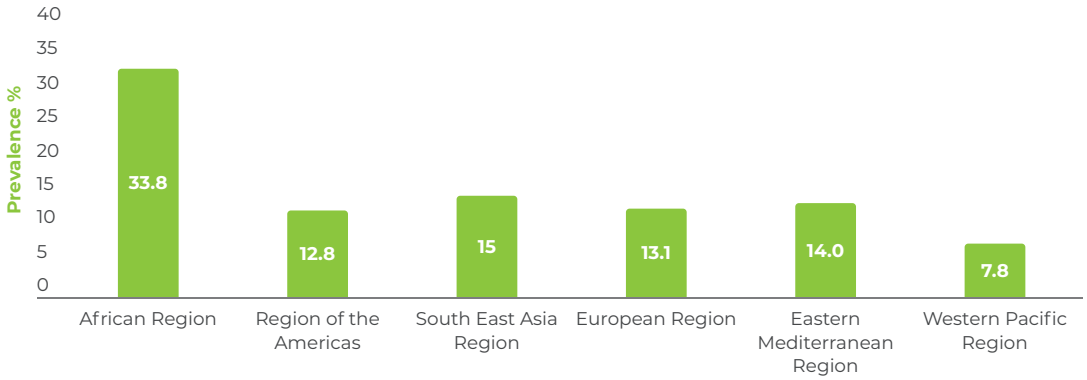
Components of nurturing care

The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families. Starting at age three or four is too little too late, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness. The best investment is in quality early childhood development from birth to five for disadvantaged children and their families."

—James J. Heckman, December 7, 2012

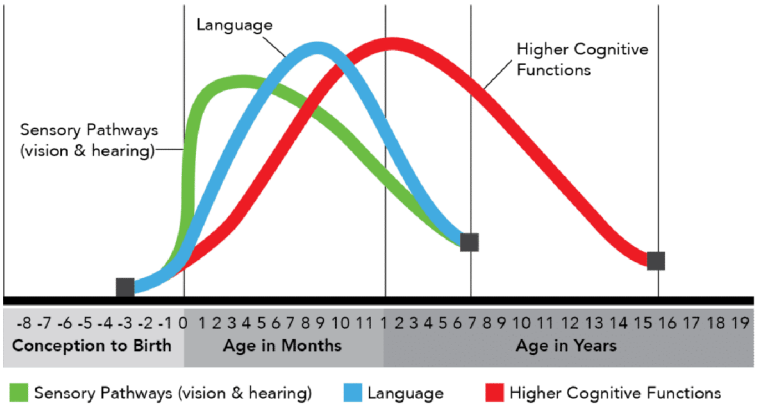
Focus on Early Childhood Development (ECD)

Globally, an estimated 250 million children under 5 are at risk of poor physical and neurological development, with the potential to lead to life-long disability, frequently as a result of undiagnosed and untreated early childhood development challenges. Almost 9 in 10 of these children live in low- and lower-middle income countries.[1] Developmental delay is defined as any delay, predominating in early childhood, in reaching population standardised thinking, social, language or motor development skills.[2] Children with delays – compounded by poverty and lack of access to health and welfare services – 'perform less well at school, earn less as adults...and are less able to economically provide for their children, leading to intergenerational poverty transmission'.[3] [4]



Estimated median prevalence of developmental disabilities in children and adolescents in the six WHO regions[2]

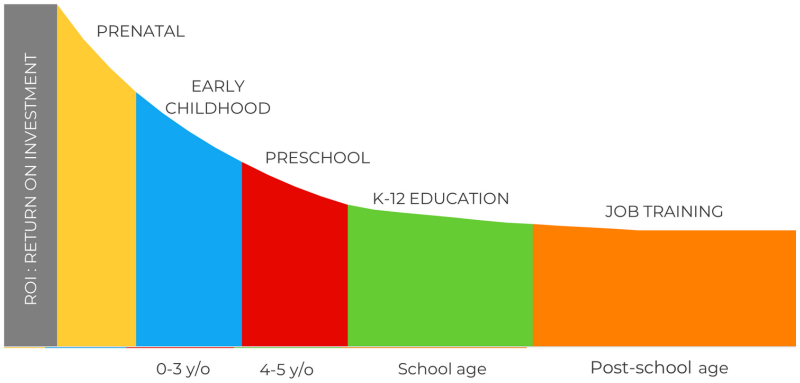
In 1990, an estimated 53 million children younger than 5 years had developmental disabilities; in 2016, the number was 52.9 million.[5] With under-5 mortality falling by more than 50% over this period, the indication is that developmental challenges consequent on greater early child survival are not – yet – being proportionally recognised and managed. Vision and hearing loss and intellectual challenge comprised the bulk of early child disability. But intellectual challenges were the largest contributor to years lost to disability, with high or rising rates in sub-Saharan Africa, South Asia and the Middle East.



Human brain development - synapse formation dependent on early experiences[3]

Early childhood is widely recognised as the best time to mitigate adverse events, identify delays, and introduce evidence-based effective therapeutic interventions.[6] [7] In the first few years of life, more than 1 million new neural connections are formed every second. Sensory pathways like those for basic vision and hearing are the first to develop, followed by early language skills and higher cognitive functions.[8]

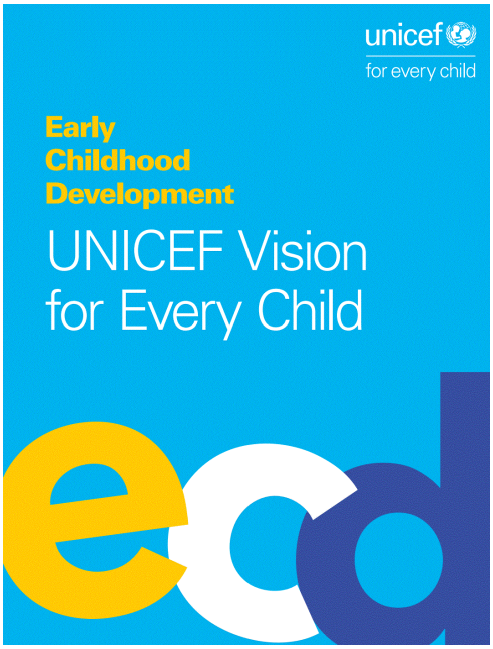
Effective low-cost intervention strategies, including home-based and parent-led care, are available and suitable in low-income settings. Both clinical and economic cost efficiency analyses point to the relative value of early intervention as the primary route to addressing the developmental challenge.[9]



Economic impact of investing in early childhood learning[4]

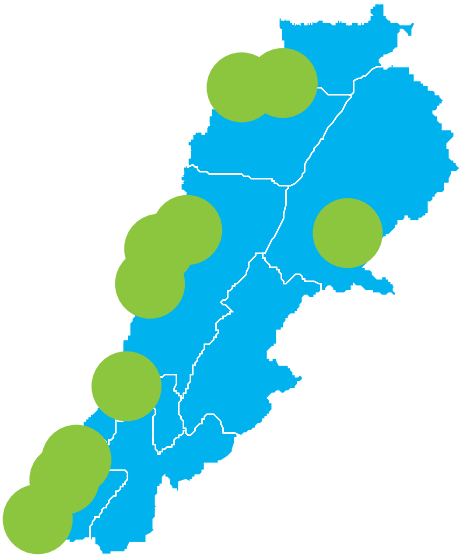
Expansion of utilisation, however, depends on significant strengthening of integrated healthcare and welfare services including better surveillance data, better inclusiveness in health sector policy and investment, better clinical awareness and supportive guidance, better linkage between health and education sectors, and reduction in social stigma. For most of the world's population – particularly those living in low- and middle-income countries (LMICs) – resources remain scarce and, whilst data on prevalence of developmental disabilities are extremely limited, we continue to see major gaps in understanding and addressing their spread globally.

This RCPCH Global Update highlights some of the new programmatic work we are developing with partners in different countries and contexts around the world, to contribute – in a modest but constructive way – to the growth of interest and investment, from policy to practice, in early childhood development and the mitigation of developmental disability, emerging in low- and middle-income countries today.



Lebanon

Almost one in four pre-school age children in Palestine are thought to have some form of developmental delay.[10] Global evidence suggests that detection tends to be lower than actual rate, sometimes considerably so. In the Middle East and North Africa (MENA) region, attention to developmental delay – in particular early identification and intervention – is inhibited by lack of policy, standardised screening tools, actionable data and clustering and gapping in the range of requisite therapeutic skills and services, as well as widespread persistence of social stigma associated in particular with cognitive impairments.



Lebanon: Palestinian refugee camps

As elsewhere, a key barrier to better ECD action in MENA is availability and use of culturally sensitive tools, validated to local differences of language and meaning, and ones which are properly adapted to resource-poor settings.[11]

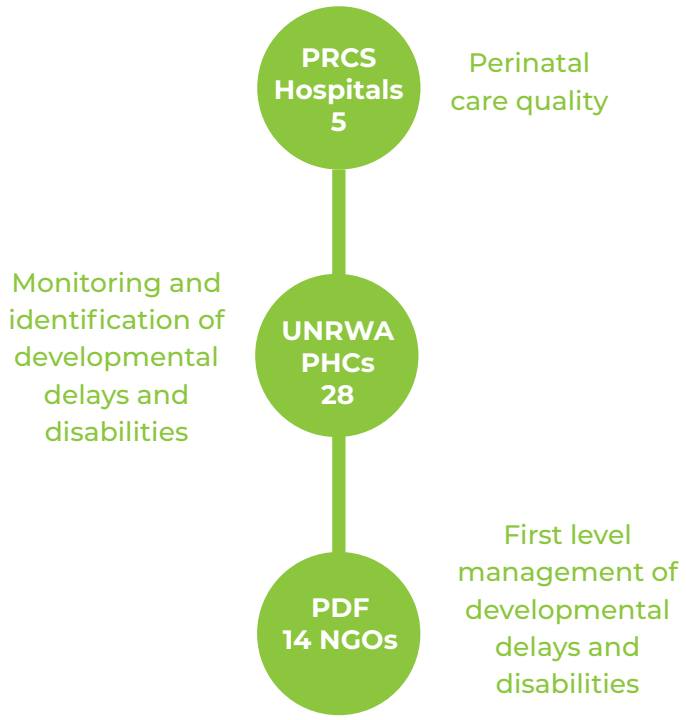
Screening should be approached cautiously, insofar as rising rates of detection increase the need for resources to provide therapeutic services in a context often characterised by short-term humanitarian funding – funding which tends to focus on more tangible aspects of conflict and crisis, to be guided by immediate donor policy perspectives, and to be shaped by competition (rather than collaboration) between local 'implementing partners'.

Crowded and difficult living conditions in Palestinian refugee camps[5]

More than 479,000 refugees are registered with the UN Relief and Works Agency (UNRWA) in Lebanon – just under half of these living in the country's 12 refugee camps. Conditions in the camps are poor – characterized by overcrowding, poor housing conditions, pervasive unemployment, poverty and a lack of access to justice. Palestinian refugees in Lebanon are wholly excluded from access to national social and welfare services, including health and education, and entirely reliant on those services provided by UNRWA.[12] Although accurate data are lacking, an estimated 15% of the Palestinian refugee population across the region is estimated to be living with some form of disability. In Lebanon, one third of the Palestinian refugee children with disability are not enrolled in school.[13]

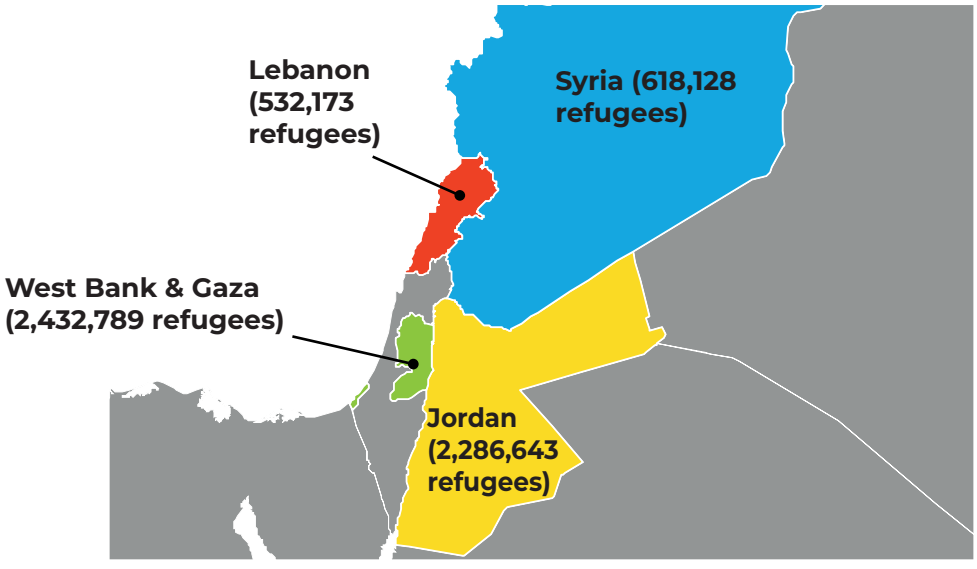
Following a generous legacy donation from College members in 2021, RCPCH Global established a new partnership to prevent, monitor and mitigate developmental delays and disability among Palestinian refugee camp communities in Lebanon, working with Medical Aid for Palestinians (MAP), the UN Relief and Works Agency (UNRWA), The Palestinian Red Crescent Society (PRCS) and the Palestinian Disability Forum (PDF).

The programme centres on strengthening developmental screening through the network of UNRWA Primary Health Centres, using the high rate of vaccines uptake and the schedule of routine immunisations over the first years of life to optimise efficiency in a resource-scarce health system. But we aim also to work upstream in the PRCS hospitals to improve perinatal care, and downstream, with the PDF, to support community access to more integrated therapeutic care for children with identified disability.



In a context of regional instability and conflict, this programme of work has been developed carefully – founded on core humanitarian principles and an absolute commitment to the health and well-being of children wherever they may be. Too often, in such contexts, attention is concentrated on immediate physical conditions and needs, with longer-run considerations about psychological and psychosocial welfare and vital measures of social inclusion relegated to a secondary level of priority. This programme seeks, quite deliberately, to maintain a focus on supporting and enhancing the long-term prospects for children through a more holistic understanding of what child health and development entail.

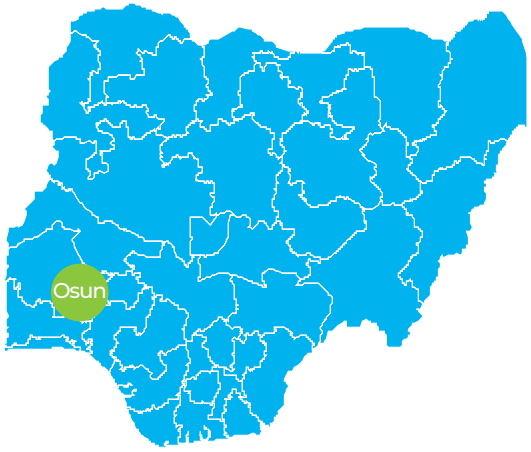
Moreover, our partnership with the multilateral system through UNRWA offers the possibility of extending the scale and impact of the programme by supporting the adoption of new screening and intervention protocols across all of the territories hosting Palestinian refugee communities throughout the Middle East region (approximately 6-6.5m population).



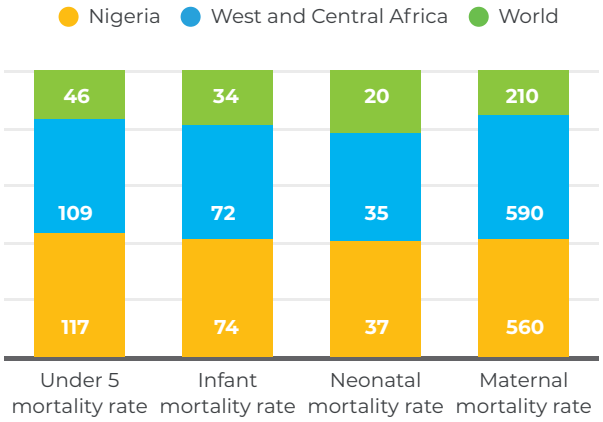
UNRWA fields of operation where the intervention could be scaled up

Nigeria

Nigeria has some of the highest rates of avoidable maternal, newborn and under-5 mortality in the world. Care during labour remains weak and premature birth – a key driver of developmental delays and disability – is high, affecting almost 25% of newborns. Neonatal asphyxia – a lack of oxygen to the baby resulting from poorly managed obstruction during delivery – affects one in three babies and is strongly associated with cognitive impairment in the early years and onset of cerebral palsy – the leading cause of neurodisability among children in Nigeria.



Nigeria - Osun State



Nigeria and comparator neonatal, Infant, under-five and maternal mortality rates[6]

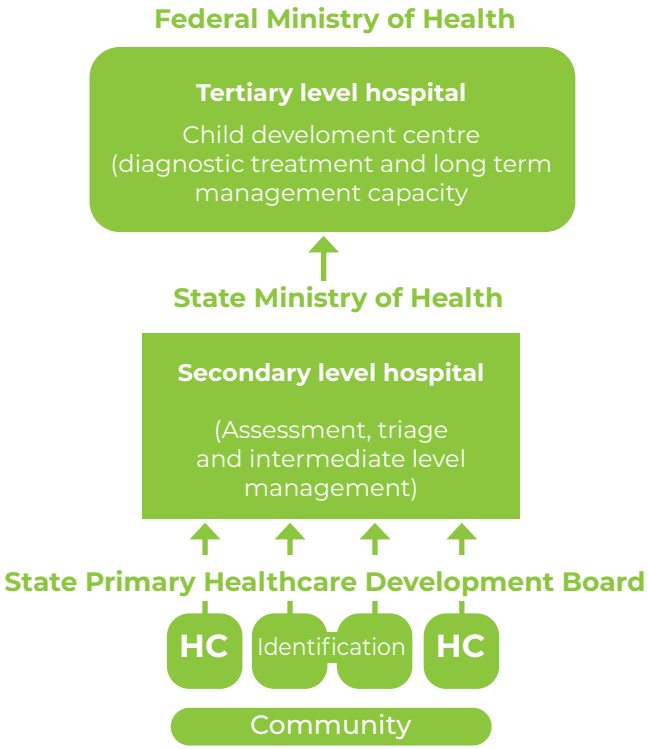
Developmental disability is likely to be substantially under-reported in Nigeria as a result of stigma in communities, and a general lack of health system capacity for screening and therapeutic intervention. As a result, a significant proportion of children in Nigeria grow up with undiagnosed and unmitigated developmental conditions and disabilities which progressively undermine their ability to participate in education and affect their long-term social and economic inclusion. It is estimated that 1 in every 10 of the population lives with some form of disability; 9 in 10 of Nigeria's disabled live below the poverty line.[14]

Attention to health and welfare issues including early childhood development exists on paper at Federal level.[15] But translation from paper to practice is hampered at each level – from nation through state to local government, ward and community – by chronic weakness in the health sector itself, as well as wider persistently high rates of household poverty, maternal and child mortality and morbidity, exclusion from social services in education, employment and welfare, and lack of coherence in policy, financing and implementation of health and social programmes.

As in other country contexts – acutely for lower-income settings – data (and thus policy attention) on developmental delay and related disabilities are scarce. Small-scale studies, for example in a tertiary hospital setting in Southwest Nigeria, suggest a third of sampled children manifesting signs of developmental delay.[16] Prevalence of developmental delay is high across all of Nigeria's geographic zones, but with significant variation – emphasising the need for locally robust surveillance.[17] As elsewhere the systematic institutionalisation of routine screening for developmental delays is the foundation on which more inclusive and effective early and continuing intervention and therapeutic support can be built.

Drawing on UK/FCDO aid grant funding, in 2023 RCPCH Global established a new partnership with Obafemi Awolowo University Teaching Hospital (OAUTH), to design and pilot a 1-year integrated programme, incorporating testing of a simplified screening tool for developmental milestones for use in selected Primary Health Centres; working with nurses in PHCs, nurses and doctors at hospitals and medical centres; with paediatric neurodevelopmental and other therapeutic specialists at OAU; and building a virtual partnership between ECD teams at OAUTH and Alder Hey Children's Hospital.

In the context of Nigeria's scale and complex health development needs, this programme – spanning 19 primary healthcare centres (PHCs), three secondary facilities, and the tertiary hospital at OAU Teaching Hospital Complex – is a modest contribution. But its design is rooted in collaboration between RCPCH, OAU, the Osun State Ministry of Health and Primary Health Care Development Board. Our aim is to trial and demonstrate what may be possible in the use of a simplified screening tool, in the development of clinical capabilities from the ground up, in the enhancement of referral pathways from primary to secondary and from secondary to more advanced specialist paediatric care, in building community understanding of neurodevelopmental challenges and disability, and strengthening parent-led care – and to bring these to State level as well as upwards to the Federal level of health and social care development.



Initial findings from the pilot intervention suggests that a simplified screening tool can be practically integrated into primary healthcare services and is effective at identifying children and supporting them to receive timely interventions. We have seen first-hand the extraordinary potential and power of caregivers in providing support to each other and in advocating for improved care and greater social inclusion for their children. And we are generating new efficiencies in the positive impact of combined virtual and in-person global child health clinical exchanges and the potential of remote mentorship to support the development of therapy services in a resource-constrained health system such as that in Nigeria.

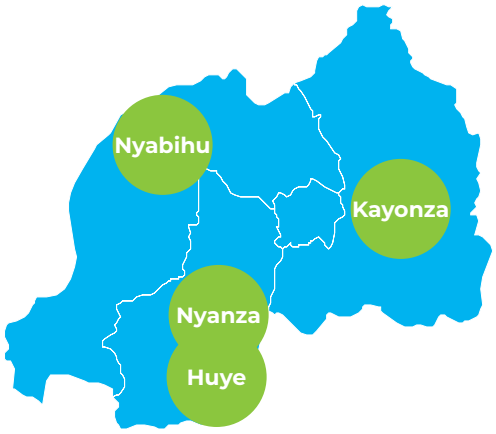
OAUTH and Alder Hey teams working together in the new Child Development Centre

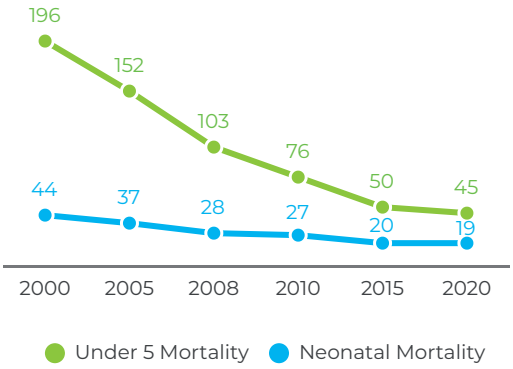
"Before we started this early intervention, one of the things that gave me concern is the age at which a child will be presenting with developmental disabilities. Typically aged 5-10 for the first time. For therapy for neuro-disability and neurodiversity in children, it's better to start early during the window when there's neuroplasticity.... Before the training the Primary Health Centres did not typically refer ... now, I've seen that the patients are being sent at an early age.... With this intervention children below one [year] are referred, and some less than six months, and for me that is very important"

- Oluwatosin Olorunmoteni - November 2024

Rwanda

Over the last three decades, Rwanda has seen some of the fastest reductions in child mortality in modern history. Since 2012, RCPCH Global has worked in partnership with the Rwanda Paediatric Association (RPA) and UNICEF, in support of the Ministry of Health and the Rwanda Biomedical Center (RBC), to contribute to this extraordinary momentum for positive change.





Trends in childhood mortality rates[7]

Although continuing to bear down on maternal and neonatal mortality, as well as enhancing quality of paediatric care more widely, over the last ten years the Government of Rwanda has started to turn its attention to the longer-term and wider social consequences of survival, including those associated with developmental delay and subsequent disability.

Prevalence data for children with developmental delays remain a significant challenge. Some smaller-scale screening studies have been done, yielding for example an overall estimate of 24.6% of children in an urban sample showing signs of delay (higher amongst younger children, between 9 and 10 months).[18] Delay was strongly correlated with prematurity – globally associated with perinatal mortality and longer-term incidence of disability, and a matter of increasing clinical concern in the Rwandan context.

Geographical and financial access to healthcare services has been massively improved. Rwanda now has in place a solid infrastructure of policies and strategic planning to engage with and manage early childhood development.[19] However, vertical integration within the care system, as well as cross-sectoral integration to strengthen the continuum of antenatal, perinatal, paediatric and longer-term health, disability, welfare and inclusion, are the new and emerging challenges with which government and partners are now engaged.[20]

92% of all deliveries happen at a health facility

38% of children live in poverty

93% of children receive all basic vaccines

Only 1 in 5 children (3 to 6 years old) attends preschool

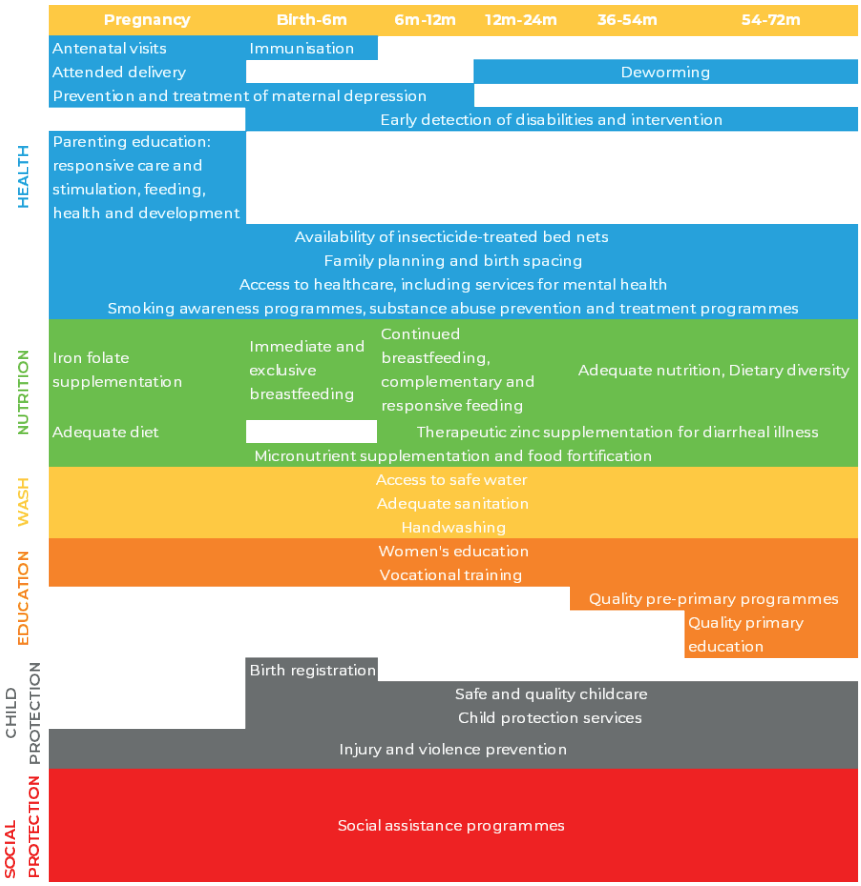
72% of children (5 to 14) are covered by health insurance

Only 1 in 5 parents engage in activities that support early learning at home

Rwanda: progress and challenges in child health and development [8]

Systematic dissemination, provision, access to and uptake of basic ECD services remains a goal in Rwanda today.[21] According to UNICEF, fewer that one in five children aged 3 to 6 attends pre-school programmes, day care or other early learning facilities. Only 1% of children age 3 and under have access to these ECD services; and around 20% of Rwandan parents engage in activities that support early learning at home, such as reading or playing games with their children.

The Rwandan Ministry of Health and RBC have adopted a structured and thoughtful approach to the development of ECD capacity within the country – continuing to ramp up community outreach and parental engagement strategies to enhance their ability to support a more holistic vision of early childhood development, health, social protection and growth.[22] [23] [24]



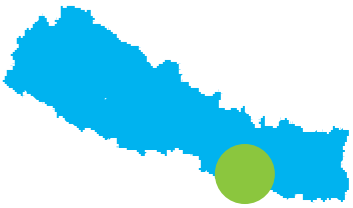
Rwanda: Strategy for essential Early Childhood Development interventions [9]

A first step is to enhance data gathering for developmental delays and related inhibition of physical, cognitive, social and emotional growth among children across Rwanda's districts.[25] As part of our current programme of District-focused perinatal care quality improvement and system strengthening, RCPCH Global is working closely with the Ministry and RBC, alongside RPA and UNICEF, to support testing of facility-based developmental screening tools as the basis for early identification of emerging challenges among newborns and infants from birth to age 5.[26]

It is through early detection that it will be possible for Rwanda to direct investment and initiatives to maximise clinical efficacy and developmental outcomes for affected children and families, and to roll out a locally appropriate, evidence-based package of ECD services.

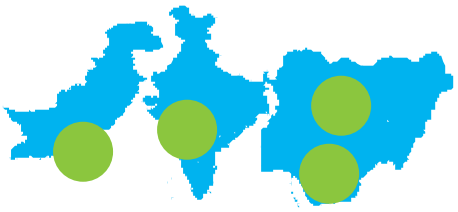
Other focus areas

In **Nepal**, we have established a pilot programme since 2022, working with the Nepal Paediatric Society, the Paediatric Nurses Association of Nepal, the Provincial Government of Madhesh Pradesh and UNICEF. We have developed two complementary workstreams – to co-create Nepali neonatal and paediatric national clinical standards and guidelines, and to test the implementation of these guidelines in clinical practice in 12 hospitals across Madhesh Province. During the first 2-year phase, our programme put in place 40 ministry-endorsed neonatal and paediatric care guidelines – the first in the country's history-supported expansion of neonatal care units from three to nine of the 12 provincial hospitals, and established the first Nepali Neonatal Nursing Network. We also ran a pilot in Kathmandu for workplace-based learning at one of the leading teachng hospitals, TUTH.



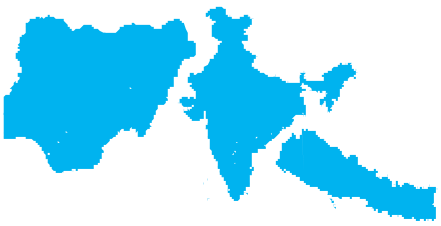
In **Myanmar**, up to 2021, we worked for a decade with the Myanmar Paediatric Society, UNICEF and the Ministry of Health and Sports, supporting emergency paediatric and neonatal care clinical skills building across 24 hospitals in four states. Following the coup, we shifted our partnership to work with the Ethnic Health Organisations, specifically in Karenni State – providing virtual teaching and learning support to undergraduate and diploma level nurses in Karenni.

In **India**, **Pakistan** and **Nigeria** we are working with local partners in Maharashtra, Sindh and Kaduna/Anambra States, respectively, to carry out an in-depth analysis of secondary hospital care functions – and to identify gaps in systems of care delivery – for mothers, newborns and children in large, powerful emerging economies with some of the highest rates of under-5 child mortality in the world.



In **Sierra Leone**, we are supporting the newly formed Paediatric Association (PASL) to develop their leadership in advocating for child health in Sierra Leone (strengthening local representation to government and international partners in shaping health investments and programmes oriented to family health care provision) and to become a central reference point for neonatal and paediatric care quality standards and clinical guidelines in the country.

In **India**, **Nigeria** and **Nepal**, we are developing a tripartite partnership with national paediatric associations in each country, supported by the Clean Air Fund, to build the local evidence base for impact of climate change and rising levels of air pollution on maternal health, fetal development and longer-term child health issues. Our aim is to collaborate with these paediatric representative bodies to help develop localised capabilities in policy advocacy leveraging maternal and child health as an argument for greater and faster climate change mitigation and active strategies to improve air quality is a vital public health issue.



Acknowledgements

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Paediatric Nursing Association of Nepal (PNAN)
Ministry of Health and Population of Nepal
Social Welfare Council of Nepal
Karenni Nurses Association (KNA)
Myanmar Nurse and Midwife Council (MNMC)
Interim Federal Nursing and Midwifery Council of Myanmar (IFNMC)
Rwanda Paediatric Association (RPA)
Rwanda Association of Neonatal Nurses (RANN)
Partners in Health (PIH)
Rwanda Biomedical Centre (RBC)
Ministry of Health of Rwanda
James Percy Foundation
Medical Aid for Palestinians (MAP)
UNRWA
Paediatric Association of Sierra Leone (PASL)
James Percy Foundation (JPF)
Sir Halley Stewart Foundation
Mukul Madhav Foundation (MMF)
Medical Association of Nigerians Across Great Britain (MANSAG)
International Child Health Group
Sierra Leone Nurses Association (SLNA)
Ministry of Health and Sanitation, Government of Sierra Leone
WHO Sierra Leone
Malaria Consortium
London School of Hygiene & Tropical Medicine (LSHTM)
Nigerian Federal Ministry of Health
Osun State Ministry of Health
Rwandan Society of Obstetrics and Gynecoology
Palestinian Red Crescent Society
Palestinian Disability Forum
Imperial College
London School of Economics

We would also like to extend a special thank you to all the clinicians advising and working on our programmes in the UK and abroad.

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Graphics

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