

# Improving the lives of children and young people: case studies from Europe

## Volume 1. Early years



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## **Volume 1. Early years**

Editors: Vivian Barnekow, Bjarne Bruun Jensen, Candace Currie, Alan Dyson,  
Naomi Eisenstadt and Edward Melhuish

## **ABSTRACT**

The WHO Regional Office for Europe commissioned a European review of social determinants of health and the health divide. The case studies published in these three volumes arise from the review's early years, family and education task group. The task group commissioned experts in the European Region to write case studies addressing childhood and inequality in their contexts. Contributors were asked to identify promising developments that would also have international resonance, to describe the issues they addressed and how they were led and operationalized, and to set out emerging evidence of effectiveness. The result is a diverse collection of case studies presented over three volumes reflecting a "life-course" approach: early years; childhood; and school. Some review major national policy developments and frameworks, others deal with specific national initiatives or with local projects driven by community organizations, and a few focus on transnational initiatives. They do not set out to offer a comprehensive overview of childhood and health in the Region, but provide examples of innovative practice that will inform and inspire policy-makers, practitioners, managers, educators and researchers at country and European levels.

## **Keywords**

CHILD WELFARE  
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## Abbreviations and acronyms, volumes 1–3

ADHD	attention-deficit hyperactivity disorder
A PAR	Association Aprender em Parceria [Learning in Partnership Association] [Portugal]
Arabkir MC–ICAH	Arabkir Medical Centre–Institute of Child and Adolescent Health [Armenia]
ASL	azienda sanitaria locale [local health unit] [Italy]
AVall	Alimentation and Physical Activities in the Eastern Valles [Spain]
BA (Hons.)	bachelor’s degree with honours
BMI	body mass index
BRÅ	Bråttsförebyggande rådet [Complaints Prevention Council] [Sweden]
BZgA	Bundeszentrale für gesundheitliche Aufklärung [Federal Centre for Health Education] [Germany]
CHIP–AE	Child Health and Illness Profile – Adolescent Edition
CI	confidence interval
CINDI	Countrywide Integrated Noncommunicable Disease Intervention [programme]
CIS	Commonwealth of Independent States
CoE	Council of Europe
DAK	Deutsche Angestellten Krankenkasse [health insurance company] [Germany]
DG SANCO	[European Commission] Directorate-General for Health and Consumers
DHS	demographic health survey
EC	European Commission
ECEC	early childhood education and care
ECERS	Early Childhood Education Rating Scale
ENHPS	European Network of Health Promoting Schools
EnRG	Environmental Research framework for weight Gain prevention
EPODE	Ensemble Prévenons l’Obésité des Enfants [Let’s Prevent Childhood Obesity Together] study
EPPE	Effective Provision of Preschool and Primary Education [project] [United Kingdom (England)]
ESF	European Social Fund
EU	European Union
EU27	countries belonging to the EU after January 2007
EU–SILC	EU Statistics on Income and Living Conditions
FAS	[HBSC] Family Affluence Scale
FAST	Families and Schools Together [programme]
FNP	family–nurse partnership [United Kingdom (England)]
FSME	free-school-meal entitlement
GCSE	general certificate of secondary education
GDP	gross domestic product
GP	general practitioner
GRSP	Global Road Traffic Safety
HBSC	WHO Health Behaviour in School-aged Children [survey/study]

HEEADSS	home, education, eating and employment, activities, drugs, sexuality, suicide/depression
HEO	Health Education Office [of the Ministry of Education and Culture] [Cyprus]
HPS	health-promoting school [approach]
ICAPS	Intervention Centred on Adolescents' Physical Activity and Sedentary Behaviour [programme]
ICT	information and communications technology
IMCI	integrated management of childhood illnesses
INCA	Etude Individuelle Nationale sur les Consommations Alimentaires [survey]
INPES	Institut National de Prévention et d'Éducation pour la Santé [National Institute for Prevention and Health Education] [France]
IRTAD	International Road Traffic and Accident Database
ISCED	International Standard Classification of Education
IVAC	investigation–vision–action–change [approach]
JOGG	Jongeren Op Gezond Gewicht [Young People at a Healthy Weight] [the Netherlands]
KEDKE–EETAA	Central Association of Municipalities and Communities of Greece–Hellenic Agency for Local Development and Local Government
KiGGS	Studie zur Gesundheit von Kindern und Jugendlichen [National Health Interview and Examination Survey for Children and Adolescents] [Germany]
LLBT	“Learning to live better together” [programme] [France]
MMR	measels–mumps–rubella [vaccination]
MOVE	Motivierende Kurzintervention für Jugendliche [brief motivational intervention for young people] [Croatia]
NCD	noncommunicable disease
NESS	National Evaluation of Sure Start [United Kingdom (England)]
NFP	nurse family partnership [programme] [United Kingdom (England)]
NGO	nongovernmental organization
ns	not significant
OECD	Organisation for Economic Co-operation and Development
OKE	Wet Ontwikkelingskansen door Kwaliteit en Educatie Act 2010 [Law and Development Opportunities through Quality Education Act 2010] [the Netherlands]
OMCYA	Office of the Minister for Children and Youth Affairs [Ireland]
OR	odds ratio
ORIM	opportunities, recognition, interaction and model
PE	physical education
PEEP	Parents Early Education Partnership [programme]
PFS	[JUMP-in] pupil follow-up system [the Netherlands]
PISA	Programme for International Student Assessment [study]
PPP	purchasing power parity
PNNS	Programme National Nutrition-Santé [France]
SD	standard deviation
SES	socioeconomic status
SGBII	Dritte Buch Sozialgesetzbuch II [Social Code Book II] [Germany]
SHE	Schools for Health in Europe [network]

SHS	school health service[s]
SWOT	strengths, weaknesses, opportunities, threats
UNCRC	United Nation's Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
WOŚP	Wielka Orkiestra Świątecznej Pomocy [Great Orchestra of Christmas Charity] [Poland]

## Foreword

*The population of children and young people up to age 18 in the WHO European Region is around 204 million. Most enjoy a high standard of health and well-being, with some countries in the Region having the lowest infant and child mortality rates in the world. The rate in other countries, however, is 25 times higher. This means that every year, more than 160 000 children in the European Region die before reaching their fifth birthday, 40% of them in the first month of life.*

*Children and young people represent the future of our Region: it is they who will drive the economies, create the prosperity and develop the conditions for healthy living on which Europe will depend as we progress through the 21<sup>st</sup> century.*

*As the new policy framework for health and well-being in the Region, Health 2020, explains, ensuring that children have the best start in life – through provision of good nutrition, immunization against vaccine-preventable diseases and access to environments that enable them to be safe and physically active – establishes a solid base for good health and contributes to healthy behaviour for years to come. Young people access new opportunities in education, social activity and occupation as they approach adulthood, but also face fresh challenges to their health and well-being status. Recognition of this is at the heart of the “life-course” approach advocated by Health 2020.*

*The case studies in these three volumes present a tool to support the implementation of Health 2020, taking their place among a range of interventions and resources being designed for this purpose. They describe how countries have used local, national and international evidence, partnerships and know-how to support children and young people at three vital stages of development – early years, childhood and school. The central pillars of Health 2020 – investing in health through a life-course approach, facing health challenges, strengthening health systems and creating suitable environments and resilient societies – feature large in the approaches adopted.*

*The case studies also have direct relevance to the European review of social determinants of health and the health divide. Some, such as the description of early childhood services and family support in Portugal, the National Nutritional Health Programme for children in France and innovative approaches to transforming school canteen meals in Denmark, will already be familiar to those who have read the review’s final report, although much more detail is presented here. Others will be new, but the areas of concern they address and the approaches they describe will be instantly recognizable to those who are familiar with the social determinants of health agenda.*

*The case studies in these three volumes provide vivid and memorable examples of innovative practice from countries across the Region that will inform and inspire policy-makers, practitioners, managers, educators and researchers at country and European levels.*

**Zsuzsanna Jakab**

WHO Regional Director for Europe



## Preface

The WHO European Region, like much of the world, is beset by significant inequalities in health outcomes. The extent to which people enjoy good health is dependent not only on individual characteristics and experiences, but also on their gender, ethnicity and socioeconomic status, on where they live, on the resources available to their countries and on the global forces that help shape what happens locally. In other words, there are significant “social determinants” of health inequalities which – in principle at least – national policy and frontline practice can help to address.

The WHO Regional Office for Europe has commissioned a European review of social determinants of health and the health divide, chaired by Sir Michael Marmot, to explore how these social determinants work and, more particularly, how they might be tackled. The case studies published here arise from the work of the Early Years, Family and Education task group, one of a range of such groups contributing to the European review.

What happens in childhood has a profound effect on the lives of adults. In particular, health outcomes are shaped by the circumstances in which children grow up, the extent to which their families can offer them a nurturing environment and the experiences they have in and out of the home, including preschool and school. The job of the task group was to explore what policy-makers, practitioners and community groups can do to ensure that all children grow up in the most supportive environment possible, so that inequalities in childhood are addressed before they translate into inequalities in health outcomes.

There is a substantial research literature in this field, and many transnational organizations have produced their own (more-or-less) evidence-based reports on how childhood inequalities might be tackled. Research evidence and generalized guidance, however, always need to be translated into local contexts: what works in one place may not be so effective – or, indeed, may not be possible at all – somewhere else. This is particularly true in the European Region, where the 53 Member States offer a highly diverse range of contexts in terms of social structure, culture, political environment, availability of resources, policy frameworks and professional skill levels. Locally developed initiatives are in many cases more effective than imported solutions and may provide a rich source of ideas from which practitioners and policy-makers elsewhere can draw to develop their own provision.

With this in mind, the task group wanted to find out what promising practices were already emerging in European countries. We therefore commissioned experts in different parts of the European Region to write case studies raising issues around childhood and inequality in their contexts and describing initiatives to address them. Contributors were asked to identify developments they considered promising in their situation that would also have international resonance. They were asked to describe the issues these developments were aiming to address, how they were being led and operationalized, and what evidence of effects on child experiences, development and health was emerging.

The result is a diverse collection of case studies presented over three volumes:

- Volume 1. Early years
- Volume 2. Childhood
- Volume 3. School.

Some of the case studies deal with major national policy developments or offer an overview of the situation of children or policy frameworks. Others deal with specific national initiatives or with local projects driven by community organizations. A few deal with transnational initiatives and many with work based in and around schools. The choice of focus was left to authors, who were simply asked to share with the task group examples of the “best” their country had to offer. Readers therefore should not look to these case studies for a comprehensive overview of childhood and health in the European Region, but they will find a wealth of ideas that may help stimulate their own thinking.

There are some inevitable limitations in a collection such as this. We activated our own networks of childhood and health experts, trying to ensure we had coverage from different parts of the Region. Other experts in the same countries would quite possibly have chosen different foci for their case studies, and other networks would have involved other countries. We are particularly aware that our range was limited by the need for contributors to write in English, and that it proved easier to find contributors in the north and west of the Region than in the south and east. We are also aware – as were our contributors – that the availability of data and evaluation evidence differs widely from country to country and initiative to initiative. The combination of high-quality national monitoring data and properly funded, well-designed evaluations seems to be rare across the Region. Identifying key issues and determining the effectiveness of initiatives consequently relies on partial evidence and on practitioners’ expertise. But problems are usually too pressing for policy-makers and practitioners to wait until gold-standard evidence appears.

What the task group made of these case studies is set out in detail in evidence we submitted to underpin the final report of the European review of social determinants of health and the health divide, chaired by Professor Sir Michael Marmot. Not surprisingly, we point to the need for better evidence, but we also argue for cross-sectoral action, for the political will to make such action effective, and for high-quality staff to implement it. The recommendations we presented to the review are based in large part on what we learned from the case studies, which in turn will help readers contextualize the recommendations. Equally important, however, is what readers make of these cases and the ways in which they encourage them to think creatively about what might be done in their own situations.

Finally, we would like to thank all of those who made the publication of these case studies possible: Candace Currie (University of St Andrews, United Kingdom (Scotland)), Bjarne Bruun Jensen (Steno Health Promotion Centre, Denmark), and Edward Melhuish (Birkbeck College, London, United Kingdom (England)), who assembled and led the teams of authors; Philip de Winter Shaw (University of St Andrews, United Kingdom (Scotland)), who edited many of the case studies; Vivian Barnekow of the Regional Office, who oversaw the publication process; and, above all, the case study authors, who met our demands with unfailing patience to make their considerable knowledge available to a wider audience.

**Alan Dyson**

**Naomi Eisenstadt**

Co-chairs, Early Years, Family and Education task group

## Editors

### **Vivian Barnekow**

*Manager, Child and Adolescent Health and Development programme, the WHO Regional Office for Europe*

Ms Barnekow started her professional career as a teacher, completing postgraduate education in health promotion. She joined the Regional Office in 1994. Her main involvement for many years was with the European Network of Health Promoting Schools, where she was responsible for the technical secretariat. She is the WHO focal point for the Health Behaviour in School-Aged Children: WHO cross-national collaborative study (HBSC).

### **Bjarne Bruun Jensen**

*Professor in Health Promotion and Education, and Director, Steno Health Promotion Centre, Denmark*

Professor Bruun Jensen's research areas include conceptual development in health promotion and prevention, with a strong focus on action competence and participatory and innovative approaches. Recently he was one of the coordinators of the European Union-funded project "Shape Up – towards a healthy and balanced growing up". He has authored and edited many journal and book publications.

### **Candace Currie**

*Professor of Child and Adolescent Health, School of Medicine, University of St Andrews, United Kingdom (Scotland)*

Professor Currie directs the Child and Adolescent Health Research Unit and is HBSC international coordinator. Her research interests are in social inequalities in adolescent health and developmental aspects of health during adolescence.

### **Alan Dyson**

*Professor of Education and Co-director of the Centre for Equity in Education, Manchester Institute of Education, University of Manchester, United Kingdom (England), and Co-chair, Early Years, Family and Education task group*

Professor Dyson works in the field of educational disadvantage and inclusion, with a particular interest in community schools and in area-based initiatives. He is currently working with Save the Children on the development of a series of "children's zones" in the United Kingdom.

### **Naomi Eisenstadt**

*Senior Research Fellow, departments of social policy and education, University of Oxford, United Kingdom (England), and Co-chair, Early Years, Family and Education task group*

Dr Eisenstadt was formerly a senior civil servant in the United Kingdom Government, where she was in charge of all early years, child care and family policy. She has authored a book on United Kingdom (England's) Sure Start programme and advises the governments in England and Scotland on early years and child poverty issues.

### **Edward Melhuish**

*Professor of Human Development, Birkbeck, University of London, and Research Professor, University of Oxford, United Kingdom (England)*

Professor Melhuish researches environmental influences upon human development using longitudinal studies. He has over 200 publications and has been an adviser to several government and nongovernmental agencies.

## Authors

### Volume 1. Early years

#### 1.1. Family support and early childhood education and care in Greece

**Konstantinos Petrogiannis** is associate professor of developmental psychology at the Hellenic Open University. His research includes early child care and education, parent–child relationships, children’s resilience and socioemotional development.

**Thalia Dragonas** is professor of social psychology at the Department of Early Childhood Education, National and Kapodistrian University of Athens. Her research includes psychosocial identity and intergroup relations, intercultural education and ethnocentrism, promotion of early psychosocial health, transition to parenthood and construction of fatherhood.

#### 1.2. Early childhood services and family support in the Netherlands

**Paul Leseman** is professor of education at Utrecht University and a researcher in early childhood education and care and family support. He is undertaking a national cohort study of the effectiveness of provision for young children. His publications focus on language development, multilingual development, emergent literacy and mathematics, and effectiveness of preschool education and care.

**Micha de Winter** is professor of education at Utrecht University. He researches youth (health) care, family support and school-based programmes for social development. He is the author of books on citizenship development and is an adviser to the government on youth health care and to The United Nations Children's Fund (UNICEF) on refugee children.

#### 1.3. Early childhood services and family support in Portugal

**Maria Emília Nabuco** has recently retired as a professor at Lisbon School of Education. She is president of the Association Aprender em Parceria [Learning in Partnership Association] and has undertaken research on parental support in Portugal.

**Claudia Costa** is a psychologist and lecturer at the Lisbon School of Education and has undertaken research on early childhood and parent support for disadvantaged families.

#### 1.4. Well-being of preschool children in Sweden – the role of early childhood education and free health care

**Ingrid Pramling Samuelsson** is professor in early childhood education at the Department of Education, Communication and Learning at Gothenburg University. Her research concerns young children’s learning and curriculum questions in early years education. She has a United Nations Educational, Scientific and Cultural Organization (UNESCO) Chair in early childhood education and sustainable development and is World President for the Organisation Mondiale pour l’Éducation Préscolaire.

**Sonja Sheridan** is a professor in education at the Department of Education, Communication and Learning at Gothenburg University. Her research includes quality issues and children’s learning, and teacher competence in preschool. She has undertaken several research projects and has been employed as a consultant by the Ministry of Education and Science on the revision of the Swedish preschool curriculum, and as an expert for the Organisation for Economic Co-operation and Development (OECD) and the Norwegian Agency for Quality Assurance in Education.

**Margareta Blennow** is a paediatrician and head of child health services in southern Stockholm County. She has served as president of the Swedish Paediatric Society and chaired the Stockholm Advisory Committee on Paediatrics and Child Health. Her research areas concern vaccinations and the effect of outdoor environment in preschools on the health and well-being of children.

#### 1.5. Developments in early years services in United Kingdom (England)

**Naomi Eisenstadt** was a civil servant in the Department for Education from 1999 to 2006 and was the senior officer in charge of many of the developments described in the case study.

**Edward Melhuish** is a research professor in human development at Birkbeck College, University of London and the University of Oxford. He has over 200 publications and his work has had substantial impact on policy for early childhood services in the United Kingdom and other countries.

## Volume 2. Childhood

### 2.1. The role of health education in addressing the health divide: evidence from two European health-promotion projects employing a participatory and action-oriented education approach

**Venka Simovska** is professor in health education and promotion at the Department of Education, Aarhus University. She is research director for the programme on “Learning for care, sustainability and health” at the department and leader of the research centre “schools for health and Sustainability”. Professor Simovska has published extensively in the field of school-based health promotion and health education. Her latest publications discuss research findings from the Shape Up project, featured in the case study.

### 2.2. Socioeconomic, education and family-related determinants of health and development of Armenian children and adolescents

**Sergey Sargsyan** is associate professor of paediatrics at the Medical University and Head of the Institute of Child and Adolescent Health at the Arabkir Medical Centre. He is WHO Health Behaviour in School-aged Children (HBSC) study principal investigator for Armenia, director of the “Healthy start” programme on child development and rehabilitation of the Arabkir Medical Centre and Vice-president of the Armenian Paediatric Association. He has participated in many activities and programmes in Armenia in relation to policy development, control of acute respiratory infections, health education, child immunization, health statistics, adolescent health and child advocacy and protection since the early 1990s.

**Marina Melkumova** is an adolescent health specialist at the Arabkir Medical Centre–Institute of Child and Adolescent Health (Arabkir MC–ICAH) and HBSC deputy principal investigator.

**Eva Movsesyan** is a coordinator of public health programmes and an active member of the HBSC team. Dr Movsesyan and Dr Melkumova also participated in most key developments in Armenia in relation to adolescent health, policy development and public health interventions.

**Ara Babloyan** is professor at the Medical University, Head of Department of Paediatrics and Paediatric Surgery and Scientific Head of the Arabkir MC–ICAH. He is also a consultant for the HBSC team and a member of the National Assembly of Armenia, where he is Head of the Parliamentary Commission on Health, Mother and Child Issues. He is President of the Armenian Paediatric Association and chief consultant to the Ministry of Health; he was Minister of Health from 1992 to 1997. He has been actively involved in the most significant health sector programmes in Armenia since the 1990s in relation to policy development and implementation, health care system reform, health financing and child and adolescent health. Currently, he is a member of the Executive Board of WHO.

### 2.3. The nutrition policy framework in France

**François Beck** is a statistician and sociologist who heads the Survey and Statistical Analysis Unit at Institut National de Prévention et d'Éducation pour la Santé [National Institute for Prevention and Health Education] (INPES) and is a researcher in the Cermes3, a sociology unit of Sorbonne Paris Cité (Paris Descartes University/CNRS UMR 8211/Inserm U988/EHESS). He is the principal investigator for the French Health Barometer survey.

**Emmanuelle Godeau** is a public health professional. She belongs to the Ministry of Education and to a research unit (UMR INSERM U1027, research team on perinatal epidemiology and childhood disabilities and adolescent health, University Paul Sabatier, Toulouse) where she works on the health and health behaviours of adolescents with a focus on special-needs students. She has been the principal investigator for the French HBSC survey since 2000, working in close contact with INPES experts.

**Hélène Escalon** is an economist and head of study at INPES, where she works on nutrition and physical activity. She is the principal investigator for the French Nutrition Barometer survey.

**Pierre Arwidson** is a public health professional who is Director of Scientific Studies at INPES. He specializes in public health intervention evaluations and represents INPES in the main French public health commissions.

### 2.4. Overview of national health policy and interventions on reducing social inequalities in health in children and adolescents in Germany

**Veronika Ottova, Carsten Rasche and Ulrike Ravens-Sieberer** are researchers in the field of mental health, well-being and health-related quality of life, working at the Child and Public Health Research Unit at the University Medical Centre Hamburg-Eppendorf, headed by Professor Dr Ravens-Sieberer. The research unit is involved in several national and international projects, including the BELLA study, a large representative study of mental health and well-being in children and adolescents in Germany, and the WHO collaborative HBSC study. The research unit has been involved in past WHO/HBSC forums on social cohesion for mental well-being and socio-environmentally determined health inequities.

### **2.5. Progress in implementing the national child and youth safety action plan in Hungary**

**Gabriella Páll, Ágota Örkényi, Emese Zsíros, Ildikó Zakariás, Dóra Várnai and Ágnes Németh** work for the National Institute for Child Health, a governmental organization coordinating the national infant and child health programme and child and youth safety action plan, supported by the Ministry of Health. It also coordinates the Hungarian HBSC survey, through which it is able to focus on investigating and analysing the prevalence and determinants of medically treated injuries in adolescents in line with the priority of child safety.

### **2.6. The development and use of a set of children's well-being indicators in Ireland**

**Michal Molcho** is a university lecturer in the Discipline of Health Promotion, School of Health Sciences, and a researcher in the Health Promotion Research Centre at the National University of Ireland, Galway. She has been a member of the HBSC study since 1997 and co-authored two of the “state of the nation's child” reports that are among the outcomes of the children's well-being indicators discussed in the case study.

### **2.7. Actions to equalize social and health opportunities in Norway through schools**

**Oddrun Samdal** has worked at the Research Centre for Health Promotion at the University of Bergen since 1993. She has collaborated with national health and education authorities and governments throughout her academic career, starting when the ministries of health and education asked the research centre to be the coordinating centre for the Norwegian part of the European Network of Health Promoting Schools. Professor Samdal was selected to be the national coordinator for the project and worked closely on planning and implementation with the ministries for 10 years. She was a member of the first national board for physical activity between 1999 and 2007 and sat on the committee that evaluated school meal arrangements in 2004/2005. Her role as Norwegian principal investigator for the HBSC study and her responsibility for several evaluations of school-based interventions means she is constantly in dialogue with national authorities, providing inputs on policy developments. She was recently part of an advisory group on how to promote daily physical activity in school.

### **2.8. Improving education and health outcomes for children with chronic disease in Poland – from social campaigns to systemic changes**

**Joanna Mazur and Agnieszka Malkowska-Szkutnik** work at the Department of Child and Adolescent Health, Institute of Mother and Child in Warsaw. They authors have been conducting research on chronically ill children's functioning in school environments for several years and participate in planning and implementing new intervention programmes and contributing to expert teams, including those dealing with issues of inequality.

## **Volume 3. School**

### **3.1. MOVE: motivating brief interventions for young people at risk in Croatia**

**Ivana Pavic Simetin, Iva Pejnovic Frelentic and Marina Kuzman** work in the National Institute of Public Health, Zagreb. Dr Kuzman is also on the staff of the University of Applied Health Studies, Zagreb.

### **3.2. Building capacity for health-promotion activities in schools in Cyprus**

**Soula Ioannou** is coordinator of school health programmes and **Andreas Kleanthous** works at the department that grants funds for schools' health promotion activities, both in the Health Education Office, Ministry of Education and Culture in Nicosia. The Health Education Office is responsible for developing and coordinating policies, actions and programmes that foster students' well-being. The main task is to encourage schools to adopt a more structured approach to promoting healthy behaviours, including paying attention to the roles of social, cultural and physical environments in influencing students' well-being. The strategies used for empowering the health promotion approach are described in the case study.

### **3.3. Can school meal provision contribute to the reduction of social inequalities in health and improve learning outcomes? The case of Sweden and Denmark**

**Bent Egberg Mikkelsen** is professor and research coordinator of the Meal Science and Public Health Nutrition Research Group, Denmark.

### **3.4. Promoting social, emotional and physical well-being, child participation, educational attainment and parent engagement in later childhood – the Finnish perspective**

**Kerttu Tossavainen** is head of the Schools for Health in Europe (SHE) research group in Finland and a member of the SHE research core group. She is responsible for Master's-level teacher education in health sciences (nursing science as a main subject) at the University of Eastern Finland and supervises PhD students. She chairs the board of directors of the Finnish Health Association and is a member of the scientific committees

of the Finnish Centre for Health Promotion and the Mannerheim League for Child Welfare. She is an associate member of the Finnish matriculation examination board in health education, led by the Ministry of Education and Culture, and a member of the board that plans, implements and evaluates basic and advanced-level health education and health promotion studies at the Open University of the University of Eastern Finland. Her work has been instrumental in ensuring the inclusion of health education as an independent subject in the national curriculum for basic education.

**Hannele Turunen** is a senior researcher in the SHE research group in Finland and a member of the SHE research core group. Like Professor Tossavainen, Professor Turunen is responsible for Master's-level education in health sciences (nursing science as a main and leadership and management as a secondary subject) at the University of Eastern Finland and is a supervisor for PhD students. She is also a member of the administrative board at the university's Faculty of Health Sciences, an associate member of the Finnish matriculation examination board in health education and a member of the board that plans, implements and evaluates basic and advanced level health education and health promotion studies at the Open University of the University of Eastern Finland.

### **3.5. Vocational college health promotion pilot project experiences in Finland, 2008–2011**

**Maria Leppäkari** and **Bengt Lindström** work for Folkhälsans Förbund, Helsinki, a Swedish-speaking nongovernmental organization that has been active in the social welfare and health care sector in Finland since 1921. It performs scientific research and provides services, information and counselling to promote health and quality of life.

### **3.6. "Learning to live better together": enabling schools and communities to implement a health promotion policy and minimize health inequalities in France**

**Didier Jourdan** is professor at the University Blaise Pascal in Clermont-Ferrand, France. He is Vice-president of the Commission on Prevention, Education and Health Promotion of the French High Council for Public Health.

### **3.7. Joint development of healthy schools in Germany**

**Merle Strigl**, **Elena Burrows**, **Ina Cramer**, **Silke Rupprecht** and **Katrin Schwarzenberg** are research assistants at the Centre of Applied Health Sciences at Leuphana University, Lüneburg. They were part of the team for the nationwide project "Developing healthy schools together".

### **3.8. Reducing health inequalities in schools in Italy**

**Francesca Ramondetti**, **Nicolò Lanati**, **Maria Sacco** and **Alessia Varetta** are physicians specializing in hygiene and preventive medicine at the Community Medicine Research Centre for Human Health Promotion, Department of Public Health and Neurosciences at the University of Pavia.

**Marisa Arpesella** is Dean of the Research and Study Centre in Community Medicine for Human Health Promotion at the University of Pavia and coordinates the team.

### **3.9. Health-promoting schools in Lithuania**

**Aldona Jociūtė** is an associate professor and researcher at the Mykolas Romeris University in Vilnius and has been national coordinator for health-promoting schools in Lithuania for over 10 years. She is a member of the international planning committee for the SHE network, of the panel of judges for the national competition for young scientists and of the commission that accredits health-promoting schools.

### **3.10. JUMP-in: promoting daily physical activity in the Netherlands**

**Judith de Meij** is senior health promoter of the Epidemiology, Health Promotion and Documentation cluster of the Municipal Health Service of Amsterdam and team leader of youth health promoters in the field of healthy nutrition and physical activity.

### **3.11. Reducing child obesity: assessment of a school-based intervention in Spain**

**Esteve Llargués Rocabrúna** is director of internal medicine and specialties, Granollers General Hospital.

**Pierre-Antoine Ullmo** is the founder of P.A.U. Education, a Barcelona-based entity that designs educational projects based on participatory schemes and community-building processes. He co-designed the Shape Up project that is recognized as a European good-practice exemplar in the field of health education.

## Early years: introduction

*Edward Melhuish*

*Birkbeck College, London, United Kingdom (England)*

There is now evidence of the importance of early years for better outcomes across the life-course, and evidence concerning what needs to be in place to ensure that all children get the best start in life. Examples of such evidence are given in the chapters from United Kingdom (England), Greece, Sweden, Portugal and the Netherlands.

The provision of early years services in United Kingdom (England) has been transformed since 2000. Two approaches seem to have worked particularly well: bringing together early education and child care provision, and service integration across agencies. In common with several Mediterranean countries, “familism” is central to Greek social structure, which is struggling between “familism” and the transformations of late modernity. The case study from the Netherlands highlights important issues about implementation and efficacy of services. Long-term developments in Sweden reveal the importance of striving for equality and equity, with the state sharing responsibility for children with parents. Experience in several countries, including Portugal, shows the great need to prevent and fight social, educational and health problems from birth and possible strategies.

While most nations generally agree on education for children from around six years there are massive cultural differences in attitudes about the role of the state, women working, time in child car, and fathers’ role in caring for children. Some basic features of a good system for young children that can improve child outcomes in health, education and socioemotional development across the life-course can nevertheless be identified.

- A universal, high-quality, affordable, early education and care system is the essential bedrock in levelling-out the vast social class differences in school attainment. An excellent system that is only available to better-off children will exacerbate rather than reduce class differences in outcomes.
- Accessible and affordable perinatal services are also essential. Quality of care during pregnancy will improve the chances of a healthy birth, and good birth experiences reduce the chances of postnatal depression.
- Service integration through co-location, sharing of data about families, joint budget arrangements or locality team arrangements help to make services more accessible to the widest range of families.
- Family support is essential. Informal culturally sensitive advice and support alongside more formal, highly structured programmes will enable the targeting of more intensive support to the families who are finding things difficult, while helping to reduce the possible stigma associated with the acceptance of support in parenting.
- Family income is a critical component in stress. An integrated approach that looks at parental leave arrangements, the availability of child care at particular ages and stages, the systems of social benefit supports (including cash transfers and the myriad of other policy areas that support parental employment and progression in work) all need to be seen together.



## 1.1. Family support and early childhood education and care in Greece

*Konstantinos Petrogiannis,<sup>1</sup> Thalia Dragonas<sup>2</sup>*

<sup>1</sup>*Hellenic Open University*

<sup>2</sup>*National and Kapodistrian University of Athens*

### Context

Early childhood care is intricately connected to family characteristics, welfare performance and labour-market opportunities. Vogel (1) grouped European countries into three clusters based on these variables: Scandinavian/Nordic, central European and southern/Mediterranean. Greece belongs to the last cluster.

“Familism” has always been a core component of the Greek social structure, as it has in other European Mediterranean countries (Italy, Spain and Portugal). It implies strong family ties, an increased sense of intergenerational obligation and family as the primary locus of social solidarity (provision of care and support) and productivity (economic activity within family businesses). Characteristics that distinguish countries in the Mediterranean cluster from those in the other two include:

- the male breadwinner enjoying higher employment protection and job stability than other labour-force groups, such as women and migrants;
- residual social assistance schemes;
- child care and care for older people being provided mainly by family; and
- relatively underdeveloped unemployment compensation and vocational training systems and welfare institutions (2).

Greece has moved from an agrarian to a late-modern society over 50 years – a much shorter period than other western countries. This has had important influences on the norms, values and ideals structuring family life and on political rhetoric and policy-making (3). The three phases of traditional, modern and late-modern family are not clearly distinct: characteristics of one phase spill over to the next. Typically, however, norms and values were clear-cut in the traditional, patriarchal family of the 1950s. Extended households were common and kin group and community were interdependent, reinforcing collective living. The driving force for marriage was reproduction rather than emotional closeness or sexual satisfaction. Men’s and women’s roles were well defined, separate yet complementary, each one striving, from his or her position in the public or private sphere, to ensure the survival of the family group. Child care was provided not only by natural mothers but also by multiple “mother figures” either in the household or community.

The extended family gave way to the nuclear family, with a highly child-centred approach. Gender roles remained separate but instead of being complementary, as was the case in the traditional society, they developed inequitably. The new family structure continued to promulgate an ideology that located women in the private sphere and men in the public. Women may have started to get paid jobs, but their primary responsibility remained housework and child care. They also started losing support from the extended family. Legislation on many areas of family law in the mid-1980s introduced gender equality between spouses during and after marriage and protection of children’s rights. The legal

framework was progressive at the time but was not always concordant with the realities of family life.

### **The Greek family today**

The transformations of late modernity, in which fluidity, contradictions and uncertainty prevail, have brought many changes to today's Greek families. No single coherent set of ideas informs everyday practice: instead, there are sets of conundrums. Different discourses concerning "the family" have surfaced, idealizing the "traditional family" and lamenting its loss, directing concern to disaggregation of family members as the primacy of the family unit diminishes, and recognizing their different needs and interests.

Change in family structures can be illustrated through decreased numbers of marriages and declining birth rates and increased rates of divorce, cohabitation, one-person households, lone parenthood and reconstituted families. The crude marriage rate (the annual number of marriages per 1000 population (4)) has fallen by 22% since 1970 (7.7% in 1970 to 5.5% in 2007) and the divorce rate has grown by 8% (which, although increasing, remains lower at 12% than the European Union (EU) average of 24%). Births outside marriage attributed to cohabiting couples and lone parents have increased, but at 5.8% are the lowest in the EU (births outside marriage account for most live births in northern European countries). Equally low is the proportion of single-parent households (2% compared with the EU average of 4%). Postponement of motherhood is an important trend, with the mean age for childbearing being 30.7 (among the highest in the EU) and the fertility rate 1.41 (lower than the EU average of 1.55). Today's family has reduced in size and the average household is very close to the European average (2.5 people per household) (5).

Greek society has seen rapid sociocultural change and today's family is emulating transformations in countries belonging to the Scandinavian/Nordic and central European clusters. Yet Greece has lower divorce rates, fewer consensual unions, a lower proportion of births outside marriage and fewer lone parents than the other two clusters. The nuclear family is prevalent and its size is shrinking, but research evidence shows that the family unit is still part of a wider network that covers many family needs and contributes actively to everyday life. Lone-parent families with the lowest personal incomes are most likely not to feel isolated and to benefit from other household resources (6).

### ***Child care and paid work***

The rise of female employment is a significant development affecting family life. Combining child care and paid work is a big challenge for men and women. Children demand time, care and labour, but their caretakers require resources to maintain themselves and their dependents.

Women's employment has risen by 6.9% in the last 10 years but still lags behind the EU average (48.7% as opposed to 59.1%) and remains more than 20% lower than that of men. Part-time employment is among the lowest in the EU, with women being far more likely to have a part-time job. Women's share of part-time work in 2008 was much higher than the EU mean (31% versus 10%).

Unemployment is higher among women, with a gender gap of 6% in 2008 (5).<sup>1</sup> The gap between female employment in Greece and the rest of the EU is particularly great for mothers

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<sup>1</sup> Reliable figures concerning employment status in the current economic situation do not exist: the situation has probably worsened for women.

looking to return to the labour market when their children have reached school age. According to data from the EU labour force survey, the employment rate for women aged 25–49 living in partnerships and with children aged 0–2 is less than 54%, barely rising to 55% for those with children aged 3–5 and to 60% with 6–11-year-olds: the EU averages are 58%, 66% and 71%, respectively. The employment rate for single women is quite close to the European mean (83% versus 84%), but Greece lags behind other EU countries (and behind the Lisbon targets) on employment for mothers, especially in relation to slow return for those previously employed and to those dropping out the labour market altogether (7).

Probably the largest single factor influencing the experience of mothering and fathering is the way the combination of paid work and child care is organized. Women, far more than men, are confronted with the problem of reconciling the pursuit of a working career with caring responsibilities. While a significant number of men spend time looking after children, this does not seem to interfere in a perceptible way with their jobs. Women in Greece are more than twice as likely to be involved in looking after children and spend much more time doing so, yet spend less time looking after children than women in Nordic/Scandinavian cluster countries such as Finland. Greek women aged 20–49 spend just 35 hours per week on child care, while their Finnish counterparts spend well over 50. The average hours spent looking after children by women aged 50–64, however, is far greater than that in Finland, meaning that more grandparents are involved (8). As a rule, the way in which women reconcile paid employment with caring responsibilities is by working part time, but as has already been shown, there are far fewer opportunities for part-time jobs for women in Greece than for those in most EU countries.

Another important family measure in reconciling career and family is maternity/paternity leave. Differences exist between public and private sectors in this area, with the former having a more generous leave policy. The right to maternity leave with full pay (first enacted in 1981) is 17 weeks in the private sector and 20 in the public, while paternity leave is limited to 2 and 5 days (respectively) upon the birth of a child.

Mothers in the public sector have two options in relation to working-time arrangements and child care leave. They are entitled to work two hours fewer per day until the child becomes two and one hour fewer until he or she turns four, or may choose to take nine months continuous leave with full pay after the birth of the child. The measure is less generous in the private sector. Parental leave is without pay and ranges between three and a half months until the age of three in the private sector to two years until the age of 6 in the public. In the vast majority of cases, mothers opt to take this leave, confirming the entrenched sexual division of labour (3).

Satisfaction levels for combining paid work and child care are reported to be very low. Only 13% claim to be pleased with the way this compromise is managed, against 40% in the rest of the EU. Frustration is encountered through long working hours, lack of child care services and work practices that are not family-friendly. While research from the 1990s suggested that men (unlike women) did not experience conflict in combining employment with parental duties, men in the 2000s tended to share the same feelings of aggravation and to report the same, if not higher, levels of frustration (9).

### ***Family and social policy measures***

Family and social policy measures in Greece are indirect in the sense that they target the individual rather than the family (10). Benefits directed towards families and children are

lower than the European average, constituting 6.2% of total social benefits and 1.5% of gross domestic product (GDP) in 2007 (EU means were 8% and 2% respectively). Differences with Scandinavian/Nordic cluster countries such as Denmark, where 3.7% of GDP is directed towards family and child benefits (5), are huge. Interestingly, while material deprivation (defined by living conditions affected by level of resources) in most EU countries is higher for children (aged 0–17) than for the whole population, Greece is among the exceptions (5). This may be explained by the child-centredness of the Greek family and its tendency to devote resources to children.

Despite relatively high economic growth in the post-war years, the welfare state has remained underdeveloped and families have had to compensate for inadequate state provision. Greece has a rather poor record in relation to measures that reflect the dominant tendency of family protection in EU countries, such as provision of child care and care for older people and those with special needs.

### ***Provision of early childhood care and education services***

Variety in early childhood care and education arrangements is limited compared to other European countries. Relatives and grandparents remain by far the most common option for “low or no-cost” in-home care. Parents have two potential alternatives: “babysitting/childsitting” in the child’s own home, or out-of-home group-based forms of care and education such as nurseries/crèches and kindergartens/pre-primary schools.<sup>2</sup> The former can prove difficult and frustrating because it is temporary, changeable and expensive, with no officially approved or registered babysitters. Many are unskilled, low-paid immigrant women hired to combine informal children’s care with domestic chores (11). No other forms of child care (such as childminders or family day care, au pairs, playgroups or organized family care) exist on any significant scale.

### ***Vrephonipiakos/pedikos stathmos [nursery/crèche/day-care centre]***

There are two basic types of extrafamilial early child care and/or education institutions (divisional system) within the private and public sectors. Vrephonipiakos stathmos [infants’ and toddlers’ centre/nursery] provides nursery care and education services for children from as young as 2–3 months (or 7 months in broader public sector nurseries) to 2½–3 years. Pedikos stathmos [children’s centre/nursery] provides similar care for children aged from 2½–3 years to compulsory school age (children enter the dimotiko scholeio [elementary school] in the year of their sixth birthday), providing early childhood care and education services. There are also nursery structures for both age groups.

These types of nursery have been available since the 1830s and the formation of charitable orphanages. A new era for public sector nurseries/crèches began in 1997 and grew gradually until 2004, when all existing and subsequent state nurseries were transferred from the Ministry of Health and Welfare to local authorities (municipalities) in an attempt to decentralize the administrative system and engage local communities. Nurseries are also provided by the private sector, companies, employee unions and nongovernmental organizations (NGOs).

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<sup>2</sup> “Nursery”, “crèche” and “day-care centre” are used synonymously in English-language literature on the early childhood care and education system in Greece. “Kindergarten” and “pre-primary school/class” are also used interchangeably.

### **Availability**

Figures on use are compiled from estimations from various sources as there is no official agency active in this field. There were approximately 1700–1800 nurseries/crèches in the private sector in 2005/2006 (Central Association of Municipalities and Communities of Greece–Hellenic Agency for Local Development and Local Government (KEDKE–EETAA), unpublished data, 2005). Average yearly total cost ranges from €3000 to €5500 depending on services provided. Public and private sector companies with 300 or more employees have 2 options under law: fund, establish and operate a day nursery for their employees (there are approximately 30–40 such centres) or negotiate with private nurseries to provide insured employees with access to child care services free of charge or at minimum cost.

KEDKE–EETAA estimated that 78 000 healthy children (aged 8 months to 6 years) were registered with nurseries in 2005 (KEDKE–EETAA, unpublished data, 2005). The latest EU Statistics on Income and Living Conditions (EU–SILC) data (7,12) based on the use of services available in 2006, show that the proportion of infants aged under 2 and not in child care was about 47% (46.5% in countries belonging to the EU after January 2007 (EU27)). Thirty-eight per cent were cared for only by their parents and 52% by grandparents, relatives, friends and babysitters. Only 10% were covered by formal centre-based child care arrangements (28% in the EU). Based on these figures, Greece is in eighteenth position in the EU27 (13), providing few formal child care facilities for children under 3 years. Underprovision of formal centre-based child care is still a problem for 3–5-year-olds. Use of child care services is the lowest in the EU27 at approximately 60%, with grandparents, relatives, friends and child sitters caring for 40%.

Ministry of Interior subsidies cover only basic operational costs. Pricing policies among local authorities vary considerably, leading to inequalities and contradictions (14). Some municipalities subsidize child care services fully, but most apply income-related fee structures (annual fees range from €50 to €1200) with priority being given to working mothers and socioeconomically disadvantaged families (such as single-parent, disabled-parent, large and immigrant families). The European Support Framework for 2011–2013 supports unemployed women to purchase care services with vouchers, which is expected to promote their employability.

### **Flexibility**

Public nurseries/crèches operate rigidly five days a week between 07:00 and 16:00. The timetable can be expanded by two hours if there are sufficient personnel and funding.

### **Staffing/training requirements**

Educators and nursery teachers in all nurseries/crèches are graduates from the three higher technological education institutes' departments of early child care and education, following a four-year degree programme that includes courses combining theory and practice. Gross minimum earnings are determined through collective agreements. Nurseries'/crèches' education programmes vary in activities and pedagogical orientation, as there are no central directives or curricular programmes.

Parents and educators attribute much importance to staff training (15–17), but there are few systematic in-service training activities funded by local authorities. A notable exception is the “Synergy” project (18), which was implemented in some Municipality of Athens nurseries in the mid-1990s following an action research programme. Despite its success, similar

approaches have not been recorded elsewhere in the country, with the exception of sporadic one- or two-day training seminars.

### **Regulation standards**

Private or organizational day-care centres must gain official approval from the local prefecture's department of social welfare. Ideally, a social worker from this department should visit every private nursery/crèche twice yearly to check the enforcement of quality standards, but this rarely occurs. No inspection mechanism exists for structures run by local authorities, rendering transparency and accountability questionable.

Most of the regulations governing the foundation and operation of public nurseries/crèches have been under each municipality's jurisdiction since 2003 (12). Operation standards mainly refer to nursery facilities' safety features, staff employed (tasks and qualifications), structural features such as child–staff ratios (defined as 1 educator and 1 assistant for up to 25 children for preschoolers (pedikos stathmos) and either 1 educator and 1 assistant to 8, or 2 educators and 1 assistant to 12, infants and/or toddlers), hygiene conditions and feeding arrangements. Headteachers' tasks are almost exclusively administrative.

### **Addressing specific target groups**

Of vulnerable groups in need of targeted action (19), young children from single-parent and large families and from socioeconomically deprived home environments (including legal immigrants) have placement priority in public sector day-care centres. Public sector provision of early childhood care and education services for children with special needs is nevertheless extremely limited; in the private sector, it is one of the most expensive services and is offered on a restricted basis. The creation of special classes for preschool children (8 months to 6 years) with special needs depends on local authorities' social policies and priorities.

### **Integrated infants'/toddlers' day-care centres**

Integrated early learning and child care programmes are becoming more prevalent internationally as part of the drive to offer more effective support for young children's development. They have been shown to produce beneficial outcomes for children's (20,21) but are extremely rare, principally due to lack of economic resources.

Centres were established in Greece under a 2002 law to provide additional segregated classes for disabled children from 2½ to 6½ years within formal day-care centres, delivered by specialist education staff. This measure goes against the principle of inclusion and children's right to share educational and communication experiences and activities with their peers. The institutions are run under the auspices of municipalities, with funding covered largely by the European Support Framework. The future of integrated nurseries is now uncertain due to a gradual decrease in European Community funds and the country's limited economic resources. At best, they are provided by only a small number of municipalities with support from specialist agencies or NGOs such as the Greek Society for the Protection of Autistic People and the Greek Society for the Protection and Rehabilitation of Disabled Children.

### **Evidence of quality**

There is recognition within the EU of the importance of high-quality early years care and education across Member States to promote children's growth, learning and development (22), especially those from deprived environments (23). Only a few, however, make the link between provision of preschool services and the quality of those services (24).

It is widely acknowledged that information on the quality of child care services in Greece is lacking (15,16,25–28), with inadequate encouragement or support for relevant research. The few research studies conducted from the late 1980s (29–33) through the mid-1990s (25,34) and early 2000s (17,27) to recently (35,36) converge on the following findings:

- there are differences between nurseries run by the various sectors;
- an average low-to-medium level of quality assessed by “global” quality measures such as the Early Childhood Environment Rating Scale;
- insufficient space and lack of appropriate buildings;
- emphasis on “minding” routines (cleanliness, safety and, in particular, nutrition); and
- problematic group sizes and child–educator ratios.

The last point about child–educator ratios may be related to another piece of evidence: early childhood educators are positive but may also exhibit an “authoritarian” style while interacting with children, probably to enforce discipline (15).

Despite some changes since the early 1990s that have aimed to support working families with very young children, early child care services have not developed sufficiently. It could be argued that the whole system of early care and education provision suffers from haphazard and poor regulation and that lack of resources is indicative of the low priority given to these structures. The new decentralized local administration system should look into the issue of early childhood care and education philosophy afresh and improve the level of care provided by introducing quality standards and evaluation procedures, developing curriculum guidelines, offering continuous in-service training for all educators and promoting good relations between services, parents and local communities. Adequate funding is a prerequisite, but is a difficult issue in the current economic crisis.

### ***Nipiagogeio [kindergarten/pre-primary school]***

Nipiagogeio [kindergarten] is a pre-primary school structure for children aged 4 to 5 years (pronipia) and, principally, 5 years to compulsory school age (nipia). Kindergartens have maintained an exclusively educational orientation since their creation in the 1830s.

Private and public kindergartens operate under the supervision of the Ministry of Education. The school year begins in early September and ends in late June. Until 1997, all public kindergartens operated from Monday to Friday between 08:30 and 12:15 (half-day schedule), an extremely gender-equality and employment-unfriendly timetable for families, often compelling them to seek provision in the private sector.

### **Olohimero nipiagogeio [all-day kindergarten]**

All-day kindergartens were introduced in 1997, expanding the daily schedule from 07:45 to 16:00. All-day kindergartens aim to:

- improve preschool education, providing children with a well-rounded preparation for primary school;
- reinforce the state’s role in eliminating educational and social inequalities by offering education to all children in the country; and
- support working parents.

All-day classes run alongside a reduced (“classic” or half-day) schedule in the same kindergarten. Children may attend the all-day schedule at their parents’ request.

They are very popular among parents, but concerns have been expressed about the risk of all-day kindergartens turning into “care centres” and losing their educational character (11). Other problems have been cited in relation to the lack of suitable infrastructure, child–teacher ratios, inability to meet all the needs of younger children (4–5 years) and lack of support from school counsellors (37–39).

### **Compulsory preschool education**

A second important change took place in 2006, with a law that defined compulsory preschool education for children aged 5 and 6 years. Multiple problems were experienced in the first year of implementation: insufficient planning meant inadequate infrastructure was in place, especially in urban areas. The government consequently permitted public and private nurseries to increase their capacity by creating kindergarten classes in the same premises, with the stipulation that the educator in charge of curriculum implementation should be a graduate of a university department for kindergarten teachers.

### **Availability**

There were 5901 kindergartens with more than 90 000 preschool children aged 5–6 years and approximately 47 000 4–5-year-olds in the academic year 2009/2010. Forty-nine per cent (2898) offered all-day classes, with 34% of children attending.

### **Regulation standards and curriculum**

Training of kindergarten teachers (organization, duration and content) and the structure and operation of primary and preschool education were set out in law in 1985. The legislation defines operational standards for private kindergartens in great detail.

Kindergartens implement the preschool curriculum. The current version, which takes an interdisciplinary approach to teaching that includes “flexible zones of interdisciplinary and creative activities”, was developed in 2000/2001. The “innovative interventions in all-day kindergartens” scheme was developed in 2007, aiming to ensure a smooth transition to primary school through activities such as projects and educational visits to places of cultural interest and the community.

### **Staff training**

Teaching staff and the legality of labour contracts are decided and defined centrally by the Ministry of Education. Only university graduates can be hired as educators for the curriculum in all types of kindergartens and in kindergarten classes in nurseries. Nine university departments of early childhood education offer the four-year programme. Kindergarten teachers can participate periodically in national-level in-service training programmes. Some training activities funded from various European schemes have been implemented in the last few years at regional and national levels.

### **Addressing specific target groups**

Promoting educational opportunities for children from ethnic, cultural and language minorities has been a priority for over 10 years, but due to political, social and economic reasons, minority children attend preschool settings less frequently.



There were 81 special education kindergartens in 2004, representing 6.8% of special education structures for all levels of education (40), but a new law on special education introduced in 2008 makes little provision for required measures at preschool level and none at all for early prevention, which is a very important stage for some children with disabilities.

### **Research in early childhood education**

Education research, particularly in the field of early childhood education, has been slow to emerge. According to some experts (16,41,42), a variety of events and conditions is responsible for this late development, including:

- bureaucratic division of early education and child care;
- policy-makers' lack of interest in preschool care and education;
- relatively recently established studies in education and teacher training at university level;
- lack of graduate studies in education since they were officially endorsed in the 1990s;
- nonexistence of psychology departments until the early 1990s;
- a weak research tradition that adversely affects the development and use of education research;
- very weak links between education research and policy; and
- long-term underfunding of education, social sciences and research in general.

### ***Centres for creative activities for children***

Relatively recent ministerial acts have aimed to reconcile work and family life for parents with preschool and school-aged children (5–12 years). The acts provide for “afterschool education services” through creative activities such as theatrical play, music, dance and painting to promote children’s psychosocial development. There are now 240 such centres nationwide with approximately 20 000 children, run by municipalities with approval from departments of social welfare of the local prefectural authority. They are financed partly by national sources but principally through EU funds.

The regulations define a ratio of 2 specialist members of teaching staff (such as kindergarten or primary school teachers or teachers of physical education, music, art and crafts) per 25 children. Subscription criteria allow priority to children from disadvantaged families. Most services are free of charge, but some involve a small fee.

There are also 34 facilities for disabled individuals from 7 to 25 years, but it is highly probable that they will have to close due to severe underfunding.

### **Conclusion**

As part of the EU, Greece has followed standards and has implemented measures to upgrade the profile of social care, such as:

- increasing parental benefits and leave, although there are considerable differences between private and public sectors and levels remain very low compared to other European states;
- transferring nurseries/crèches from the central state to local authorities between 1997 and 2003;
- increasing the number of nurseries/crèches through European Support Framework programmes, although there is still insufficient coverage of publicly funded early

childhood care and education services, especially for those under three years and for children in the preschool age range with special needs and disabilities;

- making preschool education for children aged 5 and 6 years compulsory, although social demand to extend public kindergarten capacity generated difficulties during implementation, with particular problems for disabled children; and
- establishing all-day kindergartens to provide an extended programme from 08:00 to 16:00 – despite parents’ favourable attitudes, all-day kindergartens still lack adequate infrastructure, quantitatively and qualitatively.

The short and rigid operating hours of nurseries/crèches and kindergartens and the long summer recess oblige parents to combine formal child care in education settings with support from others, usually grandparents or a woman hired to assist the mother in childminding and domestic work (43). Due to the strong family ties noted above, parents have been trying until recently to avoid outside care, with a child’s attendance at a day-care centre meeting with disapproval, especially for children under one year (44).

The division between “education” and “care” that was devised under certain historical and socioeconomic conditions still exists, affecting pedagogical practice and young children’s learning experiences and opportunities.

Early childhood care and education services have been expanded since the mid-1990s using European Support Framework funding resources to create new public infrastructure. Subsidies from the state budget are required, however, to maintain service capacity. Current fiscal pressures on Greece may have negative effects on operational costs and retention of personnel in the coming years.

The lack of quality assessment of provision of care represents a serious shortcoming. The few research studies undertaken since the early 1990s (for a review, see Petrogiannis (45)) indicate deficiencies in some quality characteristics, particularly in nurseries/crèches. “Good” early childhood care and education provision requires constant reassessment. In an era of dramatic demographic and sociopolitical changes across Europe, policy-makers need to base changes in early childhood care and education on relevant, research-evidenced knowledge that indicates how service provision could work to optimize child development. Despite some successful research endeavours, there have been disconnects in reflecting new knowledge within the mainstream of early childhood care and education and family/social policy.

The early childhood care and education system needs to be organized systematically with clear targets. It must be up to date to provide the right experiences to meet children’s needs.

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## 1.2. Early childhood services and family support in the Netherlands

*Paul P.M. Leseman, Micha de Winter  
Utrecht University*

### Context

The Netherlands has a population of almost 17 million, of whom 2.5 million are aged 0–12 years, 1.2 million 0–6, and 800 000 0–4. It is fifth for overall population happiness according to a recent Gallup poll, tenth on the list of the world's wealthiest countries and had the sixteenth largest economy in the world in 2009.

Official national criteria based on parents' education level (junior vocational training at best) show that 15% of 0–6-year-olds are considered socioeconomically disadvantaged and eligible for special programmes to increase developmental outcomes and educational opportunities. Wider criteria are used in most of the bigger municipalities, with not having Dutch as the first language being among the disadvantage factors. On these wider criteria, about 20% of 0–6-year-olds can be considered educationally at risk.

The overall structure of the system of early childhood services and family support in the Netherlands can best be described along vertical and horizontal axes. Vertically, the system can be divided in two phases: the preschool phase (0–4) and the primary school phase (4–12), including two years of kindergarten (4–6). The horizontal axis can be divided by sectors governed by different national ministries and local authorities. These sectors, which operate under different regulations and legislation and are financed in different ways, are: youth health care sector; youth care sector (including mental health care and justice sector involvement); education sector; social welfare sector; and the partly private, partly public day-care and childminding sector.

Two main questions stand out in the current system: how can childhood outcomes in health, mental health and education be improved and equalized in a more effective and efficient way; and how can the different sectors and subsystems achieve improved coordination and integration to save costs and increase efficacy? Significant budget cuts have been announced in all sectors recently alongside further decentralization of youth care from national to municipal level.

The nature and structure of the system for 0–6-year-olds will be described by dividing services and institutions into the main subsystems: youth health care; youth care, preventive youth care and family support; universal early childhood education and care; and targeted education programmes for disadvantaged children and families.

“Universal” in this context means that services are in principle accessible to all normally developing children and their families, but additional constraints may reflect the child's age and parents' occupational status. No medical, psychological or judicial grounds for placement are involved. “Special” education and care involves a medical, psychological or judicial indication. As a rule, children are referred to these services by professionals. Access to “targeted compensatory” education is based on socioeconomic or ethnic criteria (seen as measures of social disadvantage) or on the presence of specific risk factors for educational

failure (bilingualism, single parenthood, family illiteracy, travelling families, refugees). The term “universal prevention” is reserved for those services that serve in principle the whole population of families with young children to prevent medical and psychosocial problems. Although accessible to the whole population, services are sometimes offered only on request and may be limited to specific age groups. Finally, “child protection” and “specific prevention” of juvenile delinquency refers essentially to the involvement of the justice sector in early childhood.

## **Approach**

### ***Public health care for children aged 0–6 years***

The backbone of the public health care system for young children is the baby and toddler health centres for 0–4-year-olds (also referred to as well-baby clinics). These form a nationwide system of public youth health care but are operated by municipal health authorities (in most cities and regions) or by the regional home care organization Thuiszorg [Homecare] in some regions. Thuiszorg came into being through a series of mergers involving several formerly independent municipal welfare services and charities and provides a broad range of services.

### **Baby and toddler health centres**

These have three major tasks: vaccination, screening of health and physical development problems, and educating young parents on nutrition, hygiene and family health care. They are located in neighbourhoods, are easily reached and visits are free of charge. The centres are notified of newborn children directly from the municipal population register. Parents are contacted by mail or telephone to organize each visit. Although attendance is voluntary and vaccination can be refused (on, for example, religious grounds), most parents respond to the call and over 96% attend most scheduled visits in the first year, with attendance between 90% and 95% in following years.

The present scheme consists of 8 visits to the centre in the first year (5 in the first 6 months and 3 in the next), visits at 14 and 18 months and then each year until the final visit shortly before the fourth birthday (at the time of introduction to primary school). Visits last around 20 minutes, during which the child’s height, weight and head circumference are measured and reflexes are tested. Gross and fine motor movement is evaluated as the child grows older. Results are noted in the growth booklet that all parents receive at the first visit and also in a digital child record. A brief interview with the parent is also standard.

The medical examination at ages 3 and 4 includes hearing and sight tests. The child may be inoculated in the first and second year and again at age four (presently, there is vaccination against almost all childhood diseases). Finally, parents receive advice about nutrition, hygiene, stimulating play activities and safety measures at home (this is also written down in the child’s growth booklet). Most examinations are carried out by (medical) nurses, but there is also a brief consultation with a paediatrician on every second visit. Parents are advised to contact the general practitioner (GP) if serious deviations from age-norms are detected, or are referred directly to a hospital or institute for mental health care.

Baby and toddler centres in most municipalities also have a home-visit programme consisting of two home visits. The first takes place within a few days of the child’s birth (for screening for phenylketonuria and hearing and sight problems) and the second within two weeks (to educate parents about health care, hygiene and nurturing and to speak to them about the first

examination at the centre). The visiting nurses also check childrearing conditions within families.

Educating parents about childrearing and screening for problematic cognitive, language and socioemotional development are now part of the centres' work, as is screening families for possible child abuse and maltreatment (similar to developments in the United Kingdom such as the "every child matters" policy). Screening instruments have been introduced to estimate such risks. A paediatrician or psychologist carries out the psychological screening using norm-referenced screening instruments. In case of serious deviations, parents are referred to a specialist service, such as the regional mental health centre, for further assessment.

The high attendance rate means centres are increasingly functioning as a place for first contact with, and an introductory channel to, youth care and family support services. Preschool compensatory programmes, for instance, often recruit participants via the local baby and toddler health centre. The centres almost always participate in local intersectoral family support systems, which are currently being integrated within local neighbourhood centres for youth and families (see below).

Maternity care (known as "Kraamzorg") consists of about 40–50 hours of care provided for mothers and babies by licensed maternity nurses in the first 8 days following birth. The service includes supporting and educating the mother (about breastfeeding, for example), caring for the newborn, modelling care behaviour, performing light household chores (cooking and cleaning), caring for other children in the family and monitoring the baby's and mother's health. The service is organized and financed by health insurance companies and is provided by maternity care organizations. Some insurance companies require users to pay an additional small fee.

Maternity care is part of the standard insurance policy that is obligatory for all citizens in the Netherlands and is provided by private for-profit and by semiprivate not-for-profit organizations. A national protocol in 2006 defined maternity nurses' tasks, set out health and well-being indicators for mother and baby and put in place care quality regulation. Maternity nurses have close contact with families, midwives and GPs.

### **Mental health care**

Regional institutes for ambulatory mental health care provide for young children. These multidisciplinary institutes were founded in 1982, integrating several previously independent institutes and services including medical pedagogical offices and child social–psychiatric services. Parents can contact the regional institutes directly or can be referred by baby and toddler health centres or GPs. The institutes provide assessment and psychodiagnostic services, education and counselling, therapeutic playgroups, psychotherapy and family therapy. Many have separate departments and staff dedicated to preventive activities such as organizing parenting courses and information meetings. These are usually taken forward in cooperation with other services and institutes in the youth care and family support sector.

Medical day-care centres and medical children's homes (see below) provide semi-residential and residential care for children with serious medical and physical problems and developmental, behavioural and emotional difficulties. They employ a highly qualified multidisciplinary workforce of psychologists, special educationists, play therapists, psychotherapists, doctors and psychiatrists.



## *Youth care and family support*

### **Youth care**

The youth care sector (for children aged 0–18 years) deals with “special needs” such as special education (psychosocial and behavioural problems and combined developmental disorders and disabilities for which remedial and therapeutic services are offered). It also has a strong preventive orientation that focuses on the contexts through which children may develop serious problems as they grow up, particularly the family context.

Youth care service provision is diverse and is layered according to the seriousness of problems presented. Highly accessible low-threshold services have a demand orientation to which parents can apply voluntarily for advice or help, but there is also non-voluntary residential care in children’s homes for very serious cases of child abuse and neglect. A juvenile court order is needed for this service, based on advice from the child protection board.

Regional front-desk offices for coordinating youth care (Bureaus Jeugdzorg) represent a significant development. Initially, an information desk, consultation hours and a public phone line for advice were provided to offer an accessible, low-threshold service to parents (and professionals such as nurses and teachers working with parents or children) for information, advice and psychological assessment. Referral to more specialist intensive care for parents worried about childrearing issues or about their child’s behaviour and development, or who were unable to care for their children because of psychiatric problems or drug abuse, was also available. Gradually, however, their main task has become coordinating services and providing case management, raising criticism about the bureaucratic way they work.

Youth care is also provided in medical day-care, day-treatment and semi-residential care centres. Medical day-care centres (for children aged 0–5 with serious developmental delay, psychiatric disorders and behavioural problems) and so-called “Boddaert centres” (providing afterschool care for children aged 4–12 attending a regular or special primary school) are present in every region. Residential care institutions increasingly provide ambulatory and semi-residential care services according to specialty. Children with serious developmental delay, mostly a combination of delays in several domains, and severe emotional and behavioural problems stay during the day for 1–5 days weekly.

The third type of youth care provision consists of institutions for residential treatment and care. Generally, problems treated in residential care are more serious than those found in other types of youth care. Most occur in combination with difficult home circumstances and require longer and more intensive treatment. Residential provision includes safe homes for abused women and children and special homes allowing temporary accommodation for divorced women and their children. There are also foster homes for children who have been removed from their homes and for whom no foster family is available (usually because treatment is needed). Children with multiple disabilities can stay permanently in specialist homes.

The fourth type is foster care. A national network of foster home agencies recruits, screens, trains and supports families willing to care for children who can no longer live with their parents, mostly because of child abuse, sexual abuse, neglect, parental delinquency or drugs addiction. The child protection board is involved in appointing a family guardian who is responsible for carefully evaluating the situation before recommending the child’s removal.

The juvenile court has to issue a court order to place the child in a foster family or residential home. The child protection board, family guardian and juvenile court fall under the authority of the Justice Department, with foster care being under national, provincial and (partly) local social welfare departments' authority.

### **Family support and preventive youth care (0–6 years)**

Preventive approaches to youth care, youth health care and preschool educational support have culminated in the concept of family support, which integrates views on how to deal (in a primary or secondary preventive way) with diverse problems and social contexts related to child development and childrearing. The concept has been introduced as an alternative to the traditional prevention and curative interventions that are so predominant in youth care, health care and compensatory education. These traditional approaches, it has been argued, are in some way built upon, and influenced by, the medical–therapeutic model (that is, identifying and isolating specific causes, presuming mono-causal linear relationships between an early therapeutic intervention and later outcome, taking a professional diagnosis as the only basis for an intervention, and prescribing top–down service delivery). As an alternative, a social-contextual, multiple-cause, multiple-systems method is advocated. This is essentially bottom–up, guided by demand and presumes complex nonlinear relationships between an early fact, state or event and later outcomes, mediated by chains of transactions between the individual and the social environment.

Two kinds of development in preventive youth care and family support have emerged with these ideas as their starting point. The first concerns the design and implementation of micro-level specific projects and programmes, working directly with parents. The second requires organizational and managerial changes at meso level, involving a system of activities, programmes and services for a community, city or region.

Some specific parenting support programmes were adopted from abroad, such as Home Start (from United Kingdom (England)), the Mothers Informing Mothers programme (Ireland), Triple P and Incredible Years (1–4). The Home Start programme is directed at socially isolated (particularly single-parent) families. It organizes community volunteers who visit the target families regularly to provide practical, advisory, emotional and social support. Several other specific programmes and approaches, such as Triple P and Incredible Years, educate parents on how to deal effectively with “difficult” children. Video home training and demonstrations by home visitors of how to play and interact with young children are also quite common. Some target socioeconomically disadvantaged groups and focus on improving early education in the family (see below).

Numerous small- and larger-scale activities and services recognized as “family support” augment these specific parenting and family support programmes. They operate from a broad definition which states that family support comprises all activities and services that “attempt to improve specifically the conditions of childrearing and child development” (5).

Adopting this broad definition, several studies found great diversity in activities offered. For instance, up to 40 organizationally different (though sometimes overlapping) family support services were counted in some municipalities (6). These included: front-desk offices offering information, advice, low-intensity guidance and home training; pedagogical advisory services connected to baby and toddler health centres; informal parent groups connected to playgroups or preschools; play-advisory centres and low-cost toy rental shops; parental education courses on specific subjects (such as for families with adopted children or with children suffering

from asthma) or general childrearing issues; assessment and psychodiagnostic services; intensive home training for children with behavioural problems; information desks to support parents' decisions about primary school choice; and educational home programmes (see below).

Many municipalities have reorganized and restructured the diverse intersectoral provision of parent and family support services in recent years as part of local preventive youth care policies. Initiatives to set up a system of family support, including a front-desk post for youth health care, youth care and family support, were launched. These attempts recently culminated in the establishment of “centra voor jeugd en gezin” [centres for youth and family], which include baby and toddler health care centres. They are similar to the Sure Start centres in the United Kingdom and sit next to regional Bureaus Jeugdzorg, which now focus more on coordination activities and long-term case management instead of providing easily accessible services. Bigger municipalities have one or more of these centres and the smaller are expected to follow soon. Although the aim is to provide low-threshold, easily accessible services to all families and children that need advice, support or professional treatment, critics fear that by concentrating services in a professional centre at the expense of grassroots outreach programmes, many parents will not be able to access the services.

### ***Universal early childhood care and education***

Regular early childhood education currently reflects two distinct traditions:

- a care tradition to support working parents in caring for their children; and
- an education tradition aiming to stimulate children's social and cognitive development and prepare them for formal education in primary school.

Both areas have seen significant developments in recent decades, surrounded by debates about quality, developmental appropriateness and effectiveness. The Wet Ontwikkelingskansen door Kwaliteit en Educatie (OKE) Act 2010 [Law and Development Opportunities through Quality Education Act 2010] became operative recently. This attempts to bring more uniformity to the field by demanding that services in the care tradition become more educational in focus and by requiring early childhood programmes in the education tradition to meet (structural and process) quality requirements set for care services. It is not clear yet how the sector will respond to the new requirements.

### **Day-care centres (0–4 years)**

The primary goal of the care tradition is to provide day care for 0–4-year-old children and out-of-school care for children aged 4 upwards whose parents are working or in full-time education or training. Several officially licensed, professional or professionally supervised forms of day care are available currently in:

- community day-care centres operated by not-for-profit organizations;
- private day-care centres that work for profit; and
- host families recruited, supported and supervised by an officially recognized not-for-profit organization.

The Child Day Care Act 2005 marked a turning point by privatizing the sector and introducing a subsidy system that has turned parents into customers via tax reductions (demand subsidy). The already growing sector has subsequently expanded significantly. Private companies became active in the child care market and saw their share in services increase. Welfare organizations and not-for-profit foundations that formerly provided

community day care were turned into private companies, although most of them still do not work for profit.

The income-dependent tax reduction was quite substantial in past years, allowing many parents from lower-income groups to use child day care, but major cuts have been announced for 2012 and thereafter. About 47% of 0–4-year-olds attended a day-care centre in 2010 for, typically, 2–3 days per week (7). The Child Day Care Act 2005 specified some structural quality requirements that all centres have to meet regarding staff education level, maximum group size and children–staff ratios. Detailed health and safety guidelines and general outlines or principles of process quality were formulated, describing, for instance, how care in a day-care centre (and also in a host family) should support the child’s autonomy and provide an emotionally safe and stimulating environment.

At first glance, practice and quality of care does not differ systematically between the different forms of day care. Most centres are open from 07:00 or 08:30 until 18:30 or 19:00 five days per week. Children spend between 16 and 24 hours per week in the centre, or about 2–3 full days. Full-time care is very rare.

Group sizes and staff–child ratios are similar and follow statutory quality regulations for day-care centres in the Child Day Care Act 2005. The maximum group size for 0–1-year-olds is 12 with a teacher–child ratio of 1:4 (meaning there should be 3 teachers for a group of 12). For a combined, age-heterogeneous group of 0–4, the maximum size is 16 provided there are no more than 8 0–1-year-olds and that the teacher–child ratio for 0–1-year-olds is 1:4, 1:5 for 1–2-year-olds, 1:6 for 2–3-year-olds and 1:8 for 3–4-year-olds. These ratios do not include management and administration staff. The act also specifies that each group should have its own room of up to 3 m<sup>2</sup> per child. There should be an outside playground as large as 4 m<sup>2</sup> per child. A separate sleeping room should be available for children up to 18 months. Further regulations concern safety and hygiene.

Day care is based on universal provision, but most centres and municipalities are forced to adopt admittance criteria as demand still far exceeds supply. Priority is generally given to children whose parents are working or in education or training; an identified social risk may occasionally result in placement and centres can reserve a few places for referral cases. Many nevertheless have long waiting lists. Tax reduction, the main way of subsidizing the sector, is not only income-dependent, but is also related to work or study.

The relative lack of attention to developmental, pedagogical and educational aspects of day care reflects the view that its function is primarily caring for children during parents’ working time. This view used to be widely held among day-care centre workers. Day-care centres hold autonomy on schedules, activities and pedagogical climate. Issues around emotional security and attachment and the importance of play for social and cognitive development have been raised through handbooks, brochures and professional journals. This literature seems to suggest that the (recommended) approach is to be strongly child-centred, with Montessori method and attachment theory influences. Day-care centres that serve low-income and ethnic minority groups are now introducing education curricula (often derived from targeted education programmes described below) as a consequence of the OKE Act 2010.

With the exception of babies, most children attending day-care centres follow a fixed schedule of eating, drinking, cleaning, tooth brushing and afternoon naps with the whole group. In between, there is time for free (unguided) play in centres with construction,

drawing and painting materials, dolls and toys (miniature cars, trains and railroads), miniature kitchens and shops and dolls' houses, and for gross-motor and whole-group activities (singing, dancing, storybook reading). There may also be sand and water tables. The outside playground is used whenever weather conditions allow. The role of more explicit educational teacher-guided or teacher-directed activities in the schedule is not clear and varies between centres.

### **Host families (0–4 and 4–12 years)**

Officially licensed host families (also referred to officially as “childminding services”) serve the same population of 0–4-year-olds. These families are usually members of large, regionally or even nationally operating not-for-profit organizations that are responsible for selecting host families, training host parents, providing continuing support and supervision, establishing complaints procedures and placing children in families. One or more of these are children of the host parents in over 90% of cases. About 9% of the 0–4-year-old children and 3% of those aged 4–12 were cared for by officially licensed host families in 2010 (7). Host families care for up to 4 children per day, occasionally more.

### **Afterschool care (4–6 years)**

Primary school becomes the most important care institution for ages 4–6, as over 95% of 4-year-olds (probably 100% in families with both parents working) and 100% of 5–6-year-olds go to primary school (it is compulsory from age 5). Children's going to school does not necessarily make things easier for working parents, however. School opening hours (from 08:30 or 8:45 to 15:00 or 15:15) are not adapted to parents' working hours. Lunch breaks are 1–1½ hours long and children are free on Wednesday afternoons and, in most schools, every second Friday afternoon. School holidays total 10 weeks per year.

Out-of-school care consists of two main subsystems: before- and afterschool care. The latter is quantitatively the more important. Out-of-school care is provided by part of the subsidized municipality and private day-care centres that extend their services to older ages. They provide before- and afterschool care on free Wednesday and Friday afternoons and during school holidays. Occasionally, afterschool care is organized by schools in cooperation with local welfare organizations.

It was estimated that about 19% of 4–12-year-olds were in out-of-school, centre-based care in 2010 (about 3% were in host family care). Although exact figures are lacking, it is assumed that the actual need is bigger, perhaps as high as the need for preschool care. Faced with waiting lists, out-of-school care centres adopt the same admittance criteria as day-care centres, giving priority to children of working parents or those who are in full-time education or training.

### **Playgroups/preschools (2–4 years)**

The pre-primary school component in the educational tradition consists of playgroups and preschools for children between 2 or 2½ and 4 years. The Dutch word is “peuterspeelzaal”, meaning “playgroup for toddlers”. However, as many playgroups that serve disadvantaged children who have Dutch as a second language have explicitly adopted educational goals and methods (as in Head Start preschools), and since at least part of the playgroups are organized by, or work in close collaboration with, primary schools to prepare children cognitively, socially and emotionally for kindergarten grades of primary school, a double translation seems most appropriate.

The first playgroups were founded by parents in the second half of the 1960s, with very general education objectives such as providing children living in cities with more play opportunities and promoting social development through interactive play. National welfare authorities have subsidized playgroups since 1975. Since 1981, they have been regarded as a general sociocultural service directly under the responsibility of municipal welfare organizations, who act as the executive branch of the municipality's social welfare policy. They are usually organized in a small-scale and semi-professional way, with groups consisting of about 12–16 children of mixed age and one professional teacher per group. Centres often have only one group and a part-time professional responsible for management but also working with the children.

The number of playgroups and preschools, usually located in local community centres or occasionally primary schools, has steadily risen since the 1960s. According to recent statistics, about 63% of 2–4-year-olds attend a playgroup or preschool for, typically, two mornings of 2½ hours per week, 42 weeks a year, often in combination with part-time day care (7,8). They are not part of the child care system because of their opening hours (09:00–11:30 or 13:30–15:00) and the typical attendance of two mornings (or two afternoons), which is seldom exceeded. Under the Child Day Care Act 2005 and due to change in the subsidy system, many parents switched from playgroup or preschool to day care (which could actually be cheaper for low-income families), leading to a decrease in playgroups; budget cuts in child day care may mean a return to playgroups, however.

Playgroups and preschools are in principle accessible to everyone. They have no constraints or requirements, although waiting lists sometimes develop. In practice, however, use is socially selective in two ways. Parents who work for a substantial part of the week have to use a child day-care centre. In modern society in the Netherlands, this tends to affect higher-educated parents, who are underrepresented among playgroup and preschool users. On the other hand, very low socioeconomic status (SES) families and, particularly, immigrant families are also underrepresented in playgroups and preschools because:

- they charge a fee (which in most cases is income-dependent);
- the free, non-authoritarian pedagogical climate does not match the parents' childrearing beliefs and values;
- out-of-home care provided by strangers is a cultural taboo; and
- educational potential (valued as such) is not recognized in the play-dominated curriculum.

Despite this, playgroups and preschools are increasingly identified as local education policy priorities because of their low threshold, relatively low costs and strong connections with local neighbourhoods. Extra efforts have been made to attract minority and low-SES children, with apparent success, particularly in inner city areas. A recent trend has seen the transformation of playgroups to preschools, starting between ages two and three and forming a continuous education trajectory through to kindergarten. Special education programmes are now being piloted in cooperating preschools and kindergartens (see below): attendance at these settings has typically been raised to four mornings (or afternoons) per week, with extra staff supplied to ensure a teacher–child ratio of 1:8.

Almost all playgroups and preschools promote informal communication with parents, not only through daily contacts, but also within “coffee-break meetings” for parents which serve as informal self-help groups on childrearing-related issues. These meetings are recognized as important settings for reaching out to parents to secure wider family support where necessary.

The OKE Act 2010 is designed to bring playgroups and preschools under the same quality regulations as day care, balancing pedagogical and educational process quality in both systems and harmonizing structural quality.

### **Kindergarten departments in primary school (4–6 years)**

Primary school (encompassing formerly independent kindergartens) is quantitatively the most important component in the educational tradition. Primary schools cater for children of 4–12 years. Teaching in reading, writing and mathematics usually does not start before third grade. Primary school is compulsory from age 5, but the Primary Education Act 1985 allows parents to send their child to primary school directly after their fourth birthday without costs: over 95% opt to do so.

Kindergartens, which were not recognized as part of the education system until 1956, were formerly independent schools subsidized by community councils, churches or charities (9). The first kindergarten was established in 1860, partly as a reaction to the asylum-type early childhood care system of that time. The curriculum was strongly influenced by Fröbel (the 19<sup>th</sup> century German founder of the kindergarten concept) but was adapted to a more school-style approach by the Netherlands educationist Haanstra. Reform movements such as Montessori, Jenaplan, Steiner, Dalton and Freinet gained influence in the 1930s and particularly after the Second World War, leading to the founding of Montessori, Jenaplan, Dalton and Waldorf kindergartens and primary schools. Kindergarten education in general was marked by the use of specially designed play–work materials, lots of time for free activity and a general child-centred approach. More programme-centred approaches were introduced in kindergartens in the late 1970s, particularly in those working with disadvantaged children.

Kindergartens were integrated with primary schools under the Primary Education Act 1985, and teacher training colleges also merged. The officially stated aim was to bridge the traditional gap between early childhood education and primary education, and it was hoped that strong elements of child- and development-centred kindergarten education would mix well with programme-centred, teacher-directed formal education in third grade.

Present-day kindergarten education within the primary school system has maintained many of its original characteristics (10). Among these are the use of age-heterogeneous combination classes with first and second graders (4–5- and 5–6-year-olds) in 80% of primary schools and equipping classrooms with several “activity centres” or “corners” (such as construction, play–work, creativity and dolls and/or kitchen centres for pretend play). The average curriculum reflects a certain eclecticism and consists of the following elements:

- circle time, intended to enhance language development and communication skill (usually at least once to a few times a week);
- book-reading time in a circle (a few times a week); and
- play–work lessons in which children work with special materials (paper, glue and scissors, folding paper, textiles, string beads, clay, paint or coloured pencils, sorting games) in small groups under teacher guidance (almost every day).

There are also work lessons involving special developmental materials (such as puzzles, sorting games and memory games) and worksheets for older children to prepare them for formal instruction. Singing and/or listening to music in the whole group (once or a few times a week), free play or free play–work activities individually or in small groups (every day),

and free gross-motor activity in the playground (every day) or under guidance in the gymnasium (once a week) also feature.

### ***Special education and care***

The system of education and care for children with special needs is even more complex than the diverse array of mainstream education and care services for young children. “Special” needs refers to sight, speech and hearing disabilities, developmental disorders, behavioural problems, learning problems, physical, mental and multiple disabilities, and chronic illness. It does not refer to the problems of children from sociologically designated groups such as those from lower social classes or ethnic and language minorities, for whom the educational priority policy and nonindigenous languages policy are operative (see below). The boundaries are fuzzy in practice, however, reflected in the overrepresentation of children from these groups in special education and youth care institutions.

### **Special preschool care (0–4 years)**

The special education system parallels the primary school system, but several special education and care services in the preschool phase, which are part of the youth care sector (see above), form trajectories with special primary education. This relates to all kinds of ambulatory services, day (or semi-residential) care and residential care (care provided in a children’s home). Central to the preschool special education system is early screening for developmental delays and conduct disorders, which takes place at local baby and toddler health centres (see above) or at parents’ request in assessment centres connected to treatment services, such as regional institutes for ambulatory mental health care.

Screening for motor, language, cognitive and social and emotional development may result in referral to specialist ambulatory services such as physiotherapy for disordered motor development, speech therapy for delayed speech development, play therapy for delayed cognitive development, and behaviour therapy for all kinds of behavioural problems. This may also include low-intensity home-based treatment (stimulation through play, improvement of parenting skills and communicative interactions in the family) and parenting education. Parents may be advised to apply for a place in a regular day-care centre, playgroup or compensatory preschool education programme. A further step involves referral to more intensive day treatment in medical day-care centres for conditions such as hyperactivity syndrome or admission to a psychiatric hospital (especially when the disorder is not easily diagnosed, as is the case with serious communication disorders). Special semi-residential and residential institutions and boarding schools are in place in the preschool phase for children with speech, hearing and visual impairments but who are otherwise developing normally.

While there is no formal cooperation between preschool special education services and the special education system from age four onward, there are several systematic connections. Special groups, such as speech–hearing and visually impaired children, usually enter special schools directly at age four or five (the age at which compulsory education starts). Similar continuous trajectories are provided for those with multiple and mental disabilities (intelligence quotient below 70), for whom there are highly specialist schools and institutions. Most children who receive some form of support or treatment in the 0–4 phase enter regular primary school.

It is no coincidence that the outflow from regular to special education in the primary school period is proportionally largest in first, second and third grade, with retention rates highest between grades two and three. Many children previously identified as having delays or



disorders are among those referred and retained. If it is decided that a child's introduction to primary school be postponed until he or she reaches the compulsory school age, preschool services will continue to age five or even six. Medical day-care centres admit children up to age six.

### **Special primary education (4–6 to 12 years)**

Special primary education for 4–6-year-olds was formerly provided in separate schools or kindergarten departments and there were three types of special primary schools for 6–12-year-olds reflecting varying degrees of seriousness of problems (learning and behaviour problems, intellectual disabilities and severe intellectual disabilities). These school systems were integrated into a single special primary school in 1998, following the earlier merger of kindergartens and primary schools. A further significant policy issue concerns the prevention of referrals to special education and the reintegration of children who have been in special education.

In addition to special primary schools, special schools provide therapeutic day- and around-the-clock (residential) treatment for children with severe psychiatric problems (such as autism), behavioural problems (such as attention-deficit hyperactivity disorder (ADHD)) and emotional disturbances (insecure attachment, anxiety), in combination with school behaviour and learning problems. Some special schools (often boarding schools) for hearing- and sight-disabled children exist at national level and there are regional schools for children with multiple and mental disabilities with, of course, a quite different education programme. The array of schools and care services for disabled children is diverse, with a high degree of specialization.

The proportion of primary-school children referred to special education has risen steadily over a number of decades, but a decline has been seen in recent years due to policies designed to reduce outflow to the special system and increase reintegration in the mainstream. Primary schools and special primary schools were obliged to set up regional networks under a national policy that became operative in 1992, and these networks were made responsible for decisions about the best treatment for individual children with behavioural and learning problems. Emphasis was placed on ambulatory treatment within mainstream settings. The main objective of this policy was to stabilize the outflow from primary education (or at least stabilize the balance between outflow and backflow). New rules for decisions about placement, models for adaptive instruction and strategies to keep children in mainstream education as long as possible by utilizing expertise and staff from special schools emerged, with budgetary instruments installed to reduce unnecessary outflow to special education.

There were mutual benefits for mainstream and special schools under the old system in referring children with even mild behavioural and learning difficulties: the mainstream school was relieved of the extra efforts these children require and teachers could concentrate on better-functioning pupils; and special schools saw their budgets rise. However, the overrepresentation in special education of lower-SES children and, particularly, those with an ethnic minority family background indicated a system that was malfunctioning, at least from a policy perspective.

Other policy measures to reduce outflow from mainstream to special education included the introduction of a personal budget to finance particular adaptations in regular primary schools (such as installing wheelchair ramps) and hiring extra staff to support the inclusion of disabled children. These measures led to a decrease of placements in special (primary)

education, yet around 2.7% of 4–12-year-olds remained in special primary education in 2010, with an additional 2.1% in other special institutions. The percentages were about 1% and 0.7% respectively for 4–6-year-olds.

Major cuts in special education and personal budgets are now planned, with even more emphasis being placed on inclusion, although not necessarily for social and educational reasons (11). The concept of adaptive education is being promoted and schools are being strongly encouraged (through incentives and penalties) to keep children with special needs in mainstream classrooms.

***Targeted compensatory education programmes for disadvantaged 3–6-year-olds***  
Targeted compensatory education programmes for socioeconomically, culturally and linguistically disadvantaged children have a long tradition in the Netherlands. The term “disadvantaged” refers here to inequalities in school careers and social opportunities based on children’s socioeconomic, cultural, ethnic and sociolinguistic background. The idea of a “compensatory” programme has been discredited in the past because of underlying assumptions about disadvantaged families and cultural communities and their indigenous childrearing practices. Terms such as “empowerment” may now be preferred, but the older terms seem more appropriate when describing and analysing current practices in this area in the Netherlands.

Education programmes currently being implemented widely can be divided into home-based and centre-based programmes. The first of a series of home-based programmes, a Netherlands adaptation of a well-known Israeli home instruction programme for preschool youngsters (12), became available in 1987. This two-year programme for 4–6-year-olds and their mothers is highly structured and requires mothers to work with their child for about half an hour each day on perceptual discrimination tasks, language exercises, picture books, logical-mathematical concepts and cognitive problem-solving tasks. The mothers are supported and motivated by other mothers who act as paraprofessional aides, explaining the week’s tasks and modelling appropriate interactive behaviour, and are expected to attend group meetings. Revision of this home-based programme led to the development of “New Step Up”, which has essentially the same format but with the contents updated to reflect research literature on emergent literacy and numeracy. Quasi-experimental evaluation research indicated partial (long-term) effectiveness, especially on grade retention (13).

Despite apparent success, home-based programmes have never been employed with more than 10 000 families, a small percentage of those eligible. Recent policy emphasis has shifted towards centre-based models: these are occasionally combined with home-based programmes, but tend to lead to reduction in their use.

The ministries of welfare and education jointly initiated the development, testing and evaluation of two centre-based curricula for 3–6-year-old disadvantaged children in 1995 to complement the home-based approach. One was a Netherlands adaptation of the High/Scope curriculum (called Kaleidoscoop [Kaleidoscope]) and the other, called Piramide [Pyramid], was an adaptation of the Success for All approach developed by Slavin et al. (14,15). Both were implemented in closely collaborating preschools (welfare sector) and kindergarten departments of primary schools (education sector), constituting a single continuous educational trajectory from age 3–6, before transition to third grade.

Kaleidoscoop is an example of a child-centred approach, valuing and stimulating children’s initiative and self-regulated experiential and self-discovery learning, and promoting the

development of autonomy. Piramide is more programme-centred and teacher-guided, but focuses on social and emotional development and security of attachment. It involves frequent norm-referenced testing and assignment of children scoring below a certain criterion to individual in-class tutoring.

Several other curricula have been developed and introduced over the years. A national agency, Erkenningscommissie Effectieve Jeugdinterventies [Accreditation Committee for Effective Youth Interventions], selected five such curricula (including Kaleidoscoop and Piramide) based on theoretical foundations, implementation strategy and available evidence, and found them to be “in theory effective”. Yet the quality and effectiveness of local versions of preschool education programmes in many municipalities remain undetermined. The number of targeted centre-based compensation programmes has steadily increased nationwide since 2000.

Teacher–child ratios in all these programmes are statutorily about 1:8 for 3–4-year-olds, 1:16 for those aged 4–5 and 1:20 for those aged 5–6. Children in the preschool phase normally attend for 4 half-days of about 3 hours for 40 weeks per year and about 23 hours each week 42 weeks a year in the kindergarten phase, as in regular primary schools. All programmes cover about 3 years if the child starts at age 2½ or 3 (which is not always the case).

In general, recent reports reveal many implementation problems regarding structural quality characteristics (staff–child ratios, teachers’ education levels, attendance hours) and process quality (insufficient compliance in carrying out teacher-guided activities) (16,17). Doubts about their effectiveness persist.

The centre-based approach has received much government support. Ambitious targets have been set: by the end of 2010, for instance, nearly 100% of eligible children should have been enrolled in an officially recognized preschool education programme. This target has not yet been fully reached. While current attendance is reported as about 13% of all 3–6-year-olds, which matches quite closely the 15% of eligible children defined as disadvantaged by official national policy, early attendance before age 4 is well below target (7).

The difficulty is that the subsidy system (which is based on the number of eligible children in a preschool or school) does not allow local organizations and schools to run a full-blown compensatory education programme, apart from in inner-city districts with a high concentration of socioeconomically and culturally disadvantaged children and families. In practice, eligible children are either not served or participate in a programme that only partially meets the requirements of the officially recognized education curriculum. In addition, the full three-year education curriculum is implemented in two separate systems: the playgroup/preschool system (2½–4) and the primary school system (4–6). Strong cooperation between preschool and primary school, which has been evident for some time, is required to implement a curriculum, but policy changes have reinforced the split in the system. Local welfare organizations are responsible for the preschool phase, school boards for the kindergarten phase, and the subsidy is divided accordingly.

## **Implementation and efficacy issues**

The Netherlands used to have the lowest infant and childhood mortality and morbidity rates in the world. Experts have little doubt that the well-organized countrywide public youth health care system was responsible, but the picture has changed in the past two decades.

A 2008 report by Mohangoo et al. (18) showed an increase in perinatal deaths over recent decades. Causes are not fully understood, but one factor is increased cultural diversity. Nonindigenous communities are reported to adhere less well to the recommendations from infant and toddler health centres and to have less access to information about pre- and postnatal health care. Parents in these communities are more likely to miss periodic health examinations for their children and never to contact the baby and infant health centre. The fact that public youth health care system services have been steadily reduced because of budget cuts and that the frequency of child examinations has decreased over the years, which may have led to more undetected health, developmental and family problems, may also be significant.

The shift of focus in youth health care and preventive youth care to screening for potential child abuse with “objective” risk calculation instruments has been criticized. Besides the low predictive value of such instruments and the potential for false alarms and false negatives, it is feared that this new focus will change trusting relationships between centres and families, resulting in some families seeking to avoid the centres.

The youth care sector is constantly under criticism. It remains rather fragmented, with many different organizations and disciplines engaging in suboptimal collaboration. The founding of central front-desk offices, the so-called Bureaus Jeugdzorg, has not brought the expected efficiency gains. Thresholds for finding help for families in need have not been lowered. The accounting system creates a great deal of bureaucracy and the balance of office hours and fieldwork is considered unfavourable to effective youth care. Instances of severely neglected and abused children, ending in child deaths, have emerged in families that were under supervision by the youth care system. Case management by the Bureaus Jeugdzorg frequently fails. The new centres for youth and family, however, are felt to be improving the fragmented system of youth (health) care and family support. They are located in neighbourhoods and integrate highly accessible public youth health care with youth care and family support. A recent report by the Algemene Rekenkamer [National Accountancy Office] is critical, however, pointing to lack of clear tasks, problems with financing and low internal cooperation within the centres (19).

The family support system has mainly been studied from an organizational perspective, focusing on internal collaboration, efficiency of supply and referrals, and coverage of needs. Specific family support programmes such as Home Start, Mothers Informing Mothers and Triple P have been more rigorously evaluated and have been found to be only partially effective (and often not in terms of child outcomes) (1–3).

Little research on the quality of day care in the Netherlands is available. Follow-up studies by the Netherlands Consortium for Research in Day Care, starting in 1996, used internationally standardized quality rating scales such as the Early Childhood Environment Rating Scale–Revised (developed by Clifford & Harms in the United States), the Infant/Toddler Environment Rating Scale and the Observational Ratings of the Caregiving Environment tool (adapted from the National Institute for Child Health and Development’s Early Child Care Research Network study in the United States) (20) to compare a representative sample of Netherlands day-care centres internationally (21). The findings show suboptimal overall quality compared to international norms, and that quality has steadily decreased since 1996. No developmental outcome measures were included in these studies.

The playgroup system has not been evaluated except for centres participating in a compensatory education programme. A national cohort study starting with two-year-old children and their families was initiated in 2010 to address the developmental effects of day care, playgroups and targeted educational preschools. Results are not yet available.

The effectiveness of primary education, including kindergarten, is persistently monitored by national cohort studies that determine educational progress every three years and relate outcomes to school policy factors. There is special interest within these cohorts in disadvantaged students' progress. Recent results suggest that the education gap is closing gradually, especially for ethnic minority children, but not for low-SES native Netherlands children, and inequalities in school careers remain a major concern.

The first generation of compensatory education programmes introduced during the 1990s have been subjected to evaluation research. Two independent evaluation studies using quasi-experimental designs indicated partial effectiveness in the short term, with medium-sized effects in language and numeracy (22,23). Follow-up research on the long-term effects has not yet been initiated. Several studies using weaker designs have been conducted since then, reporting no clear positive effects. The aforementioned national preschool cohort study should bring more clarity to implementation and efficacy issues.

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## 1.3. Early childhood services and family support in Portugal

Maria Emília Nabuco,<sup>1</sup> Cláudia Costa<sup>2</sup>

<sup>1</sup>School of Education, Lisbon, and Association Aprender em Parceria (A PAR)

<sup>2</sup>School of Education, Lisbon

### Context

“Early childhood” in Portugal covers children aged 0–6 years. The two main categories of early childhood services are care services for children aged 0–3 and nurseries/preschools for 3–6-year-olds. Teachers who work in nurseries/preschools are referred to as early childhood or nursery teachers.

Preschool education in Portugal started in 1882, but the Ministry of Education did not decree a law related to this level of education and the few nursery classes disappeared during the first years of the Republic (1910–1926). Public preschools were set up in 1978 under Law 5/77 of 1 February in response to the increasing number of women entering the workforce. The same law also provided for public sector early childhood teacher training schools (private institutions for teacher training had been introduced during the 1940s) (1). This long history has led to huge demand for equitable access to early childhood programme services (2) and quality provision within centres (3).

Law 5/97 of 10 February 1997 set up a judicial system for developing and expanding early childhood education. The fifth article called for cooperation between the ministries of education and social solidarity in promoting quality, helping families in need and providing financial support to institutions, the sixth demanded family involvement in each centre’s curriculum and the seventh imposed equity in the preschool system. The state was charged with providing free access for low-income families.

### Types of care

Children aged 0–3 years have access to three types of care provision, including informal and family crèches. Families, friends, neighbours, domestic staff, licensed and non-licensed nannies and babysitters provide informal care. Crèches offer daily care in an educational environment during parents’ working hours. They normally open 4–11 hours daily 5 days a week, providing a family-like environment and covering nearly 25% of population needs. Groups of nannies who live in the same geographic area and who are technically and financially supported by regional centres or social institutions run family crèches.

Nursery/preschool is the most common type of service for children aged 3–6. Law 5/97 of 10 February 1997 increased the coverage of preschool education: 73.4% of children attended preschool in 2000 (4), but this had risen to 82.3% in 2008/2009 (5), representing a significant step towards achieving the goal of universal access for all preschool children.

### *Characteristics of early childhood teacher training*

Law 115/97 of 19 September 1997 made it compulsory for early childhood teachers to have completed a bachelor’s degree with honours (BA Hons). Prior to this, early childhood teachers undertook four years of post-secondary school study at polytechnics or universities.

In 1999/2000, 19.8% had a BA Hons degree, 79.9% a BA and 0.3% a Master's or doctoral degree. These percentages in 2008/2009 were 82.9%, 15.5% and 1.6% respectively (5). The new training emphasizes the importance of relating theory to practice and enables individual supervision (6).

### ***Health care***

The Ministry of Health describes the evolution of health care in early childhood over the last 30 years as “a success story” (7). Infant mortality decreased rapidly from 77.5% in 1960 to 3.4% in 2007 due to the country's improved socioeconomic conditions, global health service reforms commencing in 1979 and increased political will to improve maternal and child care facilities. Improved service delivery and physician education have also been significant. The maternal and infant health programme has been evaluated every two years.

Study cycles in neonatology for paediatricians commenced in 1982 and the neonatology section of the Portuguese Society of Paediatricians was created in 1984. A registration procedure for low-birth-weight babies (less than or equal to 1500 gm) was introduced in 1994, allowing comparison of maternity units.

The pre-birth mortality rate in 2007 was 2.1% and infant mortality was 3.4%. Universal vaccination further improved infant and juvenile health, with 93% of infants between 12 and 23 months being vaccinated in this year (8).

### ***Social benefits***

Some families in Portugal, such as single-parent and larger families or low-income families with disabled children, receive family allowances linked to tax liabilities. Social protection during pregnancy takes several forms, including allowances exclusively for the mother or father or which are shared, and allowances are offered for those adopting a child and for supporting children with disabilities or chronic disease.

### ***Children and young people at risk***

Multidisciplinary teams within centres for family support and parenting advice work to prevent social risk and to help children and youth in dangerous situations in their own communities. “Street teams” and host families, who receive children or young people and make them comfortable in the family environment, also provide support. Centres can offer temporary accommodation and protection for up to six months, after which children and young people can move to residences if risks persist. As they grow older, they are offered special accommodation in small community-based apartments as they transition to adult life. Holiday and leisure centres also exist to help establish physical and psychological stability in children's and young people's lives.

### ***Disabled children and young people***

Disabled children and young people receive a small monthly allowance for special education under Law 133B/97 of 30 May 1997, but special centres to help these young people as they grow up to seek employment and become independent are lacking. Allowances are too small to meet the needs of families that assist these children or young people.

### ***Suburbs of larger cities***

Lisbon and other Portuguese cities have severe problems in providing effective support for families with young children (aged 0–3 years). Severe lack of effective bonding between



parents and children in city suburbs may lead to literacy and numeracy problems and low self-esteem in children and adults. This particularly affects the families of single parents, adolescent parents and those living in situations of social exclusion, with its attendant disruption. Many are unemployed and left school early.

### **The Association Aprender em Parceria programme**

The need to prevent and fight social, educational and health problems from birth led to the creation of the Association Aprender em Parceria (A PAR) [Learning in Partnership Association] programme. Like the Parents Early Education Partnership (PEEP) programme in the United Kingdom, this is an early childhood primary intervention that aims to support and help parents of young children living in disadvantaged communities.

Research has found that development takes place at an incredible rate during the first few years of life, with the brain tripling in size by age three years (9,10). A child's first experiences have an effect on learning capacity, and programmes are more successful when parents are truly involved (11). Early interventions against disadvantage and exclusion are more successful than late interventions (12).

A PAR adopted an ecological model of development called transactional regulation (13). The authors of the model proposed that no single factor demands or facilitates children's development. Developmental outcomes are not a function of the individual alone, or of just his or her experiences. What is important in this approach to intervention is to consider with equal emphasis the effects on the child of all aspects of the environment, such as economy (with a focus on poverty), family structure and processes within the family, educators and the school system.

#### ***A PAR groups***

A PAR particularly focuses on children who do not have places in crèches or nurseries and most of its work since April 2007 has been in small groups with families and children arranged according to age. The A PAR groups take place in community centres, crèches, nurseries and schools and each follows an age-related curriculum. Materials such as songbooks with CDs for children and parents have been produced and are given to families.

Each group is managed by a leader and an assistant trained by A PAR. Following initial preparation, group leaders receive ongoing monthly training and assistants have a two-hourly session each term. Leaders tend to be experienced licensed nursery teachers who have undertaken four-year university degree programmes. Assistants have four years of study and experience of working with children and their families.

A PAR groups have the same fundamental elements as PEEP groups:

- circle time: parents, carers and children are led in a variety of carefully chosen songs and rhymes, with all being offered a songbook containing those used in the programme;
- story time: as daily storytelling is a fundamental aspect of the curriculum, this is a very important part of every session;
- book sharing: books for parents to share with their children during group time;
- talking time: an opportunity for adults to discuss information and ideas, share experiences and offer support;
- borrowing time: a library of playpacks, which contain a book and play materials related to the stories, is made available weekly; and

- home activities: practical suggestions for games and activities that are closely related to and support the curriculum.

The A PAR programme aims to promote:

- positive bonding between parents and children
- self-esteem
- positive attitudes towards learning, curiosity and confidence
- children's education achievements, especially in literacy and numeracy
- reductions in school dropout levels
- social support between families and within communities.

Its mission is to create “confident communities, learning together with their children” (A PAR will be implemented in healthy communities in future) and it has seven objectives (Box 1.3.1).

#### **Box 1.3.1. A PAR objectives**

1. *Promoting the idea that parents and families are central to children's health and well-being.* Caring adults are more important than resources and equipment, but children grow in environments with complex interactions of relationships involving education, community, family, cultural and socioeconomic factors.
2. *Promoting the idea that relationships with other people (both adults and children) are of crucial importance in a child's life.* Children learn by doing rather than by being told. Learning is a shared process; children learn most effectively when helped by trusted and knowledgeable adults and when they are actively involved and interested.
3. *Promoting the idea that babies and children are social beings.* They are competent learners from birth. Parents and carers need to be aware of this process of learning.
4. *Supporting parents and carers to help their children develop positive attitudes to learning.* A PAR promotes play and creativity (music, movement, dance, poetry and literature and drama expression) as essential elements for learning at an early age.
5. *Ensuring parents know that reading books to their child from an early age helps to develop their literacy skills.* A PAR also teaches parents that daily family life situations make an important contribution to acquisition of basic knowledge of mathematics and numeracy.
6. *Involving parents' and carers' social networks in children's education.* A PAR's wider aspirations are to contribute to the health, proactivity, well-being, creativity, and development of the community as a whole.
7. *Encouraging parents and carers to recognize the need for lifelong learners.* A PAR sees parents as a starting point in developing and recognizing their own skills and potentials, thereby contributing to the process of adult empowerment.

#### ***A PAR research***

A PAR's effectiveness was evaluated using a cross-sectional quasi-experimental design to compare a sample of families with children from the A PAR catchment area in Lisbon and suburbs with a comparison group from a matched community who accessed crèche and nursery education but not the A PAR intervention programme.

Cognitive and socioemotional measures were explored over three years (2008–2010) with children in two groups (intervention and comparison). Parents were interviewed on their capacity for interacting with their children and their ability to observe daily progress, identify key interaction moments and recognize that they are the most important role models for their

children. The study also explored interactions between parents and children, pleasure derived from parenting activities and parents' ability to identify and seek social support.

The intervention sample consisted of 220 children (recruited after their parents volunteered to participate in the study and had granted consent) who attended A PAR groups between January 2008 and December 2010. The comparison group (212 matched for age, gender and social characteristics with the families of A PAR groups) was not selected from the same area as the intervention to reduce any effects of programme leakage. Other areas in Greater Lisbon that shared similar social characteristics were selected, with a few crèches and nurseries chosen to form a demographically matched comparison group. Letters of consent were sent to crèches and nurseries asking for permission to include them in the study and to parents to include their children.

Results from the three cross-sectional studies A PAR conducted between 2008 and 2010 are presented in more detail below, but they showed that when parents take part in an A PAR group, their children develop significant advantages in:

- self-esteem, with higher cognitive competence than those with no A PAR experience;
- verbal comprehension, vocabulary, phonological awareness (rhyme) and writing their names; and
- visual–perceptual matching, spatial orientation, early number concepts and nonverbal reasoning.

Parents who registered for A PAR groups benefitted from the intervention by improving their capacity for interacting with their children, being able to observe daily progress, identifying the key moments of interaction and believing that they are the most important role models for their child. They also took part in joint activities with their children, took pleasure in parenting activities and were able to seek social support, feeling that the A PAR programme was in itself a source of social support. Comments from parents included: “Participating in the A PAR programme has changed my way of interacting with my son. I pay more attention to him and create more routine and activities”; and: “For me, it was very good to share concerns with other A PAR parents. I am enjoying meeting new people, having more ideas on how to play with my kids and identifying good-quality books and songs”.

### **Self-esteem (cognitive competence)**

Children in the A PAR groups gained confidence through stories, “learning by doing” and by receiving praise from group leaders and parents for their efforts as well as their successes. Katz (*14*) suggested that high and low feelings of competence or incompetence are learned in the course of children's early experiences: they are constantly being learnt or shaped, intentionally or otherwise.

### **Literacy development**

The A PAR theoretical framework is based on ORIM (opportunities, recognition, interaction and model), which Hannon (*15*) claimed is related to different aspects of literacy development in early years and primary school. Children in the A PAR groups were encouraged to hear different sounds, music and rhymes, to tell stories and share books from an early age, building understanding that books are fun, exciting and informative. This enabled them to progress greatly in ORIM.

### **Cognitive development**

A PAR-group children were given opportunities to make “collections” of people and objects and to match and sort them into groups. They were also assisted in comparing one object or person to another and to order, sort and describe their relative positions. They spoke about sizes and amounts during play to further their understanding of these processes. The A PAR curriculum aims to help children to grow and develop their minds through procedures such as these.

Nunes & Bryant (16) argued that doing mathematics is a socially defined activity. Children’s approaches to mathematical problems depend crucially on how they define and respond to the social situation in which they are presented. If children learn mathematics through everyday life experiences, such as going shopping or counting beans in the kitchen, they will be well prepared to make future progress in this area.

### **Parent–child interaction and role modelling**

Parents who registered for A PAR groups differed in their capacity to interact with their children. The A PAR groups worked with parents and children simultaneously, facilitating interaction and inviting them to work or play together during the group sessions. Activities included singing songs and rhymes, dancing, listening to stories, sharing books and art working, all overseen by well-trained leaders.

Gardner (17) suggested that it is not just the amount of time spent in joint activities that may protect against the development of behaviour problems, but also the quality of the joint activities. This is important in promoting social behaviour and reducing problems in children.

According to Moran et al. (12), “the quality of the parent–child relationship is fundamental to effective parenting support of all kinds: without good communication and warm relations between parent and child, even the most promising programmes may fail to deliver good outcomes”. They also pointed out that those working with parents and children at the same time can encourage more interaction and be role models.

### **Pleasure in parenting activities**

A PAR leaders adopted a non-judgemental attitude towards parents, maintaining confidentiality about what they shared in the group and respecting their opinions. This created an environment of reciprocal confidence among adults, fostering a positive perception of their parenting skills. There are indications in the literature that parents who derive pleasure from parenting can provide greater emotional support to their children (18).

### **Parents’ social support**

Cooperation between leaders and parents was a key element of the A PAR groups. “Talking time” provided adults with an opportunity to discuss information and ideas, share experiences and establish support networks among parents in the same community.

Social support plays a significant role in parenting and is linked to social relationships, with individuals and institutions having the potential to provide emotional and practical support (12). The absence of social support can lead to emotional, mental and physical ill health, creating difficulties in coping with the parenting role (19).

These results provide robust support for the A PAR approach, but difficulties in implementing the programmes persist, including:

- parents believing that their babies are too young to be educated
- heads of schools thinking that parents will not wish to be involved in the groups
- lack of state and private financial support.

The general perception (including that of government) is that early intervention and prevention is not a priority.

## Implications for policy

The three cross-sectional studies have important implications for policy development. Positive outcomes for children in socioemotional, literacy and cognitive development are very important. These children received the A PAR intervention in groups with their parents at a very young age, before entering primary school: the opportunities they have had should make them more resilient than those who did not receive the programme and may enable them to reach a level similar to children from communities not at risk.

Policy-makers who support early intervention could advise public and private agencies to provide money to support such programmes now to save money for the future. As demonstrated by the High Scope evaluation (20–22), future savings relate to school failure, school dropout, adolescent pregnancy, mental health and children at risk.

## Financial constraints

Funding to support a follow-up research study to chart progress over time in the children and families who participated in the A PAR programme is providing difficult to obtain. There is a great need for such studies in Portugal to enable understanding of how to break the poverty cycle and support health, emotional and cognitive development.

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## 1.4. Well-being of preschool children in Sweden – the role of early childhood education and free health care

Ingrid Pramling Samuelsson,<sup>1</sup> Sonja Sheridan,<sup>1</sup> Margareta Blennow<sup>2</sup>

<sup>1</sup>Gothenburg University

<sup>2</sup>Karolinska Institute, Stockholm

### Context

Democracy has been the dominant discourse over many decades in Sweden, uniting many different forces in efforts to create good living conditions for all citizens independent of age, economic status and health. Successive social democratic governments have successfully striven to achieve equality and equity in society through shared and common work with unions and social and health care systems. Government goals have recognized and focused on every citizen's right to good health, well-being and education and the state has introduced numerous reforms to ensure that it shares, in partnership with parents, responsibility for children.

Wilkinson & Pickett (1) examined the gap between the richest and poorest 20% in fairly well-off countries. The smallest gap is found in Japan and the Scandinavian countries, while the largest is in Singapore, United States, Portugal and the United Kingdom. Inequality is reflected in people's level of trust, rates of mental illness (including drug and alcohol addiction), life expectancy and infant mortality, obesity rates, children's educational performance, teenage births, homicides, imprisonment rates and social mobility.

Corporal punishment has been prohibited in Sweden since 1979. Sweden was the first country in the world to pass a law forbidding parents to hit their children and the first to establish a Children's Ombudsman. The Ombudsman's duty is to protect children's rights and interests and allow them to voice their opinions on societal issues. Child-centredness and family-support approaches have been developed in health, education and care systems across Scandinavian countries (2), bolstered by a vision of democracy.

### *Policy and the development of early childhood education and care*

Early childhood education and care (ECEC) existed on a rather limited basis in Sweden until the 1960s. That decade marked the start of an explosive expansion, mainly in day care, which developed when the call for an enlarged workforce was directed towards women, who consequently required a safe place for their children while they were working. Even if kindergartens were initially developed to provide benefits for children, their expansion in Sweden and other westernized countries can be related more to the need for an available, flexible and mainly female workforce.

Preschool became an important part of Swedish society due to this enormous expansion, especially in the civil sector. The government took responsibility for the life and development of young children in general by introducing key economic and structural reforms. These include child allowance (introduced in 1946) and maternity leave in 1974; the Parental Leave Act of 1995 set leave at 480 days shared by both parents. The right to access to preschool for all children whose parents asked for it was granted in 1994 and a 2003 act gave each child the right to participate in preschool activities from the age of three, even if his or her parents

were out of work or mother or father was on parental leave. The National Agency for Health and Social Welfare worked on developing and distributing guidelines for preschool and afterschool centres during the late 1970s and 1980s. The work of these institutions has therefore been debated for quite some time (3).

Decentralization of the public sector, allowing it to goal- rather than regulation-oriented, is one of the main reforms influencing work and quality in preschool and school. The philosophy underpinning this reform is to empower people directly involved with, and affected by, relevant issues by devolving decision-making to local authority level.

Flexibility in school starting age was introduced in 1991, giving parents the right to decide if their child should start at age 6 instead of 7 (the compulsory school age in Sweden). Very few parents took advantage of this reform, mainly because most of the children (96%) already attended a preschool class (for children at six years of age), which became a recognized school form within the school system in 1998. The perspective on transfer has also changed: the question now is not whether a child is mature enough to start school, but if school is ready to meet the child's needs (4).

Preschool was described in official texts in 1994 as “the foundation for lifelong learning”, something preschool teachers and researchers had always believed. The Ministry of Education assumed responsibility for preschool in 1996 and it received its first national curriculum in 1998 (5), reinforcing the view that lifelong learning starts at birth.

The government gave the National Agency for Education a mandate to revise the preschool curriculum in 2008, and this was transferred to a small group working at the Ministry of Education and Science in 2010. The overall intention was to raise preschool's aspirations towards a more pedagogical orientation. Content and goals relating to literacy, mathematics, science and technology were developed and strengthened and a new area of evaluation and development of the quality of preschool was introduced, while continuing to focus on values, play and traditional ways of working (6). Preschool for children of 1–5 years became a school form on its own within the Swedish school system with the new Education Act (2010).

The reforms of main interest in this case study are the Maximum Fee Reform and the 2003 Public Preschool Reform. These give all children from age one year the right to a full day in preschool for a low fee and without charge from age three. The Maximum Fee Reform grants parents the right to have their children in preschool for a maximum fee of 3% of the family's total income for the first child, 2% for the second and 1% for the third. A ceiling is set for monthly costs. The aim is to create equality between children and between local authorities, but it has also meant that the number of children in each group has risen.

Hopefully, preschool, like school, will soon be offered free of charge and will be considered a right for children. This is especially important as 87% of children aged 1–5 now attend preschools in Sweden (7).

## **Health promotion for children**

### ***The health care system***

Sweden has a decentralized health care system run by 20 county councils and regions, each governed by a political assembly responsible for ensuring access to good and equal health care. Preschool children are offered free health check-ups in child health care centres, and approximately 2000 district or paediatric nurses are available to give advice and support (GPs



and paediatricians examine the children only occasionally at these centres during the preschool years).

The aim of Swedish child health care services is to promote children's health, development and well-being by supporting parents, preventing and identifying physical and mental ill health and observing risks in the environment (8). They have been developing since the foundation was laid by Parliament in 1938. From the outset, services have been provided free of charge and have focused on the nurse building a trusting relationship with the family.

After years of concentrating on hygiene and feeding problems, services started general vaccination and child accident-prevention programmes in the 1950s. Attention in the 1960s focused on physical abuse and breastfeeding. Growth charts, surveillance of developmental disorders and a national structured record that follows the child were introduced during the next decade. Language screening and a national registry of children exposed to tobacco smoke in the family have developed over the last two decades alongside programmes to prevent obesity in children and alcohol and mental health problems among caretakers.

### ***Organization***

A full-time district or paediatric nurse offers health care to 60–70 neonates per year and is responsible for providing a basic programme to 450–500 children aged 0–5 years. Child health care centres, which are part of primary health care services, are financed by local taxes. A growing number are nurse-run, with attendance being voluntary and free of charge (8). GPs or paediatricians work 3–4 hours per week at the centres as part of consulting services, which also include psychologists, orthoptists, audiology assistants and dentists.

The Swedish child health care programme has a range of delivery methods. Nurses make home visits, examine babies, talk about breastfeeding, ask about any problems and stimulate parents to find their own solutions. They provide information about the child health care programme, such as how to prevent sudden-infant-death and shaken-baby syndromes. Children and parents attend child health centres for regular and structured visits 14–20 times during the first year and then once a year until the child starts school. A GP (or, more rarely, a paediatrician) examines the child and observes developmental milestones at different ages, according to a national protocol.

Most children are screened for language problems at 2½ or 3 years and are assessed for mild intellectual disabilities or other cognitive problems at age 4. The purpose of the examination of 5-year-olds is to prepare them for starting school.

Mothers of newborn babies are screened for postnatal depression. Research shows that on average, 13% develop postpartum depression, which can disturb the interplay between parent and child and have long-term negative effects on the child's development. Using the simple Edinburgh Postnatal Depression Scale, nurses can identify mothers requiring help and support. Supportive counselling by nurses has proven effective, with 80% of mothers who received 6 counselling visits recovering compared with only 25% of those having routine visits (9). Parents are offered a chance to participate in nurse-led parent groups during their child's first year. Common topics include children's need for time, love, contact and bonding, normal development, safety and delicate subjects as parenthood and relationships, smoking and alcohol.

***Checklists for safety prevention***

Checklists to support parents in adjusting their homes, cars and surroundings to be as safe as possible are distributed and discussed at certain ages.

**Passive smoking**

Nurses ask parents about their smoking habits and those of others in the household when the child is four-weeks-old and again at eight months using an evidence-based programme called Smoke-free Children. Results are compiled by the National Board of Health and Welfare.

**Child abuse**

Child health clinic nurses and doctors have an important task in recognizing and reporting to social services when a child is at risk of being abused mentally or physically and needs support. Child health care services in two regions have been compiling numbers of children reported to social services since 2009.

**Lifestyle habits**

Structured programmes to promote good eating habits and physical activity have been introduced in the last decade. Parents prepare themselves by answering questions sent in advance of the nurse visit. Nurses are trained to use a motivational interviewing technique when discussing lifestyle habits.

***Health promotion activities – results so far***

Practically all 0–5-year-old children (99%) and their parents are enrolled at child health care centres. The incidence of sudden-infant-death syndrome in 1992 was just above 1 per 1000 live births: by 2008, this had decreased dramatically to 0.13 (10). Parents were instructed to put their babies on their backs to sleep, breastfeeding was promoted and the Smoke-free Children programme was introduced. Ninety-seven per cent of children born in 2010 were breastfed in the first week, 87% at 2 months and 63% at 6 months; 5% of neonates were exposed to tobacco smoke by their mothers (11).

Almost all (98%) are vaccinated according to the national vaccination programme, but the figure for measles–mumps–rubella (MMR) is 96.5% (12). The percentage of overweight/obesity among 23 000 4-year-olds born in 2002 and 2006 in Stockholm County is similar (9.3% overweight and 2.1% obese among those born in 2002 and 9.4% and 1.9% in the group from 2006). Seven per cent were referred to a specialist due to deviation in development in 2009. An average 0.2% of children born between 2006 and 2011 were reported to social services in Stockholm County in 2011 as being at risk of abuse, but there was great variation by municipality (13).

**The preschool context**

UNICEF published a report on the standard of ECEC in 25 Organisation for Economic Co-operation and Development (OECD) countries in 2008 (14). The benchmarking system for each country was:

- parental leave in place;
- a national plan for disadvantaged children;
- subsidized and regulated ECEC for 25% of children under 3 years and 80% of 4-year-olds;
- 80% of staff trained (50% with tertiary education with relevant qualification);
- minimum staff–children ratio of 1:15;

- 1% of GDP spent on ECEC;
- child poverty rate less than 10%; and
- near-universal outreach of essential child health services.

Sweden was the only country that reached the highest score of 10 benchmarks; United Kingdom (England) was ranked number 13 with 5, Switzerland had 3, while Ireland, with 1, occupied twenty-fifth place.

International comparisons, however, tend to focus on national and overall support for children and families. Such broad comparisons say nothing about the quality of children's everyday experiences in preschool. Even in top-ranking ECEC countries, evaluation of children's experiences reveal wide variation in preschool quality, highlighting inequalities in learning conditions (15).

The state determines overall goals and guidelines for the education system, while municipalities are responsible for implementation. Municipalities are obliged to follow the national curriculum, which also provides a foundation for determining whether a private preschool fulfils stipulated requirements. Private preschools have to follow the national curriculum and are not allowed to charge higher fees than those in municipality facilities. Both receive the same state subsidies and are responsible to the National Agency for Education.

### *The preschool curriculum*

Pedagogical intentions have always had a strong influence on preschool activities, and the national preschool curriculum for is linked to the curriculum for compulsory school. The preschool curriculum embraces the fundamental values, tasks, goals and guidelines for preschool activities but does not specify the means by which goals should be attained, which is an issue primarily for preschool teachers. Each teacher is expected to become involved as a "curriculum maker" by interpreting and adapting the goals for their group of children (16). They are also, like the children, participants in the democratic learning process (17).

Democracy forms the foundation of the preschool, and all activities should be carried out in accordance with fundamental democratic values to help children acquire the values on which Swedish society is based. The inviolability of human life, individual freedom and integrity, the equal value of all people, equality between the sexes and solidarity with vulnerable people are actively promoted through work with the children. These values express the ethical attitude that should characterize all preschool activity. Children's right to participate and influence ongoing activities in preschool and the overall learning environment have also been strengthened in the revised curriculum (5) and the Education Act 2010.

Preschool should also lay the foundations for lifelong learning by being enjoyable, secure and filled with opportunities for learning based not only on interaction between adults and children, but also on what children learn from each other. Care, nurturing and learning form a coherent whole.

Goals in the preschool curriculum are formulated as something to which teachers and children can aspire. They set out work directions and define targets for quality development. Goals and guidelines are presented for the following areas: norms and values; development and learning; children's influence; preschool and home; and cooperation among preschool classes, schools and the afterschool centres. They set out how preschools should support

children to develop a positive image of themselves as creative individuals, strengthen confidence in their own ability, increase their competence, help them acquire new knowledge and insights through activity and stimulate their language development.

Preschool children are able to create and communicate through different forms of expression such as pictures, song, music, drama, rhythm, dance and movement, and spoken and written language. This also involves designing, building and using various materials and technologies, among which multimedia and information technology can be appropriate in developing and applying creative processes. Other goals focus on children making sense of the world around them, culture, natural science, reading and writing, and mathematics (5).

Preschool is responsible for involving children and providing opportunities to develop as active and competent individuals, in compliance with the goals. Activities should stimulate play, creativity and joyful learning and should exploit children's interest in learning and mastering of new experiences, knowledge and skills. Flows of ideas and diversity should be explored. Preschool should strive to ensure that children feel secure in developing their own identity, free to develop their ability to listen, narrate, reflect and express their own views, strengthen their vocabulary and conceptual abilities and develop their communication skills. It should also ensure that each child develops his or her ability to discover, reflect on and work out positions on ethical dilemmas and fundamental questions of life and daily reality.

Interrelated with the learning and development goals in the curriculum are the so-called "everyday-life skills" (18). These correspond to qualities (properties and skills) such as cooperation, responsibility, initiative, flexibility, reflectivity, active attitudes, communication skills, problem-solving skills, critical stance, creativity and the ability to "learn to learn". These are seen as being integral to all preschool and school subjects and form a central dimension in preparing the children and students of today for the society of tomorrow (18).

### ***New preschool teacher education***

New holistic preschool teacher education is being planned, with new goals, courses and content. Teachers will have to develop knowledge in different subject areas and in how to work with specific content with young children. This will hopefully open new possibilities, highlighting the meaning of a learning-oriented preschool that requires education to be compliant with modern theories of children's learning and development and with changes in society. If teachers only develop knowledge of different subjects based on old theories of children's development, there is a risk that "preschool" will turn into "school".

The ambition is to educate preschool teachers in such a way that they can keep preschool as it is, with a broad perspective on children's learning. Traditional school subjects will be approached through preschool pedagogy and didactics with the goal of making preschool the start of lifelong learning. It is necessary to develop pedagogy and didactics specifically for young children, instead of trying to adapt school subjects for early years (19,20). This will be the challenge for preschool and for the new preschool teacher education.

The number of university tutors on preschool education programmes who have doctoral degrees has increased markedly during the last decade, which may indicate an important step forward.

## **Child perspectives and children's perspectives**

Swedish NGOs were heavily involved in developing the United Nation's *Convention on the Rights of the Child* (UNCRC) (21). The UNCRC refers to both child perspectives and children's perspectives, two notions that are central to early child education in Scandinavia. Child perspectives (what is best for a child) have to be taken into consideration when environments are planned in many institutions and parts of society, but it is now also normal to take children's perspectives (listening to their views and ideas) into consideration (22). Children's participation is an important ideal in society as a whole, as well as in early education.

Education starts at birth and lays a broad foundation for life in terms of health, values, attitudes and well-being. It is not only about academic learning, even if it is important for a child to learn reading, writing and mathematics early in life. It calls for a holistic approach and for wholeness in the social and education mission of all people involved at state level, in municipalities, in teacher education and in family support for health and education; and it requires high-quality ECEC. The quality of preschool makes a difference to children's learning (15). This means that the teacher's professional approach is decisive in determining what children learn.

Sweden is ranked as having a high-quality ECEC system, but preschool quality varies. A 2009 study evaluated the learning of 1–3-year-olds in language, communication and early mathematics (15). Thirty-eight preschools, 225 children and their teachers and parents participated. Preschool quality was evaluated through an adapted and updated version of the Early Childhood Education Rating Scale (ECERS) (23). The variation in quality was astonishing: around 10 preschools maintained "excellent" quality and 19 were "good", but 9 were externally evaluated as being of "low" quality. The results also revealed differences between teachers' self-evaluations and evaluations with ECERS: while teachers in preschools externally evaluated as being of "low" or "good" quality tended to evaluate their own quality as high, teachers in "excellent" preschools tended to underestimate.

The results highlight three qualitatively different learning environments: separating and limiting; child-centred negotiating; and challenging. The variety of learning environments of low, good and high quality indicates that children have unequal opportunities for learning in preschool.

Analyses through four intertwined dimensions of quality highlighted indications of a link between high quality in preschool and children's learning in mathematics and communication. Even children under 3 years who attended preschools of excellent quality were more successful in communication and language and early mathematics tasks. The knowledge generated by this study is important to ECEC research as it provides additional evidence that children's opportunities for learning depend on the quality of their preschool experience (24).

Research has shown that preschool quality can be enhanced through directed and long-term competence development (25). An intervention and control group took part in an evaluation of the effects of a specifically designed development programme whose content and form depended on, and continuously interacted with and influenced, each other. Lecture content could be changed according to teachers' interests, understanding, questions and difficulties. Their questions were scrutinized in light of different perspectives and theories and were tested in action in their own practice. The competence development programme embraced the

whole working team: they developed ideas together about how to improve quality in relation to curriculum goals.

Two years later, ECERS evaluations showed that the intervention group had enhanced the quality of their work while the control group was evaluated as being of lower quality. Enhancement of quality was evident in daily work activity, interaction and communication between teachers and children and in the learning environment. Teachers approached children as competent beings, communicated with them in different ways and were more sensitive to their intentions and wishes. Differences between the two groups can be explained by directed development input that changed and evolved continuously through the teachers' influence. The researcher and university co-worker supporting, guiding and closely following the teachers' development process was also important (25). This study highlights the importance of preschool teachers continuously taking part in competence development.

Sweden is now a multicultural society, with immigrant children (often segregated in certain metropolitan areas) representing 17% of the school population. This was recognized as early as 1998, when the Swedish Parliament adopted the Metropolitan Initiatives.<sup>3</sup> The Parliament agreed two overall objectives for the policy:

- to provide metropolitan regions with suitable conditions for long-term sustainable growth, enabling them to contribute to the creation of new employment opportunities in the metropolitan regions and in other parts of the country; and
- to break down social, ethnic and discriminatory segregation in metropolitan regions and to work to bring about equal conditions for people living in cities.

Twenty-four residential areas in municipalities have been affected, including Gothenburg, where a total of SKr 345 million (€37.1 million) was allocated for 2000–2005. Preschool and primary/middle school curricula state clearly that all children shall be given an equal opportunity to achieve academic success. Many children in the areas covered by the Metropolitan Initiative have a native language other than Swedish and there can be considerable variation in how much Swedish the children have managed to learn. Special approaches are therefore required to provide multilingual students with the same schooling.

Preschools calling themselves “language preschools” now exist all over the country, reflecting the strategy for supporting children's linguistic development and the Metropolitan Initiatives. Evaluations show that children's and young people's language skills, knowledge and reading ability have tangibly improved and cooperation with schools and other relevant associations has been reinforced.

The idea of democracy as solidarity, equity and equality, not least between genders, has long been established in Sweden. This is why preschool for all children from the early years is vital. Children's (and mothers') health and well-being are not negotiable and, from a child perspective, health care for young children cannot be separated from education. They need to be included together in the wholeness of children's well-being and education.

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<sup>3</sup> The basis for this was Government Bill 1997/98:165, Development and Equity – a Policy for Metropolitan Regions in the 21st Century.

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## 1.5. Developments in early years services in the United Kingdom (England)

Naomi Eisenstadt,<sup>1</sup> Edward Melhuish<sup>2</sup>

<sup>1</sup>Department of Education

<sup>2</sup>Birkbeck College, University of London

### Context

The overall structure and provision of early years services in the United Kingdom (England) has been transformed in the last 12 years. The previous government established universal free provision of 15 hours per week early education and care from age 3 to the start of school and the current administration is expanding provision for disadvantaged 2-year-olds. Availability of child care for working parents has been expanded and local authorities now have a duty to ensure adequate provision, either directly through local government or by private or third-sector agencies. Parents can use their free 15 hours per week in any registered setting. Hours above this limit are paid by parents with support through tax credits for low-income families.

The national network of over 3500 Sure Start children's centres provides family support, interventions to improve parenting and the home learning environment, advice on employment and benefits, health advice and social facilities to allow parents (mainly mothers) to meet in an informal child-friendly setting. They have become centres of community activity as well as sources of advice and support for young families and are generally seen as successful. Funding comes mainly from central government and is weighted according to poverty levels in local areas.

Opportunities for flexible working and maternity and parental leave arrangements have also improved significantly over the last decade. The United Kingdom was late to comply with an EU directive granting all parents with young children the right to ask for flexible and/or part-time hours. Over one million parents requested changes to working hours to fit in with family responsibilities in the first year of the policy, coming into effect in 2003. The vast majority of requests were granted and the fear that such arrangements would prove unpopular with employers was unfounded (1). Maternity leave is now one year, with nine months paid at national minimum wage rates. The current government is looking to extend the leave by a month and bring in arrangements to make the leave flexible between the mother and father. Families could then make their own decisions on who stays at home in the first months of a child's life.

Given that most of these developments were brought in by the previous government, there is now concern that some of the gains made will be reversed by the present coalition administration, particularly because of the need for budget cuts to manage the United Kingdom deficit. So far, early years services have been largely protected, but the government has removed the "ring-fencing" on early years spending, which ensured that funding allocated to local areas for a particular purpose could only be spent on that purpose. Allocations made to a local authority for children's centres will be calculated on local child data, but may be used by the local authority for any public purpose. Local authorities now have much more flexibility in their distribution of funding and may use early years money for other purposes. The amount of money parents receive through child care tax credits may also be reduced, which would mean a greater proportion of child care costs falling on families.

## Approach

Two approaches adopted in England on a system-wide basis that seem to have worked particularly well are:

- bringing all early education and child care provision under a common regulatory framework; and
- integrating services across agencies, particularly through the Sure Start programme.

The country has collected a range of policies designed to eliminate, as far as possible, the distinction between early education and care. Historically, early education was delivered through the school system, with a rigid schedule of half-day sessions five days a week during school terms only. Child care for working parents was delivered through social care or private and third-sector providers; it was flexible, full or part time and available during school terms and holidays. Research from the Effective Provision of Preschool and Primary Education (EPPE) project found that the quality of provision had long-term effects on children's cognitive and social development. EPPE also found that quality was more evident in education than care settings, mainly because of staff qualifications (2).

Several policy changes resulted from these findings, enshrined in legislation (the Child care Act 2006). They included a defined curriculum, the "early years foundation stage", which applied to children from birth to 5 years and was required in all registered settings. All settings were required to provide some degree of flexibility in hours to suit working parents to ensure that children who needed care because of parental employment were not disadvantaged by experiencing poorer quality than those in less flexible, but usually higher quality, early education settings. Considerable investment has also been made in developing a new qualification, the Early Years Professional: this tertiary-degree-level programme is especially designed for staff in early years settings. These changes reflected the fact that government was reflecting research evidence in early years policy development.

Several European countries were well ahead of the United Kingdom in provision of early education and care, but the emphasis in England on integrated working marks an innovative approach. This way of working was first tested in early years through Sure Start and was later developed to encompass all services for children. An historical problem of "silo working" existed at central and local government levels, with particular departments or agencies only being interested in the service for which they were responsible and not with the effects on families of a range of services. Access to health, education and social welfare services were important for families with young children, but the way in which the services operated often created fragmentation of experience for the family and wasted professionals' time. There was frequent duplication of assessments and requests for information, with some families receiving no service because they were not in touch with the right agency.

The first programme designed to address this issue was Sure Start. Aimed initially at areas of the country with high levels of child poverty, the programme was designed to bring together health, education and social welfare services at neighbourhood level for all families living in the area with children under 4 years. Strong emphasis was given to involving local parents in the design and delivery of the programme to ensure it was relevant to local needs and circumstances (the variety of different ways of delivering Sure Start at local level proved a significant challenge for the programme evaluation). There was also an emphasis on improving parenting skills and providing support for parents to reduce pressures on family life. The section below provides evidence of what worked and did not work in the Sure Start

approach. Government ministers were keenly interested in the evaluation results and changed the programme accordingly to improve the likelihood of success.

Sure Start proved to be enormously popular with parents. The government published a strategy in 2004, announcing the development of a national network of Sure Start children's centres. The emerging thinking was that by concentrating only on poor areas, many poor children living in small pockets of deprivation would miss out on the service. It was also recognized that most families with young children need support of some kind and that offering support more widely would be beneficial.

The third example of an approach that seemed to work is an adaptation of the nurse family partnership (NFP) programme from the United States (3). The government announced in late 2006 the evidence-based and licensed NFP intervention programme would be provided in 10 demonstration sites to test whether it could be implemented (4).

The NFP is an intensive nurse home-visiting programme designed to improve the health, well-being and self-sufficiency of first-time parents and their children. It has some of the best evidence of effects and cost-benefits of any early years programme (5). Visits start early in pregnancy and continue until the child reaches 24 months. The specially trained nurse home visitor's attention is focused on the social, emotional and economic context of the client's life, and activities are based on understanding human interactions.

The programme in England has been renamed the family-nurse partnership (FNP). It is now offered in 50 locations, providing support to more than 6000 families (the aim is to extend this to 13 000 by 2015) (6). While programme expansion is supported across the country, service commissioners have raised concerns about its cost and the proportion of vulnerable mothers who are eligible (7).

## Evidence

Two major studies provide the evidence for success and the significant influence of government-funded research in policy design and implementation: the EPPE project (8,9) and the National Evaluation of Sure Start (NESS) (10).

The EPPE study started in 1997 and has followed 3000 children since entering preschool at age 3 years. It has focused particularly on the effect of different kinds of preschool provision, differing ages of starting preschool and the effect of different hours of attendance over a week. It has also broken down the effects on children from a variety of backgrounds. Key findings from EPPE include the following.

- Two to three years of high-quality early years education can provide up to eight months of development advantage in literacy compared to children who enter school with no early years experience at age 5.
- While high-quality preschool experience provides a boost, the greatest predictor of success at primary school is the home learning environment. What parents do with their children before they are in formal education and, indeed, their engagement with education when children are in school has the largest effect on likely positive outcomes.
- The quality of preschool is correlated with staff qualifications; quality can be directly correlated to better outcomes for children.

- Effective preschools have a high level of adult–child verbal interaction and staff who understand and deliver the curriculum, understand how young children learn and are skilled at resolving conflicts among the children.
- Good preschools help parents to support their child’s learning at home.

EPPE is ongoing and the effect of early years provision on children at age 14 provides important evidence of ongoing positive effects of educational achievement and social adjustment of early years provision (11).

The NESS study looked at the first 250 Sure Start programmes. It was commissioned in 2001 and studied Sure Start through four major workstreams:

- local programme implementation: how local areas went about setting up a new programme with a wide range of local players, including parents;
- local context analysis: characteristics of the chosen areas, poverty levels, employment, quality of education and health services, and change in these areas;
- value for money: the relationship between investment and outcomes, focusing on whether some areas spent more per child than others (and why) and what particular features made programmes more efficient and better value for money; and
- effects on children and families: measurable improvements in child development and change in parenting practices.

This case study summarizes the results of the impact study; all the other studies are available on the NESS web site (12).

The first impact study was published in 2005, comparing children aged 9 months and 3 years in Sure Start areas with similar children in equally poor areas who did not yet have Sure Start. The 2007 and 2010 studies followed the 9-month-old children from the first study, comparing them at ages 3 and 5 with similar children from the British Millennium Cohort Study. The 2005 study found Sure Start was beginning to have positive effects on most of the children, particularly those whose mothers were beyond their teenage years. These children had greater social competence and fewer behaviour problems, with parents using negative parenting techniques less frequently. It was particularly disappointing, however, that children of teenage parents were not doing as well as their counterparts in non-Sure Start areas. They had lower social competence levels, more behaviour problems and poor verbal ability. Sure Start seemed to be working for poor children, but not the very poorest. Ministers agreed that a greater emphasis on reaching more children was required, improving the offer to children and families in line with the research findings.

The early NESS evidence and EPPE results showing that integrated children’s centres were a particularly effective form of early years provision supported the children’s minister’s decision that all Sure Start programmes should become children’s centres, with a more clearly specified set of services and stronger integration of health, child care, education and parent-support services. This change became operative in 2006 and was to influence profoundly the future of Sure Start.

The second impact study showed real improvements (13). There was no difference between children of teenage and other mothers and all sections of the population showed improvements, including: positive social behaviour; greater child independence and self

regulation; improvements in home learning environments and parent–child relationships; less harsh parenting; and increased service use.

The third impact study, conducted when children were 5 years old, continued to show improvements, but this time primarily for child health (lower rates of overweight among the Sure Start children and better general health) and parenting (less home chaos, better home learning environments, mothers reporting greater life satisfaction and a reduction in worklessness in the Sure Start families compared to similar families without Sure Start) (14).

Small ongoing improvements in assessments of all 5-year-olds in school and, most importantly, a small but significant narrowing of the gap in results between the poorest children and their better-off peers have been seen. Children in the most deprived areas moved from 39% working securely in the main areas of learning in 2008 to 47% by 2010, while children in other areas moved from 55% to 61% (15). While these changes were small, they indicated that a series of policies, including universal provision for 3- and 4-year-olds and Sure Start's multiagency approach, were beginning to show results at whole-population level and that the poorest children improved at a faster rate over the three measurement years.

Evidence of the FNP's success is found mainly within implementation, as it is too early to demonstrate clear child outcomes. Implementation evaluation of the first sites showed that nurses appreciate the new way of working, families offered the programme are enthusiastic and likely to accept the offer, and a substantial majority remain involved until their children are 24 months (16–18). Emerging evidence suggests it has the potential to improve parenting by reducing smoking in pregnancy (16), increasing the likelihood of breastfeeding (16) and increasing mothers' sense of self efficacy (18). Children of mothers continuing with the programme have good language development and few behaviour problems. An ongoing randomized controlled trial will examine outcomes in more detail.

FNP is only available to mothers under 20 who are expecting their first child, but a variation has been developed for a wider group including young mothers who already have a child. It provides the same programme content but in a group setting, and only until children are 12 months. Preliminary research indicates that group FNP is particularly well received and that the group context allows for social support to develop between mothers (Barnes & Henderson, unpublished data, 2011).

## **Facilitators of and barriers to success**

The most significant facilitator of these changes seems the hardest to replicate: political will. The previous government came to power in 1997 committed to expanding early education for all 3- and 4-year-olds and developing a national child care strategy to support welfare-to-work strategies. In 1999, the then Prime Minister pledged to end child poverty in a generation. A strong economy meant the government could disproportionately invest in early years programmes, compensating for a history of very little investment and no overall strategy. The government's willingness to invest in evaluation and develop policy based on evidence was also a key facilitator of success.

The second facilitator was the involvement of Her Majesty's Treasury in policy formulation. Once Treasury officials became convinced of the importance of early years to lifelong outcomes and potential savings to the public purse through better employment rates, lower crime and better health, their willingness to support early years programmes was secured. Their involvement also facilitated cross-government working. It became increasingly clear

that high-quality early years provision had to include policies from the departments of health, education and employment: the Treasury had always worked with spending departments and now was playing a major role in getting the departments to work together on social policy issues.

Negotiating between departments' differing interests was a barrier to success and continues to be challenging. The parts of government concerned with employment wanted to keep the costs of child care low to ensure more women could afford to work. Keeping costs low compromises quality, which is of concern to the departments of health and education, who were fundamentally more concerned with improving child outcomes than maximizing employment.

A further issue was the view that it was important to keep entry barriers to child care employment low to ensure single parents without qualifications could get jobs. Clarity of policy intent is therefore essential for success: examples include an antipoverty strategy that emphasizes employment, a child outcomes strategy that emphasizes quality of child experience, and a family support strategy that focuses on quality of parenting programmes. There was, and continues to be, confusion about precisely which of these is most important and, consequently, where resources, now much reduced, should be invested.

Staff issues proved to be major barriers in implementing Sure Start and the wider early education and care policies. There was a failure to anticipate the complexities of setting up a local Sure Start programme. Bringing services together at local level, encouraging information-sharing and ensuring health services, particularly midwifery and health visiting, actively contributed to the programmes proved very difficult. In addition, local programmes were given significant capital funding to commission new buildings. All this took much longer than anticipated: results were therefore slow to emerge as services took at least three years to develop.

The most important error was the failure to anticipate the skill levels needed to run such complex operations and the paucity of available staff, particularly in the early years field, who could successfully manage the programmes. Early years has traditionally been a low-pay and low-status occupational environment in the United Kingdom, so even programme managers with the requisite skills and understanding were unlikely to command the esteem at local level that would enable the kind of collaborative working across health and education to ensure real service integration.

Staffing was also a fundamental problem for the expansion of child care and its integration with early education. Wide salary and career structure differentials between teachers and the wider child care workforce persist. Teachers are paid significantly more and are usually less willing to work the extended hours and school holiday periods required of child care staff. Boosting the skill levels of managers of child care settings and of those working with young children in classrooms continues to be a critical part of creating a high-quality system. There has been significant investment on the curriculum side with the "early years foundation stage" and on the training side with the creation of the early years professional status, but pay and conditions have not substantially improved. Attracting skilled people into work with young children consequently continues to be an issue. It is unlikely, given the current economic climate, that this will be remedied in the next few years: indeed, there are signs that small areas of progress may be reversed, as requirements for qualifications are being relaxed.

## Lessons for other countries

There are some important lessons from the experience in England which suggest that the following are necessary for success:

- a connected approach from pregnancy to school age
- health, social care and education working together
- services for all children, appropriate to children's and families' particular needs
- system-wide regulation and accountability
- quality
- political will.

It is critically important to see services for young children as starting in pregnancy and connecting to primary school and beyond. Child development starts at conception and continues well into the teenage years. Any approach to ensuring good outcomes for children must include an understanding of different stages of development and how different needs emerge at various stages. The children's centre model works well in terms of better integration of services across time.

The biggest gap in services seems to exist in the first two years, after birth and before preschool. This is the key time for the development of secure attachment, which is critical for emotional, social and language development. More attention needs to be paid to family support and parenting advice at this crucial stage. Staff and parents do not always appreciate the consequences of children's daily experiences in these early years for long-term development.

The separation of services creates duplication of effort and a poor service for families, particularly in countries where resources are scarce. Health professionals can play a key role in early learning by encouraging reading and a good diet. Similarly, education staff should, and often do, encourage good diet and physical activity. All professionals should be thinking of the whole child, not just their agency's particular role.

Debate continues on the relative merits of targeted and universal provision. As all other studies in health inequalities show, the gradient in outcomes affects all but the wealthiest. Much of the need is missed by concentrating only on the poorest. The introduction of universal preschool provision has benefited all children in the country. Similar to investment in education, the ongoing boost in performance from early years provision will eventually feed through to better employment opportunities and improved health in the adult years. The challenge is to develop a system-wide universal approach that disproportionately invests where need is greatest (so-called "progressive universalism"). This principle has been widely accepted for health services but not for preventive services across social care and education agencies that reduce ill health throughout the lifespan. Inevitably, some families will have complex and deep-seated problems that require multiple services and come at a high cost. A system-wide preventive approach will reduce the numbers of such families.

It has been crucially important to develop a regulation and inspection system that applies to all settings with young children in early years services. Young children's needs do not differ whether they are in a setting provided by a state-based education agency or a private sector child care organization. The standards and requirements of settings should not differ either. Linked to inspection and regulation is the importance of data to ensure the quality of services and child outcomes improve. While debates about the nature of assessment persist, some

form of standard assessment around the age of 5 provides evidence that services are doing what is expected. Without national measures, it is difficult to identify if policies are effective and money is being well spent.

Quality of provision is important, but improving quality is expensive and is often not appreciated. Politicians win votes by expanding services: improving early years services is rarely noticed not only by the wider public whose taxes pay for the improvements, but even by the parents who use the services. A conscious decision was made in England to get a universal infrastructure in place and then focus on quality. The country has largely avoided the poorest quality of provision, which can actually damage children, through rigorous inspection, but still needs to improve overall quality. It will be important for countries with fewer resources to ensure at least a basic minimum quality.

Political will was critical to the developments. Along with political will goes clarity of content. Experience suggests that different parts of government want early years services for different reasons. Antipoverty strategies that only concentrate on employment can drive the expansion of poor quality and unregulated child care. Employment is critical for reducing child poverty but must be accompanied by quality, affordable child care. Getting general support from the population, engaging lobby groups and influential NGOs and working with the media will help to drive political support to improve services for young children. Without government support, programmes will be patchy and will fail to reach most children.

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# Improving the lives of children and young people: case studies from Europe

This is Volume 1 of a three-volume collection of case studies.  
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## **World Health Organization Regional Office for Europe**

UN City  
Marmorvej 51  
DK-2100 Copenhagen Ø  
Denmark

Tel.: +45 45 33 70 00  
Fax: +45 45 33 70 01  
E-mail: [contact@euro.who.int](mailto:contact@euro.who.int)  
Web site: [www.euro.who.int](http://www.euro.who.int)

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