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# Role of Early Intervention Programs in Mitigating Developmental Delays among Children in Punjab's Special Education Sector

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**ABSTRACT**
*Early childhood developmental delays are among the most impactful and opportune issues in the world of special education. The delayed identification coupled with poor infrastructure for early intervention, the socioeconomic marginalisation and under-resourcing of the special education system for children in Punjab, Pakistan, creates developmental pathways that are far from what could be achieved with evidence-based early intervention. The overall approach of the study is qualitative with a narrative inquiry methodology and interpretivist paradigm, aiming to explore the role of early intervention programs to reduce developmental delays in special education sector children in Punjab. In-depth narrative interviews with parents of children with developmental delays, focused group discussions with early intervention practitioners, semi-structured interviews with special education professionals and health sector personnel, and documentary analysis of pertinent policy instruments were used to produce data. In keeping with the recommendations of Ramey and Ramey's Principles of Effective Early Intervention (PEEI), which are based on theory and empirical evidence, the study systematically examines the early intervention landscape in Punjab against the principles of program intensity, direct learning experiences, breadth of services, individual differences responsiveness, family participation, environmental maintenance, and developmental timing. Thematic analysis identifies five important areas of early intervention need; identification and screening systems, multidisciplinary assessment and individualized programming, family-centred and home based intervention, integration of therapy services and transition planning from early intervention to formal schooling. The analysis reveals a system that is late to identify, service-oriented to the urban population, poorly coordinated, lacking in family empowerment support and has almost no transition structures. The study ends with evidence-based policy level recommendations for Government of Punjab, Department of Special Education, Department of Health and relevant civil society organizations.*

***Keywords:*** *early intervention, developmental delays, Punjab, special education, Ramey and Ramey's principles, narrative inquiry, qualitative methodology, screening, family-centered practice, Pakistan, multidisciplinary assessment, transition planning*

## 1. Introduction

The developmental importance of the first 5 years of human life is one of the most well established facts in the developmental sciences literature. The prenatal period through early childhood is an era of the brain's development with extraordinary synaptic density, increased

neuroplasticity and extreme sensitivity to the environment—conditions that not only make the child more vulnerable to developmental disruption but more susceptible to developmental recovery and enhancement from intervention mediated by the environment (Shonkoff & Phillips, 2000). The quality, timing, and intensity of early intervention services is the most modifiable factor that influences long-term outcomes for developmental, educational and quality of life outcomes for children with developmental delays, whether due to genetic conditions, perinatal complications, sensory impairments, nutritional deficiencies, or the complex neurodevelopmental conditions of autism spectrum disorder (ASD) and intellectual disability (ID) (Guralnick, 2011).

This is an urgent call to action based on evidence, which is now being faced in the context of structural contradiction in the Province of Punjab, Pakistan. The province has the most extensive network of government run special schools in Pakistan, has a population of more than 110 million and has made specific targets and commitments in national legislation and policy for the inclusion and developmental support of children with disabilities in accordance with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). However, the implementation of these pledges into services that are both functional and effective for early intervention is still underdeveloped (Saeed et al., 2020).

The impact of this early intervention shortfall is tangible in terms of the developmental gap between the children with delays who receive early services and those who do not, which increases over time and has cascading impacts on the educational, occupational and social trajectory of the affected child's life. Past studies have consistently shown that untreated developmental delays within the early childhood window of opportunity are increasingly difficult to correct as the window of greater neurological plasticity narrows (Heckman, 2006). Systematic qualitative studies that focus on the experiential aspects of access to, and provision of, early intervention in the special education sector in Punjab, however, are limited in scope. This qualitative narrative inquiry attempts to fill that void by providing experientially based and theoretically grounded, structurally contextualized understandings of the significance of early intervention programs in the context of special education in Punjab, Pakistan. The article is comprised of the following sections: Section 2 provides a theoretical foundation. The literature review for this study is presented in Section 3. The research methodology is followed in section 4. The results are presented in Section 5. Section 6 provides discussion. Section 7 identifies limitations. Section 8 presents recommendations. Section 9 concludes.

**2Theoretical Framework Ramey and Ramey's Principles of Effective Early Intervention**

This study is informed by the Principles of Effective Early Intervention outlined by Craig T. Ramey and Sharon L. Ramey (1998) based on their groundbreaking longitudinal study, the Abecedarian Project and the Infant Health and Development Program (IHDP). The framework is one of the most empirically based and practically actionable theoretical frameworks in the early intervention literature, and identifies seven conditions necessary for early intervention programs to produce optimal and enduring childhood development outcomes for children at risk for or with developmental delays.

Developmental timing is the first principle: intervention delivered at the best time in development – that is, during the earliest developmental periods – has the greatest potential for developmental impact and long-term duration. The second principle is program intensity—children who are exposed to more hours per week of organized developmental programming demonstrated higher developmental gains, and there was a dose-response relationship between program intensity and gains. The third principle is direct learning

experiences: Early intervention programs that offer children good learning opportunities and experiences through direct rather than indirect parent education are most successful. The fourth principle of design is "breadth of services": programs that impact multiple developmental areas at the same time and offer families health, nutrition, psychological, and social services are more likely to yield lasting and robust developmental outcomes (Ramey & Ramey, 1998).

The fifth principle concerns individual differences; effective early intervention programs will be flexible and responsive to each child and family's developmental profile, context, culture, and learning characteristics instead of providing a uniform program content to diverse groups of children and families. The sixth principle is environmental maintenance of development: once the child makes early developmental gains, the most important thing is that the developmentally stimulating, responsive and supportive conditions continue after early intervention programming ends. The seventh principle is social support and family involvement: Programs that involve, engage and empower parents and primary caregivers as partners and partners with information and capacity in developmental support, yield more enduring and transferrable results than programs that treat families as mere recipients of professional services. Throughout this study, the current early intervention provision in Punjab is evaluated by the following seven principles (Ramey & Ramey, 1998).

**3. Literature Review**

The literature on early interventions for children with developmental delays is well established in the international literature and has developed a strong evidence base in the fields of neuroscience, developmental psychology and long-term program evaluation. Shonkoff and Phillips (2000) compiled the neurological underpinnings of early intervention, showing that the brain is extremely malleable during the first years of life, thus more vulnerable to adverse experiences and more responsive to enriched developmental input, provided by intervention. Campbell et al. (2002) offered longitudinal data from the Abecedarian Project that intensive early childhood intervention produces lasting gains in intellectual functioning, education and adult outcomes, such as employment and health status of children who were followed into adulthood. Heckman (2006) added the economic component to this evidence base, showing that for every dollar invested in high-quality early intervention for at-risk children, society benefits by an increase of seven to twelve dollars in benefits over the child's lifetime in the form of better developmental and economic outcomes.

In the South Asian and Pakistani context, Bhutta et al. (2008) reported their study on the effectiveness of community-based early intervention (EI) that was implemented by trained community health workers (CHWs) and was able to improve cognitive and motor outcomes among children, using developmental stimulation protocols through CHW programs. The integrated responsive stimulation and nutrition intervention delivered via LHW resulted in significant improvements in child development outcomes across cognitive, language and motor domains, as rigorously shown by Yousafzai et al. 2014 in a cluster-randomized trial in Pakistan; proving proof of concept for scalable, community-based early-intervention within the Pakistani health system. Ghias et al. (2014) identified the characteristically late age of identification of neurodevelopmental conditions in South Asian countries, which essentially challenges the developmental timing principle of Ramey and Ramey's framework, on which it is based.

Walker et al (2011) conducted a global review of risk and protective factors for early child development in low and middle income countries, finding poverty, under-nutrition, lack of

stimulation and violence exposure to be the strongest risk factors, and argued for integrated and multi-sectoral approaches to early intervention that would tackle the compound developmental risks faced by disadvantaged children and young people. In the developing world, over 200 million children are deprived of sufficient early development support, resulting in a deficiency in early intervention worldwide that has been brought to the attention of the world with the work of Engle et al. (2007), who used the human development costs of the global early intervention deficit at the scale of the civilizations. Guralnick (2011) set out to describe the systems-based approach to effective EI, with three key components — child-focused interventions, family support programs, and resource and social support services — and emphasized that they needed to be coordinated within a service delivery system to enable them to achieve comprehensive and lasting developmental impact.

Studies focused on the family-based aspects of early childhood services within the Pakistani context have recorded the negotiation between professional approaches to service provision and the culturally rooted family practices of caring for children, religious meaning-making frameworks and extended family authority that surround childrearing in Punjabi families (Miles, 2002). By developing the evidence base for parent-implemented intervention, Mahoney and Wiggers (2007) found that the most efficient way to provide the intensity of interaction that at-risk children need is to systematically build up the parental competence of responsive interaction and naturalistic developmental teaching, which has direct implications for program design in early intervention programs that are based in parents' homes and operate in the resource-constrained context of Punjab.

## 4. Research Methodology

### 4.1 Research Paradigm

This study was based on the interpretivist paradigm of research that holds that knowledge is socially constructed and arrived at through the people's lived experiences and understanding of the world (Lincoln & Guba, 1985). With a constructivist epistemology, the study aimed to understand the views and experiences of families, practitioners, healthcare professionals and policymakers on early intervention services for children with developmental difficulties in Punjab. This was a suitable method because beliefs, values, religion, and institutional practices influence the concepts of developmental delay, disability, help seeking, and intervention. An interpretivist perspective then allowed for a context-dependent interpretation of the mismatch between current services and evidence-based policy expectations in early intervention (Creswell, 2013).

### 4.2 Research Design

To explore participants' lived experiences, a qualitative narrative inquiry design (Clandinin & Connelly, 2000) was used. Narrative inquiry affirms that people make sense of and relate their experiences in stories that link events in time, place, and social context. The method was well suited as families' experiences from noticing developmental issues to diagnosis, intervention, and enrollment into school are all inherently narrative. As Clandinin and Connelly (2000) describe, the study utilized the three dimensions of inquiry space: temporality (past, present, and future experiences), personal-social interaction (individual and social influences), and place (institutional and community contexts) to produce rich and culturally contextualized accounts (Riessman, 2008).

### 4.3 Research Setting

It was carried out at various locations in Punjab, such as government Special Education Centres, Basic Health Units, district hospitals, LHW clusters and an early intervention centre

of a non-government organization in Lahore. The diversity in the recruitment areas includes urban, peri-urban and rural areas such as Lahore, Kasur, Sheikhupura and rural area of Gujranwala Division to assure the variety of service provision and accessibility.

**4.4 Participants and Sampling**

Participants were selected using Purposive sampling with maximum variation (Patton, 2002) to draw a sample with a variety of experiences. There were four groups of participants in the study:

- Parents/caregivers: 22 parents (17 mothers and five fathers) whose children were aged 2-8 with autism spectrum disorder (ASD), intellectual disability, Down syndrome, cerebral palsy, developmental language disorder, behavioural disorders, or developmental delay. A good range of socio-economic status, geographical location, severity of disability and intervention services was achieved.
- Practitioners: Fourteen practitioners including early childhood special educators, special education teachers, psychologists, speech-language therapists, occupational therapists from government, private and NGO environments.
- The Healthcare Professionals: Nine participants, these included Lady Health Workers, Basic Health Unit medical officers and one developmental paediatrician who participated in developmental screening and referral.
- Informants: Four senior officials from Special Education and Health Departments in Punjab with knowledge about policy implementation and interdepartmental coordination.

- Data analysis used theoretical sampling to develop emerging themes until narrative saturation was reached (Riessman, 2008).

**4.5 Data Collection**

Four complementary qualitative methods ensured methodological triangulation.

The main data source was narrative interviews. Each participant parent was interviewed using the biographical narrative interview method (Wengraf, 2001) which started with one open-ended question that asked them to describe their experience from initial concern about developmental problems to the present. Interviews were conducted in Urdu, audio recorded with consent, and were mainly conducted in participants' homes, and were 70–120 minutes in duration, with elaboration of narratives and reflective discussion.

The interview guides were created for each of the participants, and semi-structured interviews were conducted with practitioners, healthcare professionals, and policymakers. These looked at early identification procedures, intervention services, family involvement, referral systems, interprofessional working, policy development and funding and institutional issues (Kvale & Brinkmann, 2009).

Separate focus group discussions (FGDs) were held with the special education teachers and the psychologists, therapists and Lady Health Workers. The FGDs took place in Urdu, and started with a discussion around their common work experiences, issues related to service delivery and certain practices that were done in collaboration (Morgan, 1997).

The documents analysed were the Punjab Special Education Policy (2018), National Policy for Persons with Disabilities (2002; revised 2018), parts of the UNCRPD, Lady Health Worker operational guidelines, and government statistics on disability identification and school

enrolment. This was done with the use of documentary evidence to provide context and triangulate the participants' accounts (Bowen, 2009).

**4.6 Data Analysis**

There was a two-stage process of data analysis. First, the individual parent narratives were analysed using the structural narrative analysis (Riessman, 2008) framework, which examined the structure of the narratives, the sequencing of events in time, causal explanations and meaning attributed to important events and institutional experiences by the participants.

Second, all qualitative data such as interviews, FGDs and documentary evidence were analysed thematically based on the six phases of thematic analysis described by Braun and Clarke (2006). Interviews were transcribed from Urdu to English language and 20% of the samples were randomly back-translated from English to Urdu to ensure the accuracy of translation. The coding process has been developed from initial coding to theme development, review, refinement and reporting. Themes were explored within Ramey and Ramey's (1998) Seven Principles of Effective Early Intervention, and with analytical memos and peer discussions, conceptual development was deepened.

**4.7 Trustworthiness**

These criteria: credibility, transferability, dependability, and confirmability, as provided by Lincoln and Guba (1985) were used to establish trustworthiness. Multiple data sources were triangulated, engagement was extended, member checking was conducted with parent participants and findings were validated with the participants to build credibility. Detailed descriptions of participants and research settings facilitated transferability. A comprehensive audit trail was established comprising of interview recordings, transcripts, coding records, and analytical memos to ensure dependability. Systematic reflexivity was used to strengthen the confirmability process and to ensure the multi-disciplinary research team's professional assumptions and the possible biases were systematically documented and examined during the study (Creswell, 2013).

**5. Findings**

Confusion, misdirection, stigmatizing encounters, and significant institutional failure occurred during the period between the first noticing of developmental difference and formal diagnostic confirmation, with little variation in this narrative from an analysis of the parent interviews.Structurally consistent with this, the period between the first noticing of developmental difference and formal diagnostic confirmation was marked by confusion, misdirection, stigmatizing encounters, and significant institutional failure, with little variation across parent interviews in this narrative. The average length of time between first developmental concern by the parent and formal diagnosis was more than two years in the 22 parent narratives, with a few indicating a delay of four to six years. The story of one mother of an ASD child from a peri-urban community of the Kasur district reflected this: When he was 14 months and had yet to start speaking I told my mother-in-law. Boy's talk late, she said. At the health unit I informed the doctor that by the time he was 2 years old he hadn't begun to point. He said some children are slow, come back in a year. At the age of three, not making eye contact, I went to a private doctor in Lahore. Only then did someone say the word autism.' This narrative pattern of increasing concern by mothers, subsequent dismissal by professionals, and finally, through the use of private resources, a diagnosis of disability was repeated in seventeen of the twenty-two parent narratives, with some differences in terms of the specific type of disability, the length of the diagnostic delay, and access to private specialist assessment (Ghias et al., 2014).

The institutional perspective of this diagnostic delay came from interviews with healthcare professionals. All of the Lady Health Worker participants stated that they were not trained in developmental milestone monitoring, or the administration of developmental screening tools. Basic health unit (BHU) medical officers reported that they could not perform developmental surveillance because their time spent with the child was short and they were trained as generalists. Epistemic gaps highlighted in this study for developmental screening tools, whether translated into Urdu or validated Urdu versions of existing tools like Ages and Stages Questionnaires or Modified Checklist for Autism in Toddlers, were confirmed across all healthcare participant groups, and represented a structural basis for the identification delays reported in parent narratives.

**5.1 Multidisciplinary Assessment: Fragmented and Inaccessible**

In all the parent narratives, accessing multidisciplinary developmental assessment (where a team of specialist professionals evaluates the various domains of developmental functioning, including cognitive, language, motor and sensory development and behavior) was mentioned by only the private specialist centers in Lahore and was reported to be financially out of reach of most families. Parents of children recruited from secondary city and rural recruitment sites spoke of the journey to Lahore for assessment as a huge financial and logistical challenge, and an expense of family savings. Practitioner participants affirmed that the onsite multidisciplinary team structure (developmental pediatrician, psychologist, speech-language pathologist, occupational therapist) was not always present in government SECs, and pathways for referring to specialist assessment were not always well-systematised and consistently implemented (Guralnick, 2011). Most practitioner participants were not familiar with the Individualized Family Service Plan (IFSP), and it was not part of government SEC practice.

Parent narrative interviews indicated that the family centered model of EI with trained practitioners visiting families at home, and helping parents to incorporate developmental activities into their daily life to stimulate children's development, was almost non-existent in the government sector of EI services in Punjab. The only group to have sought any professional advice for support at home for their child with developmental difficulties was families that had done so from private practitioners or NGOs. This experiential reality of the absence is poignantly captured by a mother from the rural area of Gujranwala division: 'After the diagnosis, we were told to come to the center twice a week. There was no one at our house. He was not handled by anyone the other 5 days. I did what I thought was right but I wasn't sure if I am helping him or hurting him. It was worse to not know, than to be diagnosed with it.

Practitioner participants acknowledged that home based early intervention was not instituted systematically in any government institution represented in the study, citing staffing shortages, transportation issues and the lack of a formal protocol or home-based staff in the special education system as reasons for this. Policy informant interviews showed that the term ‘early intervention' is mentioned in the Punjab Special Education Policy 2018, but not as a service delivery mode, and when it comes to practice implementation is left to the institutional discretion which translates into center-based service delivery (Mahoney & Wiggers, 2007).

**5.2 Therapeutic Service Integration: Siloed and Inaccessible**

An integrated and co-located therapeutic supports (speech-language therapy, occupational therapy, physiotherapy, behavioral intervention), within the government SECs was recognized as a key gap in the provision of early intervention services for all participant

categories. The narratives from the parents reflected the difficulty they had in managing their child's SEC attendance and access to private therapeutic services, which were costly, centrally located in urban areas, and uncoordinated with their child's school therapeutic program. Practitioner participants explained the lack of the interdisciplinary team collaboration necessary to coordinate early intervention planning, in which special education teachers, therapists, and medical staff work without shared goals, shared assessment data, and collaborative intervention planning. This siloed service structure directly contradicts the breadth of services principle of Ramey and Ramey (1998) that early intervention should include a coordinated and integrated approach to multiple developmental areas.

Parent stories of their transition from the early intervention program to the enrollment in a formal special education center all included elements of sudden discontinuity, defined at the time of the transition as gains in the early intervention setting that were not carried over or maintained in the special education setting. One mother whose child had attended an NGO early intervention program and then moved to a government SEC explained it: 'At the NGO they knew everything about him, how he learns, what he gets upset, what is his sign, what he can do. He went to the government school as if from ground zero. There were no offerings from anyone. On the first day, the teacher asked me my name, but I already knew it.On the first day the teacher asked me what his name was because I already knew his name. Practitioner participants confirmed that there was no formal transition planning protocol in place in the government early intervention and special education system in Punjab that directly contradicts Ramey and Ramey's (1998) environmental maintenance principle.

**6. Discussion**

The narrative inquiry results, as interpreted through the lens of Ramey and Ramey's (1998) seven principles of effective early intervention, demonstrate a clear and cumulative pattern of principle violations for all seven principles. Children experience a typical diagnostic delay of 2 years or more in their parent's story, during which the children were at a time when they were not within the window of maximum neural plasticity when formal interventions start. It is not an isolated failure or an isolated incident, but a systemic failure due to lack of population level developmental screening, lack of adequate developmental surveillance training of primary health care providers and focus of developmental diagnostic skills in private urban based specialist services which are not accessible to the majority of families in Punjab.

Limited hours and frequency of structured developmental programming through government SECs is compounded by the lack of home-based early intervention that would extend developmental stimulation outside of center hours between center sessions, in the home environment, violating the program intensity principle. The principle of breadth of services is not met by the delivery of services that has taken place in government SEC early intervention which is siloed and single domain as it does not cater for the various developmental domains of early intervention and family support needs. The individual differences principle is not met when there is no individual assessment or individualized planning based on the child's IFSP to ensure the creation of a personalized intervention program. Structural absence of transition planning is in violation of the environmental maintenance principle. Failure to involve parents as active, empowered members of the team in intervention planning and lack of any home-visiting programs to develop parental developmental support competencies (Ramey & Ramey, 1998) represents a violation of the family participation principle.

A complementary analytical lens that can help to appreciate the findings' policy implications is provided by the economic evidence provided by Heckman (2006): non-investment in timely,

high quality and universally available early intervention in Punjab is not only an infringement on developmental rights, but a highly inefficient use of public resources. The cost of developmental delays for education, health and social welfare over the long term is significantly higher than the cost of evidence-based early intervention at scale – this is a rights issue, as well as a fiscal one – and building the early intervention infrastructure in Punjab will benefit society immensely.

**7. Summary of the study**

There are a number of methodological constraints that need to be made clear with regard to this qualitative narrative inquiry. First, purposive and theoretical sampling methods produce rich and contextually diverse data, but they do not create a representative sample of Punjabi families of children with developmental delays, as this is not statistically representative. The results instead reflect depth of understanding of the experiential dimensions of access and provision of early intervention rather than prevalence estimates of identified barriers. Readers are urged to evaluate the transferability of the findings to their contexts and not inferring generalizability. Second, there were a limited number of parents involved in parent narrative (seventy-seven mothers and five fathers) not because it was a conscious choice but rather because it is the gender distribution of primary caregiving in Punjabi homes.Second, it not a conscious design decision but rather reflects the gender distribution of primary caregiving responsibility, and so the number of fathers who participated in the parent narrative was limited to five. Targeted recruitment should be designed to more fully capture the perspective of the father's story in the future. Third, the retrospective nature of narrative interviews (in some cases several years old) could raise the possibility of memory reconstruction effects that may not necessarily represent the immediate experience of early intervention events. To reduce the problem of significant inaccuracy, member checking of narrative portraits of individual students was used, however, the reconstructive nature of retrospective narrative data is a methodological limitation of the narrative inquiry approach. Fourth, the six-months of data collection in the study is a snapshot of a longitudinal process, as longitudinal narrative inquiry following family early intervention trajectories over the course of the whole journey from developmental concern to formal school entry would yield greater depth and analytical complexity in the results.

**8. Recommendations**

The Government of Punjab should implement a universal developmental screening program within the existing primary healthcare infrastructure, with validated developmental screening tools in Urdu such as adapted versions of Ages and Stages Questionnaires (ASQ) and Modified Checklist for Autism in Toddlers (M-CHAT) which will be administered at the 6, 12, 18, 24 and 36 month well-child visits in all public health facilities. Structured training to all should be provided for the administration of screening instruments, interpretation of the results, and sensitive communication with families, especially for the use of Lady Health Workers, Basic Health Unit staff, and district hospital pediatricians. Universal developmental screening is the most cost-effective and equitable means to attain the single goal of early identification identified by the developmental timing principle of Ramey and Ramey, as being essential for the greatest impact of interventions (Bhutta et al., 2008).

District-level Multidisciplinary Early Intervention Assessment Teams to be comprised of developmental pediatricians, clinical psychologists, speech-language pathologists, occupational therapists, and early childhood special education specialists should be established jointly by the Departments of Health and Special Education with a protocol for coordinated assessment and IFSP development. An evidence-based, structured Lady Health

Worker cadre trained in parent coaching techniques should be established and used to deliver regular Home Based Early Intervention Programme visits to children with developmental delays in the birth to three years age range, with a family centered focus on goals (Yousafzai et al., 2014). An intersectoral Early Intervention Coordination Framework with formal inter-departmental memoranda of understanding between Health, Special Education and Social Welfare should provide a consistent referral process, common data systems and shared responsibility mechanisms. Children who are moving out of early intervention programs into government placements in SEC or mainstream school should have formal, documented Transition Plans, and development of IEPs should start at six months before they transition out of early intervention. Financial barrier reduction - in the form of disability linked cash transfers in existing social protection programmes - should focus on the economic exclusion of the poorest families that prevents them from accessing the services they need (Heckman, 2006).

**9. Conclusion**

It has resulted in a theoretically informed and contextually rich and empirically robust account of the role and the extraordinary failure of early intervention programs to reduce developmental delays in children in the special education system of Punjab. The study has taken an interpretivist approach and applied a dual analytical lens of narrative analysis and the principles of effective early intervention as described by Ramey and Ramey to document a systematic narrative of principle violation across all seven dimensions of the effectiveness framework, indicating an early intervention landscape that fails to provide children with the timely, intensive, individual, family centered and multi-service support that both evidence and rights frameworks call for during the most developmentally critical period of a child's life. Children are among the most vulnerable citizens in Punjab whose neural windows of maximum intervention have been missed out due to failure of the system. Their families, who experience the diagnostic journey, access to services, and emotional burden of caring for a disability without adequate professional help, deserve a response from the government of equal urgency and rights-based necessity to their situation. Recommendations in Section 8 represent a well-researched and evidence-based blueprint for designing the early intervention system required by Punjab's developmental rights commitments, which includes early identification, comprehensive assessment, intensive family-focused support, coordinated therapeutic and educational services, and effective planning and individual transitions to school. The investment this roadmap calls for is significant and the developmental, social and economic costs of failing to invest in it are incalculable. **References**

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