Early child development in the European Region: needs, trends and policy development

An overview based on five country assessments

By: Ramona Velea, Giorgio Tamburlini

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ABSTRACT

Early childhood is the period of most extensive (and intensive) parental responsibilities related to all aspects of children's well-being covered by the Convention: their survival, health, physical safety and emotional security, standards of living and care, opportunities for play and learning, and freedom of expression. Accordingly, realizing children's rights is in large measure dependent on the well-being and resources available to those with responsibility for their care. Recognizing these interdependencies is a sound starting point for planning assistance and services to parents, legal guardians and other caregivers. State parties are required to render appropriate assistance to parents, legal guardians and extended families in the performance of their child-rearing responsibilities (arts. 18.2 and 18.3), including assisting parents in providing living conditions necessary for the child's development (art. 27.2) and ensuring that children receive necessary protection and care (art. 3.2)

(United Nations General Assembly, General Comment No.7, 2005)

Keywords

CHILD DEVELOPMENT
HEALTHCARE SECTOR
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EXECUTIVE SUMMARY

In recognition of the need to establish a strong early foundation for health, sustainable development, and equity, WHO is emphasizing the need of paying attention to the early years as a crucial period to prevent disease, promote cognitive, social and emotional development and reduce inequity. In the European Region, this is even more important as most countries are successfully addressing the main causes of mortality, while developmental disorders, noncommunicable diseases, mental health problems represent the emerging challenges. Even in member States where there is still an unfinished child survival agenda, investments in the earliest periods of life since conception are the most effective way to further reduce the burden of mortality and disability, reduce health and social inequity and promote the full developmental potential of all children. Although effective investments in the early years require a “whole of government”, multisector approach, the health sector, by ensuring early and universal interventions, can play a crucial role in preventing exposure to risk factors, promoting good parenting practices and ensuring effective and equitable care.

This review of ECD status and policies in a representative sample of countries of European Region has been commissioned by WHO Regional office for Europe with the purpose of informing the ongoing process of implementation of the Child and Adolescent Health Strategy. Specific objectives of the review are: a) to describe, based on key indicators, the spectrum of current issues regarding the main ECD dimensions and determinants, such as health, nutrition, early education and parenting practices; b) to provide an overview of the current policies and programmes having impact on ECD; c) to provide an overview of internal and external positive and negative factors affecting the development of ECD-related policies; d) to Identify key actions to promote ECD with particular emphasis on the role of the health sector.

The data gathered for the purpose of the present report were collected by questionnaires and structured interviews with key informants in five selected countries: Armenia, England, Italy, Kazakhstan and Republic of Moldova. The country selection was meant to provide insight into countries that belong to different areas of the European Region (central Asia, Caucasus, Southeastern, Northwestern and Southwestern Europe).

Although there have been some limitations in the overview, mainly due to incomplete or non homogeneous data, the findings provide some clear analytical and programmatic indications.

The limitations in the currently available data across the Region show that an integrated, cross-sector research and Europe-wide survey instruments are needed in order to provide an appropriate evidence basis for policy development, at a national as well as at a transnational level. Currently, analytical tools at a European level are insufficient. MIC surveys cover many ECD issues including a focus on child rearing practices but are carried out only in eastern Europe, the Caucasus and central Asia.

Unsurprisingly, the review shows that ECD status varies across the five countries. This is mainly the consequence of the quite different historical and political background, economic and social development.

For example, in Armenia, Kazakhstan and Republic of Moldova there are still problems related to undernutrition. Anaemia is widespread, stunting still prevalent and there is a rising burden of

early onset overweight and obesity, which represent already an alarming issue in England and Italy. Action to improve infant and young child nutrition, with focus on community and family practices is therefore still a priority in all countries. Day care is lacking in all three CIS countries, while the situation is significantly better in England and Italy, where there are still big disparities in service provision between North and South. Provision of accessible and quality day care, starting from the very first years of life is therefore another key priority in all countries.

Available information is not sufficient to assess parental practices at scale. However, MIC surveys in Armenia, Kazakhstan and Republic of Moldova and ad hoc studies carried out in England and Italy show that inadequate parental practices are still prevalent and contribute to existing and increasing inequalities. This indicates the need to further develop, based on the existing evidence, and implement at scale policies and interventions to support parenting skills, with enhanced services provided for families and children at risk or with special needs within a universal approach. Currently ongoing programmes in England and Italy may provide the basis for identifying best practices.

In terms of ECD policy development and implementation, England has 2 major active programmes and 2 more to be soon implemented. Italy offers an increasing richness of programmes, some of which promoted by civil society, but lacks sufficient government support for country-wide policy implementation and suffers from the severe consequences of budget restrictions on access to day care. Armenia, Kazakhstan and Republic of Moldova show a strong connection with international actors/organizations who take the lead in the existing programmes, in terms of funding and coordination. Due to their common political background Armenia, Kazakhstan and Republic of Moldova have strong pre-school culture although financial and social reforms have been decreasing, until recently, the availability and access to preschool day-care.

ECD policies are now well established and seem to receive increasing attention in England, while in Italy there is a patchwork of situations at local level, ranging from excellence in access and quality to almost complete lack of services, while there has been lack of continuity and decreasing investments at Government level.

In at least 4 of the five countries there is therefore the need to develop comprehensive multisector ECD policies and plans, to address all the main determinants of child development: household income, family and parental knowledge and skills, community services and particularly provision of day care. The following actions can be identified as key to strengthen ECD policy development and implementation in all countries: a) increasing the inter-sector collaboration and develop integrated mechanisms; b) increasing funding for ECD services; c) increasing awareness on ECD issues among policy-makers, society in general and parents; d) developing clear guidelines on effective implementation and sharing them among stakeholders; and e) developing evaluation frameworks

The role of the health sector in promoting effective ECD interventions and ensure universality is crucial. However, with the exception of England where the home visitation programme provides a good basis for ECD implementation, the recent incorporation of Care for Development interventions in IMCI in Kazakhstan and programmes run in Italy at national level by NGOs, the health sector provides still insufficient support to ECD policies. Key actions to strengthen the role of the health sector in ECD include: a) incorporating ECD contents in health

sector plans and in service delivery, with a clear equity focus; b) incorporating ECD contents in training curricula and job description of all child health professionals; c) developing clear technical guidelines for ECD interventions to be delivered by the health sector; d) taking an active role in developing cross-sector policies at government level and inter-sector collaboration agreements at local level; and e) developing monitoring and evaluation frameworks within comprehensive child health and development M&E systems.

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LIST OF ACRONYMS

CIS = Community of Independent States

CEE= Central Eastern EuropeCRC = Convention on the rights of the child

ECD = Early Child Development

FNP = Family Nurse Partnership
IMCI = Integrated Management of Childhood Illness

M&E = Monitoring and Evaluation

MICS = Multi Indicator Cluster Survey

MoH = Ministry of Health

WHO = World Health Organization

UNICEF = United Nations Children's Fund

1. INTRODUCTION

1.1 Rationale

The European Region as defined by WHO includes a wide variety of situations as far as child health and development are concerned. In the EU, under five mortality is on average between 3 and 7 per thousand, nutrition problems are confined to overweight and obesity and at least in principle access to preschool and health services is guaranteed to all children. There are, however, increasing poverty rates and rising inequities among children and the evidence shows that many of the existing disparities have their origins in the first years of life, emphasizing the need of a life course approach to health and development starting from conception (Cattaneo et al.,2011; Wolfe et al. 2013; Tamburlini et al. 2014).

In the CEE/CIS region, child mortality has been decreasing significantly but is still well above 10 per thousand on average. However, the child survival agenda is still unfinished particularly in some countries and population groups and many children have not the opportunity to grow and develop adequately (UNICEF, 2012).

Child development and well-being in the region is compromised by a lack of understanding about the importance of early child development and the lasting impact of exposure to abandonment, institutionalization, abuse and neglect (WHO, 2013). Underlying reasons are complex and include a wide spectrum of economic, social and cultural determinants as well as public policy issues. Parents, especially those from disadvantaged populations, need information and practical support in how to care for and how to promote the development of their young children.

The WHO Regional Office for Europe developed in 2011 “Health 2020”, a strategy to address health challenges along the life course, and to translate principles and new scientific knowledge into concrete intersectoral actions.

There are several reasons for paying increased attention to the early years of life.

a. Child rights

The Convention on the Rights of Children (1989) and subsequent comments and developments provide a clear human rights framework for investments in early childhood, particularly by supporting parenting skills. States parties are reminded that article 6 of the CRC encompasses all aspects of development, and that a young child’s health and psychosocial well-being are in many respects interdependent. (general Comment no.7, 2005)

b. Life course relevance

Many diseases and conditions that arise in childhood, and later along the life-course, have causes that start in the earliest years of life. Exposure to inadequate nutrition, to chemical and physical pollutants, to infectious agents, to social and psychosocial adverse conditions may interfere with early organ and system development, disrupt metabolic pathways, modify disease susceptibility and have profound effects on outcome at birth and on health during infancy, childhood, and throughout the entire life-course. The early years are particularly crucial for brain development and as a consequence for cognitive social and emotional functioning,

thus influencing a wide range of outcomes, from health to social adjustment and productivity. Table 1 offers an overview of how early exposures are associated to specific health risks and how, in turn, these are distributed along the early life stages.

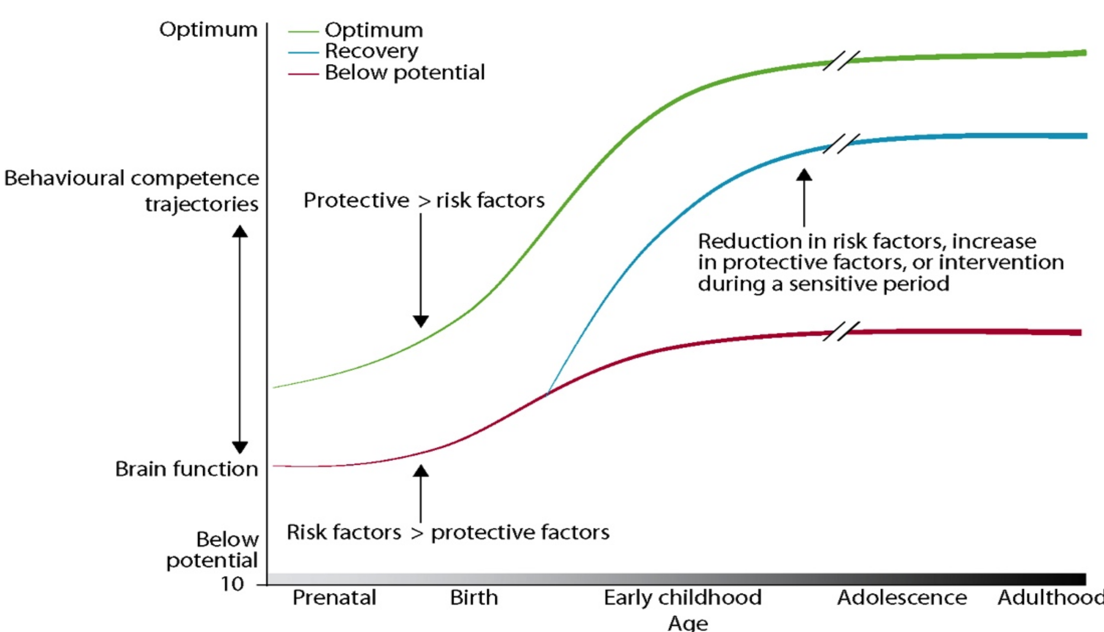
Table 1. Early exposures, risks and outcomes (source: Cattaneo et al. 2011)

Main Exposures	Main health risks	Embryo-foetal life	Birth to 2 years	Preschool (3-6 years)	School (7-12 years)
Poor maternal health	Prematurity and low birth weight	++++	+++	++	++
Inadequate nutrition	Over & underweight, anaemia, infections	++	++++	++	++
Poor attachment/ parental care	Psychosocial & behavioural disorders		++++	++	++
Lack of cognitive and social inputs	Psychosocial & developmental disorders	++	+++	++	++
Environmental Toxicants	Congenital anomalies, lung, neural and endocrine disorders, cancer	+++	+++	++	+
Unsafe Environment	Injuries	+	++	+++	+++
Insufficient physical activity	Obesity, cardiovascular & metabolic	+	+	++	+++
Alcohol and Tobacco	Congenital anomalies, prematurity/LBW/respiratory disorders	++++	++	+	+(++)

c. Equity

When WHO's Commission on the Social Determinants of Health envisioned a new era of global health equity, one of the key factors identified was support for children's early development. A child's life trajectory (Fig.1) is influenced by a wide range of determinants acting at different times and places. Some increase risks while others are protective. Interventions should reduce the former and enhance the latter. Consequently, there is increasing attention worldwide at intervening early to prevent these risks and strengthen the protective factors.

Fig. 1. Life behavioural and developmental trajectories are determined in the early years (source: Walker et al. 2011)

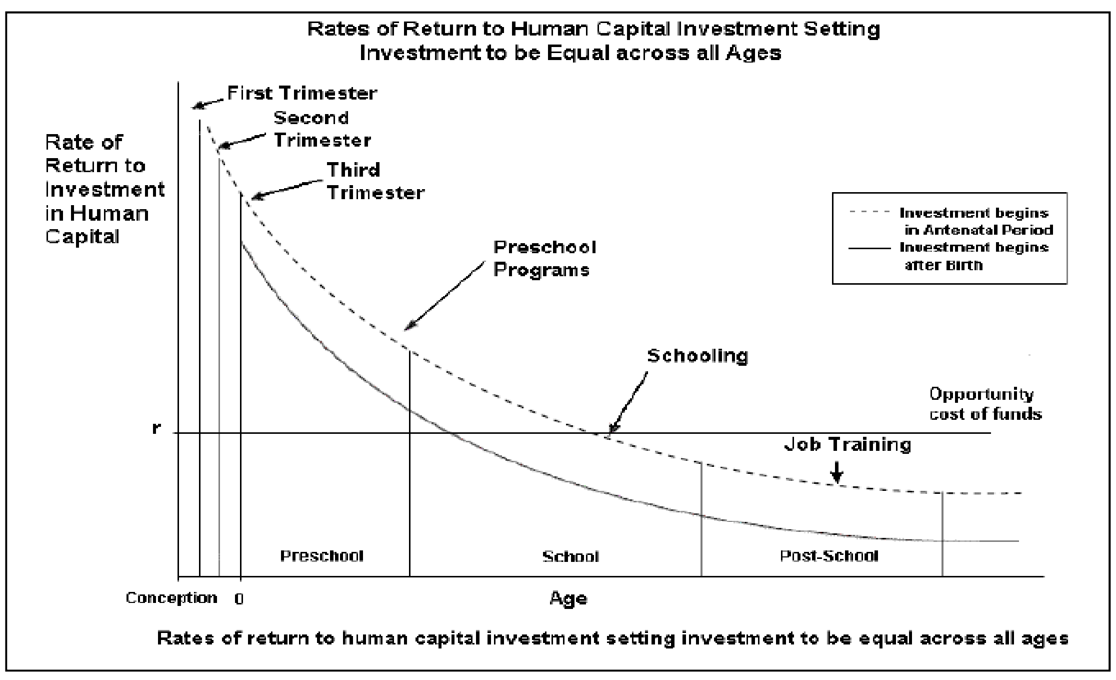


Several studies and reviews provide information on the economic returns of early investment in child health and development. It has been shown that the earliest the investments along the life course, the greatest the benefits. The rates of return of investments are higher in the first periods from conception to school age (fig.2) by having a cumulative effect along the life-course, early interventions produce the greatest dividends (WHO, 2008). Returns of early investments in support to parents and day care, for example, have been shown as particularly high in a wide range of programmes in the US and United Kingdom (Rand corporation, 2010).

Based on this three-fold rationale, and In recognition of the need to establish a strong early foundation for health, sustainable development, and equity, WHO is emphasizing the need of paying attention to the early years. In the European Region, this is even more important as most countries are successfully addressing the main causes of mortality, while developmental disorders, noncommunicable diseases, mental health problems represent the emerging challenges (Wolfe et al. 2013). Even in member States where there is still an unfinished child survival agenda, investments in the earliest periods of life since conception is the most effective way to further reduce the burden of mortality and disability which is increasingly concentrated in the perinatal period (Vos et al., 2012)

Addressing these risk factors and their underlying social determinants across the range of domains implicated, requires an integrated response. In most cases, it will also require an approach from the government in full collaboration with civil society, local communities, the private sector and international institutions and agencies.

Fig. 2. Economic returns of investment are higher in the early years (source: Carneiro and Heckman, 2007)



In addition, although effective investments in the early years require a typical "whole of government", multisector approach, the health sector can play a crucial role in preventing exposure, promoting good practices and ensuring effective and equitable care, by ensuring early and universal interventions (Engle et al., 2012).

1.2 Objectives

This review includes a sample of countries in the European Region, which may be considered representative of the wide variety of situations related to ECD. The review was been commissioned by WHO/Europe with the purpose of informing the ongoing process of implementation of the Child and Adolescent Health Strategy in the area of ECD, identified as one of the priority areas.

Specific objectives of the review are:

- Describe, based on key available indicators, the spectrum of current issues regarding main ECDs dimensions and determinants, such as **health and nutrition, early education and parenting practices.**
- Provide an overview of the current **policies and programmes** having impact on ECD
- Provide an overview of **internal and external positive and negative factors** affecting the development of ECD-related policies
- Identify key factors that may support the development of ECD policies with particular emphasis on the **role of the health sector**

Based on the review, effective actions to improve ECD are identified and proposed to governments, international partners, civil society organizations and local authorities. The role

of WHO/Europe in providing technical guidance and support to member States in the area of ECD related policies and programmes are highlighted.

2. METHODS

The data gathered for the purpose of the present report were collected by means of: i) qualitative questionnaire, ii) in-depth interviews with key informants in five selected countries (Armenia, England, Italy, Kazakhstan and Republic of Moldova). For the purpose of gathering further data, relevant websites have been also consulted *(see References)*. The country selection was meant to provide an insight from different areas of the European Region (central Asia, Caucasus, south-eastern Europe, north western and south western Europe).

The questionnaire was designed in order to: i) cover the key ECD dimensions (child poverty, infant and young child nutrition, access to day-care, parenting practices and psychosocial well-being), ii) collect key information about the current status and trends about policies, plans and programmes, iii) provide an overview of strengths, weaknesses, opportunities and threats towards improved ECD policies.

The first section of the questionnaire collects available quantitative and qualitative data related to ECD status indicators along the dimensions of poverty, nutrition, day care and parenting practices. Some of the selected indicators were chosen among the Early Childhood Development indicators used in UNICEF Multiple Indicator Cluster Survey.

Sections two, three and four of the questionnaire collect information about ECD-relevant policies, plans and programmes which are implemented at national level.

Section five assesses factors affecting the further development of ECD policies at national level, by Strengths, Weaknesses, Opportunities and Threats analytical framework, and focuses on the role of the health sector in promoting and supporting ECD policies and interventions.

For Armenia, Kazakhstan and Republic of Moldova, the questionnaire was filled in with the collaboration of WHO National Professional Officers, who in their turn consulted national officers from the relevant government Departments and national and international officers from international agencies, mainly from UNICEF.

For England, information was collected through interviews. The interviews were conducted following the outline of the questionnaire. The respondents were experts from a variety of institutions (University of London, Birkbeck College; King’s College – Florence Nightingale School of Nursing and Midwifery, Health Visiting and School Nursing; Institute of Education, London; University of Oxford, Oxford).

For Italy, the information was collected through experts belonging to the CRC monitoring network – a network of NGOs in charge of monitoring the implementation of the International Convention and from official statistics.

For both England and Italy, the profiles of the respondents cover a wide range of stakeholders in ECD: researchers, health sector representatives, civil servants.

3. RESULTS

3.1 Country snapshots: Indicators of ECD status

The following country overviews are a synthesis of data related to four selected indicators from the original questionnaire:

- Child poverty
- Nutrition
- Pre-school enrolment
- Adult support for learning

The complete data are available in Annex I.

3.1.1. Country Snapshot: Armenia

- Child poverty

The National Statistical Service reports in the "Social Snapshot and Poverty in Armenia 2011 and 2012" that the proportion of poor children is very high and that children are exposed to a higher risk of poverty and extreme poverty than the total population. Slight differences are registered in gender and geographical distribution. Families who reside in smaller urban centres have the highest consumption poverty rate. This is also true for extreme poverty. Extreme poverty affects 3 per cent of the population overall (UNICEF, 2012)

* the respondent reported data related to all children population under 18 years of age

- Nutrition[1]

The nutrition status is critical, with a fifth of the child population suffering from stunting or chronic malnutrition. The distribution of data shows significant disparities by residence, but surprisingly not by SES quintiles. Nutritional problems seem to be caused by inappropriate feeding practices and lack of parental knowledge rather than by lack of food, as stunting and obesity coincide in terms of geographic distribution.

* the respondent reported data related to all children population under 18 years of age

- Pre-school enrolment[2]

The enrolment rate for 0-5 years is 27.9% (0-3 years 7.8% and 4-5 years 49%) and is much higher in urban (36.6%) than in rural areas (13.8%). Girls' enrolment is slightly higher.

- Adult support for learning

There is no available information on this issue, since no MICS survey has been carried out in Armenia and no specific survey or ad hoc studies were reported.

[1] Armenia Demographic and Health Survey (DHS) 2010 http://armstat.am/en/?nid=82&id=1253
[2] Social Situation in Armenia (2012) http://armstat.am/file/article/soc_12_1-2.pdf

3.1.2. Country Snapshot: England

- Child poverty[3]

17% of the child population lives in households with an income below 60% of median net disposable household income before housing costs (BHC), and 27% after housing costs (AHC).

- Nutrition[4]

Government reports based on surveys indicate the absence of significant under nutrition. There is growing concern around the increasing child obesity: 28% of children between 2 and 15 years of age are overweight.

- Pre-school enrolment[5]

Pre-school enrolment rates for the past 5 years indicate that over 80% of the total population under five is attending pre-primary school, although data on pre-primary enrolment for 2008 indicate that the rates increase drastically only for children older than 3.

- Adult support for learning

Within the fieldwork interviews carried out for the purpose of the present report, experts highlighted that the child care system is socially perceived as a substitute for the best care that is perceived as that provided by parents. There are several programmes which aim to support parents in their rearing practices, including through home visitation

3.1.3. Country Snapshot: Italy

- Child poverty

In 2012 18% of children lived in relative poverty and 9% in absolute poverty. Rates increased from 2007 (15% of children were living in relative poverty and 5% in absolute one).

There are dramatic geographical and social disparities: child poverty is 5% in North, 25% in the South, and 50% among migrant families.

- Nutrition

Under nutrition is not reported while overweight and obesity represent an increasing problem. An increasing proportion of children is reported as being overweight with respect to WHO growth standards from 8–9 months onwards. As shown by a recent survey, feeding practices are often inadequate: only 8% and 10% of children were taking five portions of fruit and vegetables daily, while 47% and 51% were consuming sugar-sweetened beverages at 36 and 60–72 months, respectively. At 60–72 months, less than 10% reported at least 1 hour of moderate-to-vigorous physical activity on 5–7 d/week, and 32% watched television or played videogames for more than 2 h/d, every day.

- Pre-school enrolment

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[3] House holds below average income (HBAI) https://www.gov.uk/government/collections/households-below-average-income-hbai--2
[4] Policy: Reducing obesity and improving diet, Department of Health https://www.gov.uk/government/policies/reducing-obesity-and-improving-diet
[5] World Bank Data http://data.worldbank.org/indicator

14% of children between 0 and 3 years of age are enrolled in pre-school structures, while 98% of children between 3 and 5 years are enrolled in pre-primary structures.

For children between 0 and 3 years of age there are quite significant disparities, with 10% enrolled in the Southern regions and 20% in the Northern ones. In some of the urban areas of the Centre and North the percentage of enrolled children may rise up to 33%.

- Adult support for learning

A survey conducted under the programme Born to Read (Nati per Leggere), reports, for 2009, that only 19% percent of parents read to their children on regular basis (children under five; regular basis: at least 4 times per week). A more recent survey (2012) conducted in a Northern Region (Veneto) reports over 60% families of 1 year-old children are aware of the importance of reading to infants and young children.

3.1.4. Country Snapshot: Kazakhstan

- Child poverty[6]

45% of children under 18 years of age live below the poverty line, as opposed to 33% of the general population.

- Nutrition[7]

As for the Armenian case, the stunting prevalence in poor and wealthy quintiles is very similar. This could indicate similarities in the diets of the two quintiles, influenced more by cultural aspects rather than economic status.

- Pre-school enrolment [8]

Available data on the pre-school enrolment rate (3-6 years), show a significant difference between age groups: 3-5 years and 5-6 years, where the latter is significantly higher (95% of the population). Also, distribution differences in attendance rates between rural and urban environments, show higher enrolment rate in the latter. Significant disparities exist across SES quintiles (45% for the richest and 29% for the poorest). The pre-school enrolment significantly improved between 2006 and 2011 (37% enrolment in 2011, as opposed to 16% in 2006).

- Adult support for learning

MICS surveys conducted in 2005-2006 (MICS 3) and 2010-2011 (MICS 4) depicted an overall satisfactory situation, particularly in the urban environment and among the richest SES quintile. However, studies on child rearing knowledge and practice (UNICEF project baseline study-2003) show that there is still little interaction between parents and children in young age. The respondent described the situation as follows:

> "Most of the activities with infants are limited to feeding, changing, and sleeping and average time spent with an infant for play is 25 minutes. Only 11% of parents said that they play with their 1-2 year old children and 30% in

[6] Kazakhstan Household Budget Survey, 2009
[7] MICS 3 (2005-2006) and MICS 4 (2010-2011) for Kazakhstan
[8] MICS 3 (2005-2006) and MICS 4 (2010-2011) for Kazakhstan

age group of 3 year, however, the time spent was less than 2 hours in average. The study showed that activities are limited to watching TV together, visiting places or people, doing housework together. Families did not mention cognitive stimulation activities. Activities such as reading book were quite rare: 2, 6% for children 1-2 years old and 8.7% for 2-3 years). 31.3% reported availability of any children's book. 64% families said they do not read to their young children at all".

3.1.5. Country Snapshot: Republic of Moldova

- Child poverty[9]

One fifth of the total children population lives below the poverty line. A striking majority of children belonging to poor families (85%) lives in the rural environment. Rural poverty pushes parents to find work abroad, which exposes children to a high psychosocial risk.

- Nutrition[10]

The stunting, wasting and underweight prevalence rates for 2012 do not show a critical nutritional situation. Furthermore, in comparison with the 2005 rates, the nutritional trends indicate an improvement.

- Pre-school enrolment[11]

According to UNICEF, between 2003 and 2009 a significant increase occurred in the pre-school attendance rate. The same trend is reported for the monthly household expenditure for the kindergarten attendance – which doubled in 2009 as opposed to 2003. Attendance to pre-school is 97.4%.

- Adult support for learning[12]

A national survey on ECD carried out by UNICEF (Early childhood care and development: Family knowledge, attitudes and practices – 2009), shows that parents focus mainly on satisfying body and physiological needs of children, underestimating their active role in the intellectual/cognitive development. The same study shows that reading to children under 2 is rare and that the practice of reading is very much influenced by the environment, educational level and socioeconomic situation of the care giver. Parents have little or no knowledge on child development, and consider as significant only issues related to nutrition and health.

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[9] Ministry of Economy of Republic of Moldova (source indicated by the respondent)
[10] MICS 3 (2005-2006) and MICS 4 (2010-2011) for Republic of Moldova
[11] http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf
[12] UNICEF. Early childhood care and development: Family knowledge, attitudes and practices. 2009

3.2 Policies and programmes

This section of the report focuses on existing national policies and programmes regarding or impacting on ECD.

Information regarding Armenia, Kazakhstan and Republic of Moldova was reported by the respondents within the questionnaire.

Information regarding England and Italy was in part reported during the face-to-face interviews and in part gathered from relevant websites/documents (see references).

3.2.1 General overview of active ECD policies

- Specific ECD Policies

Table 2 describes the situation in each country. The presence of at least one active policy in a given field is marked by the green symbol, while the absence by the red symbol.

The data show that policies exist in all countries in the fields of nutrition, early education, parental leave and prevention of maltreatment.

Table 2. Presence of specific ECD policies at national level.

Policy field	**Armenia**	**England**	**Italy**	**Kazakhstan**	**Republic of Moldova**
Nutrition policies	☺	☺	☺	☺	☺
Early education policies (pre-school)	☺	☺	☺	☺	☺
Psychosocial family support policies	☹	☺	☹	☺	☺
Conditional cash transfer policies	☹	☹	☹	☺	☹
Family income benefit policies	☺	☺	☺	☺	☺
Parental leave policies	☺	☺	☺	☺	☺
Deinstitutionalization in child care policies	☺	☹	☺	☺	☺
Prevention of maltreatment	☺	☺	☺	☺	☺

However, the mere existence of policies does not guarantee their implementation, as shown by the information reported below about existing programmes.

- Early Child Development policies within comprehensive policies

The following table indicates the existence of comprehensive policies which address ECD issues within a broader policy approach (whether child, mother and child or family-focused).

The table shows that Western countries tend to addressed ECD issues within broader policies, while the same is not true for Eastern/CIS countries. As it will be discussed later on in the report, the existence of comprehensive policies does not guarantee integrated implementation (see Section 4 – Assessment).

Table 3. Presence of Comprehensive policies with ECD components at national level.

Policy scope	Armenia	England	Italy	Kazakhstan	Moldova
Child policies	☺	☺	☺	☹	☹
Family policies	☹	☺	☺	☹	☹
Child education policies	☹	☺	☺	☺	☹
Maternal and child health policies	☺	☺	☺	☺	☺

3.2.2 Overview of active ECD policies and programmes

Active ECD policies and programmes in Armenia

- According to informants, there are several specific ECD active policies in Armenia:
  - Nutrition policies
  - Early education policies
  - Family income benefits policies
  - Parental leave policies
  - Deinstitutionalization in child care policies
  - Prevention of maltreatment policies
- A big emphasis seems to be given to early education policies. Particularly, kindergartens benefit from a special attention of the law makers/Government, as they seem to have had a major role in overall ECD strategy of Armenia.
- Also, strategic plans with an ECD component were developed and are under Government evaluation for approval:
  - National Child and Adolescent Nutrition Strategy draft
  - Draft Law on promotion of breastfeeding and marketing of breast milk substitutes.
- The respondent reports several Government programmes with ECD components, which benefit from the support and guidance of international actors, such as UNICEF and World Bank.

In addition, the respondent underlines that there is no comprehensive/integrated policy for all ECD components in the country.

Active ECD policies and programmes in England

- The country witnessed a change in policy for the last 15 years (in the 1980s, State or organizational involvement was present only when a child was at risk).
- The political interest towards investing in ECD policies and programmes has been influenced by several research findings in the field (e.g. Effective pre-school and primary school education study – collaborative project involving several universities in England, following 3000 children from early childhood on, that showed how EC quality services influence positively the development of children, especially the most disadvantaged ones). As a result of the study a new law was introduced in 2004, which gave a free part time pre-school place to all children from their 3 to 5 years. This measure has been expanded to 2 to 5 year olds, since September 2013.
- Initially the shift in political attitude towards the ECD issues was dictated by the need of increasing maternal presence among the overall national workforce.
- Research findings contributed to increase knowledge and awareness of the long terms benefits of ECD investments.
- Research also influenced the policies regarding the maternity leave, by showing its benefits for both mother and children. Thus, from 5 they increased to 12 months (9 months paid and 3 unpaid, depending on the employer; many employers maintain the wages also for the last 3 months, though). This leads to the scenario where the available resources can be addressed mostly towards children older than 12 months.
- Two major programmes have been implemented:
  - Sure Start Programme (from 1997, ongoing) funded by the Government.

Initially the funds were allocated in the 20% most deprived areas of United Kingdom. The programme was meant to provide a wide range of services related to parent support and early childhood. The first years of implementation lead to variable results, overall not as good as expected. The most important milestone was the recognition/funding of the Child Centres: one centre which integrates all the services needed for the child – health screening, immunization, health care, parents support, early education, a “one stop shop”. In the initial phase of the programme, the guidelines for funding implementation were minimal, thus leading to a heterogeneous implementation across different areas.

Research findings, showing that Children Centres were very effective, lead to another change in policy so that since 2006 all Sure Start programmes in the country included Children Centers. Also, the service was expanded in all areas and became a universal one (from 600 Children Centres in 2006 to 3500 in 2010). The implementation of the programme continues to vary in terms of quality of the services offered.

- **Healthy Child Programme**[13] – programme developed under the **"Giving all children a better start in life"** policy – Department of Health and Department for Education.

The programme started quite recently under the umbrella of initiatives of the Department of Health in Early Years. The main initiative at the moment regards the increasing in numbers of the health visitors, as the professional group that delivers the Healthy Child programme. The programme aims at:

- Helping families to have the best start in life
- Helping parents to keep their children healthy
- Encouraging healthy living from an early age
- Improving the health visiting service
- Protecting children through immunization
- Supporting mothers and children with mental health problems
- Improving chances for children with vulnerable mothers
- Providing free school meals

The Healthy Child programme is set out according to the plans drawn in the "Healthy Lives, Healthy People – Strategy for Public in England"[14] white paper (2010), which also sets the guidelines for the FNP and health visitors service. The paper responds to Professor Sir Michael Marmot's Report, "Fair Society, Healthy Lives" and adopts its framework and focus of wider social determinants for health – with strong emphasis on early years.

The Department of Health aims at increasing the number of health visitors by 4200 (initiative started in 2013, should be completed in 2015), i.e. by 50%, through a combined retention, recruit and return human resource strategy. Training of the health visitors is commissioned to universities but also include training in service. The new public health system foresees that, from 2015, the Healthy Child Programme for children 0-5 years will be managed by the Local Authorities.

- A third relevant programme is the **Family Nurse Partnership**[15] , originally developed by David Olds at the University of Colorado. The programme has been running in England since 2006, when the first ten pilot sites were activated (London, County Durham and Darlington, Manchester, Barnsley, Derby City, Walsall, South East Essex, Slough, Somerset, Southwark and Tower Hamlets)[16].The ten test sites were the subject of a formative evaluation by Birkbeck, University of London. The evaluation showed the programme can be delivered well in the United Kingdom, families liked it and the potential for positive outcomes was good. On this basis, the Family Nurse Partnership was expanded to cover more areas and is now well-established in England. A

[13] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf
[15] http://www.nursefamilypartnership.org/Nurses/Nurse-home-visitors--role
[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222323/DCSF-RW051_20v2.pdf

randomized control trial is now underway in England, which is due to report initially in 2014.

In 2010 the Government made a Commitment to increase the number of places on FNP, up to 13 000 by 2015. Presently there are around 9000 places in 74 teams in 80 local areas[17].

The FNP is a highly targeted and intense programme which works with teenage first time mothers. The workload is one nurse for 25 cases, while in Healthy Child the workload goes up to one nurse for two hundred cases. The programme has a maternal and early years focus and works within a prevention framework: a nurse is assigned to every family in the programme. The aim of the programme is to enable young mothers to:

- Have a healthy pregnancy
- Improve their child's health and development
- Plan their own futures and achieve their aspirations.

Active ECD policies and programmes in Italy

- The Government develops two distinct multiyear policies, the National Plan for the Family (*Piano Nazionale per la Famiglia*) and the Childhood and Adolescence Plan, (*Piano Per l'Infanzia e l'Adolescenza*) which are periodically updated and funded. Such policies are essentially socially-oriented, as they include mainly provisions for family benefits and for day care. Funds have been progressively cut over the last 5 years.
- Among nation-wide programmes focusing on ECD components, which are still active, two may deserve attention:
- Parents Plus (Genitori più)
  - Actors: Ministry of Health- Department of Health Promotion and Prevention – Veneto Region Health Authority– Paediatric Associations
  - Objectives: To promote seven actions to promote health from conception to age 1 – periconceptional folic acid, avoiding alcohol and smoking, back to sleep, exclusive and prolonged breastfeeding, safe transport in car, immunizations, reading to infants
  - Target groups: Parents
  - Coverage: More than 90% in the areas where the programme is active (approx 20% of total population)
  - Equity focus: multilingual materials, several points of care, home visits
  - Duration – since 2007
  - Funding: initial funds from Ministry of Health, then funding from local health authorities
  - Participation: media campaigns, TV spots, groups meetings with parents. Communities not really involved in planning and implementation.

[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programmeme-Information-leaflet.pdf

- Born to Read (Nati per Leggere)
  - Actors: Professional associations (librarians and paediatricians), an NGO (Centre for Child Health and Development) in charge of managing the programme, training, materials, monitoring etc. Support from Ministry of Culture
  - Objectives: to promote reading to infants and young children since 6 months of age, to improve literacy and parent –child relationship
  - Target groups/beneficiaries: parents, ultimately children
  - Coverage: last survey indicates about 20-25% coverage on national basis, with great disparities between centre north and south of Italy
  - Activities: advice given by paediatricians and other health professionals, books provided for free or at low price, training of health and education professionals; book fairs, prizes to the best performing local programmes, and professionals and to children's books; reading in public places, markets etc.; annual events such as week of reading to children etc.
  - Equity focus: multilingual material, family paediatricians ensure coverage of all children where the programme is active
  - Duration: since 1999
  - Funding: mostly from donation and fundraising activities; some support from Ministry of Culture
  - Participation: this is a highly participated programme with parents associations and volunteers involved in supporting the project at local level. Social networks involve over 100.000 fans and discussion groups.
- Most of ongoing ECD programmes, including the education, parenting and health aspects, however, are implemented at local level, by regions and municipalities. For this reason the implementation is very patchy, with Centre and North Regions and cities being in a far better situation than the Southern Regions and cities. In some Regions and Cities for example there are ***Centri per la famiglia*** (Family centers), which provide economic and psychosocial support to families in disadvantaged conditions, migrant families, etc.
- Usually Municipalities are in charge of such programmes. Other local administrations implement Carta Famiglia or Benvenuto Bimbo programmes (economic benefits for poor families, or more integrated packages of information, support in case of special needs, starting at birth or during pregnancy). An overall comprehensive ECD policy and plan is lacking.

Active ECD policies and programmes in Kazakhstan

- According to National experts, in Kazakhstan there are several active specific ECD policies, such as:
  - Nutrition policies
  - Early education policies (pre-school)

  - Psychosocial family support policies
  - Conditional cash transfer policies
  - Family income benefit policies
  - Parental leave policies
  - Deinstitutionalization in child care policies
  - Prevention of maltreatment
- Ongoing reforming process:

Social support sector

There are attempts to develop framework for social services to protect vulnerable children. Jointly with the Ministries of Health, Education, Internal Affairs, Ministry of Labour and Social Protection has developed and endorsed in 2009 the Law on Specialized Social Services, which provides a general framework to protect vulnerable children, where social work functions have been assigned to three Ministries of Social Protection, Education and Health and local government.

Health sector

The MINISTRY OF HEALTH has established the additional staff of social workers to support vulnerable group of population at the level of PHC in 2011. There are 16 regional IMCI training centres which provide in-service trainings on a regular basis, where a component for Early Child Care for Development is included into the programme to develop counselling skills of health providers (both for doctors and home visiting nurses) at PHC level. The current IMCI\Better Parenting training coverage is 54% for PHC doctors\ medical assistants (feldchers) and 47% for home visiting nurses.

Education sector

The Ministry of Education agrees to develop curriculum for parents of children 1-3 years of age and regulation setting on the conceptual basis for early childhood development programme if any international technical assistance will be available.

- The services supporting the early child development are provided by different Ministries. The experts define the existing policies and legal commitments as underdeveloped and fragmented, as there seems to be a lack of communication and coordination between different legal entities.
- Even though there are several agreements which regulate the inter-sector cooperation, the effectiveness of the system is hampered by the lack of actual integration and internalization of these mechanisms.
- However, the conditions for further development of integrated services are positive, as crucial factors such as resources and political will are very strong.
- The experts emphasize the need of international technical support in order to accomplish the above objectives.

- Two ECD programmes are running currently in the country, with support by UNICEF and WHO.
- Although ECD components and interventions may be found in several State Action Plans and Programmes, some of which supported by International Agencies, no comprehensive ECD plans exist in Kazakhstan.

Active ECD policies and programmes in Republic of Moldova

- According to National experts, the following specific policies on ECD are active in Republic of Moldova:
  - Nutrition policies
  - Early education policies (pre-school)
  - Psychosocial family support policies
  - Family income benefit policies
  - Parental leave policies
  - Deinstitutionalization in child care policies
  - Prevention of maltreatment
- The respondent underlines the lack of a comprehensive/integrated ECD policy in the country. The medium term and final targets for reducing infant mortality (IMR) and under5 mortality rate (U5MR) have been reached. In spite of the fact that in 2008 the definition of the "live birth" was adapted to the meet the provisions of the World Health Organization (WHO), including new-born children over 500 g, the infant mortality rate increased for only one year, and afterwards it returned to a downward trend, registering, for the first time in 2012, a value lower than 10 (more exactly, 9.8, the target by 2015 being 13.2)[18]. The under5 mortality rate also reached a stable level which had decreased since 2009, achieving in 2012 the level of 12.1 per 1,000 live births Nevertheless, even though this "work" has already been done in relation to MDG 4, these indicators are far from being similar to those set in the European Union states (4.3 in 2011)[19].
- A number of factors over the last 12 years have contributed to this success, especially the introduction in 2004 of compulsory health insurance, thus guaranteeing a package of free services and medicines for children and pregnant women. The implementation of the Reform of Primary Health Care also had an impact[20]. The National Program in Perinatology, implemented in the country within 3 large stages: fortification (1998-2002), operation optimization (2003-2007) and modernization (2006-2014) of the perinatology system, contributed significantly to reducing infant mortality based on the early neonatal system (by 50%). This success was made possible due to regionalization of the perinatology/neonatology services in three levels, equipping maternities of all the levels with essential medical devices and the perinatal centres of II and III levels with

[18] The Third MDG Report. Republic of Moldova, Chisinau 2013
[19] Eurostat database.
[20] The Third MDG Report. Republic of Moldova, Chisinau 2013

sophisticated equipment, as well as implementation of essential interventions for mothers and newborns, and of modern technologies necessary to take care of extremely premature children, and increasing their rate of survival. In spite of all these achievements, there are still neonatal deaths induced by prematurity (60%) and death of children in the first 3 months of their lives (30%), especially due to congenital malformations. These efforts are necessary to support the provision of quality maternal services (in line with standards in 80% of cases) and paediatric hospitals[21].

- The Republic of Republic of Moldova was among the first countries from the WHO European Region which, starting in 1998, implemented the Integrated Management of Childhood Illness (IMCI) initiative, as the most efficient strategy to improve mother and child health. At that time, child mortality at home was higher than 20 per 1,000 live births, and children from Republic of Moldova suffered from malnutrition and insufficiency of vitamin D. Almost half of under5 deaths were caused by respiratory pathologies, and half of them could have been prevented.
- The IMCI Program aimed to tackle in the Republic of Republic of Moldova the main causes of child mortality, by improving the skills of the medical personnel in case management area, improving the performance of the health system and care practices at the family and community levels. The aim of the project was to support efforts to reach the Millennium Development Goals in Republic of Moldova for reducing infant mortality rate and under5 mortality rate. In partnership with PAS Centre, UNICEF has assessed the impact of IMCI as crucial for decreasing this indicator (UNICEF, PAS, 2011)
- Under5 mortality rate at home has decreased over these two years by two times, and the same goes for the infant mortality at home (in 2010, the indicators accounted for 3.0 and 2.3, respectively).Boys face higher risks than girls in relation to the under5 mortality, registering considerable differences since 2007 (in 2010 – 16 boys and 11 girls). Child mortality at home also decreased due to improved access to primary health care services, the single guaranteed program, as well as due to the information to parents and child caregivers about the danger signs and what to do in such cases. A major contribution in reducing this indicator was made by national campaigns for family education and community mobilization carried out in the framework of "Regionalization of paediatric emergency and intensive care services in the Republic of Republic of Moldova Project (REPEMOL) and the Perinatology Program. At the same time, the intervention of medical-social multidisciplinary teams, contributed to reducing infant mortality at home. The main causes of under5 mortality remained the same – respiratory pathology, trauma and intoxications, acute viral infections, and acute diarrheic diseases
- The Demography and Health Survey in 2005 has registered disparities related to the average value of the national IMR of 13 deaths per 1,000: 23 in rural area, 31 in the South and 20 in the first quintile. For U5MR, rural children are affected by higher rates (30 per 1,000) than urban children (20 per 1,000), and children from the lower quintile (29 per 1,000) are affected by higher rates than those from the higher quintile (17 per 1,000). Children from the southern part of the country registered the highest U5MR (38

[21] Source "Report of the study for needs' assessment in mother and child health area", Chisinau, 2013

per 1,000), while the children from Chisinau have the highest chances of survival in the first 5 years of life. Although there are no disaggregated stratified data on IMR by ethnic criterion, the UNDP survey from 2007 shows that IMR in Roma people group is twice as high compared to non-Roma groups (29 comparing to 17 per 1,000). The survey revealed a concentration curve showing pronounced inequity of infant mortality among disadvantaged poor children (PAS Centre, 2010). According to the recent studies, vaccination levels among Roma children are not significantly lower; but they incur more problems related to migration, late registration and early delivery. This is confirmed by a recent study carried out by UNICEF "Vaccination of small children, knowledge and skills" (2012). Coverage of Roma families with compulsory health insurance is lower. Hence, only about 35% of Roma people have individual health insurance policies, as compared to 71.2% in other ethnic groups (UNICEF, 2012).

- There are several groups that are particularly vulnerable. The evaluation report of the Integrated Management of Childhood Illness in the Republic of Republic of Moldova for 2000-2010 identified vulnerability (as defined by health professionals) is more frequently associated with the following categories of population: single mothers or families with many children, poor families, unemployed parents, young parents, detainees, patients with TB and HIV/AIDS, high risk behaviour groups, Roma people, some religious groups (because of their reticence to access medical services and decline medical interventions). A recent and popular trend is represented by emigrant mothers and mobile populations. These trends of inequities related to vulnerable families are also pointed out by other recent studies (PAS Centre, 2009).

  After a four-year period of decline in between 2006 and 2010, the vaccination rate among children under2 remains significantly below the target level (91.3% in 2012). The Ministry of Health has considerably enhanced the communication strategy on the benefits of vaccination and has organized several major and active campaigns promoting vaccination, including according to the National Vaccination Program 2011-2015. The ROR vaccination is provided free of charge at the age of 1 and 6-7 years old. After a number of years with no cases, in 2011, some cases were registered among Roma unvaccinated children. The study of parental attitudes to vaccination highlighted that the vast majority (95%) of respondents consider that vaccines are beneficial for children's health, and about 98.4% mentioned that their children are vaccinated. The respondents from rural areas, those with a lower level of training, and those from the lower quintile have a lower level of knowledge about the benefits of vaccines[22]. Additional data will be generated by the MICS study in 2012. According to the opinion of public health specialists (Melnic A., Gheorghita S.), parental refusals are the main causes of a decline in the vaccination rate. The prevailing causes are misinformation from the Internet, biased or incorrect messages in mass-media, and affiliation to different religious communions. Medical contraindications from specialists, such as neurologists, oncologists, surgeons, which are frequently unfounded, and also make their contribution to an increasing number of non-vaccinations through immediate medical omission (the same source). The plan of the MH and NCPH includes information for

[22] National Study on families' knowledge, attitudes and practices in the area of children care and early development. 2009. Summary report

parents, religious leaders, primary health specialists, and the continuous medical training departments from the medical university to ensure a better quality of information about the vaccination benefits[23].
On November 29, 2013, the Republic of Republic of Moldova and the European Union initialled an Association Agreement, following four years of negotiations. This reconfirms Republic of Moldova's EU aspirations and obligations in meeting highest standards of human rights, economic development and democracy. This is the only such Agreement to contain a chapter on protection of the rights of the children, resulting from UNICEF's advocacy.

- A number of the KAP studies in ECD were conducted and finalized with the following recommendations[24]:

  - Comprehensive approach to ECD: Continue evidence-based advocacy aimed at convincing the Government to invest in comprehensive, community-based ECD programs that are open to all children and families, beginning with preconception and prenatal education and care, and continuing with fully integrated parent education and support programs linked to preschools and child protection systems;
  - Develop Child-Centred ECD Policy documents that would include curriculum and guides for working with parents, School readiness Early Development Instrument and adjust them to European best practices;
  - Improve professional skills of medical staff and educators in parenting counselling regarding various health and education issues, especially for most vulnerable families with children (rural areas, low socioeconomic status, low education level, etc.);
  - Improve parental skills that is especially needed among parents, particularly those in rural areas or coming from disadvantaged families as parents who lack parenting knowledge and skills are unable to provide their children with the necessary conditions for their adequate development:
    - Continue parent education for children feeding, especially encouraging exclusive breastfeeding and age-appropriate complementary feeding;
    - Promote appropriate hygiene practices in families;
    - Improve parent knowledge and practices in injury and prevention, identification of health danger signs and care of child sickness;
    - Strengthen parent knowledge and practices in stimulation for development including cognitive development;
  - Expand community based services, especially in localities that are currently are without the kindergartens. Increasing the equal access to inclusive ECD programs for all children, especially the most vulnerable ones (children with disabilities, Roma children, children with migrant parents, HIV/AIDS infected children, poor children), is a priority.
  - Strengthen Social Partnerships and local community involvement in ECD programs.

[23] The Third MDG Report. Republic of Moldova, Chisinau 2013
[24] National Survey, Early Childhood Care and Development: Family Knowledge, attitudes and practices; UNICEF Republic of Moldova, 2010

4. ASSESSMENT

4.1 Opportunities and challenges for further ECD policy development at country level

This section aims to underline the opportunities and challenges towards the development of ECD policies in the countries under focus. For each country a SWOT matrix was developed, according to inputs given by the national experts through the questionnaire (and interviews for England and Italy).

The matrix shows the main Strengths (Positive and Internal to the context factors), Weaknesses (Negative and Internal to the context factors), Opportunities (Positive and External to the context factors) and Threats (Negative and External to the context factors) around the issue at stake in ECD policy development.

On the basis of the individual country SWOT matrix, a General SWOT has been drawn, in the attempt of underlying common characteristics of the issue in all five countries under focus.

4.1.1 ARMENIA: Opportunities and challenges

Table 4. Armenia SWOT matrix for ECD policy development

	Positive	**Negative**
INTERNAL	• Standing Committee on Health, Maternal and Child issues in Parliament is supportive/has good political will • ECD programmes in the country have been expanding with a World Bank Loan in the framework of "Education quality and relevance II" programme, as well as in the upcoming "Education quality and relevance III" programme. Over 200 preschools have been established or expanded with their staff trained by UNICEF since 2010. A new budget line on preschool education in the state budget provided continuous funding for preschools established in the school buildings in the framework of the above mentioned World Bank programme • ECD standards have been developed by UNICEF and approved by Ministry of	• ECD is not high on the political agenda of health and social sectors • Lack of inclusive preschool services to accommodate the needs of children with disabilities • Lack of early identification and intervention services for developmental delays and disabilities • Lack of coordination among different sectors (education, health, social) • Lack of ownership among governmental officials and local governments The financing of ECD is a responsibility of the community – so the more vulnerable communities do not afford to have these services.

	Education.	
EXTERNAL	• Ministry of Education plans to amend the law on preschool education. • National Child and Adolescent Nutrition Strategy will be developed and approved soon • Draft Law on promotion of breastfeeding and marketing of breast milk substitutes will soon be approved by Parliament • Support from UN Agencies, particularly UNICEF and World Bank Armenia have ECD-related issues in its agenda • UNICEF plans to model and pilot alternative preschool for sparsely populated communities in remote rural areas. • ECD components are on the agenda of several international organizations working in Armenia (World Vision Armenia, Mission East, Children's of Armenia Foundation (COAF) • Adoption of ICF and ICF-CY as a framework for disability and special education needs assessment and intervention (with UNICEF efforts)	• Limited allocations for ECD-related issues in Ministry of Health budget/ from state budget • Lack of appropriate skill mix on ECD and psychological-related issues among staff of health sector and educational sector • Poor developed institute of social workers in the country • Lack of integration among health, education and social sectors and services

Main positive aspects

- Expression of interest and commitment at Government/Parliament level for ECD issues
- Support from UN Agencies and other national and international NGOs (World Vision Armenia, Mission East, Children's of Armenia Foundation)

Main negative aspects

- Lack of funding
- Lack of trained staff
- Lack of communication and integration between sectors

4.1.2 ENGLAND: Opportunities and challenges

Table 5. England SWOT matrix for ECD policy development

	Positive	**Negative**
INTERNA	• Change in the political climate that recognizes the value of promoting ECD • Strong political will (all three parties agree on prioritizing ECD) • A universal level of Early childhood services (not ideal, but it is universal and state funded) • Existing functioning programmes (e.g. Sure Start and Healthy child) • Commitment at a high level in delivery • Existence of a specific professional group to deliver the programmes – (e.g. health visitors) • National coverage of at least one programme (i.e. Sure Start) • Path dependency and popularity of these programmes make difficult for future governments to reduce preschool funding. • Basic infrastructures – approx. 90% take up on child-care services • High level of awareness among policy-makers	• Poorly trained workforce • Poor integration between health sectors and other sectors of ECD • Not sufficient health visitors yet, factor that obstacles the delivery of the Healthy Child Programme • Current financial constrains in the country • Knowledge on and attitude towards ECD issues are very poor among society as a whole • Very high costs of the services • Low status of the workers in the ECD sector makes it unattractive for well trained professionals (very low salaries; preschool is traditionally seen as a job for unqualified or poorly qualified women) • Quality of services is not good enough everywhere. • Over formalization – education policies impose very strict/formal structure since a very early age, which is counterproductive
EXTERNAL	• The overall economic situation is improving, thus, when the budget deficit will be overcome there will be more spending in ECD. • Moving towards the Scandinavian model, politically and socially: Universal child care of high quality • Commissioning of services to Local authorities under the new reform in the health sector • The aim of achieving integrated ECD services is an opportunity to design new ways of policy-making that put the child at the centre	• Lack of improvements in training and career structure can lead to an instable and unprepared workforce, as people will not stay in the sector if no valid incentives are given. • Inadequate infrastructure for joint/integrated coordination between sectors (e.g. different communication systems – PC systems) • Economic austerity could drive to a large number of further cuts in the budgets of social programmes. • Growing levels of deprivation and inequality in England, with negative

	• Opportunity for preschool policies and programmes to continue their development. • The planed integrated check at 2 years of age – integrated/joint education and health issues will be monitored – written record on the needs of the child/family. • A Better Start – programme -financed by the Lottery- pilot programme – developed, soon to be implemented.	effects on many children, particularly from disadvantaged households. • The strong advocacy for ECD issues could lead to a "burn out" of the core ideas • Major restructuring in primary care in England – which will put pressure on the reorganization and not as much on the health priorities.

Main positive aspects

- Strong political will at all levels
- Existing successful programmes and prospects for new programmes

Main negative aspects

- The quality of the services is not homogenous
- Lacks of staff and adequate training levels
- Lack of communication and integration between sectors

4.1.3 ITALY: Opportunities and challenges

Table 6. Italy SWOT matrix for ECD policy development

	Positive	Negative
INTERNAL	• Strong pedagogical cultural tradition in day-care-pre-school services and existence of centres of excellence in the field • Models of quality integrated services provided in some regions and municipalities • Strong professional associations (day care educators) • Strong civil society organizations that promote interactive education, early reading and other positive parenting practices • Existence of national comprehensive policy frameworks for Child and Family	• Low awareness among most policy-makers • Day care still viewed by parts of society mainly as baby parking • Lack of collaboration among health education and social services • ECD contents still Insufficiently covered by most training curricula, or dealt with in a too theoretic way • Excess of devolution and decentralization results in striking geographic and socioeconomic disparities: less services are provided to those most in need

EXTERNAL	• Existence of National plans for early childhood and for families that are underfinanced and need to be updated • Part of the political arena keen to invest more on early education • Low (but increasing) awareness about health professionals on the importance of ECD • Increased social awareness and civil society initiatives	• Budget constraints for the key entities (both at Government and Municipal, Regional level) that support programmes for families and finance for day care • New digital technologies propose a very individualized approach and many parents are not able to use this opportunity for shared experiences in early childhood

Main positive issues:

- Existence of models of quality integrated services at Regional/Municipal level
- Increasing advocacy and initiatives from the Civil Society
- Increased awareness of the importance of ECD interventions among the general public

Main negative issues:

- Training curricula of some key professionals (particularly health) not yet
- incorporating ECD
- Lack of communication and integration between sectors
- Low awareness among policy-makers

4.1.4 KAZAKHSTAN: Opportunities and challenges

Table 7. Kazakhstan SWOT matrix for ECD policy development

	Positive	Negative
INTERNAL	• Awareness and political commitment towards child health are high. Among priorities included into the agenda of state policies and strategies there is a special attention to the issues of social support to families and children (National strategy "Kazakhstan 2050"). • Intersectoral coordination mechanism at the Government level: a) National Committee on Health at the Prime Minister Office was established to achieve strategic direction of State Health System Development for inter-sector collaboration on health promotion. b)The Interagency Commission on Issues of Children and Protection of their Rights was created. • Ongoing reforming process in the Social, Health, and Education sectors provide excellent opportunities for innovation and integration.	• Low awareness on ECD among policy-makers and society. • Weak advocacy on Early Child Interventions at the level of key policy and decision-makers and society (lack of data and advocacy materials) • Limited number of surveys\studies and lack of uniform database providing up-to-dated and disaggregated information on early child development (0-8 years) child protection issues (prevalence and causes), quality of education and parenting practices • The existing policies\programmes are fragmented. No integrated children's policy to ensure a full package of preventive services and specialized care. • Weak inter sector coordination mechanisms at service level.
EXTERNAL	• Existing Ministry of Health potential (16 IMCI regional in-service training centres established under current government health programme with allocation of funds for 2011-2015) as resource for ECD trainings • New national rehabilitation centre and regional branches can be used for developing ECD resource centre for implementation of Early Child Interventions and establishing services for ECD secondary\tertiary prevention, specialized care and rehabilitation. • The new national health programme 2016-2020 will be developed in 2014-15 and there is room for increased focus on early child interventions with allocation of funds.	• Lack of the national organization primarily responsible for Early Child Intervention (driving force). There is no single Ministry\organization with sole responsibility for early child development and protection • Frequent change of officials/continuity problem • Lack of availability of skilled professionals in the health and education sector on early child interventions Lack of specialists in health and education system for child assessment, early childhood interventions and developmental-behavioural paediatrics • Inadequate training and experience of health providers and insufficient

		secondary-and tertiary-level health centres that can provide support to primary health care workers in dealing with the developmental difficulties.

Main positive aspects:

- Strong political commitment towards improving child health interventions
- Ongoing reforms processes in several fields relevant for ECD

Main negative aspects:

- Insufficient data and monitoring frameworks for assessing needs in the ECD field
- Lack of training curricula and specialized professionals in ECD
- Low awareness among policy-makers and society in general

4.1.5 REPUBLIC OF MOLDOVA: Opportunities and challenges

Table 8. Republic of Moldova SWOT matrix for ECD policy development

	Positive	**Negative**
INTERNAL	• MCH is a viewed as a priority for Republic of Moldova • MCH is included in all priority policy documents and is reflected not only in health sectors policy documents • Existence of Parliamentarian Health and social protection committees	• ECD is not seen as a separate area of action and the education sector is mainly involved • Insufficient coordination among different stakeholders (education, health, social) • Lack of financial investment to ECD programmes, as only donors supported.
EXTERNAL	• CAHD Strategy for Republic of Moldova in currently being developed • UN Agencies, such as UNICEF and WHO support Government in ECD area, i.e. countrywide implementation of the IMCI “Care for development” component. • NGOs are involved in the implementation of the actions in ECD, mainly supported by UNICEF • WHO provided support to Ministry of Health in assessment of the quality of care provided within paediatric hospitals, which includes children’s rights dimension.	• Ministry of Health gets involved in ECD only if the overall health field is considered • Lack of professionals in the health sector who are adequately prepared to work in ECD implementation

Main positive aspects:

- Increasing recognition at political level of the need of prioritizing ECD interventions
- UN agencies support

Main negative aspects:

- Lack of specific and integrated ECD policies, as well as poor communication between different relevant sectors
- Lack of trained professionals
- Low awareness among policy-makers and society in general

Critical constraints[25]

An important constraint for a better result in reducing infant mortality is the education and information level of caregivers (parents). An evaluation of mortality cases at home and during the first hours after hospitalization revealed that in half of all these cases, children manifested signs of illness the previous day, but parents failed to ask for help, due to a lack of knowledge, lack of telephone, long distance to the medical institution, and fear of hospitalization. Many of these families are poor and there are also signs of negligence towards children. The study also concludes that lack of social assistance and no involvement of local authorities also figure among the factors determining the mortality level[26].

Reduced access to health services for vulnerable groups, including in rural areas is a constraint, imposing general actions to improve access to health services for all the groups. These actions should include improving the attitudes of medical workers' so as to build a health service which will serve the entire population.

Social integration and the quality of life of children with neuromotor disabilities is not at an acceptable level and depends on efficient enforcement of the system of early intervention and individualized recovery.

Reduced capacity of monitoring and evaluation – although the efficient means for monitoring early perinatal/neonatal mortality is evident in the sanitary system, tools for post-neonatal mortality monitoring and evaluation, as well as the managerial capacities of the primary health care specialists currently have limited effects.

Possible opportunities and success factors

In August 2012, the Government and the Ministry of Health reconfirmed their efforts by signing the Global Committing to Child Survival: Promise Renewed" which is a UNICEF global initiative, which aims to continue efforts to save small children's lives. Existence of donors and key partners who are active in the area of mother and child protection provide an important

[25] The Third MDG Report. Republic of Moldova, Chisinau 2013
[26] Ministry of Health, Ministry of Social Protection and Family, and Lumos Foundation

support to the Government in its endeavours[27]. The existence of a regionalised service in perinatology, the national system for diagnosis of new-borns' and surveillance, development and approval of mechanisms for inter-sector collaboration in the medical-social area for preventing and reducing the rate of infant and under5 mortality at home, strengthening technical-materials and implementing new technologies (specialized ambulances and equipping regional reanimation and intensive therapy departments), and centres for continuous training for paediatrics in intensive and emergency therapy – all these are factors that give some optimism for success sustainability and even hope for improvements in the post- 2015 period[28].

Important joint projects are implemented with the support of development partners, which will have a positive impact on the quality of perinatal and paediatric services. In particular, there are two important Republic of Moldovan-Swiss Projects: “Modernization of the perinatology system”, currently in the third stage of implementation and Regionalization of paediatric emergency and intensive care services (REPEMOL)”, in its second stage. A number of subdivisions from specialized medical institutions were established or enhanced: the Emergency Admission Department in the Institute of Mother and Child; work finished to the joint Reanimation and Intensive Therapy Department in Cahul Rayon Hospital; the Toxicological Information Centre was established and equipped in the Institute of Mother and Child. In parallel, protocols and standards in the area have been updated and relevant personnel are trained. Communication and educational campaigns are organized, including at a national level, within the framework of the REPEMOL and Perinatology Projects, as well as with other international development partners – UNICEF, WHO and UNFPA.

4.1.6 SUMMARY SWOT: Common opportunities and challenges

Table 9. Summary SWOT: common factors to all five countries under focus

POSITIVE	NEGATIVE	
STRENGTHS • **General political awareness is increasing** (overall political willingness not yet associated with implementation) • **Existence of active ECD programmes and policies** (there are significant differences among countries, but all of them are experiencing ECD programmes and/or policies)	WEAKNESSES • **Awareness** on ECD issues among policy-makers and society in general is still insufficient (in some cases linked to poor advocacy. • Lack of inter-sector cooperation and coordination mechanisms. • **Lack of human resources** (poorly trained and/or insufficient staff)	INTERNAL

[27] Governments of Switzerland and Japan, the European Bank of Reconstruction and Development, UNICEF, UNDP, Swiss Agency for Development and Cooperation (SDC), World Bank
[28] See for more information on institutional framework and information campaigns on mother and child health in MDG 5.

OPPORTUNITIES	THREATS	
• Development of new policies and/or programmes undergoing • Support of international agencies/organizations (applies to Armenia, Kazakhstan and Republic of Moldova)	• Economic austerity and further economic cuts due to economical crisis • Changes at political level lead to reorganization/restructuring/reforms, that can have a negative impact on ECD services/issues in terms of continuity	EXTERNAL

4.2 Main challenges for improving the health sector involvement in the development and implementation of ECD policies and interventions

The following table illustrates the key actions needed to improve the health sector role in ECD policies for each of the countries, based on the respondents' views. When identifying this list, the respondents chose freely the dimensions to address, and did not follow a common grid/structure. This was a methodological choice in the drafting of the questionnaire, as the purpose of the present research was that of exploring national contexts and perspectives on ECD policies development.

Table 10. Crucial factors for improving the Health Sector involvement in ECD at country level

Country	CRUCIAL FACTORS FOR IMPROVING the role of the HEALTH SECTOR
ARMENIA	• More active role of Ministry of Health in the process • Active role of the Standing Committees on Health, Maternal and Child Issues in the Parliament • Re-shaping the role of PHC in addressing of early childhood development issues • Advocacy from health sector side on the importance of ECD issues • Ensure implementation of existing and future strategies with ECD components
ENGLAND	• Integration of health services with other ECD relevant sectors: need of an administrative structure which supports the integration – joint coordination (e.g. one department responsible for all ECD service delivery) • Commissioning the ECD services by Local authorities to the health sector, that will lead to a greater acknowledgement of the health visitors' role in ECD • There are universal programmes but there are not uniformly implemented, mainly because of lack of staff
ITALY	• ECD awareness and specific training among health professionals • Incorporation of ECD-related tasks in child health professionals task descriptions • Development of home visitation services

	• Specific inter-sector plans and agreements to ensure collaboration on achieving ECD objectives, with clearly identified roles of health services
KAZAKHSTAN	• Updating and endorsing the care for development package for PHC providers (education and advocacy materials, training modules, monitoring and evaluation framework, child and family assessments tool) • Developing communication materials for prenatal education, parent education, infant psychosocial stimulation, child development, • Developing a system for detection and management of developmental difficulties • Capacity building trainings for ECD specialists and training of specialists in developmental-behavioural paediatrics
REPUBLIC OF MOLDOVA	• Improvement of the infant and young child nutrition at country level • Improvement of the health workers ability to support early child development • Development of the early intervention services for children with disabilities • Development of the sectorial protocols on violence prevention

4.3 Main challenges for strengthening ECD policy development

The following table illustrates the crucial factors for strengthening ECD policy development for each of the countries under focus. The factors were reported by the respondents, and thus reflect the specific country situation. When editing the country list, the respondents chose freely the dimensions to address, and did not follow a common grid/structure. This was a methodological choice in the drafting of the questionnaire, as the purpose of the present research was that of exploring national contexts and perspectives on ECD policies development.

Table 11. Crucial factors for strengthening ECD policy development at country level

Country	CRUCIAL FACTORS FOR STRENGTHENING ECD POLICY DEVELOPMENT
ARMENIA	• Implementation of approved strategies/policies on ECD • Involvement of civil society and parents in the process of policy development and implementation • Improved training of the relevant workforce
ENGLAND	• Increase Governmental expenditure for ECD • Improve inter-sector cooperation • Improving the training of the workforce and the career structure • Improving the quality of services through monitoring and evaluation • Keep a universal service and strengthen services for the poorest • Improve societal awareness

	• Develop specific guidelines on implementation
ITALY	• Improve societal and policy-makers awareness about the benefits of ECD interventions • Clear guidelines on requisites for effectiveness of policies and interventions • Intersectoral collaboration, legislation and planning at governmental and local level • Adoption of evaluation frameworks • Improve societal and policy-makers awareness about the benefits of early child development interventions
KAZAKHSTAN	• Strengthen advocacy at the top management level to promote integrated ECD framework in Kazakhstan. • Development of ECD situation analysis based on uniform national database for providing up-to-dated and disaggregated information on child development • Revision of existing legislation and service provision with regard to support of child health, education, protection aiming at integrated programme\framework development • Development of an ECD Framework and Inter-sector National Action Plan • Establishment of a National and Regional ECD Council or ECD Working Group for vertical and horizontal coordination of ECD implementation.
REPUBLIC OF MOLDOVA	• Increasing of active rearing practices knowledge among the population • Education and counselling for parents in nutrition, early stimulation of development, violence prevention, identification of danger signs in children • Improvement of pre-school education for children younger than 3 years old • Advocacy at Governmental level for implementation of the legal framework with regard to flour fortification with iron and folic acid in order to prevent anaemia among women and children

CONCLUSIONS

There have been certain limitations in this overview, mainly due to incomplete data, or non homogeneous data across countries. Information on parental practices is poor for all five countries. While in CIS countries we can rely on MICS, data can be only gathered from survey and individual studies in England and Italy.

However, the methodology used in the preparation of the present report may provide a model and a reference for future, more extended, surveys. Also, the findings provided interesting insights of country situations that may stimulate self-assessment, comparisons across countries, foster debate and promote action, as they reflect variety across the European Region.

The first important indication provided by the report is the need for developing an ECD policy research agenda in the European Region. Currently, structured frameworks of analysis at a European level are poor. MIC surveys cover most of the ECD issues and have a good focus on parental rearing practices but are carried out only in eastern Europe, the Caucasus and central Asia. An integrated, cross-sector research, and a Europe-wide ECD periodic survey will be essential in order to provide an appropriate analytical background and framework for policy development, not only at a national level but also at a transnational one.

Structured research, development of clear indicators of ECD policies and tools for assessment are needed in order to better assist national and transnational policy-makers and stakeholders.

Unsurprisingly, the data show that ECD status varies across the five countries. This is mainly the consequence of the quite different historical and political background, and economic and social development of western European countries such as England and Italy – which share a similar average income and standard of living and belong to the G8 countries – and countries in eastern Europe, Caucasus and central Asia. The only similarity among the five countries regards the educational status, which is generally good in all countries at population level.

In the CIS countries, there are still problems related to under nutrition. Anaemia is widespread, stunting still prevalent and there is a rising burden of early onset overweight and obesity, which represent already an alarming issue in England and Italy.

Action to improve infant and young child nutrition, with focus on community and family practices is therefore still a priority in all countries.

Day care is lacking in all three CIS countries, while the situation is significantly better in England and Italy. In Italy though, there are still big disparities in service provision between North and South. Migration creates specific problems to children in countries, such as Republic of Moldova, where a significant proportion of adults have migrated abroad and many children are deprived of adequate parenting.

Provision of accessible and quality day care, starting from the very first years of life is a priority in all countries.

Available information is not sufficient to assess parental practices at scale. However, MIC surveys in Armenia, Kazakhstan and Republic of Moldova and ad hoc studies carried out in

England and Italy show that inadequate parental practices are still prevalent and contribute to existing and increasing inequalities.

There is the need to further develop, based on the existing evidence, and implement at scale policies and interventions to support parenting skills, with enhanced services provided for families and children at risk or with special needs, within a universal approach. Currently ongoing programmes in England and Italy may provide the basis for identifying and disseminating best practices.

In terms of ECD policy development and implementation, England has 2 major active programmes and 2 more to be soon implemented. Italy offers an increasing richness of programmes, some of which promoted by civil society, but lacks sufficient government support for country-wide policy implementation and suffers from the severe consequences of budget restrictions on access to day care.

Armenia, Kazakhstan and Republic of Moldova show a strong connection with international actors/organizations who take the lead in the existing programmes, in terms of funding and coordination. Due to their common political background Armenia, Kazakhstan and Republic of Moldova have strong pre-school culture although financial and social reforms have been decreasing, until recently, the availability and access to preschool day-care. ECD Policies are now well established and seem to receive increasing attention in England, while in Italy there is a patchwork of situations at local level, ranging from excellence in access and quality to almost complete lack of services, while there has been lack of continuity and decreasing investments at Government level.

In at least four of the five countries there is the need to develop comprehensive ECD policies and plans, while in England the challenge is to reach out for all population groups with the existing programmes and to achieve better integration among services. Such policies should be multi sectoral and address all the main determinants of child development: household income, family and parental knowledge and skills, community services and particularly provision of day care.

The following actions were identified as key to strengthen ECD policy development and implementation in all countries:

- Increasing the inter-sector collaboration and develop integrated mechanisms
- Increasing funding for ECD services
- Increasing awareness on ECD issues among policy-makers, society in general and parents
- Developing clear guidelines on effective implementation and sharing them among stakeholders
- Developing evaluation frameworks

The role of the health sector in ECD is unanimously considered as crucial. However, with the possible exception of England where the home visitation programme provides a good basis for ECD implementation, the recent incorporation of Care for Development interventions in IMCI in Kazakhstan and national programmes run in Italy by NGOs, the health sector provides still insufficient support to ECD policies. The summary table in section 4.2 provides a useful overview of what need to be done in order to strengthen the role of the health sector in ECD. Key actions include:

- Incorporating ECD contents in health sector plans, with a clear equity focus (how to reach out for all children)
- Incorporating ECD contents in training curricula and job description of all child health professionals
- Developing clear technical guidelines to incorporate ECD contents in health service delivery
- Taking an active role in developing cross-sector policies at government level and inter-sector collaboration agreements at local level
- Developing monitoring and evaluation frameworks to be included in comprehensive child health and development M&E systems.

REFERENCES

Armenia Demographic and Health Survey (ADHS). National Statistical Service (NSS), 2010 (http://armstat.am/en/?nid=82&id=1253).

Armenia Demographic and Health Survey (ADHS). National Statistical Service (NSS), 2012 (http://armstat.am/file/article/soc_12_1-2.pdf).

Barker DJP (2004). The developmental origins of adult disease. J Am College Nutr 2004; 23:588S-95S.

Barne J, Ball M, Meadows P, McLeish J, Belsky J and the FNP Implementation Research Team. Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England Pregnancy and the Post-partum Period, DH Research Report No DCSF-RW051. Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London, London (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222323/DCSF-RW051_20v2.pdf)

Cattaneo A, Cogoy L, Macaluso A, Tamburlini G, editors. Child Health in the European Union. Luxembourg: European Commission, 2012.

Convention on the Rights of Children Network. 7th Report on the implementation of the CRC. Rome, May 2014.

Cunha F, Heckman JJ. Investing in our young people. Working Paper No. 16201. Cambridge: National Bureau of Economic Research, 2010.

Dawson G, Ashman SB, Carver LJ. The role of early experience in shaping behavioral and brain development and its implications for social policy. Dev Psychopathol 2000; 12: 695–712.

Effective pre-school and primary school education study project (EPPE). England (http://www.education.ox.ac.uk/research/fell/research/effective-pre-school-primary-and-secondary-education/).

Household Budget Survey (HBS) Kazakhstan. Agency of the Republic of Kazakhstan on Statistics, 2009.

Households below average income (HBAI) Collection. Government of United Kingdom: Department of Work and Pensions, 2014 (https://www.gov.uk/government/collections/households-below-average-income-hbai–2).

Jednoróg K, Altarelli I, Monzalvo K, et al. The influence of socioeconomic status on children’s brain structure. PLoS One. 2012;7(8):e42486.

Jefferis, BJMH. Power, C. Hertzman, C. (2002). Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study. BMJ, 325, 305.

Kazakhstan Multiple Indicator Cluster Survey 2005/2006 (MICS). UNICEF: Agency of the Republic of Kazakhstan on Statistics. Astana, 2007 (http://www.childinfo.org/files/MICS3_Kazakhstan_FinalReport_2006_Eng.pdf).

Kazakhstan Multiple Indicator Cluster Survey 2010/2011 (MICS). UNICEF: Agency of the Republic of Kazakhstan on Statistics. Astana; 2012 (http://www.childinfo.org/files/Kazakhstan_MICS4_Final_Report_Eng.pdf).

Murray CJL, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990 – 2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet 2012;380:2197 – 223. 4.

National Survey –Early Childhood care and development: family knowledge, attitudes and practices, 2010, Government of Republic of Moldova and UNICEF (http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf).

Policy: Reducing obesity and improving diet. Government of United Kingdom: Department of Health; 2013 (https://www.gov.uk/government/policies/reducing-obesity-and-improving-diet).

Regional Analysis Report on trend affecting children in the Region, UNICEF CEE/CIS, 2012 Geneva, 2012.

Sethi D, Bellis M, et al, editors, European report on preventing child maltreatment. Copenhagen, WHO Regional Office for Europe, 2013.

Social Snapshot and poverty in Armenia. Measuring poverty in Armenia: Methodological Clarifications; National Statistical Service (NSS); 2012 (http://armstat.am/file/article/9.poverty_2013e_6.pdf).

Tamburlini G, Blair M and Wolfe I. Child public health in Europe. Eurohealth, 20:1, 12-15, 2014.

The Family Nurse Partnership Programme Information leaflet Government of United Kingdom: Department of Health; 2012 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf).

UNICEF. Situation Analysis of Children in Armenia, 2012.

Walker, S.P., Wachs, T.D., Grantham-McGregor, M., et al., “Inequality in early childhood: risk and protective factors for early child development”, The Lancet, 2011, 378(9799), 1325-1338.

White Paper: Healthy Lives, Healthy People: Our strategy for public health in England. London: HM Government; 2010 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf).

Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. WHO, Geneva, 2008.

Health 2020: the European policy for health and well-being. Copenhagen: WHO Regional Office for Europe; 2012.

Wolfe I, Tamburlini G, Wiegersma PA, et al. Child public health. In: Wolfe I, McKee M, editors. European Child Health Services and Systems: Lessons without borders. Berkshire: McGraw-Hill; 2013 (http://www.mcgraw-hill.co.uk/html/0335264662. html).

Wolfe I, Thompson M, Gill P et al. Health services for children in western Europe. The Lancet 2013; 381:1224–1234.

Websites

www.data.worldbank.org

www.mf.gov.md

www.nursefamilypartnership.org

www.unicef.org

ANNEX I – DETAILED INDICATORS DESCRIPTION

- The following tables illustrate the data gathered by means of the questionnaire from the National Officers in Armenia, Kazakhstan and Republic of Moldova.
- The data regarding the indicators under focus was requested in the first section of the questionnaire (see Annex II).
- For the purpose of this Annex, the data has been systematized by: i) country, ii) set of indicators and iii) specific indicators (e.g.: Armenia, Indicators A –Risk factors for ECD – A1. Child poverty).
- The reported data related to each indicator has been structured in three different tables, colour coded as follows:
  - Green table – Definition of indicator reported by the respondent
  - Violet table – Data reported by the respondent (last available rates and previous survey rates)
  - Orange table – Distribution of the reported data (respondents were free to choose the type of distribution – *"Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other"* – see Annex II)
  - No available data, reported as such by the respondents is indicated by red boxes with the heading: Not available data
- The tables reflect the requested from the respondents in the questionnaire (see Annex II).
- All the information used in the tables was reported by the respondents.
- All references were indicated by the respondents.

(A) ARMENIA

INDICATORS A – risk factors for ECD

A1. CHILD POVERTY	
DEFINITION OF INDICATOR	**Source: given by respondent**
The following rates and related comments/description apply to all children under 18 years of age. The concept of *poverty line* is defined as the monetary value of the minimum consumer basket, which represents the amount of goods and services that meet the needs of the minimum level of living standards formed (actually expressed) in society. Poverty lines per adult equivalent AMD/month, 2009[29]: Food line 17,483 Lower poverty line 25,217	

[29] MEASURING POVERTY IN ARMENIA:METHODOLOGICAL CLARIFICATIONS, "Social Snapshot and poverty in Armenia, 2012" from National Statistical Service (NSS), http://armstat.am/file/article/9.poverty_2013e_6.pdf

Upper poverty line 30,920					
DATA					
Last available data			**Previous survey data**		
Rates	Year	Source	Rates	Year	Source
36.2%: Total Poverty [NSS, 2013]; 3.3%: Child poverty rate (extreme) [NSS, 2013]	2012	"Social Snapshot and poverty in Armenia, 2013" from National Statistical Service (NSS) http://armstat.am/en/?nid=82&id=1503	41.9%:Total Poverty [NSS/ILCS 2011] 4.7%: Child poverty rate (extreme) [NSS/ILCS 2011]	2011	1) "Social Snapshot and poverty in Armenia, 2012" from National Statistical Service (NSS) http://armstat.am/en/?nid=82&id=1397 2) 2011 Integrated Living Conditions Survey of Households (ILCS)

DISTRIBUTION

Child poverty per gender, 2012	**Source: NSS/ ILCS 2012**			
	All children under 18 years of age	Boys	Girls	Population headcount
Extreme poverty	3.3%	3.4%	3.3%	2.8%
Total poverty	36.2%	35.8%	36.5%	32.4%

Dynamics of Child poverty rates, 2008-2012	**Source: NSS/ ILCS 2012**		
	Extremely poor	Poor	Non poor
2008	1.6%	29.8%	70.2%
2009	3.8%	35.7%	64.3%
2010	3.7%	41.4%	58.6%
2011	4.7%	41.9%	58.1%
2012	3.3%	36.2%	63.8%

Child poverty per gender, 2011	**Source: NSS/ ILCS 2011**			
	All children under 18 years of age	Boys	Girls	Population headcount
Extreme poverty	4.7%	4.7%	4.7%	3.7%
Total poverty	41.9%	42.9%	41.1%	35.0%

Poverty Rates, Gaps and Composition (percent) by Regions, 2011	**Source: NSS/ILCS 2011**				
	Child poverty rate (extreme)	Child poverty rate	Poverty gap	%- in poor population	Composition of all children
Yerevan	3.8	33.1	7	24.4	30.8
Aragatsotn	1.5	18.0	3	1.5	3.5
Ararat	3.8	49.2	10	10.0	8.5
Armavir	5.6	47.0	12	10.1	9.0
Gegharkunik	1.8	43.5	8	6.1	5.9
Lori	6.8	52.1	13	12.4	10.0
Kotayk	8.1	51.3	16	14.3	11.7
Shirak	8.2	56.0	13	13.0	9.8
Syunik	-	31.7	6	3.1	4.1
VayotzDzor	2.4	33.6	5	1.5	1.9
Tavush	2.0	31.5	6	3.6	4.8
Total	4.7	41.9	10	100	100

A2. CHILD MALNUTRITION

- **DEFINITION OF INDICATOR – Given by respondent**
- **Source: Armenia Demographic and Health Survey – National Statistical Service, Yerevan, Armenia 2010**[30]

- The data relates to the percentage of children classified as malnourished, according to:
  - height-for-age
  - weight-for-height
  - weight-for-age
  - indices by demographic and other background characteristics.
- The analysis focuses on the children for whom complete and plausible anthropometric and age data were collected.

DATA

Last available data			**Previous survey data**		
Rates	Year	Source	Rates	Year	Source
19% children under age 5 are stunted or chronically malnourished.	2010	Armenia Demographic and Health Survey (DHS) 2010	No available data		

[30] Source:Armenia DHS 2010, http://armstat.am/en/?nid=82&id=1253

DISTRIBUTION	
Levels of Child Malnutrition	**Source: Armenia DHS 2010**[31]

- 19% of children under age 5 are stunted or chronically malnourished
- (height-for-age below -2 SD);
- 8% of children are severely stunted(Table 12.1).
- Children 36-47 months (26%) are the most likely to be stunted, and those 9-11months are the least likely to be stunted (13%).
- Male children are slightly more likely to be stunted than female children (20% compared with 18%).
- The extent of stunting increases as the birth interval increases.
- Children considered by their mother to be smaller than average at birth(26%) are more likely to be stunted than children who are average or larger at birth (19%).
- In general, children born to mothers with less education are more likely to be stunted.
- Rural children are just slightly more likely to be stunted than their urban counterparts (22 and 17 percent, respectively).
- There is substantial regional variation in the prevalence of stunted children, ranging from a low of 11% in Yerevan to a high of 37% in Syunik.
- There is no clear relationship between wealth quintile and stunting although it is clear that stunting is more common in the lowest quintile (26%) than in the other wealth categories (16-19%).
- 4% of children under age 5 are wasted (weight-for-height below -2 SD).
- Children younger than age 6 months are at least three times more likely to be wasted than children age 6-59 months.
- There is little difference in the level of wasting by sex, birth interval, or residence.
- The prevalence of wasting is particularly high in the Ararat region (12%) compared with other regions.

Trends in Children's Nutritional Status	**Source: Armenia DHS 2010**[32]

Overall, the percentages of children who are stunted and who are underweight have increased slightly since 2000. The percentage of stunted children under age 5 increased from 17 percent in 2000 to 18 percent in 2005, and then to 19 percent in 2010. The proportion of underweight children under age 5 also went up, from 2 percent in 2000 to 5 percent in 2010. The proportion of children who are wasted rose to 5 percent in 2005, but this percentage has come down slightly, to 4 percent, in 2010.The proportion of overweight children has also increased in the five years, from 11 percent in2005 to 15 percent in 2010 (Fig. 12.2).

- Note: Data are based on children whose mothers were interviewed and calculated according to the new WHO Child Growth Standard adopted in 2006.

[31] Source:Armenia DHS 2010, http://armstat.am/en/?nid=82&id=1253
[32] Source:Armenia DHS 2010, http://armstat.am/en/?nid=82&id=1253

Child Nutrition Overview	Source: "Situation Analysis of Children in Armenia 2012", UNICEF 2013[33]

- Overall, Armenia's indicators show a slightly worse nutritional situation compared with other CEE/CIS countries. The nutritional status of children in Armenia has deteriorated between 2005 and 2010, with the main nutritional problems reflected in the levels of stunting and chronic malnutrition.
- The stunting level increased to 19 per cent in 2010. Four regions – Syunik, Aragatsotn, Lori, and Gegharkunik – showed the highest stunting rates. WHO sets a threshold for strongly recommended public health intervention at a 20 per cent prevalence rate; and since Armenia has almost approached that threshold, the issue should now be considered a public health priority.
- In Armenia the prevalence of wasting is 4 percent, and severe wasting is 2 per cent. The wasting rate in Armenia has almost reached levels of high public health concern, as the WHO threshold is a 5 per cent prevalence rate and higher. Alarmingly, the data show a wasting rate of 11.6 per cent in Ararat region.
- Obesity at 15 per cent prevalence is another major problem among young children in Armenia. Ironically, stunting and obesity coincide: Lori, Gegharkunik and Syunik have the highest stunting and obesity levels. Thus, obesity seems to indicate wrong feeding patterns more than the availability or abundance of food. Overall, 5 percent of children are underweight, more than twice the 2.3 per cent average found in a well-nourished population, indicating chronic malnutrition in children.
- There has been almost no progress over the past five years in the proportion of children under six months who are exclusively breastfed – at 35 per cent in 2010 compared to 33 per cent in 2005.
- Serious problems also exist in complimentary feeding practices. According to the 2010 ADHS, 10 per cent of children under six months are given other milk, 15 per cent are given water or other liquids, and 17 per cent are given solid or other soft food. Whereas the average duration of any breastfeeding is 12.5 months, the average duration of exclusive breastfeeding is only3.2 months.

A3. IODINE DEFICIENCY	No available data

A4. ANEMIA

DEFINITION OF INDICATOR	Source: Armenia Demographic and Health Survey – National Statistical Service, Yerevan, Armenia 2005[34]

- The rates relate to children from 6-59 months of age;
- Levels of anaemia:

[33] Source: UNICEF Armenia 2013Report "Situation Analysis of Children in Armenia 2012", UNICEF 2013http://www.unicef.am/en/library/1/1

[34] Source:Armenia DHS 2005, http://armstat.am/en/?nid=82&id=53

- Any anaemia (<11 g/dl)
- Mild anaemia (10.0-10.9 g/dl)
- Moderate anaemia (7.0-9.9 g/dl)
- Severe anaemia (below 7.0 g/dl)

DATA

Last available data			**Previous survey data**			
Rates	Year	Source	Rates		Year	Source
No available data			Any	36.5%	2005	DHS 2005
			Mild	16.5%		
			Moderate	18.7%		
			Severe	1.2%		

DISTRIBUTION

Anaemia in Children	**Source: Armenia DHS 2005[35]**

- ADHS surveys show that between 2000 and 2005, anaemia rates among children have increased by 50 percent rs (mainly due to the increase in a moderate level of anaemia). According to the 2000 ADHS survey, 24 percent of Armenian children age 6-59 months had any anaemia, compared to 37 percent in 2005. This apparent increase is even more surprising given that fieldwork for the 2005 survey took place during September through December, following the harvest season, when anaemia is expected to be lower than at other times during the year.
- Yerevan and Gegharkunik show the largest increases between 2000 and 2005. For example, the proportion of children with any anaemia has tripled in Yerevan, from 13 percent in 2000 to 45 percent in 2005. Similarly, in Gegharkunik, the proportion of children with any anaemia doubled from 32 percent to 63 percent in 2005.
- Such large increases are unlikely. Although migration of poorer families to the city might help to explain the seemingly anomalous anaemia results for Yerevan and Gegharkunik, it is also possible that data collection errors occurred, such as poor techniques with reading the test results or problems with the reagents or supplies used for the anaemia testing.
- When tables on anaemia are produced without Yerevan and Gegharkunik, there is no increase in anaemia prevalence over time and the relationship between anaemia prevalence and education of the mother reverses, so that anaemia is higher among children of mothers with less education.

[35] Source:Armenia DHS 2005, http://armstat.am/en/?nid=82&id=53

Anaemia in pre-schoolchildren	**Source: "Situation Analysis of Children in Armenia 2012", UNICEF 2013[36]**
The 2005 ADHS reported a substantial prevalence of anaemia (primarily due to iron deficiency) among pre-schoolchildren (37 per cent) and women of childbearing age (25 per cent). **Some potential reasons for the deteriorated nutrition situation of children in Armenia are related to wrong practices in the timing of the introduction of complementary foods to breastfeeding children and the variety of foods provided at that time; inadequate knowledge of parents; and poor counselling on nutrition issues by health care providers.**	

INDICATORS B – family care and parenting practices

- The respondents underline that Multiple Indicator Cluster Surveys (MICS) was not conducted in Armenia, thus information related to family care and parenting practices is not available for the country.

B1. AVAILABILITY OF BOOKS	**No available data**
B2. FAMILY/ADULT SUPPORT FOR EARLY LEARNING	**No available data**
B3. FATHER SUPPORT FOR LEARNING	**No available data**
B4. FAMILY KNOWLEDGE OF POSITIVE CHILD REARING PRACTICES	**No available data**
B5. POSITIVE CHILD REARING PRACTICES IMPLEMENTATION	**No available data**
B6. CHILD TRAUMA AND INJURY RATES	**No available data**
B7. CHILD MALTREATMENT	**No available data**

INDICATORS C – preschool and primary education

C1. GOVERNMENT EXPENDITURE ON EDUCATION		
DEFINITION OF INDICATOR		**Given by respondent**
Expenditure on Education as a percentage of GDP		
DATA		
Last available data		
Rates	Year	Source
2.3%	2013	State Budget of Armenia 2014

[36] Source: UNICEF Armenia 2013Report "Situation Analysis of Children in Armenia 2012", UNICEF 2013http://www.unicef.am/en/library/1/1

DISTRIBUTION	
Trends in Government Expenditure on Education	UNICEF Armenia 2013 Report "Situation Analysis of Children in Armenia 2012")[37]

- The budget for education in 2013 has increased in nominal terms by 2.5% compared to previous years allocation, but it has decreased as a percentage of GDP from 2.5% to 2.3% and will further be reduced to 2.2% of the GDP in 2014 according to MTEF 2013-2015. These continued reductions can have a grave implication on the access and quality of education in the country.
- It is notable that the ratio of special education to inclusive education financing has narrowed from 3:1 in 2012 to 2.2:1 in 2013. There has been a 43% increase in inclusive education allocation whereas special education allocation has increased by 2% only.
- Even though special education financing is still more than twice higher than inclusive education, this serious reduction in the gap gives a positive sign that the Ministry of Education and Science is committed to promoting inclusion.
- The Ministry should continue its planned initiatives on transforming special schools and reallocating their resources to inclusive system.

Trends in Government Expenditure on Pre-schools	UNICEF Armenia 2013 Report "Situation Analysis of Children in Armenia 2012")[38]

- The state budget allocations to preschools doubled from 2012 to 2013, and increased by 73% from 2013 to 2014 as the government committed to finance preschools opened in schools buildings in the framework of 'Quality and Relevance of Education II' programme.

C2. PRE-PRIMARY ENROLMENT RATE	
DEFINITION OF INDICATOR	**Given by respondent**
Enrolment of children aged 0-5 in preschool institutions.	

DATA						
Data (0-3 age group)[39]	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
	7.8%	2012	NSS	7.0%	2011	NSS
Data (3-5 age group)	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source

[37] Source: UNICEF Armenia 2013Report "Situation Analysis of Children in Armenia 2012", UNICEF 2013http://www.unicef.am/en/library/1/1
[38] Source: UNICEF Armenia 2013Report "Situation Analysis of Children in Armenia 2012", UNICEF 2013http://www.unicef.am/en/library/1/1
[39] If available, please provide data for both 0-3 and 3-5 (or 6) age groups

	49.1%	2012	NSS	47.3	2011	NSS
DISTRIBUTION						
Pre-primary Enrolment Rate	**Source: Social Situation in Armenia 2012[40]**					

- The enrolment rate for 0-5 is 27.9%.
- Urban enrolment is much higher (36.6%) than rural (13.8%).
- Girls' enrolment is slightly higher than boys'.

(B) KAZAKHSTAN

INDICATORS A – risk factors for ECD

A1 CHILD POVERTY

DEFINITION OF INDICATOR

The child poverty data comprises rates related to:

- The Wealth Index Quintile: distribution of children under 5 in according to household's wealth has been made for MICS survey
- GNI per capita, Atlas method
- GDP growth (annual%)
- Poverty headcount ratio: the percentage of the population living below the national poverty line. National estimates are based on population-weighted subgroup estimates from household surveys.

DATA

	Last available data (MICS-4)			**Previous survey data (MICS-3)**		
	Rates	Year	Source	Rates	Year	Source
Wealth Index Quintile: Distribution of children under 5 according to household's wealth (%): Poorest Richest	24.1 17.7	2010\2011	MICS	27.0 17.4	2006	MICS
GNI per capita, Atlas method (current US$)	9,780	2012	World Bank Data	8,200	2011	World Bank Data
GDP growth (annual%)	5%	2013	World Bank Data	7.5%	2011	World Bank Data

[40] Source: Social Situation in Armenia (2012)http://armstat.am/file/article/soc_12_1-2.pdf

Poverty headcount ratio at $1.25 a day (PPP) (% of population)	3.8%	2012	World Bank Data	5.5%	2011	World Bank Data

DISTRIBUTION

Distribution of children under 5 according to household's wealth (%):				**Wealth Index Quintile: Poorest Richest**		
	Last available data (MICS-4)			Previous survey data (MICS-3)		
	Rates	Year	Source	Rates	Year	Source
Poorest	24.1	2010\2011	MICS		2006	MICS
Richest	17.7			27.0		
				17.4		

Distribution of poverty rates in children under 18	**UNICEF Report 2013**

- 45% of all children under 18 years of age are living in poverty (Household Budget survey – 2009)
- 33% of all population of the country lives in poverty
- 7% of all children are living in households with consumption below 60% of the minimum subsistence level
- Across all regions of the country poverty rates are slightly higher for children under 5 years of age
- Across all regions of the country poverty rates are significantly higher than for adults

A2 MALNUTRITION

DEFINITION OF INDICATOR

- **Stunting prevalence**: – Percentage of children under age five that fall below minus two standard deviations from the median height for age of the NCHS/WHO standard (moderate and severe)
- **Underweight prevalence**: – Percentage of children under age five that fall below minus two standard deviations from the median weight for age of the NCHS/WHO standard (moderate and severe)
- **Wasting prevalence**: – Percentage of children under age five that fall below minus two standard deviations from the median weight for height of the NCHS/WHO standard(moderate and severe)
- **Low-birth weight infants**: – Percentage of live births in the 2 years preceding the survey weighing below 2,500 grams

DATA						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Underweight prevalence	3.7	2010\2011	MICS	4.0	2006	MICS
Wasting prevalence	4.1	2010\2011	MICS	3.8	2006	MICS
Stunting prevalence	13.1	2010\2011	MICS	12.8	2006	MICS
Low birth weight infants	4.5	2010\2011	MICS	5.8	2006	MICS
Low birth weight infants: percentage of live births weighing below 2,500 grams	5.9	2013	MOH data	5.9	2012	MOH data

DISTRIBUTION						
Stunting prevalence				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	12.8%	2010\2011	MICS	10.7%	2006	MICS
Rural	13.4%			14.9%		
Poorest	14.4%			8.4%		
Richest	12.1%			15.7%		
Kazakh	13.6%			14.5%		
Russian	11.9%			7.9%		
Highest per regions	Aktobe region (36.2%) Astana city (19.7%)			Aktobe region (23.5%) Kzylorda region (23.3%)		
Low birth weight infants						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	4.1%	2010\2011	MICS	6.2%	2006	MICS
Rural	5.1%			5.4%		
Poorest	4.9%			5.0%		
Richest	3.5%			5.8%		
Kazakh	4.3%			5.7%		
Russian	5.0%			5.2%		

Highest per regions	North Kazakhstan region (9.3%)			Pavlodar region (19.4%)		
Lowest per regions	Astana city (3.0%) Almaty region (3.0%)			Mangystau region (4.0%)		

A3 IODINE DEFICIENCY						
DEFINITION OF INDICATOR						
Iodized salt consumption: Percentage of households with salt testing 15 parts per million or more of iodine/iodate						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Iodized salt consumption	85.4	2010\2011	MICS	92.0	2006	MICS

DISTRIBUTION						
Iodized salt consumption				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	86.4%	2010\2011	MICS	92.1%	2006	MICS
Rural	83.9%			91.8%		
Poorest	78.0%			90.7%		
Richest	86.5%			91.1%		
Lowest per regions	South Kazakhstan region (64%) Almaty city (64.9%)			Pavlodar region (68.3%)		

A4 ANEMIA IN CHILDREN						
DEFINITION OF INDICATOR						
• Prevalence of Iron Deficiency Anaemia: Percentage of 6-59 month old children with low concentration of hemoglobin in blood • 2.Prevalence of Iron Deficiency: Percentage of6-59 month old children with low blood ferritin level						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Iron Deficiency Anaemia Prevalence	38.9	2011	Iron Deficiency Anaemia Prevalence	44.7	2008	UNICEF\Kazakh Academy of Nutrition data
Iron Deficiency Prevalence	38.1	2011	Iron Deficiency Prevalence	No available data	2008	UNICEF\Kazakh Academy of Nutrition data

INDICATORS B – family care and parenting practices

B1. AVAILABILITY OF BOOKS						
DEFINITION OF INDICATOR						
Percentage of children under age of 5 who have three or more children's books						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Children's books	47.8	2010\2011	MICS	66.4	2006	MICS

DISTRIBUTION						
Children's books				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	61.1%	2010\2011	MICS	76.9%	2006	MICS
Rural	35.4%			55.5%		
Poorest	24.2%			43.8%		
Richest	75.6%			88.7%		
Lowest	South			South Kazakhstan		

per regions	Kazakhstan region (17.8%) Kzylorda region (21.0%)			region (49.1%) Kzylorda region (52.6%)		

B2. FAMILY/ADULT SUPPORT FOR EARLY LEARNING

DEFINITION OF INDICATOR

Support for learning: Percentage of children in the age group 36-59 months with whom an adult household member was engaged in 4 or more types of learning and school preparation activities within the past 3 days

Early child development index: Percentage of children in the age group 36-59 months who are developmentally on track in the physical, social-emotional and learning domains

Learning materials for play: Percentage of children under the age of 5 who has two or more objects for playing

DATA

	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Support for learning	91.5	2010\2011	MICS	81.0	2006	MICS
Early child development index	86.1	2010\2011	MICS	No available data	2006	MICS
Learning materials for play	44.8	2010\2011	MICS	19.8	2006	MICS

DISTRIBUTION

Support for learning				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	94.0%	2010\2011	MICS	82.9%	2006	MICS
Rural	89.3%			79.1%		
Poorest	84.1%			79.7%		
Richest	96.3%			86.9%		
Lowest per regions	South Kazakhstan region (84.2%) Almaty region (84.9%)			Almaty region (60.4%) Zhambyl region (69.7%)		

Early child development index				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban Rural Poorest Richest Lowest per regions	87.2% 85.1% 83.3% 92.1% South Kazakhstan region (81.5%)	2010\2011	MICS	No available data	2006	MICS
Learning materials for play				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban Rural Poorest Richest Lowest per regions	45.8% 44.0% 39.9% 48.6% Almaty region (0.5%) Atyrau region (3.8%)	2010\2011	MICS	19.9% 19.6% 20.6% 18.1% South Kazakhstan region (21.1%) Atyrau region (23.9%)	2006	MICS

B3. FATHER SUPPORT FOR LEARNING						
DEFINITION OF INDICATOR				**MICS**		
Percentage of children aged 0-59 months whose father has engaged in one or more activities to promote learning and school readiness in the past 3 days						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Father's support for learning	49.1	2010\2011	MICS	46.9	2006	MICS
DISTRIBUTION						
Father's support for learning				MICS		
	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source

Urban Rural Poorest Richest Lowest per regions	55.4% 43.3% 37.5% 60.8% South Kazakhstan region (31.6%),Atyrau region (30.6%).	2010\2011	MICS	56.1% 37.3% 30.0% 68.8% South Kazakhstan region (11.7%).	2006	MICS

B4 FAMILY KNOWLEDGE OF POSITIVE CHILD REARING PRACTICES	**No available data**
B5 POSITIVE CHILD REARING PRACTICES IMPLEMENTATION	**No available data**

B6 CHILD TRAUMA AND INJURY RATES						
DEFINITION OF INDICATOR	**MICS**					
Crude death rate per 100 000 among children under 5 and percentage of all deaths						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Falls Accidental drowning and submersion Exposure to smoke, fire and flames Accidental poisoning by and exposure to noxious substances Intentional self-harm Assault All other external causes	2.0495 (0.46%) 5.9002 (1.33%) 1.4285 (0.32%) 3.8506 (0.87%) 0 0.9937 (0.22%) 17.8248 (4.01%)	2010	WHO database	No available data		

B7 CHILD MALTREATMENT

DEFINITION OF INDICATOR

Violent forms of discipline: Percentage of children aged 2-14 years who experience any violent discipline (physical punishment and \or psychological aggression)

Inadequate care: Percentage of children under 5 left alone or in the care of another child under 10 years old in past week at least once

DATA

	Last available data			Previous survey data		
	Rates	Year		Rates	Year	
Violent forms of discipline	49.4%	2010\2011	MICS	52.2	2006	MICS
Inadequate care	4.4%	2010\2011	MICS	9.8	2006	MICS
Children in residential care, percentage of total child population	15%	2007	UNICEF Fact Sheet	No available data		
Proportion of infants below 3 in residential care – children residing in institutions (e.g. orphanages, children's homes, boarding schools, etc).	2.6%	2007	UNICEF Fact Sheet	No available data		

DISTRIBUTION

Violent forms of discipline — **MICS**

	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
Urban	48.9%	2010\2011	MICS	54.7%	2006	MICS
Rural	49.9%			49.1%		
Poorest	50.3%			51.0%		
Richest	46.1%			54.2%		
Highest per regions	Kostanai region (72.6%) Mangystau region(65.3%)			Karaganda region (68.8%) North Kazakhstan region (65.9%)		

Inadequate care — **MICS**

	Last available data	Previous survey data

	Rates	Year	Source	Rates	Year	Source
Urban	4.2%	2010\2011	MICS	10.4%	2006	MICS
Rural	4.6%			9.2%		
Poorest	5.0%			7.6%		
Richest	4.0%			10.0%		
Highest per regions	Mangystau region (12.7%), East Kazakhstan region (6.2%)			Aktobe region (27.3%) and Akmola region (24.9%)		

INDICATORS C – preschool and primary education

C1 GOVERNMENT EXPENDITURE ON EDUCATION (as percentage on total government expenditure)

DEFINITION OF INDICATOR

Public spending on education: total percentage of GDP

Public expenditure on preschool education: the percentage of total the government expenditure for education in a given financial year.

DATA

	Last available data			Previous survey data		
	Rates	Year		Rates	Year	
Public spending on education (% of GDP)	4,2	2012	the Ministry Education report	3,8	2011	Ministry of Education
Public expenditure on pre-schoolchildren education	10,7	2012	the Ministry Education report	9,35	2011	Ministry of Education

C2 PRE-PRIMARY ENROLMENT RATE

DEFINITION OF INDICATOR

- Early childhood education: Percentage of children in the age group 36-59 months attending some early childhood development programme
- School readiness: Percentage of children attending first grade who attended preschool in previous year
- Percentage of children aged 3 to 6 years who attended some form of pre-school education or training
- Percentage of children aged 5 to 6 years who attended some form of pre-school education
- The percentage of children in school age with the development disabilities enrolled in inclusive education

DATA						
	Last available data			**Previous survey data**		
	Rates	Year		Rates	Year	
Data (0-3 age group)	No available data					
Data (3-5 age group) Early childhood education inthe age group 36-47 months	32.4	2010\2011	MICS		2006	MICS
Early childhood education inthe age group 48-59 months	41.7	2010\2011	MICS		2006	MICS
Early childhood education in the age group 36-59 months	37.0	2010\2011	MICS	16.0	2006	MICS
School readiness	81.6	2010\2011	MICS	39.5	2006	MICS
Percentage of children aged 3 to 6 years who attended some form of pre-school education or training	65.4	2011	National Agency of Statistics data	71.5	2012	National Agency of Statistics data
Percentage of children aged 5 to 6 years who attended some form of pre-school education	94.7	2011	National Agency of Statistics data	96.0	2012	National Agency of Statistics data
Percentage of children in school age with the development disabilities enrolled in inclusive education	19.1	2011	National Agency of Statistics data	20.3	2012	National Agency of Statistics data

DISTRIBUTION						
Early childhood education in the age group 36-59 months				**MICS**		
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Urban	45.3%	2010\2011	MICS	24.1%	2006	MICS
Rural	29.4%			7.0%		
Poorest	18.7%			2.8%		
Richest	60.5%			44.8%		
Kazakh	35.9%			12.4%		
Russian	51.2%			29.4%		
Lowest per regions	Almaty region (15.1%)			Almaty region (7.1%) Kzulorda (8.2%) Aktobe regions (8.8%)		

(C) REPUBLIC OF MOLDOVA

INDICATORS A – risk factors for Early Child Development

A1 CHILD POVERTY

DEFINITION OF INDICATOR

No definition was given by the respondent

DATA

	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
	20%	2012	Ministry of Economy			

DISTRIBUTION

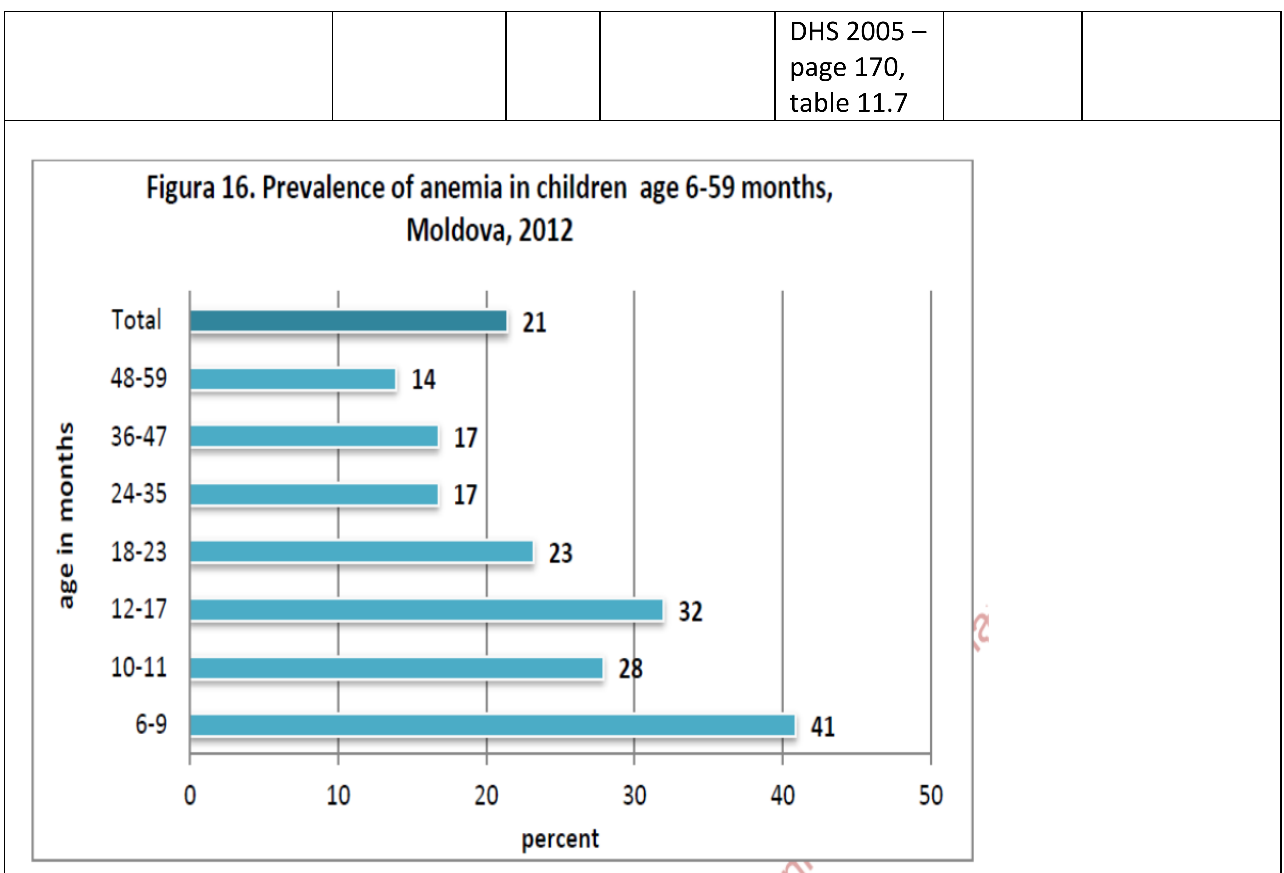
- Children are exposed to a higher poverty risk as compared to the total population, as the poverty rate among children exceeds the average national rate.
- About 20% of the children in the Republic of Republic of Moldova are at the poverty limit.
- The highest poverty rates are registered for households with 3 or more children.
- About 38% of families with three or more children fall under the poverty incidence. Although the poverty level for the respective category is 2 times higher than the country average, it actually dropped by 2.2 percentage points as compared to 2010, and by 13.0 percentage points as compared to 2009.
- The share of families with 3 or more children is only 12%, while the proportion of families without children is 47%.
- Most of the poor children live in villages.
- About 85% of all poor children live in rural areas.
- This situation is provoked by the higher share of the rural population, in general, and by the fact that economic opportunities in villages are very limited. Besides material poverty, the children from villages are also very vulnerable and exposed to social risks.
- To ensure the family’s survival in the village, the parents frequently emigrate abroad, leaving the children to be cared by relatives, grandparents, or elderly sisters and brothers. Even though this leads to improving the family’s economic situation, emigration negatively influences the emotional health, as well as the scholastic achievements of the child.

A2 MALNUTRITION						
DEFINITION OF INDICATOR			WHO			
The key indicators for monitoring the nutritional status of a child under the age of five are underweight (weight-for-age), stunting (height-for-age) and wasting (weight-for-height). These three indicators are expressed in standard deviation (SD) units from the International Reference Population median recommended by the World Health Organization.						
DATA						
	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
For under 5 age group	Weight-for age -2SD – 2% -3SD – 0.2% Height-for-age -2SD – 6% -3SD – 1% Weight-for-height -2SD – 2% -3SD – 0.5%	2012	MICS	Weight-for age -2SD – 5.9% -3SD – 0.8% Height-for-age -2SD – 9.2% -3SD – 1.9% Weight-for-height -2SD – 3% -3SD – 0%	2005	DHS

A3 IODINE DEFICIENCY						
DEFINITION OF INDICATOR						
In the earlier attached reports no clear definition, but the results of the insufficiency are listed						
DATA						
	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
	36.8%	2005	DHS*		2009	ECD national survey

A4 ANEMIA						
DEFINITION OF INDICATOR			DHS 2005, page 169			
Anaemia is a condition characterized by a reduction in the red blood cell volume and a decrease in the concentration of hemoglobin in the blood(DHS 2005, page 169)						
DATA						
	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
	Table below	2012	MICS	Table with data that are different –	2005	DHS

				DHS 2005 – page 170, table 11.7		



INDICATORS B – family care and parenting practices

B1 AVAILABILITY OF BOOKS						
DEFINITION OF INDICATOR						
No definition was given by the respondent						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
	Low Availability of Books. Supply of books in the household was assessed by asking about availability of various types of children books (colouring books, books with games, poetry, fairy tales, story books etc). The results suggest a low availability of books, as 26.3 per cent had none of these types, 17.9 per cent had only one type, 48.0 per cent had two to four types and only 7.8 per cent had high level of supply (over 4 types). http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf					

B2 FAMILY SUPPORT FOR EARLY LEARNING						
DEFINITION OF INDICATOR						
http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
	66%	2009	ECD report	44%	2003	ECD report

B3 FATHER SUPPORT FOR EARLY LEARNING						
DEFINITION OF INDICATOR						
http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
	67%	2009	ECD report			

B6 CHILD TRAUMA						
DEFINITION OF INDICATOR						
Available in annual statistic report of Ministry of Health, the age group is 0-18 years old. 2011 – 454.2 per 10000 pop 2012 – 466.4 per 10000 pop						
DATA						
	Last available data			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Age group 0-18	466.4 per 10000 pop	2012	Annual Statistic Report of Ministry of Health	454.2 per 10000 pop	2011	Annual Statistic Report of Ministry of Health

INDICATORS C – preschool and primary education

C1 GOVERNMENT EXPENDITURE ON EDUCATION	
DISTRIBUTION	
Education	3,431,769.2
Preschool education	41,605.0
Secondary education	734,476.1
Higher education (university)	637,428.2
Post graduate education	57,668.7
Continuous training	16,163.5
Other educational activities	50,682.9
College education	444,102.4
http://mf.gov.md/TranspDeciz/ProiecDeciz/bsparl – approved state budget	

REFERENCES FOR ANNEX I

Annual Statistic Report of Ministry of Health 2011. Republic of Moldova: National Center of Health Management. Chisinau, 2012 (http://ms.gov.md/sites/default/files/rapoarte/anuar_2011.pdf).

Armenia Demographic and Health Survey (ADHS). National Statistical Service (NSS), 2010 (http://armstat.am/en/?nid=82&id=1253).

Armenia Demographic and Health Survey (ADHS). National Statistical Service (NSS), 2012 (http://armstat.am/file/article/soc_12_1-2.pdf),

Demographic and Health Survey 2005 (DHS). National Scientific and Applied Centre for Preventive Medicine: Ministry of Health and Social Protection of Moldova. Chisinau, 2006 (http://dhsprogramme.com/pubs/pdf/FR178/FR178.pdf).

Household Budget Survey (HBS) Kazakhstan. Agency of the Republic of Kazakhstan on Statistics; 2009.

Integrated Living Conditions Survey of Households (ILCS); National Statistical Service (NSS). Armenia; 2011 (http://www.armstat.am/en/?nid=378).

Integrated Living Conditions Survey of Households (ILCS); National Statistical Service (NSS). Armenia; 2012 (http://www.armstat.am/en/?nid=378).

Kazakhstan Multiple Indicator Cluster Survey 2005/2006 (MICS). UNICEF: Agency of the Republic of Kazakhstan on Statistics. Astana, 2007 (http://www.childinfo.org/files/MICS3_Kazakhstan_FinalReport_2006_Eng.pdf)

Kazakhstan Multiple Indicator Cluster Survey 2010/2011 (MICS). UNICEF: Agency of the Republic of Kazakhstan on Statistics. Astana, 2012 (http://www.childinfo.org/files/Kazakhstan_MICS4_Final_Report_Eng.pdf).

National Survey –Early Childhood care and development: family knowledge, attitudes and practices, 2010, Government of Republic of Moldova and UNICEF (http://www.unicef.org/moldova/2010_007_ECD_KAP_Study_ENG.pdf).

Social Situation in Armenia. National Statistical Service (NSS), 2012 (http://armstat.am/file/article/soc_12_1-2.pdf).

Social Snapshot and poverty in Armenia. Measuring poverty in Armenia: Methodological Clarifications. National Statistical Service (NSS), 2013 (http://armstat.am/en/?nid=82&id=1503).

Social Snapshot and poverty in Armenia. Measuring poverty in Armenia: Methodological Clarifications. National Statistical Service (NSS), 2012 (http://armstat.am/file/article/9.poverty_2013e_6.pdf).

UNICEF Report "Situation Analysis of Children in Armenia 2012". UNICEF Armenia; 2013 (http://www.unicef.am/en/library/1/1).

Websites

www.mf.gov.md

www.unicef.org

www.gruppocrc.net

ANNEX II – QUESTIONNAIRE

Early Childhood Development – Policy assessment and state of the art

The aim of this questionnaire is to collect information about Early Childhood Development (ECD) in a number of countries of the European Region (Armenia, Italy, Kazakhstan, Moldavia, and United Kingdom). The gathered information will provide an important input for the WHO European office in its efforts to review the current WHO Regional Office for Europe Child and Adolescent Health (CAH) strategy, which includes ECD as one of the key priorities.

The questionnaire was designed to cover all the main ECD issues (nutrition, access to day-care, parenting practices, psychosocial well-being) and to collect key information about the current status and trends (through indicators that are widely used in current statistics and/or in international surveys such as the MICS) as well as about policies, plans and programmes, including a brief view of main strengths, weaknesses, opportunities and threats in each country.

Respondents are kindly asked to look for the existing information and answer to all questions. If specific information is not available, a brief note should explain the difficulties in finding it. Of course, the fact that an information is not available represents by itself is an important information.

SECTION I – STATUS INDICATORS

- This section collects data related to ECD status indicators and includes three different sets of indicators.
- For each of the indicators, please provide the definition used.
- Please provide the last available country data, in terms of rates and distribution (indicating year and source of information).
- Please provide also data from a previous survey, in order to allow for an evaluation of trend.
- Please feel free to give any type of information/details on the indicator in the box Any additional comments.

A. RISK FACTORS FOR ECD:

A1. CHILD POVERTY						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, rural vs urban environment, or other)						
Any additional comments						

A2. CHILD MALNUTRITION						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

A3. IODINE DEFICIENCY IN CHILDREN						
Indicate the precise definition which is being used for the indicator	Indicate the precise definition which is being used for the indicator					
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by						

geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

A4. ANEMIA IN CHILDREN						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B. FAMILY CARE AND PARENTING PRACTICES

B1. AVAILABILITY OF BOOKS						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B2. FAMILY/ADULT SUPPORT FOR EARLY LEARNING	
Indicate the precise definition which is being used for the indicator	

Data	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B3. FATHER SUPPORT FOR LEARNING						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B4. FAMILY KNOWLEDGE OF POSITIVE CHILD REARING PRACTICES						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B5. POSITIVE CHILD REARING PRACTICES IMPLEMENTATION						
Indicate the precise definition which is being used for the indicator						
Data	**Last available data**			**Previous survey data**		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

B6. CHILD TRAUMA AND INJURY RATES	
Please provide any data about child trauma and injury in the age group 0-5, if available (e.g. mortality rates, or hospitalization rates)	

B7. CHILD MALTREATMENT	
Please provide any available data about child maltreatment (no of reported cases, if available by main type of maltreatment: physical, sexual etc.)	

C. PRESCHOOL AND PRIMARY EDUCATION:

C1. GOVERNMENT EXPENDITURE ON EDUCATION (as percentage on total government expenditure)	
Indicate the precise definition which is being used for the indicator	
Data	**Last available data**

	Rates	Year	Source
Any additional comments			

C2. PRE-PRIMARY ENROLMENT RATE						
Indicate the precise definition which is being used for the indicator						
Data (0-3 age group)[41]	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
Data (3-5 age group)	Last available data			Previous survey data		
	Rates	Year	Source	Rates	Year	Source
Please provide any additional information on distribution by geography, SES quintiles, rural vs urban environment, or other)						
Any additional comments						

SECTION II – POLICY ACTIONS (relevant legislation approved by Government and/or Parliament)

A. SPECIFIC ECD POLICIES (policies addressing only ECD issues)

1. Please indicate whether there are active ECD policies in Your country, in the following fields:

Policy field	Yes	No
Nutrition policies		
Early education policies (pre-school)		
Psychosocial family support policies		
Conditional cash transfer policies		
Family income benefit policies		
Parental leave policies		

[41] If available, please provide data for both 0-3 and 3-5 (or 6) age groups

Deinstitutionalization in child care policies		
Any other existing policy		
……………………………………………………………....		

2. For each of the indicated policies, please provide a brief description (50 to 100 words), indicating also the year of adoption of the policy and state of implementation – whether starting, partial or complete.

……

Note: When answering the questionnaire, please feel free to attach any official documentation about a specific policy/issue (only if available in English).

B. INTEGRATED POLICIES (broader policies which include an ECD component)

1. Please indicate whether there are active ECD integrated policies in Your country, in the following fields:

Policy field	**Yes**	**No**
Child policies		
Family policies		
Child education policies		
Maternal and child health policies		
Any other existing policy		
………………………………………………………………..		

2. For each of the indicated policies, please provide a brief description: (50 to 100 words), indicating also the year of adoption of the policy and state of implementation – weather starting, partial or complete.

SECTION III – PLANS

1. Please indicate any action plan on, or including a component of, ECD approved in Your country in the last 10 years. Please give a brief description of the existing plans in terms of: funding, timeline, resources etc

……

Note: When answering the questionnaire, please feel free to attach any official documentation about a specific policy/issue (only if available in English).

SECTION IV – PROGRAMMES (specific programmes regarding one or more ECD components that may be funded and/or run by the Government or by other agencies)

1. Please indicate up to a maximum of 5 active programmes focusing on important ECD components.

Please provide a brief description for each programme, focusing on the following aspects:

- Agency/agencies in charge and partners -Who? (e.g. Government sector, national and o/or international NGOs/CSOs, international organizations etc)
- Objectives (general and specific) – Why? (e.g. poverty reduction, increasing of the enrolment pre-school rate, promotion of positive child rearing practice etc)
- Target groups/beneficiaries – For whom? (e.g. individual children, individual families, organized groups, vulnerable/at risk groups etc)
- Coverage – How many? (e.g. number of and/or proportion of the total population children/families covered by the programme)
- Activities – What? (e.g. workshops for parents)
- Equity focus – Is there any specific way to reach out for the most marginalized groups?
- Duration -How long? (*e.g. timeline*)
- Funding – How? (e.g. public funding, private donations etc)
- Participation – Is there any specific way to involve communities/families in the planning and implementation of the programme?

………

Note: When answering the questionnaire, please feel free to attach any official documentation about a specific policy/issue (only if available in English).

2. For each of the programmes, please specify the implementation level:

Programme name Starting Partial Complete

Programme name	**Starting**	**Partial**	**Complete**

3. If an evaluation has been done, please provide synthetic information on the achieved results for each programme.

………

4. For each of the programmes, please describe briefly the involvement of the health sector, in terms of role: leadership, collaboration etc.

………

SECTION V – ASSESSMENT

1. With regard to the further development of ECD policies and programmes in Your country (whether as a component of comprehensive policies or not), please provide as many relevant/influential factors as possible, according to the following scheme:

POSITIVE	NEGATIVE	
STRENGTHS • *E.g. increased awareness at political level (e.g. parliament sessions, committees, declarations etc.)* •	**WEAKNESSES** • *E.g. Low awareness among policy-makers and/or society* •	**INTERNAL**
OPPORTUNITIES • *E.g. a maternal and child policy will be soon approved and there is room for increased focus on ECD* • *support from UN Agencies* •	**THREATS** • *E.g. lack of availability of skilled professionals in the health sector (PHC) or education sector* •	**EXTERNAL**

2. (a) Please name 5 different factors which You consider to be crucial for improving the ECD policy development in Your country.

………

2. (b) Please name 5 factors which You consider to be crucial for improving the contribution of health sector to ECD policies in Your country.

………

Please feel free to add any further comment you consider relevant to the topic of the questionnaire!

Thank You!

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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