

Emotional Stimulation in the Context of Emergency Food Interventions



Final Report

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Play Therapy Africa

The Society for Protection and Therapeutic Aid in Africa



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Summary

Management of severe acute malnutrition through the provision of Ready-to-Use Therapeutic Food¹ is the mainstay of Nutrition Interventions in Emergencies together with Food Aid and Supplementary Feeding. RUTF have been equated to a silver bullet able to drastically reduce the problems of treatment of severely malnourished children. In some villages, RUTF is called ‘the magic food’ such is their perceived role in responding to severe acute malnutrition.

However, a growing body of research suggests that the long term benefits of these interventions are vastly increased when combined with interventions to strengthen psychosocial bonding between caregiver (usually the mother) and child.² This is because the effects of hunger and food insecurity are not only physical; they also cause psychosocial stress on the entire population.³ This in turn impairs the care-giving capabilities of adults, frequently resulting in parental emotional detachment, withdrawal and neglect. This can give rise to a vicious cycle involving reduced appetite in the child, and ever greater parental despair and detachment. This severely diminishes the overall survival rate of children, even when given adequate food.⁴ Even if a child survives, the combination of nutritional deprivation and lack of social/emotional stimulation frequently causes long term mental and cognitive disabilities as well as stunting and poor growth.

The introduction of emotional stimulation is of paramount importance not only for responding but also for allegedly preventing severe malnutrition. It also allows re-positioning the discourse of treatment of malnutrition within the realm of family relationships and bonding not just supply of sachets: a child needs attention, affection and love, not just RUTF.

In addition to the above, the Sphere Handbook for Food Security, Nutrition and Food Aid in Emergencies and the Inter-Agency Standing Committee’s (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings provide very clear standards for the provision of complementary mental and physical stimulations for children and caretakers in situation of food crisis.⁵ IASC’s standards regulate that a minimum response on Nutrition Emergency Interventions *must* be coupled with a specific set of complementary psychosocial and emotional relief interventions to greatly enhance a positive outcome of emergency interventions such as supplementary feeding and micronutrients distributions. Such twin-track approach aims at minimizing the long lasting physical, mental and emotional negative outcomes of food crisis on children over their life span, as well as increasing the survival rate of malnourished children.⁶

¹ RTUFs are foods designed for specific, usually nutritional, therapeutic purposes. Plumpy’nut and BP-100 are examples of RUTF. They don’t require additional water for their preparation, eliminating the need for clean water source for proper dilution. Neither they require cooking or other preparation.

² Patrice L Engle et al.: **Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world.** *The Lancet* 2007, Volume 369, Issue 9557, Pages 229 – 242.

³ Susan P Walker et al.: **Child development: risk factors for adverse outcomes in developing countries.** *The Lancet* 2007, Volume 369, Issue 9556, Pages 145 – 157.

⁴ Sally Grantham-McGregor et al.: **Developmental potential in the first 5 years for children in developing countries.** *The Lancet* 2007. Volume 369, Issue 9555, Pages 60 - 70.

⁵ Sphere Project. *Humanitarian Charter and Minimum Standards in Disaster Response.* Geneva: Sphere Project, 2004. Website:http://www.sphereproject.org/handbook/hdbkpdf/hdbk_c3.pdf

⁶ Inter-Agency Standing Committee (IASC). *Guidelines for Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC.

A strong maternal-infant (or caregiver-infant) bond provided through psychosocial stimulation is essential for positive child survival and development. The formation of this bond at the beginning of life is an essential step that sets the stage for cognitive, emotional, and social development later in life. Feeding and other care practices provide opportunities for psychosocial stimulation and help to establish a positive attachment between caregiver and child. This becomes particularly important during emergency situations, where the survival of children critically depends on their inner resilience and mental health as much as relief interventions. Many caregivers are unavailable or unable to provide psychosocial stimulation to their children during food crises due to their own poor physical or mental health. A lack of psychosocial stimulation has adverse consequences for children's survival, development (cognitive, motor, language) and mental health.

During the 1980s, studies involving severely malnourished children in Jamaica and Bangladesh showed that compared to food alone, combined nutritional and psychosocial interventions resulted in improved long term physical and cognitive outcomes⁷. Yet these results were based on sophisticated tools for psychosocial stimulation, elaborated indicators for measuring impact, and advanced skills by health professionals. The combination of these factors made the above results very difficult to be replicated on the field and at scale, in contexts where human resources have very low level of training. Therefore, nutrition protocols of most countries have not included emotional stimulation as a complement for therapeutic food treatment.

Play Therapy Africa embarked in the mission of designing an effective methodology for the delivery of emotional stimulation easy to be adopted during emergency food crisis, allowing the intervention to be brought to scale, to remain easy and cheap in nature, and to be administered by professionals with a limited level of training. Play Therapy Africa in collaboration with UNICEF recently tested and adopted these interventions to Ethiopia, where seasonal malnutrition is a chronic problem. The government of Ethiopia and selected NGOs were already providing emergency therapeutic feeding around the country, using the structures and resources of the Health Extension Programme (HEP). The HEP delivers primary health and nutrition services at a sub-district level using the skills of two basically trained health extension workers –both female-, based in health extension posts. Currently, there is a Health Post per sub-district to cover an average of 5,000 people.

Play Therapy Africa joined this intervention with a brief, intense psychosocial bonding exercise known as Filial Play Coaching. During four weekly 40 minute group sessions, a Health Extension Worker helped mothers reconnect with their malnourished children using the four principles of 1) focusing complete attention on the child, 2) boundary setting, 3) imitation and 4) play using toys that could be easily constructed from local materials such as cloth and wood.

During the 2008 food crisis in Ethiopia, Play Therapy Africa tracked records in 34 Outreach Therapeutic Sites and 1 hospital in the severely affected Southern Nations, Nationalities and People's Region (SNNPR). In a UNICEF sponsored study, Play Therapy Africa has compared

⁷ See for instance the groundbreaking work of Grantham-McGregor S, Schofield W, and Harris L.: **Effect of psychosocial stimulation on mental development of severely malnourished children: an interim report.** *Pediatrics.* 1983;72:239-43.

their innovative combined intervention of emergency therapeutic feeding and psychosocial stimulation with the standard therapeutic feeding intervention. The findings were as follows:

- 1- **Reduced Mortality rates** : the mortality rate of children admitted to the hospital with severe malnutrition was reduced from 28.6 % over 1 month, to 20.6 % over 3 months;
- 2- **Increased Speed of Recovery**: In the intervention sites, 31.2% of children who received the psychosocial stimulation were discharged at the end of the 4th treatment week, and 40.7% were discharged at the end of the 5th treatment week. In the control sites, no children were discharged before the end of the 6th week (when the project ended).
- 3- **Prevention of emotional, development and intellectual loss/damage**: Using the internationally recognized “Ages and Stages Questionnaire” (ASQ), we assessed the cognitive, emotional and development capacities of children in the intervention and control groups. Control group children who only received therapeutic feeding showed a severe loss of cognitive, emotional and development potential, whereas the children in the intervention group showed similar ASQ scores to those who had not experienced severe acute malnutrition⁸.

We predict that this intervention might result in increased resilience to future severe acute malnutrition. While this prediction has not yet been fully documented, initial qualitative data suggest changes in care giving patterns that could prevent future episodes of malnutrition, even during seasonal food shortages. Verification of this will obviously require further investigation.

We also saw evidence that the effect of filial play coaching on the behavior of children was so striking that it improved gender relations and communication within the family and community, and increased women’s empowerment and decision making. This qualitative finding will also be better studied in October 2009.

The combination of emergency therapeutic feeding for children coupled with emotional stimulation has a leveraging effect not just on short term survival and physical and emotional outcomes for children, but also on the prevention of long term deficits, including death.⁹

During a Nutriset mission to Ethiopia in August 2009, the company also expressed interest in the findings of the study to guide their current design of a social marketing strategy for some of their products.

We believe that the findings have provided the ground for a renewed discussion for complementing in-country protocols for treatment of severe acute malnutrition, as well as providing evidence based policy orientation for the scaling out of the programme. This will account also for IASC and Sphere standards that contain already an often neglected component of psychological support for both the child and the caring mother.

⁸ Therapeutic feeding addresses severe acute malnutrition (SAM) condition. A SAM condition is defined as an insufficient weight-for-height (WFH) or edema, as opposed to stunting defined by an insufficient height-for-age (HFA), and underweight –weight-for-age (WFA).

⁹ See also Grantham-McGregor et al. Development of Severely Malnourished Children who Received Psychosocial Stimulation: Six Years Follow-Up. Pediatrics 1987. Vol.

Introduction

As many studies have nowadays shown, the survival rate of malnourished children during emergency food crisis critically depends not just on the availability of appropriate therapeutic food, but also on the emotional and physical stimulations available for both the child and the caretaker (usually the mother). Studies have also shown that the combined use of emergency nutrition and emotional stimulation techniques provide for:

- 1- lower malnutrition rates,
- 2- a higher rate of child survival,
- 3- a quicker physical recovery from malnutrition, and
- 4- a limited long term brain damage to the malnourished child.¹⁰

Nutritional deficiencies and a lack of stimulation create a vicious cycle in which deprivation in one can result in further deprivation in the other. For example, a malnourished infant may show reduced psychomotor activity (e.g., the child is less likely to crawl and engage in creative play). As the child becomes more apathetic and less demanding, parents often provide less stimulation. The interaction between parent and child becomes less mutually rewarding, and ultimately their bond is threatened, opening the door for premature death that cannot be prevented with just therapeutic feeding interventions.

When a child is malnourished, the mother (or caretaker) starts an unconscious process of detachment to reduce the grief for the expected loss of the child. It's a natural mental coping mechanism that allows the mother (or caretaker) to focus on the children with higher chance of survival. This automatically translates into attitudes of discrimination and neglect that quicken the pace of malnutrition leading to child death. On the other side, the malnourished child does not receive the emotional and physical stimulations that allow him to intake necessary macro and micro-nutrients. The inner resilience of the child results diminished, and his survival chances drastically reduced.¹¹

As a consequence, combined psychosocial support, and nutritional interventions must be instituted in situations of severe food shortages to facilitate caregiver-child relations and prevent developmental delays and mental disorders. With appropriate intervention, these problems are largely preventable and can greatly enhance the survival rate of children.

Similarly to results from a multi year project in Jamaica, preliminary data from Ethiopia gathered through the following programme show how the implementation of emotional stimulation interventions in the context of Therapeutic Feeding Programmes (OTP) has a positive effect on increasing the speed of recovery for severely and acutely malnourished children, and reducing the emotional impact of malnutrition on child's intellectual and development abilities. In the context of Ethiopia, Therapeutic Feeding Programmes are composed by both Outreach Therapeutic Programmes and Therapeutic Feeding Units.

¹⁰ See for instance the groundbreaking work of Grantham-McGregor S, Schofield W, and Harris L.: Effect of psychosocial stimulation on mental development of severely malnourished children: an interim report. *Pediatrics*. 1983;72:239-43.

¹¹ Grantham-McGregor S, Powell C, Walker S, Chang Fletcher P. The long-term follow-up of severely malnourished children who participated in an intervention program. *Child Dev*. 1994;65(2 Spec No):428-39.

Objectives of the Programme

Using Early Stimulation, Filial Coaching and Psychosocial Rehabilitation techniques, to increase the survival rate and recovery pace of malnourished children admitted within Therapeutic Feeding Programmes through complementing emergency nutrition interventions with emotional and physical stimulations for children and their caretakers.

Implemented Activities

- Gathering Support and Mobilizing Key Actors

PTA's team had extensive meetings with Federal and Regional authorities to introduce the project, and to share objectives and responsibilities. The most important role of the project coordinator has been to educate authorities and decision makers on the scientific evidences linking lack of emotional stimulation, child malnutrition, and child mortality. In doing so, the Team has gathered evidences from a number studies around the world to support a new approach to be used within therapeutic feeding units and OTP in Ethiopia.

We have been requesting this sort of training for long, but nobody cared about giving malnourished children more than just therapeutic food. People thought that food is enough to keep these children alive. They are wrong.

(Quote from a training participant)

The project was presented to Federal authorities and the Head of the National Nutritional Programme has been extremely supportive of the innovative intervention and he has mobilized a wide network of national professionals to review the methodology proposed for the intervention. The Head of the National Nutrition Programme also provided all necessary institutional and political contacts to allow the project to take place in the Southern Nation and Nationalities People Region (SNNPR).

The Bureau of Health was contacted and involved in the selection of the sites for the intervention. The Bureau of health has requested PTA to start with the selection of 5 woredas, different kebeles in each woreda, and 1 hospital. The involvement of hospitals seemed important due to the willingness of the Government to test the interventions beyond out-patient therapeutic sites.

Once sites were selected, PTA has traveled to the different woredas to sensitize the communities and to make sure that community leaders, local authorities, and professionals working there understand the benefits of applying early stimulation techniques to therapeutic feeding interventions to increase the survival rate of children. Communities were gathered together and an open discussion was held with each community to ensure the largest possible community support and contribution to the programme. Most of the selected woredas are placed in hard to reach areas, only a minority of communities is of easy access, posing additional logistical constraints to the project.

PTA has also involved the Bureau of Youth for the selection and screening of youth that will be trained and will take part to the project. With this intention, PTA has traveled to the different sites to assess which youth clubs were active in the selected woredas, and which youth could be involved in the project. While the initial idea was to only train youth to be deployed in therapeutic feeding sites and hospitals (2 youth per site), the government has proposed having 1 youth and 1 health extension worker trained and deployed per site. PTA has accepted this proposition since the presence of a health extension worker besides the youth will strengthen the way the intervention is managed, and will

increase the adherence of mothers to the treatment. The idea was also to compare the feasibility of having this done by Youth versus HEW.

In this regard, PTA has developed a competency-based-framework of skills and capabilities that will guide the selection of youth and health extension workers into the programme, and the application of the skills that youth will acquire through training.

The SNNPR's regional health authorities, in collaboration with PTA, also organized a participatory regional workshop in Awassa (SNNPR's regional capital) to present the project to NGOs operating in the region and to allow for more explanations on the contents and objectives of the interventions, modalities, and expected outputs.

- **Developing a Scientifically Grounded Methodology**

Once this first round of extensive consultation was finalized, PTA has started to work on the finalization of the methodology of intervention taking into account the feedbacks provided by partners and beneficiaries (See attached Annex I).

- **Creating an Ethical Framework for Intervention**

The ethical considerations involved in the present proposed methodology and research tools are substantially two:

1-Ethical considerations related to children and mothers involved in the project as beneficiaries.

2-Ethical considerations for youth involved in the project as coach and employed professionals.

Ethical considerations related to the involvement of children and mothers gear around the safe practice of filial play in emergency contexts, safe interactions between the mother and the child with emergency nutrition contexts, the safe interaction between the mother and the health extension worker or youth at the therapeutic feeding units and OTP, and the safe interaction between the health extension worker or youth and the malnourished child.



Health Extension Workers and Community Volunteers learning how to coach mothers of severely acutely malnourished children in the use of different sensorial toys

*I felt totally apart from my child, he was still there but to me he was already dead. He was crying but I only heard my own cry. The simple idea of watching my sick child made me mad. I couldn't stand him, I was angry with God
(Quote from a parent)*

- [Advanced Training on Filial Play Coaching, Emotional Stimulation and Nutritional Recovery for Supervisors](#)

PTA has organized an initial training for child practitioners at the beginning of December 2008 to create specialized capacities in Ethiopia on emotional stimulation in emergency nutritional contexts. 30 professionals were selected among different NGOs, Universities, medical institutes and child care institutes to attend the training. The overall goal of the training was to build specialized skills in the area of emotional stimulation, baby massages, and emotional recovery for

children that are severely acutely or chronically malnourished.

The participants were selected on the ground of their performance and practice's results from previous training and child care work that PTA had monitored over the past months. This group of participants was selected based on their proved experience, positive commitment and practice, and track record of positive results with abused children. The skills that the professionals had previously applied in the context of abused children and children victims of HIV/AIDS, were now adapted to the context of severely acutely malnourished children. A special attention was paid in creating the necessary skills for this group of participants for becoming supervisors in emotional stimulation for malnourished children. In fact, the role of this group of professionals is not the one of directly delivery services to malnourished children, but rather periodically clinically supervise the services delivered on the ground by selected youth and health extension workers to malnourished children.

*Yesterday, after the morning session, I called my children and I told them that I love them. They were surprised and they couldn't understand why I was crying while telling them how much I love them.
(Quote from a training participant)*

This group successfully went through a number of supervisory exercises of motivational training, clinical measurement of intervention, positive supervision, and good parenting before terminating the training. The training has been designed to be 75% experiential, with regular yet limited theoretical inputs, to promote as much as possible an 'how to do' agenda grounded on practical experience as opposed to theoretical one. This allowed participants with low degrees of education to fully understand the theoretical basis of intervention, without necessarily provide for an excessive burden of psychological theories upon which emotional stimulation is based.

The adaptation of the training to the Ethiopian context, the development of the specialized curricula, and the training itself has been delivered by a team of senior trainers and clinical therapists sent from England by Play Therapy International in collaboration with the Canterbury Christ Church University and the Academy of Play and Child Psychotherapy (APAC), East Sussex, UK. The above mentioned institutions in collaboration with PTA have been working on the project for over one month prior the deployment of the trainers. The adaptation of training curricula proved difficult and will require additional attention for future interventions. In particular, standard exercises proposed in 'european cultures' needed further adaptation to the Southern Nations traditional believes, culture, and practices.

- Emotional Stimulation, Baby Massage and early recovery for severely acutely malnourished children's training

After the training of supervisors, PTA has organized the proper training of health extension workers and youth working in selected sites of Southern Nations with severely acutely malnourished children. The complete list of selected sites is the following:

Woreda	Sites	Case-load every 3 weeks (Dec. 2008)	Responsible Body	Participants requested to Attend the first training	Total
Dale	1 OTP 2 Integrated ¹² OTP 1 Hospital	180 children	ACF (NGO)	1 health extension worker and 1 youth per site	4 Health extension Workers 4 Youth
Wonsho	2 OTP 1 Integrated OTP	103 children	ACF (NGO)	1 health extension worker and 1 youth per site	3 Health extension Workers 3 Youth
Aletha Wondo	2 OTP 3 Integrated OTP	165 children	ACF (NGO)	1 health extension worker and 1 youth per site	5 Health extension Workers 5 Youth 5 NGO workers
Domot Woyide	4 Integrated OTP	144 children	Concern (NGO)	1 health extension worker and 1 youth per site	4 Health extension Workers 4 Youth 5 NGO workers
Maskan	7 integrated OTP	92 children	Government	1 health extension worker and 1 youth per site	7 Health extension Workers 7 Youth

The training for the health extension workers, the health extension workers, and the youth was organized in the Southern Region of Ethiopia, Awassa Town. This second training of 8 days was delivered by the same trainers and institutions that provided the training for supervisors. The focus for this second training was to provide specialized skills to health extension workers and youth workers to increase the survival rate of severely acutely malnourished children. The training was also designed to clinically assess the impact of intervention over 4 months period.

The training presented specific techniques to increase child emotional recovery in the following areas:

Bahavioural Area	Definition
Self-Regulation	The child's ability or willingness to calm or settle down or adjust to physiological or environmental conditions or stimulation.
Compliance	The child ability or willingness to conform to the direction of others and follow rules.
Communication	The child ability or willingness to respond to or initiate verbal or non-verbal signals to indicate

¹² 'Integrated Sites' are sites where NGOs and the Government work together to bear the logistics and functionality of the Center.

	feelings, affective or internal states.
Adaptive functioning	The child success or ability to cope with physiological needs (i.e. sleeping, eating, safety).
Autonomy	The child's ability or willingness to self-initiative or respond without guidance (i.e. moving to independence).
Affect	The child's ability or willingness to demonstrate his or her own feelings and empathy for others.
Interaction with people	The child's ability or willingness to respond to or initiate social responses to parents, other adults and peers.

The presented areas of child development are negatively affected every time the child is subjected to a shock such as malnutrition, depression or maternal detachment.

Participants to the training were explained the ways severe acute malnutrition affect the different areas of child's brain and the functional areas of child development. Subsequently, the participants undertook a series of exercise to stimulate the malnourished child with a focus on the different behavioural areas.



Four youth making toys and puppets during the training and exercising emotional stimulation techniques on dolls.

Participants learned how to detect maternal depression, how to assess parents-child interaction, how to assess child play and how to clinically measure child's emotional development status. They then learned how to link the initial assessment outcomes to specific interventions to stimulate the child and the caretaker. They learned how to develop a specific emotional stimulation programme for individual children or for group therapy, always making sure to link emotional stimulation with therapeutic feeding. Participants learned how to coach the mother in the use of filial play, also using scrap material as toys or emotional stimulation's objects. Participants also learned how to assess the child's emotional status at the end of intervention to clinically measure impacts of the programme.

Quantitative and qualitative tools were also presented to the training participants as a part of a scientific research that will allow to measure the impact of the programme on child survival, speed of emotional and physical recovery, and prevention of future severe acute malnutrition. This is an extremely important component of the project since it will allow to present the programme's outcomes in a scientific and sound manner to demonstrate the extent and nature of positive programme's outcomes for malnourished children.

As for the training presented to supervisors, the training for health extension and health extension workers was 75% experiential, with constant practical exercises, concrete case studies and application of what presented in plenary. Participants were invited to adapt different intervention models to their specific context of work (therapeutic feeding units in hospital and health centres, outreach therapeutic programmes in hospitals, health centres and health posts, etc.).

- **Supervision and Clinical Monitoring**

The implementation of the project has been strictly and systematically supervised. The trained supervisors from CIAI have been deployed regularly on the field once every 20 days. They have undertaken the task of monitoring the smooth implementation of the project, reviewing the practice of health extension workers, collecting data from the health posts, talking to reached beneficiaries, and finally sharing ideas and solutions with youth practitioners.

*We have run emotional stimulation for only two weeks but you can already see the impact on the survival and recovery of the child. I tell you, you don't need to wait for the end of the project for seeing an impact here.
(Quote from a HEW)*

All data generated were inserted into a specially designed database which helped in keeping track and analyze the data regularly received.

PTA also regularly deployed its professional on the field to ensure the quality of data gathering, the consistency of interventions, and the clinical follow-up of filial play coaching. PTA's professional also involved local authorities every time they were going to the field to ground the intervention within local acceptance of the work promoted. Local authorities accompanied PTA's member in joint field visits and grasped a firsthand understanding of the project's philosophy and outcomes directly from the ultimate beneficiaries.

Local and regional authorities were also presented the clinical results of the project.

The impact of the project

The following part of the current report has the purpose of providing information on the clinical results of the project implemented

The study intended to test the following assumption:

- 1- Adding Emotional Stimulation to Therapeutic Feeding reduces Mortality.
- 2- Adding Emotional Stimulation to Therapeutic Feeding increases the speed of recovery from Malnutrition.
- 3- Adding Emotional Stimulation to Therapeutic Feeding minimizes (or prevent) the loss of development potential ('capacity to learn') of the child.

The following terminology is used in the following pages:

'Malnourished Not Treated' : these are children that were screened positive for severe malnutrition. These children received therapeutic feeding, but they DID NOT receive emotional stimulation (Not Treated). For these children the study monitored at the same time the evolution of their Emotional Status over 3 months, and the evolution of their body weight over 3 months.

'Malnourished Treated' : these are children that were screened positive for severe malnutrition and they received at the same time therapeutic feeding AND emotional stimulation (Treated). For these children the study monitored at the same time the evolution of their Emotional Status over 3 months, and the evolution of their body weight over 3 months.

'Non Malnourished Not Treated' : these are children from semi-rural and peri-urban areas of SNNPR that were NOT screened positive for malnutrition (Non-Malnourished) and that were NOT emotionally stimulated (Not-Treated). For these children the study monitored the evolution of their emotional status over 3 months.

'Non Malnourished Treated' : these children from semi-rural and peri-urban areas of SNNPR were NOT screened positive for malnutrition (Non-Malnourished) and they were stimulated emotionally (Treated). For these children the study monitored the evolution of their emotional status over 3 months.

'Hospital' : these are children that were screened positive for malnutrition and that were admitted to hospital due to complications in the treatment of malnutrition. These children were provided with therapeutic feeding and emotional stimulation at the same time. For these children the study monitored at the same time the evolution of their Emotional Status and the evolution of their body weight until dismissal (or expiration).

RESULTS

Number of Children Reached for whom data collection/recording has been generated*

	Number of Sites	Number of Cases	Boys/Girls	Girls %
Malnourished Not Treated	3	46	20/26	G=56.5%
Malnourished Treated	20	376	185/191	G=50.84%
Non Malnourished Not Treated	5	52	28/24	G=46.1%
Non Malnourished Treated	5	52	28/24	G=46.1%

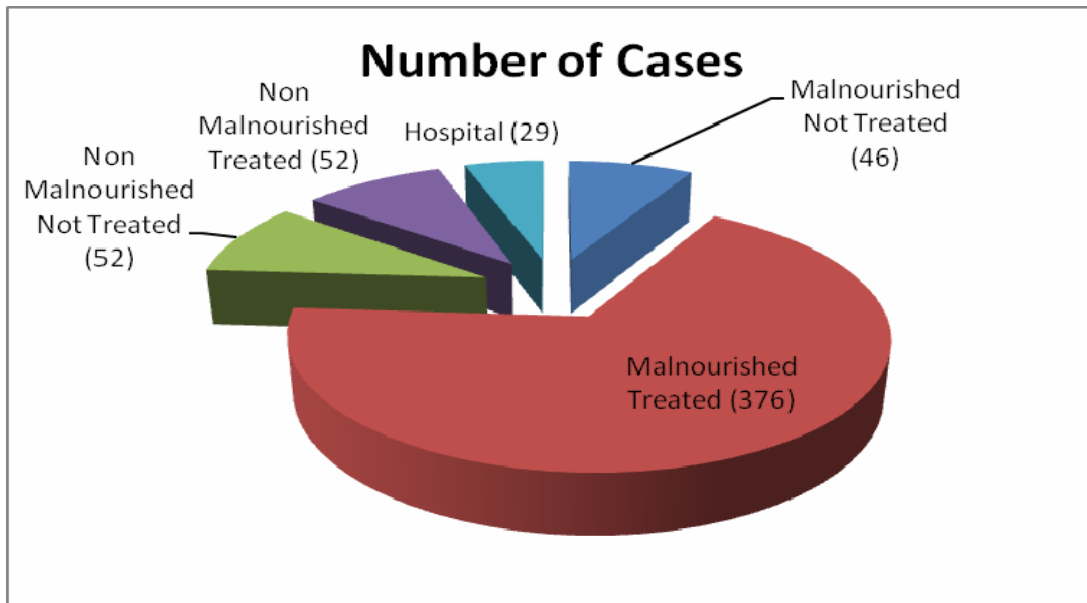
What children need the most it's only us, the parents, that can give it to them. It is inside us and not in the emergency food they take (Quote from a health extension worker)

Hospital	1	29	17/12	G=41.4%
Total	34	555	278/277	G=49,9%
<i>Source: Authors</i>				

*many more children were reached during the intervention period, but data presented here are only the data generated for the children enrolled in the initial months of intervention to allow to have an overview of their evolution over 3 months.

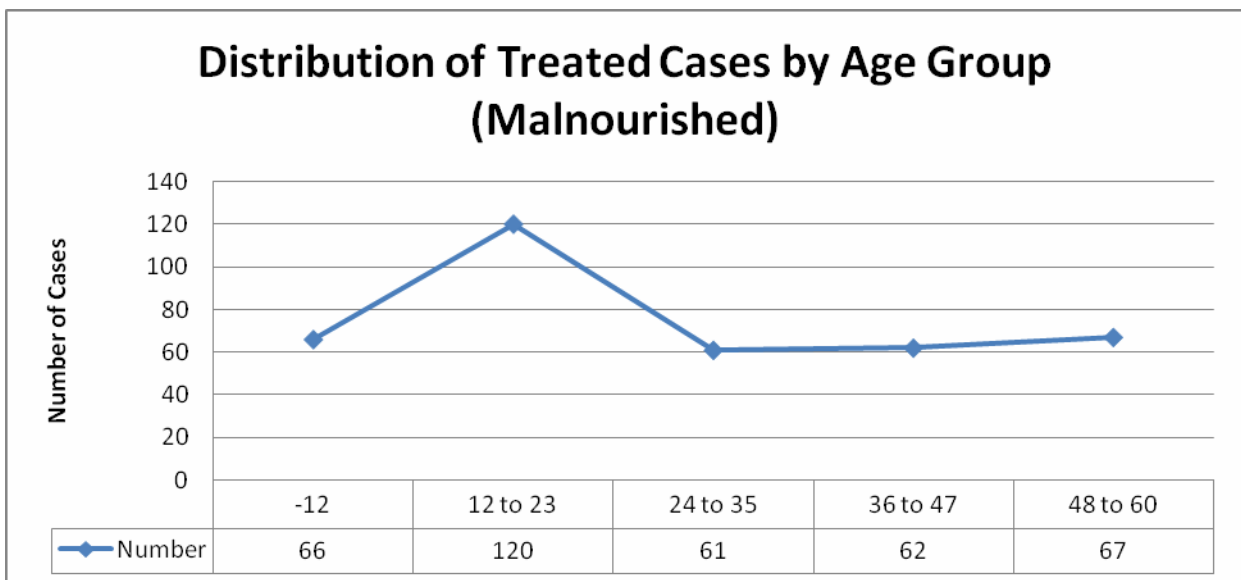
The above Table tells us that 555 children in 34 different Therapeutic Feeding Programmes (TFU and OTP) of Southern Nations of Ethiopia were reached and systematically traced for a period of at least 3 months over an overall intervention that lasted 6 months. More sites and children were reached during these 6 months interventions, but for the purpose of this study and clinical monitoring of the intervention, only 555 were systematically traced and from whom the present data was generated.

The above table also tells us that the gender ratio of the study was extremely balanced (50,1% boys and 49,9% girls), so that the results are gender neutral and are equally valid for boys and girls.

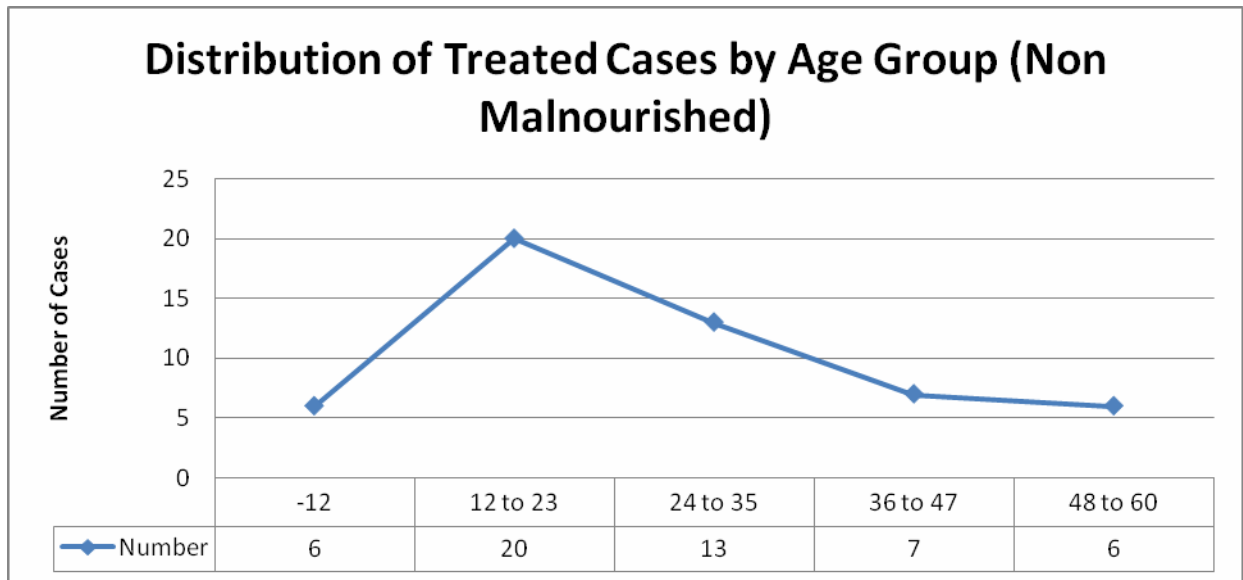


Source: Authors

- **Age Distribution of treated children**



Source: Authors



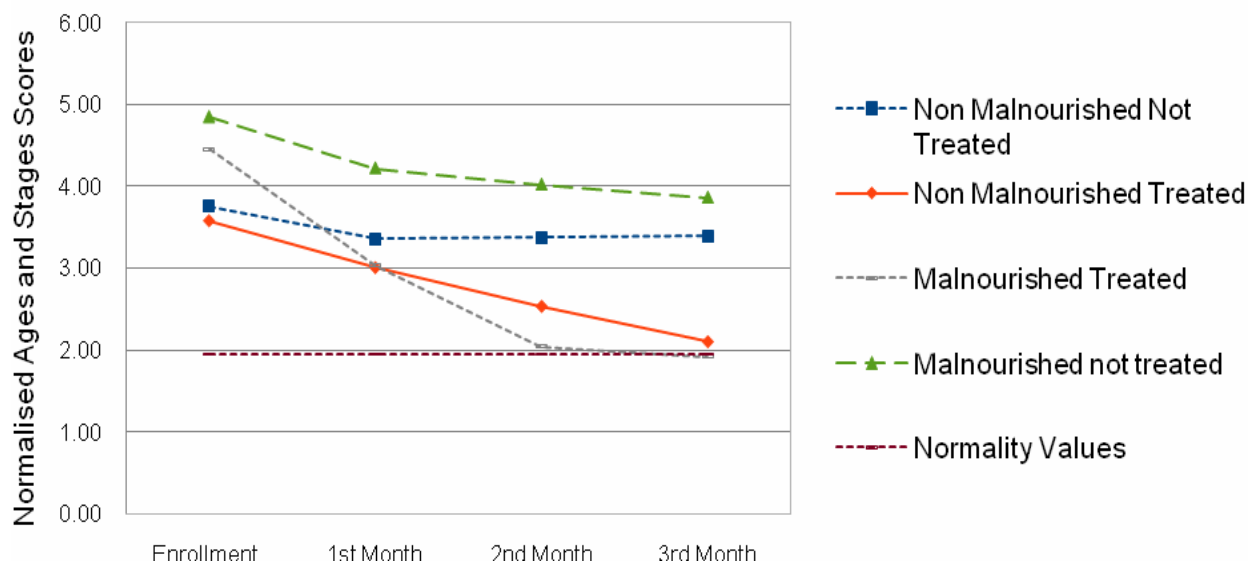
Source: Authors

The above figures tell us that the vast majority of children suffering of severe acute malnutrition and being admitted in Outreach Therapeutic Programme have an age between 6 to 60 months, with a pick in the second year of life (12 to 23 months) –this is when they are more at risk and vulnerable to malnutrition.

- Effects of Emotional Stimulation on Ages and Stages Scores**

The following figure is very important. The results have been obtained using the Ages and Stages Questionnaire tested and validated for acceptability and consistency in the context of Ethiopia.

Effects of Emotional Stimulation on Ages and Stages Scores



Source: Authors

The horizontal line named 'Normality Values' is the benchmark for emotional stability and normal behavioral attitudes. Below this line, children have a 'normal' development status for their age and stage. Below this line, they don't need any form of emotional support or stimulation because their brain is developing normally. They therefore have all their cognitive potential intact. ABOVE the line, the emotional and cognitive status of the child is troubled. The higher the score on the vertical axis, the more traumatic and troubled is the emotional and cognitive status of the child. A child with a 'Normalised Ages and Stages Score' between 4 and 5 is a child that can have symptoms such as frequent nightmares, bedwetting, is not responsive to external interactions, is depressed, is not speaking/listening/focussing, is troubled, is extremely anxious or extremely withdrawn, etc. The severity or recurrence of these and similar symptoms is of a very high scale.

*After two days training I felt the heavy weight of responsibility not just for the children I support in my daily work, but also for my own children. It was like if suddenly I realized that what these children are and will become, crucially depends on my ways to stay with them. I never felt like this before: proud for the work I do, and worry for the consequences that my work can bear on these children.
(Quote from a training participant)*

The data clearly shows that the group of malnourished children started with a significant higher cognitive and emotional instability compared with the non-malnourished control group.

*Youth that were trained were sent to the communities to identify severely and acutely malnourished children. Yesterday for instance, nine children were admitted at the OTP site thanks to the scouting and screening work done by the trained youth. You could argue that those nine children would have died in the coming 10 days if this project hadn't started.
(Quote from a Health Extension Worker)*

As we see from the figure, in only two months, malnourished children that were at the same time provided with therapeutic feeding and emotional stimulation are able to gain a level of cognitive and emotional stability nearly 'normal'. Between the second and third month we still have an improvement but it is minimal vis-à-vis the gain of the first two months. It is important to stress that at the end of intervention, malnourished or not, the treated groups reached the same normal level of cognitive and behavioural level.

Similarly, for Non-Malnourished Children that were emotionally stimulated, the intervention managed to bring them to nearly normality levels in just 3 months interventions.

On the contrary, the two control groups of Malnourished Not Treated, and Non-Malnourished Not-Treated remain with emotional levels that are very high, entailing a substantial loss of development potential. In the case of children 'malnourished not treated', the relative improvement of their emotional level is the sole outcome of the effects of RUTF on their brains' development.

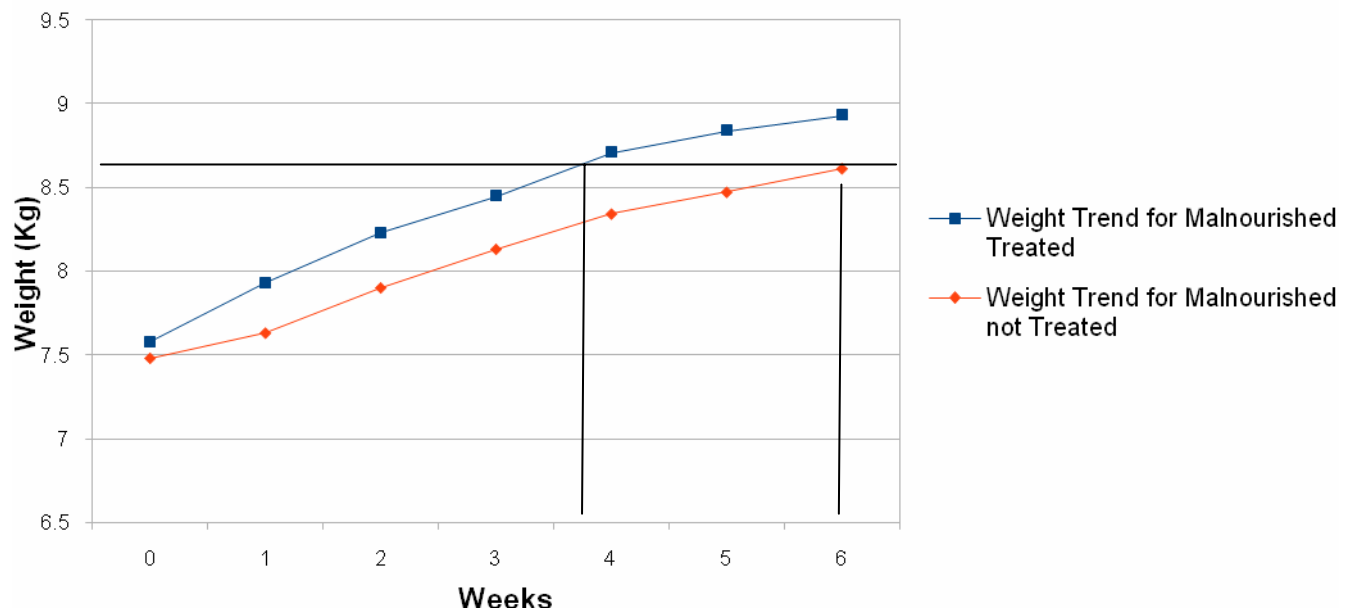
For these two last groups, this translates into an important loss of development potential for malnourished children : keeping them alive through therapeutic food will not have an impact in their capacity of learning and developing. From a cognitive point of view. These are children that if they go to school will not be able to learn as their peers, and will not be able to recreate a significant attachment with their prime caretaker.

The above results clearly shows that doubling Emotional Stimulation with Therapeutic Feeding prevents the loss of development potential, with an intervention of just 2 months.

- **Effects of Emotional Stimulation on Body Weight Gains**

The following figure investigates the effects of emotional stimulation on the speed of recovery of Malnourished Treated against Malnourished Not-Treated children.

Weight Gains for Acutely and Severely Malnourished Children



Source: Authors

From the presented results, we can clearly see that children that were provided with a combination of Emotional Stimulation together with therapeutic feeding have the tendency of gaining weight at a higher speed than children that were only provided with therapeutic feeding. After 6 weeks, the Malnourished Not-Treated have a body weight which is equivalent of the body weight that the Malnourished Treated had 2 and half weeks before.

This has important implications for both the financing of the project, as well as the capacity of existing OTPs to manage cases. In fact, a short recovery period per child will entail a massive saving in the unit cost of each treated child, allowing for the intervention to be fully self sustainable. At the same time, the increased speed of recovery will also allow for a quicker case management of each admitted child, resulting in more children being reached with the same logistic arrangements already in place, an important factor that could reduce the overcrowding of OTP during emergency periods.

- **Discharge Rates**

The increased speed of recovery presented above, was also confirmed looking at the discharge rates of treated children compared to control groups. The following table shows that malnourished children that were emotionally stimulated are discharged much quickly than children that are only supported through therapeutic feeding. Again, this is an important finding since the cost of therapeutic food and logistics decreases considerably if children stay in therapeutic feedings for shorter periods.

A detailed calculation on costing has not been done, however, the intervention seems to be a cost saving investment since the per-child-cost of intervention of emotional stimulation only consisted of roughly 1,000 usd monthly investment per site.

It is to be noted that after the 5th week it has not been possible to make a comparison on discharge rates because for some sites the discharge date and parameters did not coincided with the discharge parameters usually requested by the protocol.

	At the end of 4 weeks	At the End of 5 weeks
Malnourished treated	31.2% Discharged	40.7% Discharged
Malnourished not treated	0% Discharged	0% Discharged

Source: Authors

- **Results from the System for Evaluating Filial Play Coaching Clinical Outcomes (Qualitative Survey Pre and Post Intervention)**

The improvements registered for children that were at the same time stimulated and treated for severe malnutrition have also been cross checked with qualitative questions asked to parents before and after the stimulation was conducted.

In particular, the perception of the prime caregiver (usually the mother) on her malnourished child, critically depends also on the quality and strength of her emotional bond towards the infant. The way her mother sees and perceived her child is at the same time an indication of her capacity to observe her infants, but can also provide indications on her depression status, not just on the depression status of the child.

Pre-Intervention Questionnaire:

Over the last week in stress situation, the child (%):	Not at All	Only Occasionally	Sometimes	Often	Most or All of the Time
has been lethargic	11.1	30	28.6	13.1	18.25
has been inattentive	8.7	24.6	34.1	17.9	14.7
displayed irritability	9.5	19	37.7	15.5	18.2
has been intolerant	9.1	22.2	29	21.4	18.2

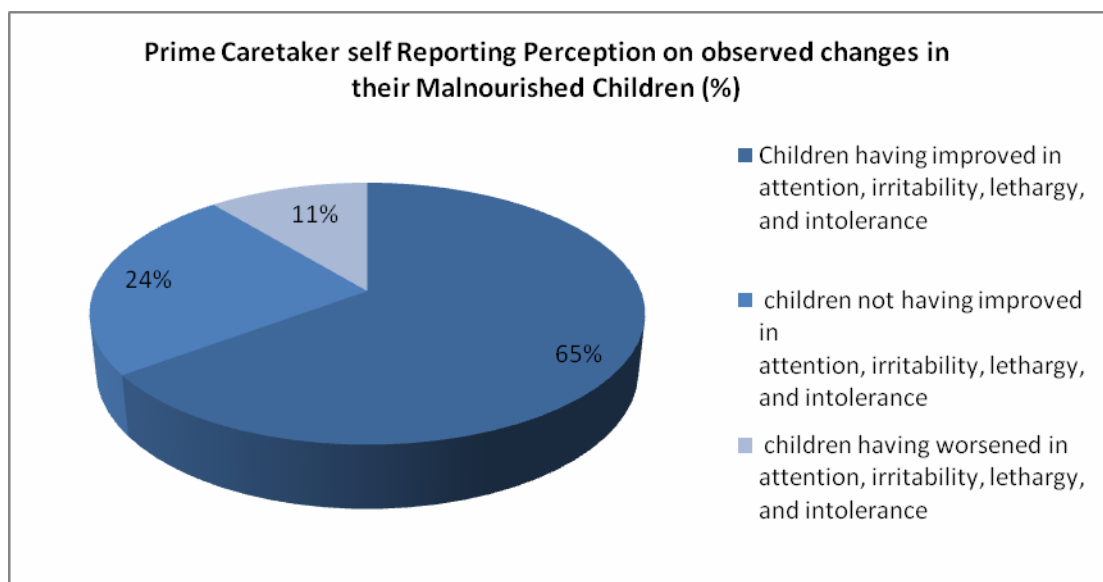
Source: Authors

Post-Intervention Questionnaire:

Over the last week in stress situation, the child (%):	Not at All	Only Occasionally	Sometimes	Often	Most or All of the Time
has been lethargic	50.4	28.2	17.5	2	2
has been inattentive	26.6	36.1	29.8	4	3.6
displayed irritability	39.7	26.6	28.6	4.8	0.4
has been intolerant	25.8	37.3	28.6	4.8	3.6

Source: Authors

The above tables are the result of a questionnaire we did with caretakers before and after emotional stimulation interventions to gain qualitative data that could confirm or deny the results we obtained through the Ages and Stages measurement of emotional and behavioral improvements of treated children.



As we observe, in the vast majority of the cases, the caretakers confirmed that their children had very severe emotional and behavioral issues ‘Often’ or ‘Most of the Times’. On the contrary, after intervention, the majority of respondents observed that the same emotional and behavioral problems were ‘Not at All’ or ‘Occasionally’ experienced by their children. An aggregate percentage of 65% of the prime caretakers have reported having observed an improvement in their children over the stimulation period.

This confirms that the clinical changes recorded through the Ages and Stages data collection tools, were also changes clearly observed in the child by the main caretaker. It also confirms a potentially corrected level of maternal depression vis-à-vis the child, even if a proper tool to assess maternal depression pre

and post intervention will need to be inserted to be conclusive on the impact of the stimulation on the mental wellbeing of the caretaker.

From the table below, we can observe how the majority of caretakers reported a decrease in depressive child behaviors pre and post therapy.

MALNOURISHED			
Over the last week in stress situation, the child:	Improved	Identical	Worsened
has been lethargic	170	53	17
has been inattentive	152	59	39
displayed irritability	169	59	22
has been intollerant	148	67	31
NON MALNOURISHED			
Over the last week in stress situation, the child:	Improved	Identical	Worsened
has been lethargic	17	18	6
has been inattentive	28	10	3
displayed irritability	25	11	5
has been intollerant	27	9	5

Source : Authors

Recommendations and Conclusions

Psychosocial support and emotional stimulation should be provided to caregivers and children as a part of the usually applicable protocol of treatment for severely malnourished children. Caregivers with physical or mental health problems may need extra support to ensure that they are able to give care to their children. Improving maternal mental health (e.g., reducing maternal depression) may be one of the most important life saving interventions in situations of severe food shortages for both the mother and child.¹³

Children who are severely malnourished should be referred for combination of nutrition/stimulation programmes that emphasize appropriate feeding practices and responsive parenting (e.g., proactive stimulation and appropriate responses). This combination has a greater impact than either intervention alone. Indeed, nutrition programmes that contain a psychosocial component are more effective in promoting survival, growth and positive child development than nutritional programmes without a psychosocial component. They may also help to decrease maternal depression.

To this extent, emergency nutrition interventions should encourage the caregiver to stimulate, feed, hold, and play with the child as much as possible. This set of emotional stimulation techniques ranges from filial play to filial coaching, physical stimulation techniques including baby massage,s and developmental touch.

¹³ UNICEF/UNHCR/WFP/WHO. *Food And Nutrition In Emergencies*. World Food Programme, Rome, 2002.

As observed during implementation of the programme, other members of the community might express the interest in taking part in the same coaching sessions that were originally presented only to caretakers whose children were admitted in OTP programmes. As we observed, many mothers and fathers from the communities gathered around the health extension workers while they were coaching mothers on how to stimulate their children. This shows a clear demand for these services beyond the context of emergency response.

Overall, the programme has indicated that introducing emotional stimulation within already existing practices and protocols will bring a return on investment much higher than the investment itself. This return can be measured in terms of reduced recovery time, prevention of loss of development potential, and reduced mortality rates.

The costs of the programme were fully compensated by the shorter period of treatment per child and the possible reduction of future relapsing of reached children in future nutrition shocks. Additionally, as observed in the programme, the skills provided to health extension workers and caretakers were used and applied beyond the length of the programme and supervision time, suggesting an immediate institutionalization of what learnt within existing and applied skills.

The above, makes a compelling case to:

- Scale out the intervention to further regions to allow for an increased service delivery, improve the tools initially developed, and allow for more data to be generated and analysed.
- To advocate for an expansion of existing protocols in line with international minimum standards of case management for malnourished children,
- Foreseen further research able to shed light on the impact of emotional stimulation on the resilience of reached children to future malnutrition shock and diseases.
- Foreseen a system of in service support for the health extension workers already trained that continue to apply the techniques at the moment without any sort of ongoing coaching or continuous education.



Annex I

Play Coaching and Emotional Development in Nutrition Emergency Contexts

Methodology proposed for the implementation of the PTA-UNICEF joint project

-Draft 0, Phase 1-

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Key Objectives to be Addressed with the Proposed Interventions

1. Increase the speed of physical recovery (body weight and high) of malnourished children and increase their survival rates;
2. Increase emotional recovery of malnourished children and their emotional development;
3. Measure the increased speed of physical and emotional recovery (quantitative and qualitative);
4. Test a methodology that can be applied at scale and in emergency contexts in Ethiopia.

The Review Process

The present methodology has been circulated among different professionals and institutions for initial inputs on the ethics and methodological tools proposed.

In particular, 5 senior professionals from Play Therapy International have reviewed the present draft for consistency on the methodological framework (non-directive child centered therapy), and consistency with the methods of coaching and impact assessment certified by Play Therapy International in collaboration with the Canterbury Christian Church University.

Teaching tools and material proposed for the UNICEF-PTA intervention have also been submitted and approved by the Academy of Play and Child Psychotherapy (APAC), East Sussex.

The project and its initial methodology have also been presented to members of all NGOs working with malnourished children in SNNPR. These professional had a chance to express their views and concerns regarding the intervention during a join review meeting held in Awassa town. Federal and Regional authorities (DPPA and DPPB) were also presented and explained the project and its proposed methodology to allow for consistency with mainstream government led programmes. The SNNPR's Bureau of Youth and Sport and the SNNPR's Bureau of health were also presented the programme and its initial draft methodology allowing for an active participation of these two Bureaus in selecting youth to be trained and interventions sites respectively.

A world-wide well reputed expert on emotional development in emergency nutrition interventions, global advisor for UNICEF, and senior psychiatrist at International Medical Corps - Dr. Lynne Jones- was also involved in the initial discussion around ethics, methodology, methods and assessment tools that the present intervention will adopt. Dr. Lynne also presented challenges and good practices from other countries around the world in the same field of intervention.

Play Therapy Africa is grateful for all positive and critical comments on the draft that helped strengthening initial ideas and helped in identifying strategy options to kick start the project. Play Therapy Africa maintains full responsibility for the content of the present draft that is now to be shared and discussed with professional at UNICEF for additional comments and final decision making.

Ethical Considerations

The ethical considerations involved in the present project proposed methodology and research tools are substantially two:

- 1-Ethical considerations related to children and mothers involved in the project as beneficiaries.
- 2-Ethical considerations for youth involved in the project as coach and employed professionals.

Ethical considerations related to the involvement of children and mothers gear around the safe practice of filial play in emergency contexts, safe interactions between the mother and the child with emergency nutrition contexts, the safe interaction between the mother and the health extension worker or youth at the therapeutic feeding units or OTP, and the safe interaction between the health extension worker or youth and the malnourished child.

In this regards, Play Therapy Africa presents methodologies of interaction, therapies and practices, that have been tested and used in several geographical and cultural contexts and undergone a number of ethical screenings and approvals before being adopted in an emergency context.

Ethical considerations related to the involvement of youth in the project gear around the equitable and fair retribution of young professionals, the safe of practice, and the adherence to a common Code of Conduct for the protection of children.

In this regards, young professionals recruited will be paid for their time, work, and skills. The remuneration rate of these youth has been set at the government's salary scale equivalent to same level youth volunteering activities. This level is the average monthly salary level for a graduate student with limited or no working experience. Considering that the youth to be involved are not necessarily graduated, and that they are currently jobless or without a stable employment, the proposed entry salary is considered to be a fair offer. Additionally, as happened in similar projects, the free of charge training and on-the-job learning and coaching, will increase significantly youth skills and therefore their market value for future employments. Setting youth remuneration levels equivalent to government's salary scale for similar works will highly increase youth chances to be considered for similar public work offers in the future.

Concerning the safety of practice in filial play and filial coaching, Play Therapy Africa, in consultation with relevant professionals, has decided to train youth only in filial play coaching as opposed to filial play. The difference being youth will coach parents in filial play as opposed to youth delivering filial play themselves to children. Filial play is most effective when delivered directly by the primary caretakers, so focusing only on coaching the parents will increase survival rates and impact on the child. Yet the young age and the little experience of youth in coaching the parents will pose ethical questions that will be attenuated by:

- 1- youth working exclusively in support to and in partnership with well established HEW,
- 2- youth workers being monitored by external supervisors on a regular basis.

For this emergency intervention, youth will not focus on recreational activities or group play with children attending TFUs, yet this could be an intervention to be considered in the future design of similar programmes.

For what concerns the Code of Conduct, assuming that all health extension workers have already been trained on a code of conduct to prevent sexual, physical and emotional violence against beneficiary children and their mothers, a simple short module on the subject will be introduced during the initial training and all youth will be requested to sign the Code of Conduct prior deployment on the field.

Finally, ethical considerations can arise around the use of a control group of malnourished children that will not receive the benefits of filial play coaching over the period of the proposed intervention. This ethical concern will be attenuated by the fact that the control group will be chosen outside the areas of interventions indicated by the government for this project. This will prevent mothers accessing the same TFU or OTP to receive two different treatments.

Play Therapy Africa will submit the present methodology to the ethical committee of Addis Ababa University to obtain prior ethical clearance in the use of the data that this intervention will generate.

Principles Used for the Proposed Methodology

Before specifying the methodology proposed, it is useful to briefly explain what the principles that guided Play Therapy Africa choices are.

- 1- **Best interest of the child first.** The strategies proposed are the ones that –we believe– bringing the maximum impact in the survival and recovery of malnourished children.

- 2- **Simple but not simplistic.** The therapeutic interventions proposed are all scientifically grounded and tested. Yet, among different and similarly effective options, we propose the therapies simpler to be learned, applied and measured.
- 3- **No compromises on quality.** No compromise on quality of interventions is made. When necessary, the intervention proposes to adjust the quantity of beneficiaries reached as opposed to dilute the quality of the therapies proposed. This principle is to be considered while acknowledging an overall framework of scarce professional resources available, difficult working environment, and time constraints. This also acknowledges for a body of literature that still does not present conclusive answers on what interventions bring the most suitable results, and how to deliver those interventions.
- 4- **Cultural sensitivity.** The tools introduced will be tested for cultural sensitiveness and modified with the participation of beneficiaries and professionals to generate material adapted to the context.
- 5- **Quantify and qualify impact.** The intervention aims not just at showing a positive impact in the physical and emotional recovery of children, but also at measuring this positive change and comparing it with a control group.
- 6- **Institutionalisation and Scalability.** The strategies presented always bear in mind issues of replicability at scale, costs, and institutionalization in the current nutrition intervention protocols in use in the country. Play Therapy Africa does not aim at ideal and perfect interventions. On the contrary, it presents potentially good strategies that can be replicated and taken to scale at an affordable cost if the project will be successful. Similarly, it is not intention of Play Therapy Africa to present an intervention without the potential for institutionalization. The ultimate goal being the one of capacitating already existing actors, and in particular the Government, to deliver the services tested in this project.

Selection of the Sites for intervention

The sites will be selected by the Bureau of Health of SNNPR. The Bureau has already made a case to select a woreda run by government and a woreda run by NGOs. All TFUs and OTPs within these woredas will be addressed by the project in a maximum of 10 sites in the government woreda, and 10 in the NGOs led woreda. The composition between TFUs and OTPs within each woreda is subjected to review once PTA will be provided with the names of the selected woredas, and data on current beneficiaries per woreda.

Selection of participants

Selection of health extension Workers: health extension workers will be selected from two woredas, one run by government, and one run by NGOs. HEW from government led health posts (10 people) will be selected by DPPA/DPPB in collaboration with Play Therapy Africa. The competencies that these HEW need to have to successfully attend the training are listed in. These competencies are NOT optional. Rather they have been developed to make sure that training delivered will bring the maximum impact to the children and their mothers. 10 HEW from NGOs led nutrition sites will be selected by the respective NGOs' head of agencies. The same competency framework for selection will apply.

In this area, PTA seeks assistance to UNICEF regarding the logistics involved in inviting selected people to attend the training, and institutionally present the project to NGOs.

Selection of Youth: youth to be trained and deployed (20-25) will be selected by the Bureau of Youth and Sport of SNNPR in collaboration with PTA. Play Therapy International has developed a competency framework for youth, that should guide the selection of young professionals. As a general rule, the youth selected will come from the same *woredas* where the intervention will take place. If this will not be possible, a pull of youth will also be selected from Awassa town to be deployed if necessary. In either case, PTA professionals will do a second screening prior the training to make sure that the youth selected meet minimum criteria for performance.

Insight on the Theoretical and Psychological Frameworks of Coaching Approaches used during the Training

In order to be fully effective as a Filial Play Coach it is necessary to have a grasp of the relevant psychological principles. However it is not necessary to have a degree in psychology. Coaching is based on counseling and therapeutic techniques:

- Solution-focused brief therapy
- CBT (Cognitive behavioral therapy) 60%
- Rational emotional therapy
- Multi-modal therapy
- NLP - life coaching

Coaching also uses positive psychology, originally applied by Martin Seligman & Mihaly Csikszentmihalyi and based on a long lineage stretching back to the 1900's (Maslow, Roger, Allport, Jahoda, Jung, James). The main principles are:

- Positive emotion – the pleasant life
- Positive character – the engaged life
- Positive institutions – the meaningful life

The approaches may be divided into two main groups: firstly those reflecting Western cultures which are task focused and goal oriented and include the application of empowerment psychology (Empsy model of problem situation and the Empsy model of intervention) and Cognitive Behavioural Therapy (CBT); secondly those reflecting Eastern cultures which include Transpersonal, Gestalt and Narrative approaches.

Understanding these different approaches will help you to build your own model by combining multiple techniques and to structure sessions. A good starting point is the GROW model which incorporates CBT and Gestalt principles.

CBT: A survey (SGCP) revealed that 60% of Coaches approaches are based on CBT. It is consistent with positive psychology and based on stoic philosophy. Beck (et al 1979). There is considerable research in the counselling field supporting the effectiveness of CBT, which for example has led to the contentious decision by NICE to declare that CBT is the *only* therapy to be recommended by the DoH. The main principle is that cognition has the power to influence emotion and behaviour, or in other words, 'Mind over matter'.

Seven steps are suggested in CBT based coaching:

1. Set a goal
2. Assess the value of the goal
3. Set SMARTER objectives
4. Assess the emotions of the coachees

5. Identify possible barriers/problems
6. Develop strategies to overcome barriers/problems
7. Review progress

The mnemonic SMARTER is useful in setting objectives, in any field, not just coaching:

- **S**pecific
- **M**easurable
- **A**greed
- **R**ealistic
- **T**ime bound
- **E**valuate and review

Gestalt: Much of gestalt theory initially came from our (then) understanding of how the brain operates and processes information and as such determines structural groupings – first put forward by Max Wertheimer in 1912. It was pioneered therapeutically by Fritz Perls. The main principle is the importance of obtaining a whole consistent picture where the whole is greater than the sum of the parts. The primary factors that determine ‘grouping’ – the characteristics of certain stimuli cause us to structure or interpret a visual field or problem in a particular way – are:

- Proximity - according to nearness
- Similarity
- Closure - complete an entity
- Simplicity - symmetry, regularity and smoothness

The gestalt approach focuses on the primacy of awareness. It has the following characteristics:

- An act of expression that stretches one’s awareness
- The presence of a witness, which enhances attention
- The presence of interpersonal relationships, which defines the coaching/mentoring process. In this sense the coach and coachee are creating the present together
- Organic – the coach and coachee switch attention from one issue to another rather than according to a set of procedures/formulae, as compared to CBT

Narrative approaches: Developed by Michael White as a therapy approach (1995). First applied to coaching by Ho Law (2006). Lineage: cultural anthropology (Myerhof 1980) and the psychology of learning - proximal development (Vygotsky).

The coaching process is based on story telling using the following assumptions:

- Meaning shapes our lives
- Life is multi, not single story – some stories are more prominent in a coachee’s life, while other stories may be neglected. These may be important to their development.
- Primary meaning making frame; - narrative practitioners regard the story line told by the coachee as a primary meaning-making frame, which enables them to construe meaning from it. This in turn gives meaning that shapes our lives.
- Individuals and communities have strengths, knowledge and skills that come into contact with us, although they may not be noticeable to themselves

The GROW Model

This simple model, which is widely used, was developed by Sir John Whitmore originally from sports coaching practice, based on the psychology of sports & exercises. It has been described in Whitmore's books 'Coaching for Work' and 'Coaching for Performance' and is now used extensively in business and management coaching. It incorporates some of the principles of CBT and gestalt practice.

The four stages are:

- **G**oals (CBT)
- **R**eality (Gestalt)
- **O**ptions (Gestalt to CBT)
- **W**ill or wrap-up (CBT)

Goals: Goal setting and achievement is the main objective of the model. The goals may be long term, short term and relate to issues. They should have an element of challenging/stretch and most importantly the parents need to take ownership.

Reality: However the goals must be realistic. The learning process should be based on the parent achieving an early success. The chances of failure because of unrealistic expectations should be minimised especially during the early stages. Part of this stage is getting feedback: 'What worked?', 'What didn't?'

Options: During this stage the Coach seeks guidance from the parents on identifying tasks to form an action plan and in generating options to maximise the parent's choices. The first part of this process should be non-critical, non-judgmental brain storming. The second part is working together to assess feasibility and priority.

Will or wrap-up: GROW is a future looking model. 'So what are you going to do now?' 'By when?' 'What obstacles/problems might you encounter?' 'What will you do about them?' 'Who can help you?'

Monitoring of the Programme's Impact

All similar interventions conducted in emergency settings presented a common shortfall when it comes to measuring their impact: they only focus on measuring the impact of the programme on mother mood and mother to child relationship. While important, these indicators do not provide any direct information and quantitative data on the impact of the project on the ultimate beneficiary, the child.

The monitoring tools chosen and here below presented will enable to measure 1- the emotional improvement on the child (emotional and social recovery), 2- the higher and faster gain of body weight and high (physical recovery), and 3- the parent to child relationship.

In filial play the parent is equally as important as the child. Although the main purpose is to help the child, in filial play the parent is the agent of change and the relationship between the parent and child is very important and cannot be excluded from the assessment.

Assessing the Child

Emotional and Social Assessment of the Child

The main tool to assess the social and emotional improvement of children aged between 3 months to 5.5 years will be the Ages and Stages Questionnaire (ASQ). The Goodman's SDQ is recommended for children over the age of 5. The ASQ has been chosen for use because it is:

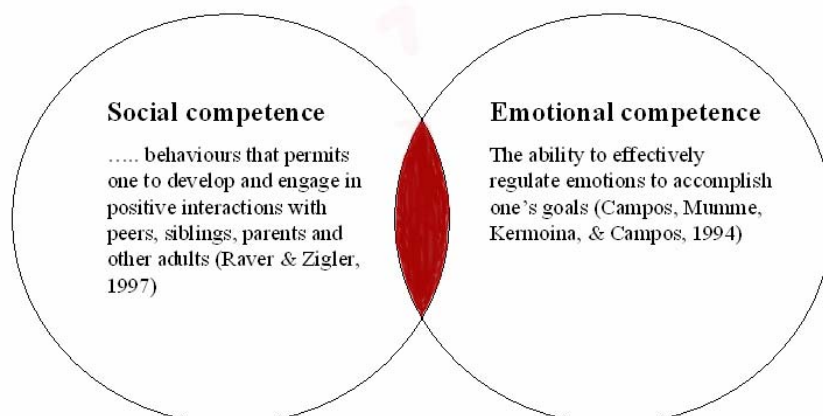
- Age sensitive
- Has been thoroughly validated
- Is easy for most parents or coaches to complete
- Quick to score
- Low cost
- The seven domains will provide useful information to guide the HEW and the youth in their approach
- A similar tool –the SDQ- has already been fully validated and used in Ethiopia for the past year.

The Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) has been developed to provide information specifically addressing the social and emotional behaviour of children ranging from 3 to 65 months of age. The authors are Jane Squires, Diane Bricker and Elizabeth Twombly of University of Oregon.

The number of questions and the cut off scores vary according to the age of the child. It is therefore very important to use the appropriate age version for the child. The cutoff scores were obtained using a Receiver Operation Characteristic (ROC) curve. Curves are generated (using a computer program) using potential cut off points. The points are then chosen that maximise sensitivity (true positives) and specificity (true negatives).

The ASQ:SE is based upon: the social learning model (Bandura, 1997; Patterson, Reid, & Dishon, 1992), which posits that social learning occurs as a function of the child's daily social interactions; the developmental organisation theory of Chichetti (1993) and the marginal deviation model (Dishon, French and Patterson, 1995).

Social competence and emotional competence are seen as representing distinct though overlapping developmental areas and behavioral processes. See also the Summary of the Development concepts by Age reported at the end of the document.



Validity and Reliability of the ASQ:SE

Validity is the extent to which a test measures what its authors claim and the appropriateness of the inferences that can be made from the test results.

Reliability is the consistency of test scores over time and between testers and the extent to which it is possible to generalise from one test result conducted by one person to test results conducted by different observers at different times.

Normative data were based on 3014 completed questionnaires; validity studies were conducted using 1041 children.

Internal consistency, which measures the extent to which items on the assessment tool measure the same underlying construct, was found to be high across age intervals with an overall alpha of .82. .70 is considered to be an adequate measure.

Test-retest reliability measures the stability of child performance across time, examining, the agreement of two ASQ:SE questionnaires completed by the parents at 1 to 3 week intervals. It was 94%.

Agreement between the ASQ:SE questionnaire and standardised assessments/disability status (CBCL & SEEC) was 92% overall. The ASQ:SE is generally accurate in discriminating between those children who are developing satisfactorily and those who need special attention as shown by overall sensitivity of 78% overall and specificity of 94% overall. Sensitivity is the proportion of children correctly identified as needing assistance or further assessment and who perform below the expected level on a standardised assessment. Specificity is the proportion of children correctly excluded as developing typically and who perform at the expected level on a standardised assessment.

It will be done at entry, once per month for the duration of intervention, and at the end.

The control group will be selected in a non-intervention woreda, where the ASQ will be done in the same way: entry, each month, and at the end of the project.

Seven behavioural areas are addressed in the ASQ:SE:

Behavioural area	Definition
Self-regulation	The child's ability or willingness to calm or settle down or adjust to physiological or environmental conditions or stimulation
Compliance	The child's ability or willingness to conform to the direction of others and follow rules
Communication	The child's ability or willingness to respond to or initiate verbal or non-verbal signals to indicate feelings, affective or internal states
Adaptive functioning	The child's success or ability to cope with physiological needs (eg sleeping, eating, safety)
Autonomy	The child's ability or willingness to self initiate or respond without guidance ie moving to independence

Affect	The child's ability or willingness to demonstrate his or her own feelings and empathy for others
Interaction with people	The child's ability or willingness to respond to or initiate social responses to parents, other adults and peers

Referral Criteria

Note that the ASQ:Se cutoff scores vary according to age:

ASQ:SE age interval	Use for children	Cutoff score
18 months	18 – 20 months	50
24 months	21 – 26 months	50
30 months	27 – 32 months	57
36 months	33 – 41 months	59
48 months	42 – 53 months	70
60 months	54 – 65 months	70

For children over 65 months the project will use the Goodmans SDQ measure

Score ABOVE the cutoff

This indicates that the child has a problem and should be considered for filial play. If however the score is above 150 the practitioner needs to consider the responses to the individual questions, the parent's concerns and comments to assess if an alternative to filial play such as play therapy should be recommended.

Score is NEAR the cutoff

For example a score of 37 when the cutoff is 39.

This indicates that a child may have a problem. Consider the responses to the individual questions and especially the parent's concerns and comments. A mother might say 'But I'm at the end of my tether.' The use of filial play may be made on the basis of parent's concerns, their relationship with child and a single behaviour that is particularly problematic.

Score BELOW the cutoff

This indicates that the child does not have a problem. If the parent is still concerned about the child another measure is taken in six months. Optionally it should be asked someone else who knows the child well to complete an ASQ. Explore whether filial play, counseling, family therapy or parenting skills development is likely to help if the issue is the relationship between the parent and the child.

Physical Assessment of the Child

Body weight and high will be used to assess the physical improvements of the child. In TFU settings, the child is measured for weight and high already, while in OTP the child is only measured for weight. This project proposes to include a measurement of high also in OTP settings for children who are enrolled into the programme.

The frequency of physical assessments will be the same than the one already foreseen by the standard procedures in use in TFU and OTP settings.

The growth curve already in use and tested in Ethiopia will be used as normality standard for age and stage physical development.

Assessing Parent/Child Play

This assessment will only be done through observation and the objectives of this stage of the assessment are:

1. Determine if the kind of play the child is capable of eg symbolic/fantasy play and if it is appropriate for their age
2. Assess how the parent interacts with the child's play, identifying opportunities for improvement

In the parent/child play session the HEW and youth will make observations under three group headings:

- 1 *Personality of the parent.*
- 2 *Behaviour/relationship with the child.*
- 3 *Play attributes.* (At this stage we would not normally expect a parent to understand the principles of non-directive play. This information is to help the Coach to decide the emphasis and priorities of the training sessions).

A Parent/Child Play Observation form is provided for this purpose to the youth and HEWs.

Supervision

Regular supervision of practitioners will be guaranteed by PTA through the deployment of 5 senior supervisors that will take charge of 8 sites each. Each supervisor will monitor 16 between youth and HEWs and the supervision sessions will have a frequency of maximum 8 days.

Supervision sessions will be individual and in pairs. Individual supervision sessions will be led by PTI's supervision rules and guidelines to monitor the safe and effective implementation of filial play coaching. Group supervision between the supervisor, the youth and the HEW operating in the same center will allow to discuss logistic arrangements, a conducive environment, exchange of experience, and to allow for a more coordinate and concerted action.

Supervisors will use the appropriate supervision forms, but they will also operate observing practitioners during coaching sessions. This joint mechanism will allow to early detect underperformance and support adherence to the principles and methods of the practice.

PTA will rely on UNICEF for arrangements concerning transport of supervisors as per contractual agreement.

Remuneration of Participants

HEWs involved in the programme will not be remunerated for their contribution. The training and supervision that PTA will provide are considered a very important additional asset that these professionals will receive for participating in the programme. This is also compatible with the ideology of testing the intervention to eventually take it up to scale at a low cost.

Youth practitioners and supervisors will be fully remunerated for their practice using a performance approach. A basic but competitive remuneration has been devised, but according to performance in terms of case load followed, proper regular sections held with caretakers, recording of periodic data, etc. additional monetary incentives will be provided.

Salaries will be disbursed on a monthly basis after full monthly data have been handled in to the supervisor.

Caseload and Work Logistics

The role of youth and HEWs in the project will be to provide filial play coaching to as many caretakers as possible, respecting issues of quality and safe practice. The actual number of children reached will crucially depend on the sites selected, yet it is expected that each practitioner will reach a maximum of 25-30 beneficiaries per month.

In the TFUs, the sessions between the practitioner and the caretaker will be daily, 3 times per day, for 15 minutes each session, after feeding time¹⁴. At TFUs, mothers will also receive 1 hour group coach every day¹⁵ for the length of their staying.

In the OTP, the sessions to coach the mother will be weekly, of one individual hour per session. The sessions will last until the child fully recovers **both** emotionally and physically. Currently, the usual length to be dismissed from TFUs is from 7 to 14 days, to then be enrolled within the OTP for 2 months. Since the criteria for dismissal from OTP are base on weight, if the child reaches a desired weight before reaching a desired emotional development, the trained youth will be requested to continue the therapy through home visit.

Group sessions at OTPs will also be organized as a complement to individual sessions or as a substitute of those. Individual sessions are more effective, while they pose substantial logistical challenges. The ideal scenario will be for the youth to request the mother to come to the OTP for one-to-one weekly sessions in addition to coming to the OTP to collect supplementary food. If this option is not viable due to distance and transport constraints, then group sessions will be considered as a favorable option.

The role of Youth will differ from the role of HEWs when it comes to the follow-up of the cases. HEW based in both TFUs and OTPs will follow the case as long as the child remains within their

¹⁴ This phase is better delivered by the nutrition worker and supported by the youth. Youth alone will have difficulties in delivering this service without the nutrition worker.

¹⁵ This can be led by the youth with or without the support from the nutrition worker.

premises. On the contrary, youth will follow the child throughout the 3 months of the project until full recovery is reached regardless of the place where food is provided. This means that when the child moves from TFU to OTP, the youth will continue following and coaching the mother, while the HEW won't.

PTA will consider to continue monitor a small sample of participants for up to 6 months - one year to see long term effects of the therapies.

Training and assessment material

All training and assessment tools will be translated into Amharic, and back translated into English to allow for quality control of translation. The initial training material has been tested in different Western countries. PTA will take this opportunity to allow for cultural practices to be observed and where appropriate introduced in the training material.

After the initial training, trainees will be involved in a participatory assessment of tools used, including sharing suggestions on how to make the training package culturally relevant for Ethiopia. These feedbacks will form the basis for the development of a training package to be deployed if the intervention shows an acceptable degree of success. This adapted material will then be used for a possible second phase of the project.

Ideally, all the data compiled will be entered in a specially designed database for an easy use and accessibility. In this first phase data will be analyzed manually, yet for future expansions of the project this will be a crucial commitment.

Defining success

The project will reach a minimum of 1,200 children and a maximum of 2,500 in this first phase. The project aims at showing a significant positive improvement of the emotional and social status of the child in at least the 75% of the cases treated regularly.

The project also intends to show that an emotional and social recovery of the child will allow for a quicker gain in body weight and high. In this respect, the project aims at allowing 50% of treated children to be dismissed from TFUs and OTPs before the average length of treatment.

Annex 2: Summary of Developmental Concepts

(Adapted from Steven Walker, *Culturally Competent Therapy*, Palgrave Macmillan, Basingstoke)

Theory	Age				
	1	2-3	4-5	6-11	12-18
<i>1 Erikson psychosocial stages of development</i>	Requires consistent and stable care to develop feelings of security. Begins to trust the environment but can also develop suspicion and insecurity. Deprivation can lead to emotional detachment throughout life and difficulties in forming relationships.	Begins to explore and seek independence from parents. A sense of autonomy develops but improved self esteem can combine with feelings of shame and self doubt. Failure to integrate may lead to difficulties in social integration.	Needs to explore the wider environment and plan new activities. Begins to initiate activities but fears punishment and guilt as a consequence. Successful integration results in a confident person but problems can produce deep insecurities.	Begins to acquire knowledge and skills to adapt to surroundings. Develops sense of achievement but marred by possible feelings of inferiority and failure if efforts are denigrated.	Enters the stage of personal and vocational identity formation. Self-perception is heightened, but there is a potential for conflict, confusion and strong emotions.
<i>2 Bowlby's Attachment theory</i>	Pre-attachment indiscriminating social responsiveness. The baby is interested in voices and faces and enjoys social interaction.	Begins to develop discriminating social responses and experiments with attachments to different people. Familiar people elicit more response than strangers.	Attachment to main parent is prominent with the child showing separation anxiety when the carer is absent. The child actively initiates responses from the carer.	The main carer's absences become longer, but the child develops a reciprocal attachment relationship.	The child and developing young person begins to understand the carer's needs from a secure emotional base.
Theory	Age				
	1	2-3	4-5	6-11	12-18
<i>3 Piaget's stages of cognitive development</i>	Sensory motor stage – infants explore their physicality and modifying reflexes until they can experiment with objects and build a mental picture of things around them.	Pre-operational stage, where the child acquires language, makes pictures and participates in imaginative play. Child tends to be self-centred and fixed in thinking believing that they are responsible for external events.	Concrete operations stage, when a child can understand and apply more abstract tasks such as sorting or measuring.	Less egocentric thinking and more relational thinking – differentiating between things. The complexity of the external world is beginning to be appreciated.	Formal operations stage – characterised by the use of rules and problem solving skills. The child moves into adolescence with increasing capacity to think abstractly and reflect on tasks in a deductive, logical way.
<i>4 Freud psychosexual stages of development</i>	Oral stage – principle source of comfort is sucking breast milk from mother and the gratification from the nutrition.	Anal stage – anus and defecation are major sources of sensual pleasure. Child preoccupied with body control with parental/carer encouragement. Obsessional behaviour and over-control could indicate problematic development.	Phallic stage – the penis is the focus of attention. In boys the Oedipus complex and in girls the Electra complex are generated in desires to have a sexual relationship with the opposite sex parent. The root of anxieties and neuroses can be found here if transition to the next stage is impeded.	Latency stage - characterised by calm after the storm of the powerful emotions preceding it.	Genital stage – whereby the individual becomes interested in opposite sex partners as a substitute for the opposite sex parent, as a way of resolving the tensions inherent in the Oedipal and Electra complexes.

