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Promoting functional development for children with cerebral palsy in low-income countries

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Monitoring of early child development is core to the United Nations Sustainable Development Goals' commitment to optimize developmental attainment for all children. An estimated 53 million children under 5 years of age are affected by developmental disability around the globe, with the majority (95%) living in low-income or middle-income countries.¹ Cerebral palsy (CP) is one of the most common motor disorders. However, the developmental trajectories of children with CP in low-income countries (LICs), where rehabilitation services are often lacking, have been infrequently reported. If we are to support children with CP in maximizing their developmental potential, it is crucial that we understand these trajectories.

Andrews et al. have examined the functional development of a population-based cohort of children with CP in eastern Uganda.² They conducted longitudinal follow-up of children with CP, aged 2 to 17 years who were recruited to an earlier prevalence study.³ Standardized and adapted tools were used to classify level of impairment and to assess

mobility, self-care, and social function. For comparison, these were mapped against the developmental trajectories of children with CP in high-income countries (HICs).

Whilst children with CP in Uganda did develop self-care and social functioning skills over time, this was not reflected in gross motor function and mobility.² Most concerning was the lack of developmental progress seen amongst those children with milder impairments, who did not mirror the steep developmental progress of their counterparts from HIC populations, particularly in motor skills and mobility.² This was most marked amongst the youngest of children, aged 2 to 5 years.

Early identification and intervention for children at high risk for CP is evidence-based to improve both motor and cognitive outcomes in HICs,⁴ however, such services are infrequent in many LICs. The lack of early detection of those most at risk, and paucity of specialist services like physiotherapy, may account for this failure to improve mobility and motor functioning. The need for a cost-effective health systems approach to early identification and care, integrated with existing government services, is vital to reversing this trend.

Access to new and existing services for children and their caregivers must also be considered if we are to improve outcomes for those most in need. Understanding the lived experience of caregivers (most frequently women as seen in the study by Andrews et al.) is essential in promoting access to care. The high social and emotional impacts, and lack of inclusion and participation experienced,⁵ disempowers families and risks a silent community of children hidden from view. Applying a gender equality and social inclusion lens to care and support services aims to empower women in accessing not only care for their children, but also support for themselves and must be prioritized.

Whilst the benefits of early intervention in HICs are well established⁴, an evidence base from LIC settings is severely lacking, but clearly warranted. Approaches that support

community transformation with regard to inclusion and participation; promote knowledge, skills, and confidence; and provide an environment of empowerment for both caregivers and healthcare workers, may facilitate access to care and improve quality of life for children and their family members. Public policies need to support people in facing economic and social difficulties. Governments should be held accountable for enabling equitable access not only to routine health services, but also to mainstream policies and systems, whilst investing in specific programmes and services for people with disabilities. Each of these things are fundamental if we are to ‘leave no one behind’ and deliver on our Sustainable Development Goals commitment for all children, inclusive of those with CP, to survive and thrive.

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